



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

January 23, 2018

Mark Teckmeyer, Administrator
Bingham Memorial Skilled Nursing & Rehabilitation
98 Poplar Street
Blackfoot, ID 83221-1758

Provider #: 135007

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Mr.. Teckmeyer:

On **January 10, 2018**, a Facility Fire Safety and Construction survey was conducted at **Bingham Memorial Skilled Nursing & Rehabilitation** 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

Mark Teckmeyer, Administrator
January 23, 2018
Page 2 of 4

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 **February 5, 2018**. Failure to submit an acceptable PoC by **February 5, 2018**, may result in the imposition of civil monetary penalties by **February 25, 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 **February 14, 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 **February 14, 2018**. A change in the seriousness of the deficiencies on **February 14, 2018**, may result in a change in the remedy.

Mark Teckmeyer, Administrator
January 23, 2018
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The remedy, which will be recommended if substantial compliance has not been achieved by **February 14, 2018**, includes the following:

Denial of payment for new admissions effective **April 10, 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 **July 10, 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 **January 10, 2018**, 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:

Mark Teckmeyer, Administrator
January 23, 2018
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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 **February 5, 2018**. If your request for informal dispute resolution is received after **February 5, 2018**, 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: 01/25/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135007	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE NF B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2018
NAME OF PROVIDER OR SUPPLIER BINGHAM MEMORIAL SKILLED NURSING & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 98 POPLAR STREET BLACKFOOT, ID 83221		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 000	INITIAL COMMENTS The facility is a single story, type V (III) structure with a two hour fire wall to the JCAHO accredited hospital. The facility was originally built in 1963 with renovation and addition in 1999. The building is fully sprinklered. The facility is licensed for 60 SNF/NF beds and had a census of 38 on January 9, 2018 and a census of 36 on January 10, 2018, the dates of the survey. The following deficiencies were cited during the annual fire/life safety survey conducted on January 9 - 10, 2018. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Chapter 19, Existing Healthcare Occupancies, in accordance with 42 CFR 483.70, 42 CFR 483.80 and 42 CFR 483.65. The Survey was conducted by: Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction	K 000	K-325 *CORRECTIVE ACTION FOR POTENTIAL RESIDENTS THAT MAY BE AFFECTED BY THIS DEFICIENT PRACTICE: All residents have the potential to be affected by this deficient practice. *MEASURES (FACILITY SYSTEMS) THAT WILL BE PUT IN PLACE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: Please find our ABHR ➤ Purell/Provon Vendor ○ A guide to Healthcare Products & Programs ○ Attached ➤ Hand Sanitizer Log Sheet was developed to meet NFPA 101 Guidelines ○ Date ○ Time ○ AREA ○ Working Correctly Yes/No ○ Replaced ○ Signature		
K 325 SS=F	Alcohol Based Hand Rub Dispenser (ABHR) CFR(s): NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet,	K 325			

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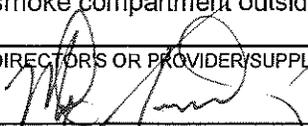
FEB - 8 2018

