



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSSELL S. BARRON – Director

TAMARA PRISOCK – ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
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

November 9, 2017

Landon Taylor, Administrator
Life Care Center of Idaho Falls
2725 East 17th Street
Idaho Falls, ID 83406-6601

Provider #: 135091

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Mr. Taylor:

On **October 31, 2017**, a Facility Fire Safety and Construction survey was conducted at **Life Care Center of Idaho Falls** 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.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided 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 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 the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office. If a State Form with deficiencies was issued, it should be signed, dated and returned along with the CMS-2567 Form.

Landon Taylor, Administrator
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Your Plan of Correction (PoC) for the deficiencies must be submitted by **November 22, 2017**. Failure to submit an acceptable PoC by **November 22, 2017**, may result in the imposition of civil monetary penalties by **December 12, 2017**.

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. If a State Form was issued as well, it should also be signed, dated and returned.

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

Remedies may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **December 5, 2017**, (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 **December 5, 2017**. A change in the seriousness of the deficiencies on **December 5, 2017**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **December 5, 2017**, includes the following:

Denial of payment for new admissions effective **January 31, 2018**.
42 CFR §488.417(a)

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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 **May 1, 2018**, 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 Nate Elkins, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, option 3; 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 **October 31, 2017**, 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>

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

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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 **November 22, 2017**. If your request for informal dispute resolution is received after **November 22, 2017**, 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, option 3.

Sincerely,



Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosures

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

Printed: 11/08/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135091	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/31/2017
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF IDAHO FALLS	STREET ADDRESS, CITY, STATE, ZIP CODE 2725 EAST 17TH STREET IDAHO FALLS, ID 83406	RECEIVED NOV 22 2017
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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
K 000	INITIAL COMMENTS The facility is a single story Type V (III) building with partial basement, which is used for records storage and houses the facility water heaters. The facility was built in 1978 with a major renovation completed in 1998. The facility is fully sprinklered with a new smoke detection system installed throughout in 2011. Currently the facility is licensed for 109 SNF/NF beds. The following deficiencies were cited during the annual Fire/Life Safety survey conducted on October 31, 2017. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy in accordance with 42 CFR 483.70 and 42 CFR 483.65. The Survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction	K 000	K-100 SPECIFIC RESIDENTS No residents were directly affected by this practice. OTHER RESIDENTS All residents are at risk from this deficient practice. SYSTEMATIC CHANGES The complete Water Management Program has been reviewed and approved by the QAPI committee. The program outlines how to identify legionella through the facility risk assessment for water borne pathogens specific to legionella; once identified how to apply control measures to reduce the hazardous conditions to prevent the spread and growth of legionella; and lastly, the program is initiated and is effective. See attached documents for specific facility policy.	
K 100 SS=F	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This Standard is not met as evidenced by: Based on record review and interview, the facility failed to demonstrate implementation of a water management program for waterborne pathogens such as Legionella, in accordance with 42 CFR 483.65. Failure to implement a water management program to avert transmission of waterborne pathogens, which considers CDC standards and the guidance of ASHRAE 188, has	K 100	MONITOR Maintenance Director or designee will ensure Water Management Program is being reviewed on an annual basis, and that the facility policy is following per industry guidelines.	12/5/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE EXECUTIVE DIRECTOR	(X6) DATE 11/20/17
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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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K 100	<p>Continued From page 1</p> <p>the potential to expose residents to Legionella and other water source bacterium. This deficient practice affected 63 residents, staff and visitors on the date of the survey. The facility is currently licensed for 109 SNF/NF beds and had a census of 63 on the day of the survey.</p> <p>Findings include:</p> <p>During review of provided maintenance and inspection records conducted on October 31, 2017 from approximately 8:30 AM to 10:00 AM, no records were available demonstrating the facility had completed or implemented a water management plan which included a risk assessment, control measures and testing protocols for the prevention of waterborne pathogens such as Legionella.</p> <p>Further review of provided company policy and records from approximately 1:30 PM to 1:45 PM, failed to demonstrate the facility had conducted a risk assessment, or that control measures and testing protocols were in place for the mitigation of waterborne pathogens.</p> <p>When asked about the missing documentation, the Administrator stated he was aware of the requirement for such a plan and the facility was in the process of its development and implementation.</p> <p>CFR standard:</p> <p>42 CFR 483.65</p> <p>§ 483.65 Infection control. The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and</p>	K 100		12/5/17

