



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 30, 2017

Jon Smith, Administrator  
Caribou Memorial Living Center  
300 South Third West  
Soda Springs, ID 83276-1559

Provider #: 135060

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

Dear Mr. Smith:

On **November 15, 2017**, a Facility Fire Safety and Construction survey was conducted at **Caribou Memorial Living 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. 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

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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.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **December 13, 2017**. Failure to submit an acceptable PoC by **December 13, 2017**, may result in the imposition of civil monetary penalties by **January 2, 2018**.

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 20, 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 20, 2017**. A change in the seriousness of the deficiencies on **December 20, 2017**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **December 20, 2017**, includes the following:

Denial of payment for new admissions effective **February 15, 2018**.  
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 **May 15, 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 **November 15, 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:

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<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:

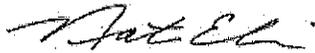
BFS Letters (06/30/11)

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

This request must be received by **December 13, 2017**. If your request for informal dispute resolution is received after **December 13, 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

HEALTH AND HUMAN SERVICES  
 MEDICARE & MEDICAID SERVICES

Printed: 11/28/2017  
 FORM APPROVED  
 OMB NO. 0938-0391

DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135060	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  11/15/2017
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NAME OF PROVIDER OR SUPPLIER <b>CARIBOU MEMORIAL LIVING CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>300 SOUTH THIRD WEST SODA SPRINGS, ID 83276</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
K 000	<p><b>INITIAL COMMENTS</b></p> <p>The facility is a two story, fire resistive building. The plans were approved in May 1967. A full NFPA 13 compliant fire sprinkler system was installed in September 2011. The building occupancy consists of a nursing home and hospital. Nursing home residents are located on the upper level with exits to finished grade. The facility is currently licensed for 30 SNF/NF beds.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on November 15, 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.</p> <p>The Survey was conducted by:</p> <p>Sam Burbank                      Health Facility Surveyor                      Facility Fire Safety and Construction</p>	K 000	<p>K100</p> <p>Action Taken: A policy and process map was completed November 20<sup>th</sup> 2017 by CMH Infection Control Nurse. Garratt Callahan has been contacted on November 27<sup>th</sup> 2017 and pre work was sent to start the process of a full water management plan. Garratt Callahan will be onsite December 20<sup>th</sup> to do an onsite evaluation and start the process of the water treatment plan.</p> <p>Identification of others affected: This affected 22 residents, staff and visitors. It has the potential to affect all residents, staff, and visitors.</p>	1/18/18
K 100 SS=F	<p>General Requirements - Other                      GFR(s): NFPA 101</p> <p>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 REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to demonstrate 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</p>	K 100	<p>Measures/Systemic Changes: CMH has started the process of a complete system correction with Garrett Callahan. The program will include management roles, a validation process, steps to respond to water borne pathogens, water system data entry, flow diagrams, hazard analysis, and control measures.</p> <p>Monitoring and Tracking: Twice a year Garratt Callahan will be onsite to do 20 test sites each time they are on site. Each site visit will come with a full</p>	

RECEIVED  
 DEC 24 2017  
 FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: CEO DATE: 12/13/17

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.

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

Printed: 11/28/2017  
FORM APPROVAL  
OMB NO. 0938-0301

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135060	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  11/15/2017
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NAME OF PROVIDER OR SUPPLIER  CARIBOU MEMORIAL LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 300 SOUTH THIRD WEST SODA SPRINGS, ID 83276
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K 100	<p>Continued From page 1</p> <p>pathogens which considers CDC standards and the guidance of ASHRAE 188, has the potential to expose residents to Legionella and other water source bacterium. This deficient practice affected 22 residents on the date of the survey. The facility is currently licensed for 30 SNF/NF beds and had a census of 22 on the day of the survey.</p> <p>Findings include:</p> <p>During review of provided maintenance and inspection records conducted on November 15, 2017 from approximately 8:30 AM to 10:30 AM, no records were available demonstrating the facility had completed or implemented a water management plan, which included a risk assessment and testing protocols for the prevention of waterborne pathogens such as Legionella. When asked about the missing documentation, the Maintenance Engineer stated he was aware of the requirement and that he had been working with the infection control department on development of the plan, but it was not yet finalized.</p> <p>GFR standard:</p> <p>42 CFR 483.65</p> <p>§ 483.65 Infection control.</p> <p>The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>Additional reference: Center for Medicaid/Medicare Services S &amp; C letter 17-30</p>	K 100	<p>comprehensive report to assure compliance is being met under 42 CFR 483.65.</p> <p>Responsible: CMH Maintenance department will comply with recommendations from Garratt Callahan under the direction of our Maintenance Manager.</p> <p>Attachment 5</p>	
K 791	Construction, Repair, and Improvement Operati	K 791		

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

Printed: 11/28/2017  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135060	(X2) MULTIPLE CONSTRUCTION A. BUILDING D1 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  11/15/2017
NAME OF PROVIDER OR SUPPLIER <b>CARIBOU MEMORIAL LIVING CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>300 SOUTH THIRD WEST SODA SPRINGS, ID 83276</b>		
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K 791 SS=F	Continued From page 2 CFR(s): NFPA 101  Construction, Repair, and Improvement Operations Construction, repair, and improvement operations shall comply with 4.6.10. Any means of egress in any area undergoing construction, repair, or improvements shall be inspected daily to ensure its ability to be used instantly in case of emergency and compliance with NFPA 241. 18.7.9, 19.7.9, 4.6.10, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure interim life safety measures were in place prior to conducting construction operations. Failure to provide interim life safety measures during construction projects has the potential to hinder egress of residents during an emergency. This deficient practice affected 22 residents, staff, and visitors on the date of the survey. The facility is licensed for 30 SNF/NF beds and had a census of 22 on the day of the survey.  Findings include:  During review of facility maintenance and inspection records conducted on November 15, 2017 from approximately 8:30 AM to 10:30 AM, no records were provided indicating the facility had performed an interim life safety assessment for ongoing construction operations. Subsequent inspection of both wings in the Living Center, revealed the north end of both halls had been blocked off and access to the exit stairwell was not possible. Further examination on the construction side of these exit doors found the stairwells were congested with construction materials and equipment, rendering them	K 791	K791  Action Taken: The Fire Chief of Soda Springs Fire Department was onsite on 12/12/17 to evaluate a reroute of fire evacuation plans. It was determined with the amount of construction that was taken place as the project was coming to a close, the current fire exits in question will not be an egress for an evacuation.  Identification of others affected: This affected 22 residents, staff and visitors. It has the potential to affect all residents, staff, and visitors.  Measures/Systemic Changes: CMH took signs down on 12/12/17, and in-service our Living Center staff on the new evacuation plan by was held on 12/12/17. New evacuation plans were posted on 12/12/17. New evacuation plan and letter from Fire Chief Dan Squires was received on 12/12/17. CMH has also created a policy with an attached form for daily rounds.  Monitoring and Tracking: CMH Maintenance department will be conducting morning rounds with the Interim Life Safety Measures Checklist form as an addition to the daily	1/18/18