FACILITY STANDARDS

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE



NHA

2.5.18

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 325	<p>Continued From page 1</p> <p>excluding one individual dispenser per room</p> <ul style="list-style-type: none"> * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, observation and interview, the facility failed to ensure Alcohol Based Hand Rub Dispensers (ABHR) were maintained in accordance with NFPA 101. Failure to test and document the operation of ABHR dispensers in accordance with the manufacturer's care and use instructions each time a new refill is installed could result in inadvertently spilling flammable liquids, increasing the risk of fires. This deficient practice affected all residents, staff and visitors on the dates of the survey.</p> <p>Findings include:</p> <p>During the review of facility inspection records on January 9, 2018 from approximately 1:00 PM to 4:00 PM, no records were available indicating ABHR dispensers were tested in accordance with manufacturer's care and use instructions when a new refill is installed. ABHR dispensers were observed throughout the facility and when asked, the Director of Engineering stated the facility was not aware of the requirement to test ABHR dispensers each time a new refill is installed.</p>	K 325	<p>*MONITORING</p> <p>A: WHO</p> <p>The ABM Housekeeping/Laundry Manager, NHA and/or Designee with will be charged with training and monitoring of the Skilled Nursing & Rehab. Center.</p> <p>Furthermore our QAPI Committee will be monitoring our progress on implementation and training.</p> <p>B: FREQUENCY</p> <p>NHA/Designee will monitor weekly for four weeks. Then, monthly for two months. Report Sheets to be forwarded from our ABM H/L Manager.</p> <p>C: STARTE DATE</p> <p>January 15, 2018</p> <p>*DATE WHEN CORRECTIVE ACTION IS COMPLETED</p> <p>February 14, 2018</p>	

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K 325	<p>Continued From page 2</p> <p>Actual NFPA standard:</p> <p>NFPA 101</p> <p>19.3.2.6* Alcohol-Based Hand-Rub Dispensers. Alcohol-based hand-rub dispensers shall be protected in accordance with 8.7.3.1, unless all of the following conditions are met:</p> <p>(1) Where dispensers are installed in a corridor, the corridor shall have a minimum width of 6 ft (1830 mm).</p> <p>(2) The maximum individual dispenser fluid capacity shall be as follows:</p> <p>(a) 0.32 gal (1.2 L) for dispensers in rooms, corridors, and areas open to corridors</p> <p>(b) 0.53 gal (2.0 L) for dispensers in suites of rooms</p> <p>(3) Where aerosol containers are used, the maximum capacity of the aerosol dispenser shall be 18 oz. (0.51 kg) and shall be limited to Level 1 aerosols as defined in NFPA30B, Code for the Manufacture and Storage of Aerosol Products.</p> <p>(4) Dispensers shall be separated from each other by horizontal spacing of not less than 48 in. (1220 mm).</p> <p>(5) Not more than an aggregate 10 gal (37.8 L) of alcohol-based hand-rub solution or 1135 oz (32.2 kg) of Level 1 aerosols, or a combination of liquids and Level 1 aerosols not to exceed, in total, the equivalent of 10 gal (37.8 L) or 1135 oz (32.2 kg), shall be in use outside of a storage cabinet in a single smoke compartment, except as otherwise provided in 19.3.2.6(6).</p> <p>(6) One dispenser complying with 19.3.2.6 (2) or (3) per room and located in that room shall not be included in the aggregated quantity addressed in 19.3.2.6(5).</p> <p>(7) Storage of quantities greater than 5 gal (18.9</p>	K 325		

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K 325	<p>Continued From page 3</p> <p>L) in a single smoke compartment shall meet the requirements of NFPA 30, Flammable and Combustible Liquids Code.</p> <p>(8) Dispensers shall not be installed in the following locations:</p> <p>(a) Above an ignition source within a 1 in. (25 mm) horizontal distance from each side of the ignition source</p> <p>(b) To the side of an ignition source within a 1 in. (25 mm) horizontal distance from the ignition source</p> <p>(c) Beneath an ignition source within a 1 in. (25 mm) vertical distance from the ignition source</p> <p>(9) Dispensers installed directly over carpeted floors shall be permitted only in sprinklered smoke compartments.</p> <p>(10) The alcohol-based hand-rub solution shall not exceed 95 percent alcohol content by volume.</p> <p>(11) Operation of the dispenser shall comply with the following criteria:</p> <p>(a) The dispenser shall not release its contents except when the dispenser is activated, either manually or automatically by touch-free activation.</p> <p>(b) Any activation of the dispenser shall occur only when an object is placed within 4 in. (100 mm) of the sensing device.</p> <p>(c) An object placed within the activation zone and left in place shall not cause more than one activation.</p> <p>(d) The dispenser shall not dispense more solution than the amount required for hand hygiene consistent with label instructions.</p> <p>(e) The dispenser shall be designed, constructed, and operated in a manner that ensures that accidental or malicious activation of the dispensing device is minimized.</p> <p>(f) The dispenser shall be tested in</p>	K 325		