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K 100	Continued From page 2 to help prevent the development and transmission of disease and infection. Additional reference: Center for Medicaid/Medicare Services S & C letter 17-30	K 100	DATE OF COMPLIANCE 11/22/2017		
K 211 SS=E	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that means of egress were provided in accordance with NFPA 101. Failure to maintain means of egress free of obstructions has the potential to hinder evacuation of residents during an emergency. This deficient practice affected residents, staff and visitors utilizing the main front entry on the date of the survey. The facility is licensed for 109 SNF/NF beds and had a census of 63 on the day of the survey. Findings include: During the facility tour conducted on October 31, 2017 from 10:30 AM to 3:00 PM, observation of exit doors revealed the following: 1) The controlled access door located at the main entrance found the door was equipped with keyed, hookbolt lock and controlled access locking arrangements. Operational testing of door revealed that when the hookbolt was activated, the motion sensors would not open the door and	K 211	K-211 SPECIFIC RESIDENTS No residents were directly affected by this practice. OTHER RESIDENTS All residents are at risk from this deficient practice. SYSTMATIC CHANGES The controlled access door located at the main entrance of the facility was corrected by having the latch lock removed from operation; allowing for means of egress being free of obstruction. The secondary location corrected was facility storage room that had a magnetic locking arrangement that remained as a use of passage, and the keyed lock was removed allowing for means of egress being free of obstruction. Signage was installed to provide operational guidance for door egress.	<i>12/5/17</i>	

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K 211	<p>Continued From page 3</p> <p>the lock would also prohibit the doors from breaking away as designed.</p> <p>When asked why the hookbolt lock was installed, the Maintenance Director stated the hookbolt was used to lock the doors at night.</p> <p>2) The storage area for durable medical equipment located on the north side of the facility was observed to have a magnetic locking arrangement, requiring use of both a push button release and keyed passage lock from the egress side.</p> <p>Actual NFPA standard:</p> <p>NFPA 101 19.2 Means of Egress Requirements. 19.2.1 General. Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7, unless otherwise modified by 19.2.2 through 19.2.11.</p> <p>19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side, unless otherwise permitted by one of the following:</p> <p>(1) Locks complying with 19.2.2.2.5 shall be permitted. (2)*Delayed-egress locks complying with 7.2.1.6.1 shall be permitted (3)*Access-controlled egress doors complying with 7.2.1.6.2 shall be permitted. (4) Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted. (5) Approved existing door-locking installations shall be permitted.</p>	K 211	<p>MONITOR</p> <p>Maintenance Director or designee will inspect all facility doors including mean of egress to no longer having door operating system that may cause obstruction to a means of egress.</p>	12/5/17

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K 211	Continued From page 4 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.	K 211		
K 291 SS=F	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9.18.2.9.1, 19.2.9.1 This Standard is not met as evidenced by: Based on record review, observation and interview, the facility failed to provide and test emergency lighting in accordance with NFPA 101. Failure to provide emergency lighting for doors equipped with delayed egress and to perform testing of emergency lighting for 30 seconds monthly and 90 minutes annually, potentially hinders identification of exits affecting resident egress during an emergency. This deficient practice affected 63 residents staff and visitors in 5 of 6 smoke compartments on the date of the survey. The facility is currently licensed for 109 SNF/NF beds and had a census of 63 on the day of the survey. Findings include: 1) During review of facility inspection and maintenance records conducted on October 31, 2017 from approximately 8:30 AM to 10:00 AM, records provided for battery backup emergency light testing did not indicate any time duration for the testing of emergency lights, but only a mark	K 291	K-291 SPECIFIC RESIDENTS No residents were directly affected by this practice. OTHER RESIDENTS All residents are at risk from this deficient practice. SYSTEMATIC CHANGES Emergency lighting was identified to missing in (12) different locations throughout facility. A 3 rd party vendor was contacted to provide services to install (12) emergency lights; appropriate lighting was identified and are currently awaiting installation per	12/5/17