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NAME OF PROVIDER OR SUPPLIER <b>CARIBOU MEMORIAL LIVING CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>300 SOUTH THIRD WEST SODA SPRINGS, ID 83276</b>
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K 791	<p>Continued From page 3</p> <p>Ineffective for egress during an emergency.</p> <p>When asked if the facility had been in contact with the local fire authority or had conducted an interim life safety assessment, the Maintenance Engineer stated the Fire Marshal had been notified, but the facility had not performed an interim life safety assessment.</p> <p>Actual NFPA standard: NFPA 101</p> <p>19.7.9 Construction, Repair, and Improvement Operations. 19.7.9.1 Construction, repair, and improvement operations shall comply with 4.6.10. 19.7.9.2 The means of egress in any area undergoing construction, repair, or improvements shall be inspected daily for compliance with 7.1.10.1 and shall also comply with NFPA 241, Standard for Safeguarding Construction, Alteration, and Demolition Operations.</p> <p>4.6.10 Construction, Repair, and Improvement Operations. 4.6.10.1* Buildings, or portions of buildings, shall be permitted to be occupied during construction, repair, alterations, or additions only where required means of egress and required fire protection features are in place and continuously maintained for the portion occupied or where alternative life safety measures acceptable to the authority having jurisdiction are in place.</p>	K 791	<p>rounds check list we already conduct to assure CMH is in compliance and or tracking changes to assure measures are taken in order to stay in compliance. This has been put into a monthly QA for monthly review until phase 1 of construction is done.</p> <p>Responsible: CMH Maintenance Manager</p> <p>Attachment 1,2,3,4</p>	
K 918 SS-F	<p>Electrical Systems - Essential Electric System CFR(s): NFPA 101</p> <p>Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source</p>	K 918		

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NAME OF PROVIDER OR SUPPLIER <b>CARIBOU MEMORIAL LIVING CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>300 SOUTH THIRD WEST SODA SPRINGS, ID 83276</b>
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K 918	<p>Continued From page 4</p> <p>and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.</p> <p>Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure the EES (Essential Electrical System) generator was maintained in accordance with NFPA 110. Failure to annually test the fuel for diesel powered generators has the potential of hindering system performance during a power loss or other emergency. This deficient practice affected 22 residents, staff and visitors on the</p>	K 918	<p>K918</p> <p>Action Taken: On November 20<sup>th</sup> 2017 Precision Power came onsite to do a test bank on our generator and we signed up for them to do a full analysis on our diesel fuel. Precision Power took a sample of the diesel and CMH is awaiting the test results from that sample that was taken. Precision Power will have the test results back to CMH no later than 12/29/17.</p> <p>Identification of other affected: This affected 22 residents, staff and visitors. It has the potential to affect all residents, staff, and visitors.</p> <p>Measures/Systemic Changes: CMH has scheduled a yearly testing of our diesel reserves to be analyzed by Precision Power. Those recordings of testing will be shared at the Safety Committee meeting in the month that they are tested.</p> <p>Monitoring and Tracking: The CMH Maintenance Department will monitor and track the sample tests and will report them to the Safety Committee when tested.</p> <p>Responsible: CMH Maintenance Manager/Safety Committee Chair</p>	1/18/18

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135060	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  11/15/2017
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NAME OF PROVIDER OR SUPPLIER <b>CARIBOU MEMORIAL LIVING CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>300 SOUTH THIRD WEST SODA SPRINGS, ID 83276</b>
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K 918	<p>Continued From page 5</p> <p>date of the survey. The facility is currently licensed for 30 SNF/NF beds and had a census of 22 on the day of the survey.</p> <p>Findings include:</p> <p>During review of annual inspection and maintenance records conducted on November 15, 2017 from approximately 8:30 AM to 10:30 AM, records provided for the annual generator inspection did not indicate any testing was completed for the fuel. When asked, the Maintenance Engineer stated he was aware of the testing requirement, but the generator contractor had not completed this testing.</p> <p>Actual NFPA standard:</p> <p>NFPA 110 8.3.8 A fuel quality test shall be performed at least annually using tests approved by ASTM standards.</p>	K 918		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135060</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/15/2017</b>
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NAME OF PROVIDER OR SUPPLIER <b>CARIBOU MEMORIAL LIVING CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>300 SOUTH THIRD WEST SODA SPRINGS, ID 83276</b>
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E 000	<p>Initial Comments</p> <p>Unless otherwise indicated, the general use of the terms "facility" or "facilities" refers to all provider and suppliers affected by this regulation. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations.</p> <p>The facility is a two story, fire resistive building. The plans were approved in May 1967. A full NFPA 13 compliant fire sprinkler system was installed in September 2011. The building occupancy consists of a nursing home and hospital. Nursing home residents are located on the upper level with exits to finished grade. The facility is currently licensed for 30 SNF/NF beds.</p> <p>The following deficiencies were cited during the emergency preparedness survey conducted on November 15, 2017. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.</p> <p>The Survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	E 000	<p>E001</p> <p>Corrective Action: An Emergency Preparedness Consultant has been hired by CMH to develop a comprehensive Emergency Operations Plan to comply with 42 CFR 483.73. He started early November 2017, and we have been meeting regularly.</p> <p>Identification of others affected: This effected 22 residents, staff, and visitors. It has the potential to affect all residents, staff, and visitors. CMH has developed an Emergency Management Program policy (Attachment 1) along with the CMH Safety Manual (Attachment 26) and General Staff Training Policy (Attachment 23) to guide the process and lead the education of CMH employees.</p> <p>Measures/Systemic Changes: CMH will be incorporating EOP (and associated Policies) training into our New Hire Orientation as well as our annual re-orientation for all employees. CMH will develop an informational packet for families and residents to inform them of the process of the Emergency Operations Plan. Training on the new Emergency Operations Plan will be January 9<sup>th</sup>, 2017. CMH will line item the EOP in the monthly safety meeting</p>	1/18/18
E 001 SS=F	<p>Establishment of the Emergency Program (EP) CFR(s): 483.73</p> <p>The [facility, except for Transplant Center] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements:</p>	E 001		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jon Smith TITLE: CEO (X6) DATE: 12/18/17

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.

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135060</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/15/2017</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CARIBOU MEMORIAL LIVING CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>300 SOUTH THIRD WEST SODA SPRINGS, ID 83276</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
E 001	<p>Continued From page 1</p> <p>*[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.</p> <p>*[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to establish and maintain a current, comprehensive Emergency Preparedness program which includes policies and procedures in accordance with 42 CFR 483.73. Failure to meet this standard has the potential to hinder facility response during an emergency which requires coordination and cooperation with local resources available. This deficient practice affected 22 residents, staff and visitors on the date of the survey. The facility is currently licensed for 30 SNF/NF beds and had a census of 22 on the day of the survey.</p> <p>Refer to E-004 as it relates to the facility failure to develop and maintain the EP program</p> <p>CFR reference: 42 CFR 483.73</p>	E 001	<p>to assure any change in operation of plan are addressed and noted for retraining.</p> <p>Monitoring and tracking: JR Consulting will submit a summary of changes or additions of the EOP to the executive team on a weekly basis. The Executive Team will evaluate the progress of the EOP in meeting the regulations by the date identified for compliance. HR and Education will provide a summary, to the executive team, of all employees who complete the training either through new orientation or general employee inservices. The executive team will audit these lists to assure that CMH employees are being trained on the EOP within the specified time.</p> <p>Responsible: The CEO/LNHA or designee will be responsible for implementation and monitoring of this correction.</p>	
E 004 SS=F	<p>Develop EP Plan, Review and Update Annually CFR(s): 483.73(a)</p> <p>[The [facility] must comply with all applicable</p>	E 004		