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K 325	Continued From page 4 accordance with the manufacturer's care and use instructions each time a new refill is installed.	K 325		
K 911 SS=F	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems 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, Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the Essential Electrical System (EES) generator was equipped with a remote manual stop switch. Failure to provide a remote manual stop station for emergency generators has the potential to prevent shutdown of the emergency generator during a system malfunction, unintentional operation or other adverse generator conditions. This deficient practice affected all residents, staff and visitors on the dates of the survey. Findings include: During the facility tour conducted on January 10, 2018, from approximately 1:00 PM to 4:00 PM, observation revealed the facility did not have a remote manual stop switch for the EES generator outside of the room where the prime mover is housed. When asked, the Director of Engineering stated the facility was not equipped with a remote stop switch.	K 911	*CORRECTIVE ACTION FOR POTENTIAL RESIDENTS THAT MAY BE AFFECTED BY THIS DEFICIENT PRACTICE: All residents have the potential to be affected by this deficient practice. *MEASURES (FACILITY SYSTEMS) THAT WILL BE PUT IN PLACE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: We have given Mountain West Electrical the bid/job to install an Emergency Remote Stop Switch to our Emergency Electrical Generators located in the basement of Bingham Memorial Hospital. These Generators supply Emergency Power to the SNRC amongst other areas of the BMH campus. ➤ Mountain West Electric ○ 586 W Highway 26 Suite 1 ○ Blackfoot, ID 83221 ○ 208-684-5463 ➤ Emergency Stop Switch to be installed just outside the door of the Emergency	

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K 911	Continued From page 5 Actual NFPA standard: NFPA 110 5.6.5.6* All installations, shall have a remote manual stop station of a type to prevent inadvertent or unintentional operation located outside the room housing the prime mover, where so installed, or elsewhere on the premises where the prime mover is located outside the building. 5.6.5.6.1 The remote manual stop station shall be labeled. NFPA 99 6.4.1.1.16.2 Safety indications and shutdowns shall be in accordance with Table 6.4.1.1.16.2. (SEE TABLE)	K 911	Generator Room. o ESS will be accessible by an BMH Employee. ➤ Job Completion no later than 2.14.18 o Validated by bill of sale with details of work completion. *MONITORING A: WHO The ABM Housekeeping/Laundry Manager, NHA and/or Designee with will be charged with training and monitoring of the Skilled Nursing & Rehab. Center. Furthermore our QAPI Committee will be monitoring our progress on implementation and training. B: FREQUENCY NHA/Designee will monitor weekly for four weeks. Then, monthly for two months. Report Sheets to be forwarded from our ABM H/L Manager. C: STARTE DATE January 15, 2018 *DATE WHEN CORRECTIVE ACTION IS COMPLETED February 14, 2018	

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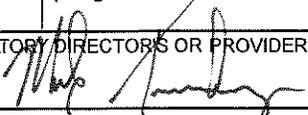
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E 000	Initial Comments Unless otherwise indicated, the general use of the terms "facility" or "facilities" refers to all provider and suppliers affected by this regulation. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. The facility is a single story, type V (III) structure with a two hour fire wall to the JCAHO accredited hospital. The facility was originally built in 1963 with renovation and addition in 1999. The building is fully sprinklered. The facility is currently licensed for 60 SNF/NF beds and had a census of 38 on January 9, 2018 and 36 on January 10, 2018, the dates of the survey. The following deficiencies were cited during the Emergency Preparedness Survey conducted on January 9 - 10, 2018. 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	RECEIVED FEB - 7 2018 FACILITY STANDARDS Please refer to Attached Plan of Correction	
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 [facility] must establish and maintain a comprehensive emergency preparedness program that meets the requirements of this	E 001		

