



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

C.L. "BUTCH" OTTER -- Governor  
RICHARD M. ARMSTRONG -- Director

DEBRA RANSOM, R.N., R.H.I.T., Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0009  
PHONE 208-334-6626  
FAX 208-364-1888

**CERTIFIED MAIL: 7012 1010 0002 0836 4247**

December 16, 2013

Lori Bentzler, Administrator  
Twin Falls Center  
674 Eastland Drive  
Twin Falls, ID 83301-6846

Provider #: 135104

RE: **FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER  
LETTER**

Dear Ms. Bentzler:

On **December 11, 2013**, a Facility Fire Safety and Construction survey was conducted at **Twin Falls Center** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. Please provide **ONLY ONE** completion date for each federal and state tag in column (X5) Completion Date to signify when you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date

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Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign both Statement of Deficiencies and Plan of Correction, Form CMS-2567 and State Form, in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **December 30, 2013**. Failure to submit an acceptable PoC by **December 30, 2013**, may result in the imposition of civil monetary penalties by **January 18, 2014**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.
- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567 and the state licensure survey report, State Form.

All references to federal regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **January 15, 2014**, (Opportunity to Correct). Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **January 15, 2014**. A change in the seriousness of the deficiencies on **January 15, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **January 15, 2014**, includes the following:

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Denial of payment for new admissions effective **March 11, 2014**.  
42 CFR §488.417(a)

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **June 11, 2014**, if substantial compliance is not achieved by that time.

**Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.**

If you believe these deficiencies have been corrected, you may contact Mark P. Grimes, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **December 11, 2013**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

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Go to the middle of the page to Information Letters section and click on State and select the following:

BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process  
2001-10 IDR Request Form

This request must be received by **December 30, 2013**. If your request for informal dispute resolution is received after **December 30, 2013**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,



Mark P. Grimes, Supervisor  
Facility Fire Safety and Construction

MPG/lj  
Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 12/16/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135104</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/11/2013</b>
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NAME OF PROVIDER OR SUPPLIER <b>TWIN FALLS CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>674 EASTLAND DRIVE TWIN FALLS, ID 83301</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	<p><b>INITIAL COMMENTS</b></p> <p>The facility is a single story Type V(111) structure that was built in 1987. The building is protected throughout by an automatic fire extinguishing system and is covered by a fire alarm/smoke detection system. The facility is currently licensed for 116 SNF/NF beds.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on December 11, 2013. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.</p> <p>The Survey was conducted by:</p> <p>Tom Mroz, CFI-II Health Facility Surveyor Facility Fire Safety and Construction</p>	K 000	<p>“This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Twin Falls Center does not admit that the deficiency listed on this form exists, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.”</p>	
K 038 SS=F	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to maintain exits free of obstructions. In the event of an emergency requiring evacuation, obstructions or impediments in the means of egress can create a time delay, create an unsafe egress path or completely make the required exit unusable. The deficient practices affected all smoke compartments, staff and 67 residents. The facility has the capacity for 116 beds with a</p>	K 038	<p><b>K038</b></p> <p><b>Specific Residents Identified</b></p> <p>The walkways that the exits from the 100 hall, 200 hall, 300 hall, 400 hall and the main dining room corridor lead to were cleared of snow on 12/12/13.</p> <p style="text-align: right;"><b>RECEIVED</b> <b>DEC 27 2013</b> <b>FACILITY STANDARDS</b></p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Joni Benter</i>	TITLE <i>Administrator</i>	(X6) DATE <i>12/26/13</i>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER <b>TWIN FALLS CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>674 EASTLAND DRIVE TWIN FALLS, ID 83301</b>		
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K 038	<p>Continued From page 1 census of 67 the day of survey.</p> <p>Findings include</p> <p>Observation on 12/11/13 between 8:00 a.m. and 12:00 p.m., revealed that the exit off of the 100 hall, 200 hall, 300 hall, 400 hall and the main dining room corridors discharged onto walkways that were covered in approximately 1-3 inches of snow with no clear path leading to a public way. The exits were identified as a required emergency exits on the facility evacuation plan and were identified by emergency illuminated exit signs. Interview with the Maintenance Supervisor on 12/11/13 at 10:00 a.m., revealed that the facility was aware the pathways had not been cleared</p> <p>The findings were acknowledged by the Administrator at the exit interview on 12/11/13.</p> <p>Actual NFPA Standard:</p> <p>7.1.10 Means of Egress Reliability. 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.</p>	K 038	<p><b>Identification of Other Residents</b></p> <p>The walkways that exit from the facility that are emergency exits were cleared of snow on 12/12/13.</p> <p><b>Systemic Changes</b></p> <p>The Maintenance Director was educated by the administrator on or before 1/3/14 regarding the requirement that means of egress from the facility shall be free of all obstructions. Snow must be removed from all walkways that lead from emergency exits.</p> <p><b>Monitoring</b></p> <p>Starting the week of 1/6/13, the Maintenance Director will complete audits weekly for 8 weeks and then monthly for two months to ensure that walkways are free from obstruction. Audits will be reviewed at the monthly Performance Improvement Committee meeting for compliance.</p> <p>The Maintenance Director is responsible for monitoring and follow up.</p> <p style="text-align: center;"><b>Date of Compliance</b></p> <p style="text-align: center;">1/9/14</p>	

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C 000	<p><b>16.03.02 INITIAL COMMENTS</b></p> <p>The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2.</p> <p>The facility is a single story Type V(111) structure that was built in 1987. The building is protected throughout by an automatic fire extinguishing system and is covered by a fire alarm/smoke detection system. The facility is currently licensed for 116 SNF/NF beds.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on December 11, 2013. The facility was surveyed under IDAPA 16.03.02, Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities.</p> <p>The surveyor conducting the survey was:</p> <p>Tom Mroz, CFI-II Health Facility Surveyor Facility Fire Safety and Construction</p>	C 000		
C 226	<p><b>02.106 FIRE AND LIFE SAFETY</b></p> <p>106. FIRE AND LIFE SAFETY. Buildings on the premises used as facilities shall meet all the requirements of local, state and national codes concerning fire and life safety standards that are applicable to health care facilities. This RULE: is not met as evidenced by: Refer to the following Federal "K" tags on the CMS - 2567:</p> <p>K038 Exit access.</p>	C 226	<p><b>C226</b></p> <p>See POC for K038</p> <p><b>Date of Compliance</b></p> <p>1/9/14</p>	<p><b>RECEIVED</b></p> <p><b>DEC 27 2013</b></p> <p><b>FACILITY STANDARDS</b></p>

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Joni Bentefer*

TITLE

*Administrator*

(X6) DATE

*12/26/13*

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