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

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E 004	<p>Continued From page 2</p> <p>Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.]</p> <p>* [For hospitals at §482.15 and CAHs at §485.625(a):] The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.</p> <p>The emergency preparedness program must include, but not be limited to, the following elements:] (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least annually.</p> <p>* [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least annually.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to develop and maintain a current Emergency Preparedness program in accordance with 42 CFR 483.73 which is reviewed and subsequently updated annually. Lack of a current comprehensive emergency program has the potential to hinder resident access to continuing care during a disaster. This deficient practice affected 22 residents, staff and visitors on the date of the</p>	E 004	<p>E004</p> <p>Corrective Action: CMH has hired JR Consulting to assist in development of the facility's EOP. This was initiated the first of November. CMH has a policy management program (Hospital Portal) that tracks policy dates to assure annual reviews are completed.</p> <p>Identification of others affected: This noncompliance effected 22 residents, staff, and visitors. It has the potential to affect all residents, staff, and visitors. In July 2017, CMH started a Professional Policy Committee that meets monthly to go through our policy management process to assure annual review has occurred by manager and division Vice Presidents before going in front of the Professional Policy Committee. The EOP and the policies that make up the plan will all be part of this process to assure a yearly review of the plan and polices that are within.</p> <p>Measures/systemic: When completed, the EOP will be placed in this program and tracked to assure compliance with annual review. The facility also has a Professional Policy Committee that meets monthly to review all new</p>	1/18/18

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NAME OF PROVIDER OR SUPPLIER <b>CARIBOU MEMORIAL LIVING CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>300 SOUTH THIRD WEST SODA SPRINGS, ID 83276</b>
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E 004	<p>Continued From page 3 survey. The facility is currently licensed for 30 SNF/NF beds and had a census of 22 on the date of the survey.</p> <p>Findings include:</p> <p>On 11/15/17 from 8:30 AM to 2:00 PM, review of the provided emergency plan, policies and procedures, revealed the facility had not developed a current policy or emergency plan in accordance with the standard. The provided emergency plan copy from the nursing station was dated 2011. The provided policies and procedures varied in dates from 2003 to 2011 and no documentation of a current annual update. When asked, about the outdated plan, the Administrator stated the facility was working with a consultant to develop a current comprehensive plan.</p> <p>a. Refer to E 0006 as it relates to conducting a facility-based and community-based risk assessment which includes strategies identified under an all-hazards approach.</p> <p>b. Refer to E 0007 as it relates to the facility resident population; continuation of operations; succession planning.</p> <p>c. Refer to E 0013 as it relates to the development of policies and procedures, which are updated annually, based on the Emergency Plan; facility and community based risk assessment; and the communication plan.</p> <p>d. Refer to E 0015 as it relates to the policies and procedures for the subsistence needs for residents and staff members during a disaster.</p> <p>e. Refer to E 0018 as it relates to the policies and.</p>	E 004	<p>policies as well as revisions. The Safety Committee will review the EOP initially and annually. They will submit any recommended changes of the EOP or associated polices to the Professional Policy Committee.</p> <p>Monitoring and tracking: The compliance department will QA the Professional Policy Committee to assure all policies have been reviewed annually.</p> <p>Responsible: The Compliance Department is responsible for monitoring this.</p> <p>Attachment: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 27</p>	

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E 004	<p>Continued From page 4</p> <p>procedures for tracking residents and staff in the event of a disaster.</p> <p>f. Refer to E 0022 as it relates to the policies and procedures for residents and staff who remain in the facility and shelter in place.</p> <p>g. Refer to E 0024 as it relates to the facility use of volunteers</p> <p>h. Refer to E 0025 as it relates to the collaborative arrangements of the facility with other care providers in the event of limitations and/or cessation of operations.</p> <p>i. Refer to E 0026 as it relates to the facility role under 1135 waiver as declared by the Secretary and the provision of care at an alternate site identified by emergency management officials.</p> <p>j. Refer to E 0029 as it relates to the development and annual update of the Communications Plan.</p> <p>k. Refer to E 0032 as it relates to the designation of primary and alternate means of communication.</p> <p>l. Refer to E 0033 as it relates to the methods for the facility to share information and medical documentation of residents with other facilities.</p> <p>m. Refer to E 0034 as it relates to the facility's means of providing information of occupancy needs and its ability to provide assistance during an emergency.</p> <p>n. Refer to E 0035 as it relates to the facility's ability to share information with family or representatives of residents and/or clients.</p>	'E 004		

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E 004	<p>Continued From page 5</p> <p>o. Refer to E 0036 as it relates to the development and implementation of an annual training and testing program as it relates to the emergency preparedness plan.</p> <p>p. Refer to E 0037 as it relates to the emergency training program and the staff knowledge of emergency procedures.</p> <p>The cumulative effect of these systemic deficient practices, impeded the facility's ability to meet the emergency preparedness standard(s) and the needs of the residents during a disaster.</p> <p>Reference: 42 CFR 483.73 (a)</p> <p>E 006 SS=F Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2)</p> <p>[(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:]</p> <p>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.*</p> <p>*[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents.</p> <p>*[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients.</p> <p>(2) Include strategies for addressing emergency</p>	E 004	<p>E006-</p> <p>Corrective Action: On November 21, 2017 members of the CMH Safety Committee participated in a HVA, facilitated by JR Consulting, for 2018-19.</p> <p>Identification of others affected: This noncompliance effected 22 residents, staff, and visitors. It has the potential to affect all residents, staff, and visitors. As part of the HVA, weighted scoring was done to determine the most likely events that might have an impact on the facility. The results are listed in the HVA portion of the Emergency Operation Plan. These identified areas will be taken into consideration as the plan is developed.</p> <p>Measures/Systemic Changes: The HVA will be reviewed annually and as needed. The EOP will then be reviewed and updated as needed to address changes in the HVA.</p> <p>Monitoring and Tracking: The Safety Committee will be reviewing the HVA during the monthly safety meeting. Changes and revisions to the HVA will be done at this time.</p> <p>Responsible: The Safety Committee Chairman will be responsible for this corrective action.</p> <p>Attachment: 2</p>	1/18/18

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 OFFICE OF INSURANCE PROGRAMS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135060</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/15/2017</b>
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E 006	<p>Continued From page 6          events identified by the risk assessment.</p> <p>* [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care.          This REQUIREMENT is not met as evidenced by:          Based on record review and interview, it was determined the facility failed to conduct a facility-based and community-based risk assessment which includes identified strategies for response. Failure to conduct a facility and community based risk assessment hinders facility response to localized disasters and emergencies. This deficient practice affected 22 residents, staff and visitors on the date of the survey. The facility is currently licensed for 30 SNF/NF beds and had a census of 22 on the date of the survey.</p> <p>Findings include:</p> <p>On 11/15/17 from 8:30 AM to 2:00 PM, review of provided policies, procedures and the emergency plan located at the nursing station did not reveal a current facility and community based risk assessment had been conducted. A generic risk assessment sample was provided by the facility, but interview of the Administrator during the exit conference on 11/15/17 from 2:30 - 3:00 PM found the facility had not yet conducted one that was site specific to the facility and/or community. The Administrator further stated the facility was in the process of developing a current emergency program.</p> <p>Reference:</p>	E 006		
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E 006  E 007 SS=D	<p>Continued From page 7 42 CFR 483.73 (a) (1) - (2)<sub>3, 4</sub></p> <p>EP Program Patient Population CFR(s): 483.73(a)(3)</p> <p>[(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:]</p> <p>(3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.**</p> <p>*Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to provide current policies, procedures and an emergency plan that had been reviewed annually, addressing the resident population including persons at risk, the facility's ability to provide in an emergency and included continuity of operations with staff succession planning. Failure to provide updated policies, procedures and succession plan, potentially hinders continuation of resident care during an emergency. This deficient practice affected 22 residents, staff and visitors on the date of the survey. The facility is currently licensed for 30 SNF/NF beds and had a census of 22 on the date of the survey.</p> <p>Findings include:</p> <p>1) On 11/15/17 review of provided policies and</p>	E 006  E 007	<p>E007-</p> <p>Corrective Action: On 12/12/17, CMH created a new organization chart for Emergency Procedures. Included with this chart is a succession planning table of leadership positions.</p> <p>Identification of others affected: This effected 22 residents, staff, and visitors. It has the potential to affect all residents, staff, and visitors. The Incident Command Organizational chart has been developed to assure all needed staffing positions have been filled in order for the EOP to be activated and carried out effectively.</p> <p>Measures/Systemic Changes: Staff assigned to these position will receive specific role training. Position packets containing job duties specific to emergency management roles will be kept in the front office, which has been designated as incident command.</p> <p>Monitoring and Tracking: CMH started a Professional Policy Committee that meets monthly to go through our policy management process to assure annual review has been completed by manager and division Vice President(s). The EOP and the policies that make up the plan will go through this process to assure an annual review of the plan and the</p>	1/18/18

