



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

December 18, 2017

Craig Johnson, Administrator
Boundary County Nursing Home
6640 Kaniksu Street
Bonners Ferry, ID 83805-7532

Provider #: 135004

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Mr. Johnson:

On **December 6, 2017**, a Facility Fire Safety and Construction survey was conducted at **Boundary County Nursing Home** 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 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

Craig Johnson, Administrator
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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 **January 2, 2017**. Failure to submit an acceptable PoC by **January 2, 2017**, may result in the imposition of civil monetary penalties by **January 20, 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 **January 10, 2018**, (Opportunity to Correct). Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **January 10, 2018**. A change in the seriousness of the deficiencies on **January 10, 2018**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **January 10, 2018**, includes the following:

Craig Johnson, Administrator
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Page 3 of 4

Denial of payment for new admissions effective **March 6, 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 **June 6, 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 **December 6, 2017**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

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

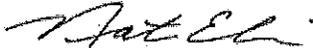
BFS Letters (06/30/11)

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

This request must be received by **January 2, 2017**. If your request for informal dispute resolution is received after **January 2, 2017**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626, option 3.

Sincerely,



Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosures

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

PRINTED: 12/15/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125004	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/06/2017
NAME OF PROVIDER OR SUPPLIER BOUNDARY COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 8840 KANIKSU STREET BONNERS FERRY, ID 83805	
(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 000	Initial Comments Unless otherwise indicated, the general use of the terms "facility" or "facilities" refers to all provider and suppliers effected by this regulation. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. The nursing facility is a Type V (111) structure, located on the upper level of a two story building, that is attached to the east end of the adjoining hospital. It is protected throughout by a complete automatic fire extinguishing system and a complete fire alarm system with smoke detection in corridors and open spaces. The nursing facility underwent a complete remodel and addition in 1994. The nursing facility is currently licensed for 28 SNF/NF beds, with a census of 25 on the date of survey. The following deficiencies were cited during the Emergency Preparedness Survey conducted on December 6, 2017. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73. The Survey was conducted by: Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction	E 000	E 001 The facility has developed and instituted Emergency Plans utilizing the HICS. However, the current plan does not meet all of the requirements of 42CFR483.73. Emergency Preparedness policies and procedures will be in full accordance with 42 CFR 483.73 to include complete Shelter in Place policies and procedures, which will also include medical supplies and pharmaceutical policies and procedures; which were lacking at the time of survey. To ensure all residents have been identified and systemic changes are implemented, all Emergency Preparedness plans will be reviewed to ensure they are complete and cover all residents, staff and volunteers which may be present in the facility. To begin re-writing the entire Emergency Operations Plan will commence no later than January 10, 2018. The Plan will be reviewed and re-written throughout the year in a manner which directly reflects the Hazard Vulnerability Assessment flow and will include detailed instructions for Evacuation and Shelter in Place, to include supplies and pharmaceuticals for all residents, staff, and volunteers that may be in the facility at the time of the event. Corrective action tracking and progress will be reported by the Facilities Director to the Interdisciplinary Committee monthly to ensure compliance, progress and monitoring.	01/10/2018
E 001 SS=F	Establishment of the Emergency Program (EP) CFR(s): 483.73 The [facility, except for Transplant Center] must comply with all applicable Federal, State and local emergency preparedness requirements. The	E 001		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE CEO (X6) DATE 1/2/2018

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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NAME OF PROVIDER OR SUPPLIER BOUNDARY COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 8640 KANIKSU STREET BONNERS FERRY, ID 83805	
(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>[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> <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:</p> <p>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 25 residents, staff and visitors on the date of the survey. The facility is currently licensed for 28 SNF/NF beds and had a census of 25 on the day of the survey.</p> <p>CFR reference: 42 CFR 483.73</p>	E 001		

Sullivan CEO 1/9/2018

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: 135004	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/08/2017
NAME OF PROVIDER OR SUPPLIER BOUNDARY COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 8640 KANIKSU STREET BONNERS FERRY, ID 83805		
(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 015 SS=F	<p>Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1)</p> <p>[(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:</p> <p>(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:</p> <p>(i) Food, water, medical and pharmaceutical supplies</p> <p>(ii) Alternate sources of energy to maintain the following:</p> <p>(A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.</p> <p>(B) Emergency lighting.</p> <p>(C) Fire detection, extinguishing, and alarm systems.</p> <p>(D) Sewage and waste disposal.</p> <p>*[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures.</p> <p>(6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following:</p> <p>(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:</p> <p>(A) Food, water, medical, and pharmaceutical</p>	E 015	<p>E 015</p> <p>To ensure all residents have been identified and systemic changes are implemented, all Emergency Preparedness plans will be reviewed to ensure they are complete and cover all residents, staff and volunteers which may be present in the facility. To begin re-writing the entire Emergency Operations Plan will commence no later than January 10, 2018. The Plan will be reviewed and re-written throughout the year in a manner which directly reflects the Hazard Vulnerability Assessment flow and will include detailed instructions for Evacuation and Shelter in Place, to include supplies and pharmaceuticals for all residents, staff, and volunteers that may be in the facility at the time of the event. Corrective action tracking and progress will be reported by the Facilities Director to the Interdisciplinary Committee monthly to ensure compliance, progress and monitoring.</p>	01/10/2018	