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K 291	<p>Continued From page 5 indicating identified light testing was completed.</p> <p>When asked about the time duration emergency lighting was tested for, the Maintenance Director stated the tests were not done for any period of time, just to see the light was illuminated when the test button was depressed.</p> <p>2) During the facility tour conducted on October 31, 2017 from approximately 10:30 AM to 3:00 PM, observation of exit doors revealed all exit doors leading to the public way were equipped with magnetic locking and delayed egress arrangements. Further observation revealed battery powered emergency lighting was not provided for these doors.</p> <p>Further interview of the Maintenance Director revealed he was not aware delayed egress doors required emergency battery powered lighting.</p> <p>Actual NFPA standard:</p> <p>19.2.9 Emergency Lighting. 19.2.9.1 Emergency lighting shall be provided in accordance with Section 7.9.</p> <p>7.9 Emergency Lighting. 7.9.1 General. 7.9.1.1* Emergency lighting facilities for means of egress shall be provided in accordance with Section 7.9 for the following: (1) Buildings or structures where required in Chapters 11 through 43 (2) Underground and limited access structures as addressed in Section 11.7 (3) High-rise buildings as required by other sections of this Code (4) Doors equipped with delayed-egress locks</p>	K 291	<p>3rd party vendor schedule with a scheduled date of completion of 11/30/2017.</p> <p>Upon emergency lighting installation testing will be completed to ensure proper operation and to be followed by an internal audit to be completed by Maintenance Director or Designee.</p> <p>MONITOR</p> <p>Maintenance Director or Designee will audit operational efficiency for a duration of 3 months to meet monthly testing standards. Audit will provide that testing be completed (x2) monthly for a duration of 30" for the first three months and every month thereafter per industry standards and to include an annual test of 90' of emergent lighting.</p>	12/5/17	

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K 291	Continued From page 6 (5) Stair shafts and vestibules of smokeproof enclosures, for which the following also apply: (a) The stair shaft and vestibule shall be permitted to include a standby generator that is installed for the smokeproof enclosure mechanical ventilation equipment. (b) The standby generator shall be permitted to be used for the stair shaft and vestibule emergency lighting power supply. (6) New access-controlled egress doors in accordance with 7.2.1.6.2 7.9.3 Periodic Testing of Emergency Lighting Equipment. 7.9.3.1 Required emergency lighting systems shall be tested in accordance with one of the three options offered by 7.9.3.1.1, 7.9.3.1.2, or 7.9.3.1.3. 7.9.3.1.1 Testing of required emergency lighting systems shall be permitted to be conducted as follows: (1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, except as otherwise permitted by 7.9.3.1.1(2). (2)*The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction. (3) Functional testing shall be conducted annually for a minimum of 11.2 hours if the emergency lighting system is battery powered. (4) The emergency lighting equipment shall be fully operational for the duration of the tests required by 7.9.3.1.1(1) and (3). (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction.	K 291		
K 321 SS=D	NFPA 101 Hazardous Areas - Enclosure	K 321		

12/5/17

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K 321	<p>Continued From page 8</p> <p>deficient practice affected staff and visitors of the utility corridor on the north side of the building on the date of the survey. The facility is currently licensed for 109 SNF/NF beds and had a census of 63 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on October 31, 2017 from approximately 10:30 AM to 3:00 PM, observation of the oxygen storage and transfill room located on the north side of the facility, revealed the room abutted two (2) spaces of the following combustible storage:</p> <ol style="list-style-type: none"> 1) The Central Supply storage to the north which housed cartons of resident sundries storage 2) The Janitorial supply storage area to the east housing bulk cartons of paper storage such as toilet paper and bulk ABHR (Alcohol Based Hand Rub) storage. <p>Further observation of the east wall separating the oxygen storage and transfill room to the janitorial central supply, revealed the wall was constructed of two inch by four inch (2x4) wood framing, with a single layer of drywall installed on the oxygen room side, along with a 90 minute fire-rated, self-closing door. The interior side of the janitorial closet was observed to be absent of drywall, exhibiting an incomplete one-hour fire resistive system.</p> <p>Actual NFPA standard:</p> <p>NFPA 101</p> <p>19.3.2.4 Medical Gas. Medical gas storage and administration areas shall be in accordance with</p>	K 321		12/5/17