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E 007	Continued From page 8 procedures and the emergency plan from the nursing station did not reveal a current, updated plan which included delegations of authority and succession planning. Policies, procedures and the emergency plans provided varied in date range from 2003 to 2011.  2) Interviews conducted of 4 of 4 staff members on 11/15/17 from 10:00 - 11:45 AM revealed staff members were unfamiliar with any plan, policies, or procedures for the succession planning of staff, or procedures for facility continuity of operations during a disaster.  Reference: 42 CFR 483.73 (a) (3)	E 007	Succession plan. The compliance department will monitor the outcomes of the Professional Policy Committee to assure all policies have been reviewed and revised as required. The LTC financial coordinator and the Living Center Director of Operations will update monthly, at Safety Committee meeting, the emergency patient book and any changes to living center organization chart.  Responsible: Safety Committee Chairman or designee will be responsible for this corrective action.	
E 013 SS=F	Development of EP Policies and Procedures CFR(s): 483.73(b)  (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.  *Additional Requirements for PACE and ESRD Facilities:  *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and	E 013	Attachment: 3, 4	

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E 013	<p>Continued From page 9</p> <p>procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least annually.</p> <p>*[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to develop current updated policies and procedures based on the Emergency Plan. Failure to develop current policies and procedures based on the emergency plan, a facility and community based risk assessment and the facility communications plan, limits the facility response capabilities in the protection of residents during a disaster. This deficient practice affected 22 residents, staff and visitors on the date of the survey. The facility is currently licensed for 30 SNF/NF beds and had a census of 22 on the date of the survey.</p> <p>Findings include:</p>	E 013	<p>E013</p> <p>Corrective Action: The facility reviewed, updated, and developed emergency preparedness policies and procedures based on the facility's Emergency Operations Plan, Risk Assessment, and Communication Plan. The Emergency Management Plan outlines that all policies will be reviewed annually.</p> <p>Identification of Others Affected: This affected 22 residents, staff and visitors. It has the potential to affect all residents, staff, and visitors. Staff were introduced to and educated on the EOP and associated policies during a training on 12/12/17.</p> <p>Measures/Systemic Changes: There will be ongoing staff training as the EOP develops. The facility maintains all policies and procedures on the Hospital Portal. Policies are controlled documents that are written and reviewed through the use of an electronic Policy Manager. Policies will be reviewed at least annually.</p> <p>Monitoring and Tracking: The Compliance Department will QA the Professional Policy Committee monthly</p>	1/18/18

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E 013	Continued From page 10  On 11/15/17 from 8:30 AM to 3:00 PM, review of provided policies and procedures revealed the current copy located at the nursing station was dated 2011. No records were available to confirm the policy had been reviewed annually and it was not determined these policies were based on a current Emergency Plan, facility-based risk assessment, or a communications plan for its development.  Interview of the Administrator during the exit conference on 11/15/17 from 2:30 - 3:00 PM, confirmed the facility was currently in the process of rewriting its policies and procedures to meet the new requirement.  42 CFR 483.73 (b)	E 013	to assure all policies are reviewed annually by appropriate Administrative staff.  Responsible: The Safety Committee Chairman and the LTC DNS/designee will be responsible for this correction.  E0015-	1/18/18
E 015 SS=F	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1)  [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:  (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and	E 015	Corrective Action: A policy addressing subsistence needs for staff and patients was created and put into a policy management process that addresses the needs outlined in CFR(s) 483.73(b)(1).  Identification of others affected: This affected 22 residents, staff, and visitors. It has the potential to affect all residents, staff, and visitors. The Safety Committee Chair did a sweep in the following areas to determine current supply: food, water, pharmaceutical supplies and alternative sources of energy (attachment 28).  Measures/Systemic Changes: A policy on subsistence has been developed. A tracking form will be used to document results of sweeps of the above named areas. The sweeps will be done to monitor and assure adequate resources.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135060</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/15/2017</b>
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NAME OF PROVIDER OR SUPPLIER <b>CARIBOU MEMORIAL LIVING CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>300 SOUTH THIRD WEST SODA SPRINGS, ID 83276</b>
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E 015	<p>Continued From page 11 safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal.</p> <p>*[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to develop and maintain current policies and procedures, which could then be reviewed annually, to provide subsistence needs of residents and staff should they need to evacuate or shelter in place during a disaster. Lack of subsistence policies limits the facility's ability to provide continuing care and services for residents during an emergency. This deficient practice affected 22 residents, staff and</p>	E 015	<p>Monitoring and Tracking: Monthly sweeps of supplies/resources will be done x 6 months to assure supplies are on hand. If expectations are met, sweeps will be changed to quarterly. If sweeps demonstrate that supplies/resources are not being maintained, they will continue to be done on a monthly basis and re-evaluated again after 6 months. Results will be reported at the monthly Safety and Quality meeting.</p> <p>Responsibility: The Safety Committee Chairman/Designee will be responsible for this corrective action.</p>	

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E 015	<p>Continued From page 12 visitors on the date of the survey. The facility is currently licensed for 30 SNF/NF beds and had a census of 22 on the date of the survey.</p> <p>Findings include:</p> <p>On 11/15/17 from 8:00 AM to 2:00 PM, review of provided policies and procedures for the facility did not indicate current policies were available demonstrating the ability of the facility to provide for subsistence of both residents and staff in the event of evacuation or shelter in place during a disaster.</p> <p>Interview of 4 of 4 staff on 11/15/17 from 10:00 - 11:45 AM, revealed they were not aware of any current policies for providing subsistence during a disaster. Interview of the Administrator during the exit conference on 11/15/17 from 2:30 - 3:00 PM, revealed the facility was currently in the process of developing and updating these policies.</p> <p>Reference:</p> <p>42 CFR 483.73 (b) (1)</p>	E 015		
E 018 SS=F	<p>Procedures for Tracking of Staff and Patients CFR(s): 483.73(b)(2)</p> <p>[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:]</p> <p>(2) A system to track the location of on-duty staff</p>	E 018	<p>E018</p> <p>Corrective Action: A policy was written 12/13/17 entitled Patient/Resident Medical Record and Victim/Patient/Resident Tracking (Attachment 6).</p> <p>Identification of Others Affected: This affected 22 residents, staff and visitors. It has the potential to affect all residents, staff, and visitors. Staff were introduced to and educated on the EOP and associated policies during a training on 12/12/17.</p> <p>Measures/Systemic Changes: There will be ongoing staff training as the EOP develops. The facility maintains all policies and procedures on the Hospital Portal. Policies are controlled documents that are written and reviewed through the use of an electronic Policy Manager. Policies will be reviewed at least annually.</p>	1/18/18

