



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

February 7, 2018

RECEIVED

Melissa Truesdell, Administrator  
Owyhee Health & Rehabilitation Center  
PO Box A  
Homedale, ID 83628-2040

FEB 20 2018  
FACILITY STANDARDS

Provider #: 135087

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

Dear Ms. Truesdell:

On **January 23, 2018**, a Facility Fire Safety and Construction survey was conducted at **Owyhee Health & Rehabilitation Center** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

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

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you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office. If a State Form with deficiencies was issued, it should be signed, dated and returned along with the CMS-2567 Form.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **February 20, 2018**. Failure to submit an acceptable PoC by **February 20, 2018**, may result in the imposition of civil monetary penalties by **March 11, 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 27, 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 27, 2018**. A change in the seriousness of the deficiencies on **February 27, 2018**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **February 27, 2018**, includes the following:

Denial of payment for new admissions effective **April 23, 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 23, 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 23, 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:

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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:

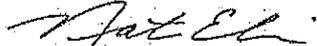
BFS Letters (06/30/11)

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

This request must be received by **February 20, 2018**. If your request for informal dispute resolution is received after **February 20, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135087	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  01/23/2018
NAME OF PROVIDER OR SUPPLIER  OWYHEE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 108 WEST OWYHEE HOMEDALE, ID 83628		
(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 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(111) construction. The latest addition was in 1990. The facility was originally built in 1959. The facility is fully sprinklered and is equipped with smoke detection in common areas and corridors. Currently the facility is licensed for 49 SNF/NF beds and had a census of 36 on the dates of the survey.  The following deficiencies were cited during the Emergency Preparedness Survey conducted on January 22 and 23, 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 and Construction	E 000	"The plan of correction is prepared and submitted as required by law. By submitting this Plan of Correction, Owyhee Health & Rehabilitation Center does not admit that the deficiency listed on this form exists, nor does the center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.  <b>RECEIVED</b>  <b>FEB 20 2018</b>  <b>FACILITY STANDARDS</b>		
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

*Melissa Truesdell*

TITLE

*Administrator*

(X6) DATE

*2/19/18*

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

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E 001	<p>Continued From page 1 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 complies with all applicable Federal, State and local emergency preparedness requirements 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 36 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>On January 22 and 23 2018, review of the provided emergency plan, policies and procedures, revealed the facility had a current policy for testing the emergency preparedness</p>	E 001	<p>E 001</p> <p><u>Corrective Action:</u> Owyhee Health &amp; Rehabilitation has been in contact with community participants/agencies including Homedale Senior Citizens Center and Homedale Fire Department to coordinate dates to conduct a full scale exercise of a simulated event to take place by March 15, 2018.</p> <p><u>Identification of others affected:</u> All residents, new admissions, staff including new hires, and visitors may be affected.</p> <p><u>Systemic Changes to ensure Deficient Practice Doesn't Repeat</u> Owyhee Health &amp; Rehabilitation will coordinate an annual calendar event with appropriate participating agencies to conduct a full scale exercise based on risk factors identified in the facility's disaster preparedness risk assessment.</p> <p><u>Monitor of corrective action</u> QAPI will follow emergency preparedness issues until they are no longer a concern to the IDT.</p> <p><u>Corrective Action Completed:</u></p>		

3/22/18

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E 001	Continued From page 2 plan, but they had not yet implemented it. They had not yet had a full scale exercise or a second exercise which met the requirements of 42 CFR 483.73. When asked, the Administrator and Maintenance Supervisor stated the facility was in contact with community emergency preparedness partners, but had not been able to schedule a full scale drill yet.  a. Refer to E 0039 as it relates to emergency prep testing requirements.  CFR reference: 42 CFR 483.73	E 001		
E 039 SS=F	EP Testing Requirements CFR(s): 483.73(d)(2)  (2) Testing. The [facility, except for LTC facilities, RNHCs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCs and OPOs] must do all of the following:  *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:]  (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based	E 039		