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

TITLE

(X6) DATE



NHA

2.5.18

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 001	Continued From page 1 section.* The emergency preparedness program must include, but not be limited to, the following elements: *[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. *[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 all residents, staff and visitors on the date of the survey. Reference: 42 CFR 483.73	E 001			
E 004 SS=F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a)	E 004			

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E 004	<p>Continued From page 2</p> <p>[The [facility] must comply with all applicable 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:]</p> <p>(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:</p> <p>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</p>	E 004			

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E 004	<p>Continued From page 3</p> <p>disaster. This deficient practice affected all residents, staff and visitors on the dates of the survey.</p> <p>Findings include:</p> <p>On January 10, 2018 from 8:30 AM to 1:00 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 was an incomplete draft that was still being developed. When asked, the two staff members tasked with developing the Emergency Preparedness Plan stated they were planning to attend a training later this month on Emergency Preparedness and were waiting until after that training to complete the 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 0009 as it relates to a process for cooperation and collaboration with local, tribal, regional, State, and Federal Emergency Preparedness Officials' efforts to maintain an integrated response during a disaster.</p> <p>d. 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>	E 004		

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E 004	<p>Continued From page 4</p> <p>e. 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>f. Refer to E 0018 as it relates to the policies and procedures for tracking residents and staff in the event of a disaster.</p> <p>g. 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>h. Refer to E 0023 as it relates to the policies and procedures for a system of medical documentation that preserves patient information, protects confidentiality of patient information and maintains availability of records.</p> <p>i. Refer to E 0029 as it relates to the development and annual update of the Communications Plan.</p> <p>j. Refer to E 0030 as it relates to the required contact information in the Communication Plan.</p> <p>k. 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>l. 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>m. 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> <p>n. Refer to E 0036 as it relates to the</p>	E 004		

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E 004	Continued From page 5 development and implementation of an annual training and testing program as it relates to the emergency preparedness plan. o. Refer to E 0037 as it relates to the emergency training program and the staff knowledge of emergency procedures. The cumulative effect of these systemic deficient practices, impeded the facility's ability to meet the emergency preparedness standard(s) and the potential needs of the patients during a disaster. Reference: 42 CFR 483.73 (a) Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) [(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:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* *[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. *[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.	E 004			
E 006 SS=F		E 006			

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E 006	<p>Continued From page 6</p> <p>(2) Include strategies for addressing emergency 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.</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 identified strategies for response to the facility-based and community-based risk assessment. Failure to include a plan for response to hazards identified by the risk assessment could hinder or slow the facility response to disasters and emergencies. This deficient practice affected all residents, staff and visitors on the dates of the survey.</p> <p>Findings include:</p> <p>On January 10, 2018 from 8:30 AM to 1:00 PM, review of the provided emergency preparedness plan revealed a current facility and community based risk assessment had been conducted. However, strategies for response to the identified hazards were not included in the plan. A generic emergency preparedness template was provided by the facility, but it was not facility specific or complete. When asked, the two staff members tasked with developing the Emergency Preparedness Plan stated they were planning to attend a training later this month on Emergency Preparedness and were waiting until after that training to complete the plan.</p>	E 006		

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E 006	Continued From page 7 Reference:	E 006			
E 007 SS=D	42 CFR 483.73 (a) (1) - (2) EP Program Patient Population CFR(s): 483.73(a)(3) [(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:] (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. ** *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 all residents, staff and visitors on the dates of the survey. Findings include:	E 007			

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E 007	Continued From page 8 On January 10, 2018 from 8:30 AM to 1:00 PM, review of provided policies and procedures and the provided emergency plan did not reveal a current, updated plan which included delegations of authority and succession planning. When asked, the two staff members tasked with developing the Emergency Preparedness Plan stated they were planning to attend a training later this month on Emergency Preparedness and were waiting until after that training to complete the plan. Reference: 42 CFR 483.73 (a) (3) Local, State, Tribal Collaboration Process CFR(s): 483.73(a)(4) [(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:] (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. * [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts	E 007			
:009 SS=D		E 009			