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E 018	<p>Continued From page 13</p> <p>and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location.</p> <p>*[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location.</p> <p>*[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location.</p> <p>*[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of</p>	E 018	<p>Monitoring and Tracking: The Compliance Department will QA the Professional Policy Committee monthly to assure all policies are reviewed annually by appropriate Administrative staff.</p> <p>Responsible: The Safety Committee Chairman and the LTC DNS/designee will be responsible for this correction.</p>	

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E 018	<p>Continued From page 14</p> <p>evacuation location(s); and primary and alternate means of communication with external sources of assistance.</p> <p>*[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records.</p> <p>*[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, it was determined the facility failed to provide a current policy for tracking of staff and sheltered residents during an emergency, or if relocated, a policy for documentation of the receiving facility or other location for those relocated individuals. Lack of a tracking policy has the potential to hinder the facility's ability to provide care and continuation of services during an emergency. This deficient practice affected 22 residents, staff and visitors on the date of the survey. The facility is currently licensed for 30 SNF/NF beds and had a census of 22 on the date of the survey.</p> <p>Findings include:</p> <p>On 11/15/17 from 8:30 AM to 2:00 PM, review of provided records, policies and procedures failed to demonstrate the facility had in place a system to track the location of on-duty staff and sheltered residents during an emergency.</p> <p>Interview of 4 of 4 staff members on 11/15/17</p>	E 018		
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E 018	Continued From page 15 from 10:00 - 11:45 AM, revealed none were aware of any policies for the tracking procedures of staff and residents during an emergency. Interview of the Administrator during the exit conference on 11/15/17 from 2:30 - 3:00 PM confirmed the facility was currently engaged with a consultant in developing its policies for tracking of residents and staff members during an emergency.  Reference:  42 CFR 483.73 (b) (2)	E 018		
E 022 SS=F	Policies/Procedures for Sheltering in Place CFR(s): 483.73(b)(4)  [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:]  (4) A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility].  *[For Inpatient Hospices at §418.113(b):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (i) A means to shelter in place for patients,	E 022	E022  A policy was written 12/12/17 entitled Shelter in Place.  Identification of Others Affected: This affected 22 residents, staff and visitors. It has the potential to affect all residents, staff, and visitors. Staff were introduced to and educated on the EOP and associated policies during a training on 12/12/17.  Measures/Systemic Changes: There will be ongoing staff training as the EOP develops. The facility maintains all policies and procedures on the Hospital Portal. Policies are controlled documents that are written and reviewed through the use of an electronic Policy Manager. Policies will be reviewed at least annually.	1/18/18

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E 022	<p>Continued From page 16 hospice employees who remain in the hospice. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to provide a current policy and procedure for sheltering in place which can subsequently be reviewed annually. Lack of a current policy and procedure for sheltering in place has the potential to leave residents and staff without resources to continue care during an emergency. This deficient practice affected 22 residents, staff and visitors on the date of the survey. The facility is currently licensed for 30 SNF/NF beds and had a census of 22 on the date of the survey.</p> <p>Findings include:</p> <p>On 11/15/17 from 8:30 AM to 3:00 PM, review of provided policies, procedures and emergency planning records, failed to demonstrate current and annually reviewed policies and procedures for sheltering in place. Records provided indicated a date range for policies and procedures from 2003 to 2011 with no subsequent reviews.</p> <p>Interview of the Administrator at the exit conference on 11/15/17 from 2:30 - 3:00 PM revealed these policies and procedures had not been updated and were currently under development with the assistance of a consultant.</p> <p>Reference:</p> <p>42 CFR 483.73 (b) (4)</p>	E 022	<p>Monitoring and Tracking: The Compliance Department will QA the Professional Policy Committee monthly to assure all policies are reviewed annually by appropriate Administrative staff.</p> <p>Responsible: The Safety Committee Chairman and the LTC DNS/designee will be responsible for this correction.</p>	
E 024 SS=F	<p>Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6)</p> <p>[(b) Policies and procedures. The [facilities] must</p>	E 024	<p>E024</p> <p>A policy was written 12/13/17 entitled Volunteer Services Emergency Management.</p> <p>Identification of Others Affected: This affected 22 residents, staff and visitors. It has the potential to affect all residents, staff, and visitors. Staff were introduced to and educated on the EOP and associated policies during a training on 12/12/17.</p> <p>Measures/Systemic Changes: There will be ongoing staff training as the EOP develops. The facility maintains all policies and procedures on the Hospital Portal. Policies are controlled documents that are written and</p>	1/18/18

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E 024	<p>Continued From page 17</p> <p>develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:]</p> <p>(6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.</p> <p>*[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to develop, document and maintain current emergency policies, procedures and operational plans for the use of volunteers to address surge needs during an emergency. Lack of current plans and policies for the use of volunteers has the potential to hinder the facility's ability to care for residents and provide continuation of care during a disaster. This deficient practice affected 22 residents, staff and visitors on the date of the survey. The facility is currently licensed for 30 SNF/NF beds and had a census of 22 on the date of the survey.</p> <p>Findings include:</p>	E 024	<p>reviewed through the use of an electronic Policy Manager. Policies will be reviewed at least annually.</p> <p>Monitoring and Tracking: The Compliance Department will QA the Professional Policy Committee monthly to assure all policies are reviewed annually by appropriate Administrative staff.</p> <p>Responsible: The Safety Committee Chairman and the LTC DNS/designee will be responsible for this correction.</p>	

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E 024	Continued From page 18 On 11/15/17 from 8:30 AM to 3:00 PM, review of provided policies, procedures and emergency preparedness records failed to demonstrate a current plan, which addressed the use of volunteers, or integration of State and Federally designated health care professionals to address surge needs during an emergency. Facility policy, procedures and emergency plan records provided, ranged in date from 2003 to 2011 with no documentation of subsequent review.  Interview of 4 of 4 staff members on 11/15/17 from 10:00 to 11:45 A.M., did not indicate any knowledge of the use of volunteers during an emergency. Interview of the Administrator during the exit conference on 11/15/17 from 2:30 - 3:00 PM revealed the facility was currently working with a consultant in updating policies and procedures for addressing surge needs and the use of volunteers.  Reference: 42 CFR 483.73 (b) (6)	E 024	E0025  Corrective Action: CMH has partnered with other local medical facilities and Nursing Homes in the area to assure that during an emergency, there are other facilities that can care for residents in an event of limitations or cessation of operations at CMH.	1/18/18	
E 025 SS=C	Arrangement with Other Facilities CFR(s): 483.73(b)(7)  [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:]  *[For Hospices at §418.113(b), PRFTs at §441.184, (b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures.	E 025	Identification of others affected: This affected 22 residents, staff, and visitors. It has the potential to affect all residents, staff, and visitors. CMH has created a regional healthcare coalition with signed MOUs to assure that if a emergent situation is to occur, prior agreements have been made to cover each of the facilities.  Measures/Systemic Changes: During the next years drills and exercises, an after exercise briefing will be done to insure that the facilities were contacted within the guidelines of the Emergency		