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E 039	<p>Continued From page 3</p> <p>full-scale exercise for 1 year following the onset of the actual event.</p> <p>(ii) Conduct an additional exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, facility-based.</p> <p>(B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.</p> <p>*[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following:</p> <p>(i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, it was determined the facility had developed a current emergency preparedness testing program, but it</p>	E 039	<p>E 039</p> <p><u>Corrective Action:</u></p> <p>Owyhee Health &amp; Rehabilitation has been in contact with community participants/agencies including Homedale Senior Citizens Center and Homedale Fire Department to coordinate dates to conduct a full scale exercise of a simulated event to take place by March 15, 2018.</p> <p><u>Identification of others affected:</u></p> <p>All residents, new admissions, staff including new hires, and visitors may be affected.</p> <p><u>Systemic Changes to ensure Deficient Practice Doesn't Repeat</u></p> <p>Owyhee Health &amp; Rehabilitation will coordinate an annual calendar event with appropriate participating agencies to conduct a full scale exercise based on risk factors identified in the facility's disaster preparedness risk assessment.</p> <p><u>Monitor of corrective action</u></p> <p>QAPI will follow emergency preparedness issues until they are no longer a concern to the IDT.</p> <p><u>Corrective Action Completed:</u></p>	3/22/18

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

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FORM APPROVED  
OMB NO. 0938-0391

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E 039	<p>Continued From page 4</p> <p>had not yet been implemented. Failure to implement an emergency preparedness testing program has the potential to hinder staff response during a disaster. This deficient practice affected 36 residents, staff and visitors on the date of the survey.</p> <p>Findings Include:</p> <p>Review of the facility emergency plan on January 22 and 23, 2018, revealed the facility had a current policy for testing the emergency preparedness plan, but they had not yet implemented it. There was no documentation that specific testing, to include a community based, full-scale annual exercise, or a second facility based exercise on the emergency preparedness plan or policies had been conducted. When asked, the Administrator stated the facility had been reaching out to community agencies, but had not yet participated in any exercises.</p> <p>Reference:</p> <p>42 CFR 483.73 (d) (2)</p>	E 039		

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K 000	<p>INITIAL COMMENTS</p> <p>The facility is a single story, type V(111) construction. The latest addition was in 1990. The facility was originally built in 1959. The facility is fully sprinklered and is equipped with smoke detection in common areas and corridors. Currently the facility is licensed for 49 SNF/NF beds and had a census of 36 on the dates of the survey.</p> <p>The following deficiency was cited during the annual fire/life safety survey conducted on January 22 and 23, 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.</p> <p>The survey was conducted by:</p> <p>Linda Chaney Health Facility Surveyor Facility Fire Safety and Construction</p>	K 000	<p style="text-align: center;">RECEIVED FEB 20 2018 FACILITY STANDARDS</p>	
K 232 SS=F	<p>Aisle, Corridor, or Ramp Width CFR(s): NFPA 101</p> <p>Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility</p>	K 232		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Melissa Truesden</i>	TITLE <i>Administrator</i>	(X6) DATE <i>2/19/18</i>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 232	<p>Continued From page 1</p> <p>failed to maintain corridor exit access free of obstructions. Failure to maintain exit access width in the path of travel, could hinder the safe evacuation of residents during a fire or other emergency. This deficient practice affected 36 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour on January 23, 2018, from approximately 9:00 AM to 11:00 AM, observation of the exit access corridors revealed the following obstructions:</p> <p>1.) Suspended heater across from room #1. Heating unit was not being used, but was mounted above the hand rail and extended from the wall into the corridor 22".</p> <p>2.) Two half circle shelves were mounted above the hand rail and protruding from the corridor wall approximately 9-1/2", located just before room #11.</p> <p>3.) Corridor measured 7'-10", and does not meet the eight foot requirement for fixed furniture. Three, freestanding chairs were placed against the wall in the corridor outside of the hair salon, and one at the exit by room #25, which reduced the corridor width to 5'-10". Chairs were below the hand rail, but were not fixed to the floor or wall.</p> <p>Actual NFPA Standard:</p> <p>19.2.3.4* Any required aisle, corridor, or ramp shall be not less than 48 in. (1220 mm) in clear width where serving as means of egress from patient sleeping rooms, unless otherwise permitted by one of the following:</p> <p>(1) Aisles, corridors, and ramps in adjunct areas not intended for the housing, treatment, or use of</p>	K 232	<p>K 232</p> <p><u>Corrective Action:</u></p> <ol style="list-style-type: none"> <li>1) The suspended heater mount and handrail across from Room #1 has been modified and no longer hangs above a handrail.</li> <li>2) The two half circle shelves mounted above hand rails near room #11 have been removed.</li> <li>3) All freestanding chairs have been removed from the corridor outside the hair salon and near room #25</li> </ol> <p><u>Identification of others affected:</u> Any resident seeking services from the facility beauty salon and residents and staff exiting or entering room 25 would have been affected.</p> <p><u>Measures to ensure Deficient Practice Doesn't Repeat</u> Maintenance and Administrator were in serviced on the requirements of NFPA 19.2.3.4 specific to fixtures overhanging handrails, and fixed vs freestanding furniture in corridors</p> <p><u>Monitor of corrective action</u> Maintenance Director has added this monitor to his weekly environmental rounds.</p> <p><u>Corrective Action Completed:</u> 01/24/2018</p>	1/24/18