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K 321	<p>Continued From page 9</p> <p>Section 8.7 and the provisions of NFPA 99, Health Care Facilities Code, applicable to administration, maintenance, and testing.</p> <p>8.7 Special Hazard Protection. 8.7.1 General. 8.7.1.1* Protection from any area having a degree of hazard greater than that normal to the general occupancy of the building or structure shall be provided by one of the following means: (1) Enclosing the area with a fire barrier without windows that has a 1-hour fire resistance rating in accordance with Section 8.3 (2) Protecting the area with automatic extinguishing systems in accordance with Section 9.7 (3) Applying both 8.7.1.1(1) and (2) where the hazard is severe or where otherwise specified by Chapters 11 through 43</p> <p>NFPA 99 11.5.2.3 Transfilling Liquid Oxygen. Transfilling of liquid oxygen shall comply with 11.5.2.3.1 or 11.5.2.3.2, as applicable.</p> <p>11.5.2.3.1 Transfilling to liquid oxygen base reservoir containers or to liquid oxygen portable containers over 344.74 kPa (50 psi) shall include the following: (1) A designated area separated from any portion of a facility wherein patients are housed, examined, or treated by a fire barrier of 1 hour fire-resistive construction. (2) The area is mechanically ventilated, is sprinklered, and has ceramic or concrete flooring. (3) The area is posted with signs indicating that transfilling is occurring and that smoking in the immediate area is not permitted. (4) The individual transfilling the container(s) has</p>	K 321		12/5/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135091	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/31/2017
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF IDAHO FALLS	STREET ADDRESS, CITY, STATE, ZIP CODE 2725 EAST 17TH STREET IDAHO FALLS, ID 83406
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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
K 321	Continued From page 10 been properly trained in the transfilling procedures.	K 321		
K 353 SS=F	<p>NFPA 101 Sprinkler System - Maintenance and Testing</p> <p>Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure fire suppression system pendants were maintained free of obstructions such as paint or corrosion. Failure to maintain fire sprinkler pendants free of obstructions could hinder system performance during a fire event. This deficient practice affected 63 residents, staff and visitors in 4 of 6 smoke compartments on the date of the survey. The facility is currently licensed for 109 SNF/NF beds and had a census of 63 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on October 31,</p>	K 353	<p>K-353</p> <p>SPECIFIC RESIDENTS</p> <p>No residents were directly affected by this practice.</p> <p>OTHER RESIDENTS</p> <p>All residents are at risk from this deficient practice.</p> <p>SYSTEMATIC CHANGES</p> <p>All facility fire sprinkler pendants located in facility shower rooms and janitorial closet located on hall 1 have been replaced to meet industry standards. Upon further review facility maintenance personnel identified additional fire sprinkler pendants that required replacement to meet industry fire safety standards, at which point they were also replaced.</p>	12/5/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135091	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/31/2017
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF IDAHO FALLS			STREET ADDRESS, CITY, STATE, ZIP CODE 2725 EAST 17TH STREET IDAHO FALLS, ID 83406	
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K 353	<p>Continued From page 11</p> <p>2017 from approximately 10:30 AM to 3:00 PM, observation of installed fire sprinkler pendants revealed the following:</p> <p>All four (4) resident shower rooms: one corroded pendant in each location Housekeeping/Janitorial storage abutting room 1: one corroded pendant</p> <p>Interview of the Maintenance Supervisor revealed he was not aware of these deficiencies prior to the date of the survey.</p> <p>Actual NFPA standard:</p> <p>NFPA 25</p> <p>5.2.1 Sprinklers. 5.2.1.1* Sprinklers shall be inspected from the floor level annually.</p> <p>5.2.1.1.1* Sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., upright, pendent, or sidewall).</p> <p>5.2.1.1.2 Any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical damage (4) Loss of fluid in the glass bulb heat responsive element (5)*Loading (6) Painting unless painted by the sprinkler manufacturer</p>	K 353	<p>MONITOR</p> <p>Fire sprinkler pendants will be audited for efficiency and industry standards to ensure that all sprinklers are void of leakage; free of corrosion, foreign materials, paint, and physical damage; and shall be installed correctly. Audit will provide that fire sprinkler pendant are inspected (x2) monthly in each shower room, janitorial closet and areas identified by facility personnel to have a high risk for the aforementioned signs effecting sprinkler pendants; for a total duration of three months at which time annual inspection to be completed.</p>	12/5/17