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E 025	<p>Continued From page 19</p> <p>(7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients.</p> <p>*[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients.</p> <p>*[For RNHCs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHC patients.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to document a current plan for collaborative arrangements between the facility and other health care providers. Without current policies for collaboration with other health care providers to accommodate for limitations and for the cessation of operations, the facility is potentially left without support services to continue care during an emergency. This deficient practice affected 22 residents, staff and visitors on the date of the survey. The facility is currently licensed for 30 SNF/NF beds and had a census of 22 on the date of the survey.</p>	E 025	<p>Communication Plan to activate discussion on resource availability with the regional healthcare coalition.</p> <p>Monitoring and tracking: Exercise briefing records will be reviewed by the safety committee to assure required elements were met. Deficiencies will be addressed and corrective action initiated. Results will be reported to the Quality Committee following each drill.</p> <p>Responsible: The Safety Committee Chairman and/or designee will be responsible for this corrective action.</p> <p>Attachment: 11, 12, 13, 14, 15</p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135060</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/15/2017</b>
NAME OF PROVIDER OR SUPPLIER <b>CARIBOU MEMORIAL LIVING CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>300 SOUTH THIRD WEST SODA SPRINGS, ID 83276</b>		
(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
E 025	Continued From page 20 Findings include:  On 11/15/17 from 8:30 AM to 3:00 PM review of provided policies, procedures and emergency plans, failed to indicate a current plan for collaboration with other health care providers. Provided plans ranged in dates from 2003 to 2011 and did not show any annual reviews had been conducted.  Interview of the Administrator during the exit conference on 11/15/17 from 2:30 - 3:00 PM, found the facility was currently rewriting all policies, procedures and developing a comprehensive plan in coordination with a consultant to address these missing components.  Reference:  42 CFR 483.73 (b) (7)	E 025	EOO26-  Corrective Action: A policy was written on 12/18/17 entitled Roles under an 1135 Waiver. As part of the process review, CMH has had verbal agreements for two alternative site buildings to continue care for residents, patients, and community members.  Identification of others affected. This affected 22 residents, staff, and visitors.	1/18/18
E 026 SS=C	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8)  [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:]  (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.	E 026	It has the potential to affect all residents, staff, and visitors. CMH has partnered with Caribou County EMS, Soda Springs School District, and the Church of Jesus Christ of Latter Day Saints to build a community alternative site plan. Meetings have been set up to formally sign agreements for 12/22/17. The agreement that has been drafted, and will be agreed upon by the four entities, indicate that incident command will be set up by Caribou County EMS with the church building being the first alternative site that will be inspected for use and the Tigert Middle School being the second option	

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NAME OF PROVIDER OR SUPPLIER <b>CARIBOU MEMORIAL LIVING CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>300 SOUTH THIRD WEST SODA SPRINGS, ID 83276</b>
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E 026	<p>Continued From page 21</p> <p>*[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to document a current plan for the facility role under an 1135 waiver as declared by the Secretary and the provisions of care at an alternate site if identified by emergency management officials. Failure to plan for alternate means of care and the role under an 1135 waiver has the potential to limit facility options during an emergency. This deficient practice affected 22 residents, staff and visitors on the date of the survey. The facility is currently licensed for 30 SNF/NF beds and had a census of 22 on the date of the survey.</p> <p>Findings include:</p> <p>On 11/15/17 from 8:30 AM to 3:00 PM, review of the provided policies and procedures revealed the facility did not have a current policy or procedure that addressed the facility role during a disaster event. Policies, procedures and emergency plans provided ranged in date from 2003 to 2011, without documentation of annual reviews.</p> <p>Interview of the Administrator during the exit conference on 11/15/17 from 2:30 - 3:00 PM, he stated the facility was working with a consultant to update and develop the emergency plan to meet the requirements of this standard.</p>	E 026	<p>for the alternative site for healthcare operations. Caribou County EMS will assist in the transportation of patients/residents with the school district having busses available as back up for transportation. (CMH has a handicap bus that will be used as primary transportation with the above as alternatives.)</p> <p>Measures/Systemic Changes: Verbal agreements for MOU's have been given. Signed MOU's are pending 12/12/17. During the next year's drills and exercises, an after exercise briefing will be done to insure that the facilities were contacted within the guidelines of the Emergency Communication Plan to activate discussion on alternative site plans with the local EMS coordinator.</p> <p>Monitoring and tracking: Exercise briefing records will be reviewed by the safety committee to assure required elements were met. Deficiencies will be addressed and corrective action initiated. Results will be reported to the Quality Committee following each drill.</p> <p>Responsible: The Safety Committee Chairman and/or designee will be responsible for this corrective action.</p> <p>Attachment: 12, 13, 14, 15, 25</p>	

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E 026	Continued From page 22 Reference:  42 CFR 483.73 (b) (8)	E 026		
E 029 SS=F	Development of Communication Plan CFR(s): 483.73(c)  (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to document a current plan for facility communications. Communication plans are an essential component during an emergency. Failure to have a current communication plan has the potential to hinder both internal and external emergency response by personnel. This deficient practice affected 22 residents, staff and visitors on the date of the survey. The facility is currently licensed for 30 SNF/NF beds and had a census of 22 on the date of the survey.  Findings include:  On 11/15/17 from 8:30 AM to 3:00 PM, review of provided disaster and emergency policies and procedures revealed no current communication plan. Records from a policy and plan dated 2003 indicated the facility would utilize backup radio communication, but failed to document any updated version, policy or procedure as to how this method was utilized.  Interview of 4 of 4 staff members on 11/15/17 from 10:00 - 11:45 AM, failed to demonstrate staff had a working knowledge of a communications	E 029	E0029-  Corrective Action: CMH has completed an Emergency Communication plan that was put into place on 12/15/17 to comply with CFR(s) 483.73(b)(8).  Identification of others affected: This affected 22 residents, staff, and visitors. It has the potential to affect all residents, staff, and visitors. The CMH Emergency Communication Plan outlines the necessary procedures in order to communicate from start to end of an emergency situation.  Measures/Systemic Changes: Current staff will be trained on the new Emergency Operations Plan on January 9 <sup>th</sup> , 2017. All new hires receive education on the Emergency Operations plan during new hire orientation. CMH holds an annual reorientation program for all current employees, where they will review the Emergency Operations Plan. During the next year's drills and exercises, an after exercise briefing will be done to insure the process in the Communication Plan were followed and effective.	1/18/18

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E 029	Continued From page 23 plan. Further interview of the Administrator during the exit conference on 11/15/17 from 2:30 - 3:00 PM indicated he was not aware of the previous policy for the radio use. The Administrator further stated the policy and plan was currently being updated with the assistance of a consultant.  Reference:  42 CFR 483.73 (c)	E 029	Monitoring and tracking: Exercise briefing records will be reviewed by the safety committee to assure required elements were met. Deficiencies will be addressed and corrective action initiated. Results will be reported to the Quality Committee following each drill.	
E 032 SS=F	Primary/Alternate Means for Communication CFR(s): 483.73(c)(3)  [[c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following:  (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies.  *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to document a current plan for the primary and alternate means of communicating with staff, federal, state, tribal, regional and local emergency management agencies during an emergency. Lack of a current plan for facility communication options has the potential to hinder response efforts by staff and	E 032	Responsible: The Safety Committee Chairman and/or designee will be responsible for this corrective action.  Attachment: 16, 17  E032-  Corrective Action: CMH has completed an Emergency Communication plan that was put into place on 12/15/17.  Identification of others affected: This affected 22 residents, staff, and visitors. It has the potential to affect all residents, staff, and visitors. The CMH Emergency Communication Plan has a primary and alternative means of communication section listed as section 3. The section addresses the primary ways of communication and if all those are down, alternative ways to complete communication to allow operations of the EOP.	1/18/18