[Handwritten Signature] CEO 1/2/2018

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

PRINTED: 12/15/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135004	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/06/2017
NAME OF PROVIDER OR SUPPLIER BOUNDARY COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 5640 KANIKSU STREET BONNERS FERRY, ID 83805		
(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 015	<p>Continued From page 3 supplies.</p> <p>(B) Alternate sources of energy to maintain the following:</p> <p>(1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.</p> <p>(2) Emergency lighting.</p> <p>(3) Fire detection, extinguishing, and alarm systems.</p> <p>(C) Sewage and waste disposal.</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 develop and maintain current policies and procedures, 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 25 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>On 12/6/17 from 8:00 AM to 1:30 PM, review of provided policies and procedures for the facility revealed, medical and pharmaceutical supplies were not included in the subsistence plan for both residents and staff in the event of evacuation or shelter in place during a disaster. The facility did have provisions in place for food, water, and alternate sources of energy.</p> <p>Interview of the Physical Facilities Manager revealed the facility was currently in the process of updating these policies and procedures to include medical and pharmaceutical supplies.</p>	E 015			

S. Jensen CEO

1/2/2018

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: 135004	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/06/2017
NAME OF PROVIDER OR SUPPLIER BOUNDARY COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 5640 KANIKSU STREET BONNERS FERRY, ID 83805		
(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 015	Continued From page 4	E 015			
E 022 SS=F	<p>Reference:</p> <p>42 CFR 483.73 (b) (1) Policies/Procedures for Sheltering in Place CFR(s): 483.73(b)(4)</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>(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].</p> <p>*[For Inpatient Hospices at §418.113(b):] Policies and procedures.</p> <p>(6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following:</p> <p>(i) A means to shelter in place for patients, hospice employees who remain in the hospice. 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 and procedure for sheltering in place. Lack of a current policy and procedure for sheltering in</p>	E 022	<p>E 022</p> <p>To ensure all residents have been identified and systemic changes are implemented, all Emergency Preparedness plans will be reviewed to ensure they are complete and cover all residents, staff and volunteers which may be present in the facility. To begin re-writing the entire Emergency Operations Plan will commence no later than January 10, 2018. The Plan will be reviewed and re-written throughout the year in a manner which directly reflects the Hazard Vulnerability Assessment flow and will include detailed instructions for Evacuation and Shelter In Place. Corrective action tracking and progress will be reported by the Facilities Director to the Interdisciplinary Committee monthly to ensure compliance, progress and monitoring.</p>	01/10/2018	

[Signature] CEO 1/2/2018

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

PRINTED: 12/15/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135004	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/06/2017
NAME OF PROVIDER OR SUPPLIER BOUNDARY COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 6640 KANIKSU STREET BONNERS FERRY, ID 83805		
(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 022	Continued From page 5 place has the potential to leave residents and staff without resources to continue care during an emergency. This deficient practice affected 25 residents, staff and visitors on the date of the survey. Findings include: On 12/6/17 from 8:30 AM to 1:30 PM, review of provided policies, procedures and emergency planning records, failed to produce policies and procedures for sheltering in place. Interview of the Physical Facilities Manager revealed the facility had verbally made plans for sheltering in place, but had not yet put it in writing. Reference: 42 CFR 483.73 (b) (4)	E 022			
E 035 SS=C	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) [(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: (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	E 035	E 035 The method for sharing information from the emergency plan or actions will be added to the "resident handbook" no later than 1.10.18, which is given to residents [or clients] and their families or representatives during the admitting process. All current residents [or clients] and their families or representatives will be given or sent a copy of the updated resident handbook. Corrective action compliance will be reported by the Facilities Director to the Interdisciplinary Disciplinary Committee on a monthly basis.	01/18/2018	

[Handwritten Signature] CEO 1/2/2018

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135004	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/06/2017
NAME OF PROVIDER OR SUPPLIER BOUNDARY COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 6640 KANIKSU STREET BONNERS FERRY, ID 83805		
(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 6 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 could potentially affect 25 residents, staff and visitors on the date of the survey. Findings include: On 12/6/17 from 8:30 AM to 1:30 PM, review of provided disaster and emergency policies and procedures revealed no documentation of a policy for sharing information with residents, their families or representatives. Interview of the Physical Facilities Manager revealed the facility had verbally made plans for the sharing of information to residents, families or representatives, but had not yet put it in writing. Reference: 42 CFR 483.73 (c) (8)	E 035			

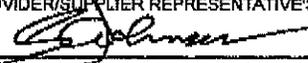
[Handwritten Signature] ASD 1/2/2018

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

PRINTED: 12/15/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135004	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE BLDG B. WING _____	(X3) DATE SURVEY COMPLETED 12/06/2017
NAME OF PROVIDER OR SUPPLIER BOUNDARY COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 6640 KANIKSU STREET BONNERS FERRY, ID 83805	
(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>INITIAL COMMENTS</p> <p>The nursing facility is a Type V (111) structure, located on the upper level of a two story building, that is attached to the east end of the adjoining hospital. It is protected throughout by a complete automatic fire extinguishing system and a complete fire alarm system with smoke detection in corridors and open spaces. The nursing facility underwent a complete remodel and addition in 1994. The nursing facility is currently licensed for 28 SNF/NF beds.</p> <p>The facility was found to be in substantial compliance during the annual fire/life safety survey conducted on December 6, 2017. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70, 42 CFR 483.80 and 42 CFR 483.65.</p> <p>The Survey was conducted by:</p> <p>Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction</p>	K 000	<p>All dates indicated are for the year 2017.</p> <p>Disclaimer: Plan of correction is being submitted in accordance with specific regulatory requirements. It shall not be construed as an admission of any deficiency cited.</p>	

RECEIVED
JAN 02 2017
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE CEO (X6) DATE 1/2/2018

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.