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E 009	<p>Continued From page 9</p> <p>to maintain an integrated response during a disaster or emergency situation, including documentation of the dialysis facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, it was determined the facility had not developed a written process for cooperation and collaboration with other entities and emergency responders within their community to promote an integrated response to emergency events. This deficient practice had the potential to affect all residents, staff and visitors on the dates of the survey.</p> <p>Findings include:</p> <p>Review of the facility emergency plan on January 10, 2018, from approximately 8:30 AM to 1:00 PM, revealed the facility failed to include a process in the Emergency Preparedness Plan to collaborate with local, tribal, regional, State, and Federal officials in an effort to maintain an integrated response. When asked, the two staff members tasked with developing the Emergency Preparedness Plan stated they were planning to attend a training later this month on Emergency Preparedness and were waiting until after that training to complete the plan.</p> <p>Reference:</p> <p>42 CFR 483.73 (a) (4)</p>	E 009			

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E 013 SS=F	<p>Development of EP Policies and Procedures CFR(s): 483.73(b)</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.</p> <p>*Additional Requirements for PACE and ESRD Facilities:</p> <p>*[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 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</p>	E 013			

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E 013	<p>Continued From page 11</p> <p>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:</p> <p>Based on record review and interview, it was determined the facility failed to develop current policies and procedures based on the Emergency Plan. Failure to develop current policies and procedures based on the emergency plan, including the facility and community based risk assessment and facility communications plan, limits the facility response capabilities in the protection of residents during a disaster or other emergency. This deficient practice affected all residents, staff and visitors on the dates of the survey.</p> <p>Findings include:</p> <p>On January 10, 2018 from 8:30 AM to 1:00 PM, review of the provided emergency preparedness plan revealed the facility was still developing policies and procedures for their Emergency Preparedness Plan. A generic emergency preparedness template was provided by the facility, but it was not facility specific or complete. When asked, the two staff members tasked with developing the Emergency Preparedness Plan stated they were planning to attend a training later this month on Emergency Preparedness and were waiting until after that training to complete the plan.</p> <p>Reference:</p> <p>42 CFR 483.73 (b)</p>	E 013		

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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		

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E 015	<p>Continued From page 13</p> <p>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 all residents, staff and visitors on the dates of the survey.</p> <p>Findings include:</p> <p>On January 10, 2018 from 8:30 AM to 1:00 PM, review of the 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. A generic emergency preparedness template was provided by the facility, but it was not facility specific or complete. When asked, the two staff members tasked with developing the Emergency Preparedness Plan stated they were planning to attend a training later this month on Emergency Preparedness and</p>	E 015		

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NAME OF PROVIDER OR SUPPLIER BINGHAM MEMORIAL SKILLED NURSING & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 98 POPLAR STREET BLACKFOOT, ID 83221		
(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 14 were waiting until after that training to complete the plan. Reference: 42 CFR 483.73 (b) (1)	E 015			
E 018 SS=F	Procedures for Tracking of Staff and Patients CFR(s): 483.73(b)(2) [(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: (2) A system to track the location of on-duty staff 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. *[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.	E 018			

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E 018	<p>Continued From page 15</p> <p>*[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures.</p> <p>(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.</p> <p>(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 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>	E 018		

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E 018	Continued From page 16 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 all residents, staff and visitors on the dates of the survey. Findings include: On January 10, 2018 from 8:30 AM to 1:00 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. When asked, the two staff members tasked with developing the Emergency Preparedness Plan stated they were planning to attend a training later this month on Emergency Preparedness and were waiting until after that training to complete the plan. 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	E 022		