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E 032	Continued From page 24 emergency management agencies. This deficient practice affected 22 residents, staff and visitors on the date of the survey. The facility is currently licensed for 30 SNF/NF beds and had a census of 22 on the date of the survey.  Findings include:  On 11/15/17 from 8:30 AM to 3:00 PM, review of provided disaster and emergency policies and procedures revealed two policies which indicated communication procedures during an emergency. One plan was dated 2003 and the second plan was dated 2011. Neither plan indicated any annual review or update.  Interview of the Maintenance Engineer on 11/15/17 from 1:00 - 1:30 PM found he knew of emergency radios to be used during disasters, but no formal or updated plan on communications.  Reference:  42 CFR 483.73 (c) (3)	E 032	Measures/Systemic Changes: All current staff will be trained on the new Emergency Operations Plan on January 9 <sup>th</sup> , 2017. All new hires receive education on the Emergency Operations plan during new hire orientation. CMH holds an annual reorientation program for all current employees, where they will review the Emergency Operations Plan. During the next year's drills and exercises, an after exercise briefing will be done to insure the process in the Communication Plan were followed and effective.  Monitoring and tracking: Exercise briefing records will be reviewed by the safety committee to assure required elements were met. Deficiencies will be addressed and corrective action initiated. Results will be reported to the Quality Committee following each drill.  Responsible: The Safety Committee Chairman and/or designee will be responsible for this corrective action.  Attachment: 17, 18	
E 033 SS=C	Methods for Sharing Information CFR(s): 483.73(c)(4)-(6)  [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following:  (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care.	E 033		

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E 033	<p>Continued From page 25</p> <p>(5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.22(c), CORFs under §485.68(c), and RHCs/FQHCs under §491.12(c).]</p> <p>(6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4).</p> <p>*[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHC's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative.</p> <p>*[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to document a current plan for sharing information during an emergency. Lack of a current plan for sharing information with other health care providers has the potential to hinder the facility's ability to continue care during a disaster. This deficient practice affected 22 residents, staff and visitors on the date of the survey. The facility is currently licensed for 30 SNF/NF beds and had a census of 22 on the date of the survey.</p> <p>Findings include:</p>	E 033	<p>E033</p> <p>Action taken: A policy was written 12/13/17 entitled Communications-Disclosure of PHI During Disaster Relief Efforts.</p> <p>Identification of Others: This affected 22 residents, staff and visitors. It has the potential to affect all resident's staff and visitors. Residents will be educated on this policy at the next Monthly Resident Council Meeting. Families will be mailed an educational training packet.</p> <p>Measures/Systemic Changes: Ongoing, residents will be educated on this policy and other pertinent policies as needed at their monthly resident council meetings. For new admissions the DNS will provide and review an information packet with new residents, families and representatives.</p> <p>Monitoring and Tracking: The DNS/designee will monitor compliance of the education process, through QA monthly. The DNS/designee will reassess the needed frequency of the QA after 6 months.</p> <p>Responsible: The LTC DNS/designee will be responsible for monitoring this correction.</p>	1/18/18

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E 033	Continued From page 26  On 11/15/17 from 8:30 AM to 3:00 PM, review of provided disaster and emergency policies and procedures failed to demonstrate a current policy which could be implemented by the facility to share information for the care of residents with other healthcare providers. The reviewed emergency plan, policies and procedures ranged in dates from 2003 to 2011, without any documentation of a annual review or update.  Interview of the Administrator during the exit conference on 11/15/17 from 2:30 - 3:00 PM found the facility was currently re-writing the emergency plan, policies and procedures with the assistance of a consultant to meet this standard.  Reference:  42 CFR 483.73 (c) (4) - (6)	E 033	E034-  Corrective Action: CMH has completed an Emergency Communication plan that was put into place on 12/15/17.  Identification of others affected: This affected 22 residents, staff, and visitors. It has the potential to affect all residents, staff, and visitors. The CMH Emergency Communication Plan has attachment B as the flow chart for reporting out to local EMS and Healthcare coalitions to assure the needs are being met for local emergency situations, as well as for those in the region in Hospitals and Living Centers. This plan will allow for back up to other organizations, as well as covering CMH with needed beds, supplies, and employees needed during an emergency.  Measures/Systemic Changes: Current staff will be trained on the new Emergency Operations Plan on January 9 <sup>th</sup> , 2017. All new hires receive education on the Emergency	1/18/18
E 034 SS=C	Information on Occupancy/Needs CFR(s): 483.73(c)(7)  [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following:  (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.  *[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command	E 034		

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E 034	<p>Continued From page 27 Center, or designee.</p> <p>*[For Inpatient Hospice at §418.113:] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to document a current plan for sharing information on needs, occupancy and its ability to provide assistance with emergency management officials. Lack of a current plan for providing information to emergency personnel on the facility's needs and abilities to provide assistance during an emergency has the potential to hinder response assistance and continuation of care of residents. This deficient practice affected 22 residents, staff and visitors on the date of the survey. The facility is currently licensed for 30 SNF/NF beds and had a census of 22 on the date of the survey.</p> <p>Findings include:</p> <p>On 11/15/17 from 8:30 AM to 3:00 PM, review of provided policies, procedures and emergency plans revealed a range of dates from 2003 to 2011, with no indication of what method the facility would use to share information on its needs or capabilities with emergency management officials. Further review found no documentation was provided indicating an annual review or update had been conducted.</p> <p>During the exit conference on 11/15/17 from 2:30 - 3:00 PM the Administrator stated the facility was currently updating the policies and procedures</p>	E 034	<p>Operations plan during new hire orientation. CMH holds an annual reorientation program for all current employees, where they review the Emergency Operations Plan. During the next year's drills and exercises, an after exercise briefing will be done to insure the process in the Communication Plan was followed and effective.</p> <p>Monitoring and tracking: Exercise briefing records will be reviewed by the safety committee to assure required elements were met. Deficiencies will be addressed and corrective action initiated. Results will be reported to the Quality Committee following each drill.</p> <p>Responsible: The Safety Committee Chairman and/or designee will be responsible for this corrective action.</p> <p>Attachment: 20</p>	

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E 034	Continued From page 28 with the assistance of a consultant to be in substantial compliance with the standard.	E 034		
E 035 SS=C	<p>Reference:</p> <p>42 CFR 483.73 (c) (7)</p> <p>LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8)</p> <p>[(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following:</p> <p>(8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to provide a current plan for sharing information on the emergency plan with residents, families or representatives. Lack of a current plan for sharing information to residents, families or representatives has the potential to create confusion and lack of understanding of the facility's response during a disaster. This deficient practice affected 22 residents, staff and visitors on the date of the survey. The facility is currently licensed for 30 SNF/NF beds and had a census of 22 on the date of the survey.</p> <p>Findings include:</p> <p>On 11/15/17 from 8:30 AM to 3:00 PM, review of provided disaster and emergency policies and</p>	E 035	<p>E035</p> <p>Corrective Action: A policy on Communication with patients/residents and families was written on 12/13/17.</p> <p>Identification of others affected: This affected 22 residents, staff, and visitors. It has the potential to affect all residents, staff, and visitors. Residents will be educated on the EOP and policy at their next monthly Resident Council Meeting. Families will be mailed an Educational Training Packet.</p> <p>Measures/Systemic Changes: Ongoing, residents will be educated on the EOP and other pertinent policies at each of their monthly resident council meetings. For new admissions, the DNS/designee will provide and review an information packet with new residents, families/representatives.</p> <p>Monitoring and Tracking: The designee will monitor compliance through QA monthly. The DNS/designee will reassess the needed frequency of the QA after six months.</p> <p>Responsible: LTC DNS and/or designee.</p> <p>Attachment: 21</p>	1/18/18