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NAME OF PROVIDER OR SUPPLIER  OWYHEE HEALTH & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 108 WEST OWYHEE HOMEDALE, ID 83628		
(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 232	<p>Continued From page 2</p> <p>inpatients shall be not less than 44 in. (1120 mm) in clear and unobstructed width.</p> <p>(2)*Where corridor width is at least 6 ft (1830 mm), non-continuous projections not more than 6 in. (150 mm) from the corridor wall, above the handrail height, shall be permitted.</p> <p>(3) Exit access within a room or suite of rooms complying with the requirements of 19.2.5 shall be permitted.</p> <p>(4) Projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met:</p> <p>(a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in.(1525 mm).</p> <p>(b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency.</p> <p>(c)*The wheeled equipment is limited to the following:</p> <p>i. Equipment in use and carts in use</p> <p>ii. Medical emergency equipment not in use</p> <p>iii. Patient lift and transport equipment</p> <p>(5)*Where the corridor width is at least 8 ft (2440 mm), projections into the required width shall be permitted for fixed furniture, provided that all of the following conditions are met:</p> <p>(a) The fixed furniture is securely attached to the floor or to the wall.</p> <p>(b) The fixed furniture does not reduce the clear unobstructed corridor width to less than 6 ft (1830 mm), except as permitted by 19.2.3.4(2).</p> <p>(c) The fixed furniture is located only on one side of the corridor.</p> <p>(d) The fixed furniture is grouped such that each grouping does not exceed an area of 50 ft<sup>2</sup> (4.6 m<sup>2</sup>).</p>	K 232		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135087	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - ENTIRE NF STRUCTURE  B. WING _____		(X3) DATE SURVEY COMPLETED  01/23/2018
NAME OF PROVIDER OR SUPPLIER  OWYHEE HEALTH & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 108 WEST OWYHEE HOMEDALE, ID 83628		
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K 232	Continued From page 3 (e) The fixed furniture groupings addressed in 19.2.3.4(5)(d) are separated from each other by a distance of at least 10 ft (3050 mm). (f)*The fixed furniture is located so as to not obstruct access to building service and fire protection equipment. (g) Corridors throughout the smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the fixed furniture spaces are arranged and located to allow direct supervision by the facility staff from a nurses' station or similar space. (h) The smoke compartment is protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.8.	K 232		