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E 022	<p>Continued From page 17</p> <p>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 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 all residents, staff and visitors on the dates of the survey.</p> <p>Findings include:</p> <p>On January 10, 2018 from 8:30 AM to 1:00 PM, review of provided policies, procedures and emergency planning records, failed to demonstrate current and annually reviewed policies and procedures for sheltering in place. A</p>	E 022			

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E 022	Continued From page 18 generic emergency preparedness template was provided by the facility, but it was not facility specific or complete. When asked, the two staff members tasked with developing the Emergency Preparedness Plan stated they were planning to attend a training later this month on Emergency Preparedness and were waiting until after that training to complete the plan. Reference: 42 CFR 483.73 (b) (4)	E 022			
E 023 SS=D	Policies/Procedures for Medical Documentation CFR(s): 483.73(b)(5) [(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:] (5) A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. [(5) or (3),(4),(6)] A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. This is what's in SOM. *[For RNHCIs at §403.748(b):] Policies and procedures. (5) A system of care documentation	E 023			

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E 023	<p>Continued From page 19 that does the following: (i) Preserves patient information. (ii) Protects confidentiality of patient information. (iii) Secures and maintains the availability of records.</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. 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 a system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. Lack of a current policy and procedure for medical documentation has the potential to leave residents and staff without resources to continue care during an emergency. This deficient practice affected all residents, staff and visitors on the dates of the survey.</p> <p>Findings include: On January 10, 2018 from 8:30 AM to 1:00 PM, review of provided policies, procedures and emergency planning records, failed to demonstrate current and annually reviewed policies and procedures for a system of medical documentation that would preserve resident information, protect confidentiality and maintain the availability of records. A generic emergency preparedness template was provided by the facility, but it was not facility specific or complete.</p>	E 023			

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E 023	Continued From page 20 When asked, the two staff members tasked with developing the Emergency Preparedness Plan stated they were planning to attend a training later this month on Emergency Preparedness and were waiting until after that training to complete the plan. Reference: 42 CFR 483.73 (b) (5)	E 023			
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 all residents, staff and visitors on the dates of the survey. Findings include: On January 10, 2018 from 8:30 AM to 1:00 PM, review of provided disaster and emergency policies and procedures revealed no current communication plan. A generic emergency preparedness template was provided by the	E 029			

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E 029	Continued From page 21 facility, but it was not facility specific or complete. When asked, the two staff members tasked with developing the Emergency Preparedness Plan stated they were planning to attend a training later this month on Emergency Preparedness and were waiting until after that training to complete the plan. Reference: 42 CFR 483.73 (c)	E 029		
E 030 SS=C	Names and Contact Information CFR(s): 483.73(c)(1) [(c) The [facility, except RNHCs, hospices, transplant centers, and HHAs] 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:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For RNHCs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian.	E 030		

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E 030	<p>Continued From page 22</p> <p>(iv) Other RNHCIs. (v) Volunteers.</p> <p>*[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers.</p> <p>*[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices.</p> <p>*[For OPOs at §486.360(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to document a communication plan with all required elements. Failure to have a communication plan complete with names and contact information, has the</p>	E 030		

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E 030	Continued From page 23 potential to hinder both internal and external emergency response by personnel. This deficient practice had the potential to affect all residents, staff and visitors on the dates of the survey. Findings Include: On January 10, 2018 from 8:30 AM to 1:00 PM, review of the facility emergency plan revealed the communication portion of the plan failed to provide the names and contact information for staff, entities providing services under arrangement, and resident's physicians. A generic emergency preparedness template was provided by the facility, but it was not facility specific or complete. When asked, the two staff members tasked with developing the Emergency Preparedness Plan stated they were planning to attend a training later this month on Emergency Preparedness and were waiting until after that training to complete the plan. Reference: 42 CFR 483.73 (c) (1)	E 030			
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	E 033			

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E 033	<p>Continued From page 24 maintain the continuity of care.</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 RNHCs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI'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). 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 could potentially affect all residents, staff and visitors on the dates of the survey.</p>	E 033			