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135060</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/15/2017</b>
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NAME OF PROVIDER OR SUPPLIER <b>CARIBOU MEMORIAL LIVING CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>300 SOUTH THIRD WEST SODA SPRINGS, ID 83276</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
E 035	Continued From page 29 procedures revealed a range of dates for policies, procedures and emergency plans from 2003 to 2011. No documentation was provided demonstrating the facility policy for sharing information with residents, their families or representatives, and no annual review or update had been conducted.  Interview of the Supervisor for the Living Center on 11/15/17 from 11:15 - 11:45 AM revealed he was not aware of any policies or procedures for sharing the emergency plan with residents, family or representatives  Reference: 42 CFR 483.73 (c) (8)	E 035	E036  Corrective Action: A policy on General Staff Training was written on 12/13/17.  Identification of others affected: This affected 22 residents, staff, and visitors. It has the potential to affect all residents, staff, and visitors. Training with the nursing home licensed and unlicensed staff was initiated at a staff meeting 12/12/17 where the following policies were reviewed: Emergency Management Plan, Shelter in Place, and Obtaining Water in an Emergency Situation.	1/18/18
E 036 SS=F	EP Training and Testing CFR(s): 483.73(d)  (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.  *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and	E 036	Measures/Systemic Changes: Under the direction of JR Consulting, this facility will develop and implement a training and testing program covering aspects of the facility's Emergency Operations Plan to be initiated January 9, 2017. Aspects of the EOP training will cover HVA results, ICS Structure, General Communications and Responsibilities, Activation of the EOP, Coordination with Local, State and Federal Resources and staff and resident safety. Other topics may be added and questions will be addressed. The program will become part of the New Employee	

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E 036	<p>Continued From page 30</p> <p>testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h).</p> <p>*[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, it was determined the facility failed to provide current emergency prep training and testing program. Lack of an emergency training and testing program covering the emergency preparedness plan and policies for the facility, has the potential to hinder staff response during a disaster. This deficient practice affected 22 residents, staff and visitors on the date of the survey. The facility is currently licensed for 30 SNF/NF beds and had a census of 22 on the date of the survey.</p> <p>Findings include:</p> <p>On 11/15/17 from 8:30 AM to 3:00 PM, review of provided disaster plans and emergency policies and procedures, revealed a range of dates for policies, procedures and emergency plans from 2003 to 2011. No documentation was provided demonstrating the facility had a current training and testing program for staff based on a specific</p>	E 036	<p>Orientation and be offered as an in-service to all facility employees. A basic pre- and post-test will be given, similar to the process developed at the FEMA Center for Domestic Preparedness Center. A record of those attending will be maintained with the facility's Education Department.</p> <p>Monitoring and Tracking: The Education Department will monitor compliance of pre- and post-testing and report to the Quality and Safety Committee monthly. The Education Department will reassess the needed frequency of the QA after six months.</p> <p>Responsible: Safety Committee Chair and/or designee, Education.</p> <p>Attachment: 22, 24</p>	

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E 036	Continued From page 31 plan, and no annual review or update had been conducted.  Interview of 4 of 4 staff members on 11/15/17 from 10:00 - 11:45 AM, revealed no specific training and testing was conducted on the emergency preparedness plan or policies. Further interview of the Supervisor of the Living Center found he was not aware of a particular program designed for training and testing on the emergency plan.  Reference: 42 CFR 483.73 (d)	E 036		
E 037 SS=F	EP Training Program CFR(s): 483.73(d)(1)  (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following:  (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles.	E 037	E037  Action Taken: Under the direction of JR Consulting, this facility will develop and implement a testing and training program covering aspects of the facility's Emergency Operations Plan to be initiated January 9, 2017.  Identification of other affected: This affected 22 residents, staff, and visitors. It has the potential to affect all residents, staff, and visitors. The program will become part of the New Employee Orientation and be offered as an in-service to all facility employees. A basic pre- and post-test will be given, similar to the process developed at the FEMA Center for Domestic Preparedness Center.	1/18/18

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E 037	<p>Continued From page 32</p> <p>(ii) Provide emergency preparedness training at least annually.</p> <p>(iii) Maintain documentation of the training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures.</p> <p>This is what's in SOM but is missing here.</p> <p>*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.</p> <p>(ii) Demonstrate staff knowledge of emergency procedures.</p> <p>(iii) Provide emergency preparedness training at least annually.</p> <p>(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.</p> <p>*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.</p> <p>(ii) After initial training, provide emergency preparedness training at least annually.</p> <p>(iii) Demonstrate staff knowledge of emergency procedures.</p> <p>(iv) Maintain documentation of all emergency preparedness training.</p> <p>*[For PACE at §460.84(d):] (1) The PACE</p>	E 037	<p>Measures/Systemic Changes: The training will also be included in the facility's annual re-orientation program. A record of those attending will be maintained with the facility's Education Department. The facility will conduct required exercises on an annual basis, either by actual events or planned exercises in conjunction with Local Emergency Responders.</p> <p>Monitoring and Tracking: The Education Department will monitor compliance of pre- and post-testing and report to the Quality and Safety Committee monthly. The Education Department will reassess the needed frequency of the QA after six months.</p> <p>Responsible: Safety Committee Chair and/or designee, Education.</p> <p>Attachment: 23</p>	
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E 037	<p>Continued From page 33</p> <p>organization must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.</p> <p>(ii) Provide emergency preparedness training at least annually.</p> <p>(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.</p> <p>(iv) Maintain documentation of all training.</p> <p>*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:</p> <p>(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.</p> <p>(ii) Provide emergency preparedness training at least annually.</p> <p>(iii) Maintain documentation of the training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.</p> <p>*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and</p>	E 037		

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E 037	<p>Continued From page 34</p> <p>cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.</p> <p>(ii) Provide emergency preparedness training at least annually.</p> <p>(iii) Maintain documentation of the training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures.</p> <p>*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, it was determined the facility failed to provide a current emergency prep training program. Lack of a training program on the emergency preparedness plan and policies for the facility, has the potential to hinder staff response during a disaster. This deficient practice affected 22 residents, staff and visitors on the date of the survey. The facility is currently licensed for 30 SNF/NF beds and had a census of 22 on the date of the survey.</p> <p>Findings include:</p> <p>On 11/15/17 from 8:30 AM to 3:00 PM, review of two provided emergency plans revealed the plans ranged in date from 2003 to 2011. No</p>	E 037		
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E 037	<p>Continued From page 35</p> <p>documentation was provided demonstrating the facility had a training program for staff based on either plan, and there was no indication an annual review or update had been conducted.</p> <p>Interview of 4 of 4 staff members on 11/15/17 from 10:00 - 11:45 AM revealed no specific training was conducted on the emergency plan or its contents. Further interview of the Supervisor of the Living Center indicated he was not sure which plan was the current plan being implemented by the facility for training.</p> <p>Interview of the Administrator during the exit conference on 11/15/17 from 2:30 - 3:00 PM confirmed the facility did not currently have a training program focused on the emergency plan as the facility was updating the content.</p> <p>Reference: 42 CFR 483.73 (d) (1)</p>	E 037		