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E 033	Continued From page 25 Findings include: On January 10, 2018 from 8:30 AM to 1:00 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. A generic emergency preparedness template was provided by the facility, but it was not facility specific or complete. When asked, the two staff members tasked with developing the Emergency Preparedness Plan stated they were planning to attend a training later this month on Emergency Preparedness and were waiting until after that training to complete the plan. Reference: 42 CFR 483.73 (c) (4) - (6)	E 033			
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	E 034			

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E 034	<p>Continued From page 26</p> <p>its ability to provide assistance, to the authority having jurisdiction, the Incident Command 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:</p> <p>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 could potentially affect all residents, staff and visitors on the dates of the survey.</p> <p>Findings include:</p> <p>On January 10, 2018 from 8:30 AM to 1:00 PM, review of provided policies, procedures and emergency planning records, failed to demonstrate what method the facility would use to share information on its needs or capabilities with emergency management officials. A generic emergency preparedness template was provided by the facility, but it was not facility specific or complete. When asked, the two staff members tasked with developing the Emergency Preparedness Plan stated they were planning to</p>	E 034			

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NAME OF PROVIDER OR SUPPLIER BINGHAM MEMORIAL SKILLED NURSING & REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 98 POPLAR STREET BLACKFOOT, ID 83221		
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E 034	Continued From page 27 attend a training later this month on Emergency Preparedness and were waiting until after that training to complete the plan. Reference:	E 034		
E 035 SS=C	42 CFR 483.73 (c) (7) 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 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 all residents, staff and visitors on the dates of the survey. Findings include: On January 10, 2018 from 8:30 AM to 1:00 PM,	E 035		

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E 035	Continued From page 28 review of the facility emergency plan revealed 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. A generic emergency preparedness template was provided by the facility, but it was not facility specific or complete. When asked, the two staff members tasked with developing the Emergency Preparedness Plan stated they were planning to attend a training later this month on Emergency Preparedness and were waiting until after that training to complete the plan.	E 035			
E 036 SS=F	Reference: 42 CFR 483.73 (c) (8) 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	E 036			

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E 036	Continued From page 29 section, and the communication plan at paragraph (c) of this section. The training and 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). *[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. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to provide current emergency preparedness 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 all residents, staff and visitors on the dates of the survey. Findings include: On January 10, 2018 from 8:30 AM to 1:00 PM, review of provided disaster and emergency policies and procedures revealed no documentation was provided demonstrating the facility had a current training and testing program	E 036			

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E 036	Continued From page 30 for staff based on a specific plan, and no annual review or update had been conducted. When asked, the two staff members tasked with developing the Emergency Preparedness Plan stated they were planning to attend a training later this month on Emergency Preparedness and were waiting until after that training to complete the 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. (ii) Provide emergency preparedness training at	E 037		

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E 037	<p>Continued From page 31</p> <p>least annually.</p> <p>(iii) Maintain documentation of the training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures.</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			

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E 037	<p>Continued From page 32</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,</p>	E 037			

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E 037	<p>Continued From page 33</p> <p>and where necessary, evacuation of patients, personnel, and guests, fire prevention, and 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: 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 all residents, staff and visitors on the dates of the survey.</p> <p>Findings include:</p> <p>On January 10, 2018 from 8:30 AM to 1:00 PM,</p>	E 037		

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E 037	<p>Continued From page 34</p> <p>review of the facility emergency plan revealed no documentation demonstrating the facility had implemented a training program for staff based on an Emergency Preparedness Plan. A generic emergency preparedness template was provided by the facility, but it was not facility specific or complete. When asked, the two staff members tasked with developing the Emergency Preparedness Plan stated they were planning to attend a training later this month on Emergency Preparedness and were waiting until after that training to complete the plan.</p> <p>Reference: 42 CFR 483.73 (d) (1)</p>	E 037		