



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

April 24, 2018

R. Ryan Beckman, Administrator
Grangeville Health & Rehabilitation Center
410 East North Second Street
Grangeville, ID 83530-2258

Provider #: 135080

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Mr. Beckman:

On **April 10, 2018**, a Facility Fire Safety and Construction survey was conducted at **Grangeville 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 **May 7, 2018**. Failure to submit an acceptable PoC by **May 7, 2018**, may result in the imposition of civil monetary penalties by **May 27, 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 **May 15, 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 **May 15, 2018**. A change in the seriousness of the deficiencies on **May 15, 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 **May 15, 2018**, includes the following:

Denial of payment for new admissions effective **July 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 **October 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 **April 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:

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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:

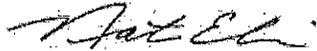
BFS Letters (06/30/11)

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

This request must be received by **May 7, 2018**. If your request for informal dispute resolution is received after **May 7, 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: 04/18/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135080	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 04/10/2018
NAME OF PROVIDER OR SUPPLIER GRANGEVILLE HEALTH & REHABILITATION C		STREET ADDRESS, CITY, STATE, ZIP CODE 410 EAST NORTH SECOND STREET GRANGEVILLE, ID 83530		
(X4) ID PREFIX TAG K 000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG K 000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	<p>INITIAL COMMENTS</p> <p>The facility is a single story, Type V(111) fully sprinklered structure built in 1967. It has smoke detection throughout corridors and open spaces. Currently the facility is licensed for 80 SNF/NF beds.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on April 10, 2016. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.</p> <p>The Survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	K 000	<p>"This plan of correction is submitted as required under Federal and State regulations and statutes applicable to skilled nursing facilities. This plan of correction does not constitute an admission of liability, and such liability is hereby specifically denied. The submission of this plan does not constitute agreement by the facility that the surveyor's conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied."</p> <p>Please accept this plan of correction as our credible allegation of compliance.</p> <p style="text-align: center;">RECEIVED MAY - 9 2018 FACILITY STANDARDS</p>	
K 100 SS=F	<p>General Requirements - Other CFR(s): NFPA 101</p> <p>General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, the facility failed to demonstrate implementation of a water management program for waterborne pathogens such as Legionella, in accordance with 42 CFR 483.80. Failure to conduct a facility based risk assessment, or defined applicable control measures, has the potential to limit relevant facility awareness and expose residents to Legionella and other water source bacterium</p>	K 100	<p>K 100 Resident Specific: Please see systemic changes.</p> <p>Other Residents: Please see systemic Changes</p> <p>Systemic Changes: The facilities Legionella plan has been reassessed with a risk assessment. A copy of our revised Legionella plan is attached.</p> <p>Monitors: This plan has been implemented with internal controls listed. Administrator will continue water temperature assessments weekly. This plan will be reviewed at the QAPI meeting, every 3rd quarter and a full review of the plan will be conducted on a yearly basis. The plan will be reviewed more frequently as a result of Change of infrastructure, Change of water treatment or water treatment problems with the City of Grangeville, and Exceedingly high or low water heating numbers</p> <p>Administrator will report findings at QA and make changes to the above plan of correction as needed.</p> <p>Date of compliance: May 7th 2018</p>	

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

TITLE

(X6) DATE

[Handwritten Signature]

Administrator

5/7/18

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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K 100	Continued From page 1 based on inconclusive data. This deficient practice affected 42 residents, staff and visitors on the date of the survey. Findings include: During review of provided water management documentation conducted on 4/10/18 from approximately 8:30 - 10:00 AM, documentation failed to demonstrate implementation of a water management plan for the transmission of waterborne pathogens such as Legionella by conducting a risk assessment that accounted for components of the facility complex water system and subsequent implementation of control measures as determined by evaluation of that system. CFR standard: 42 CFR 483.80 § 483.80 Infection control. The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. Additional reference: Center for Medicaid/Medicare Services S & C letter 17-30	K 100		
K 374 SS=E	Subdivision of Building Spaces - Smoke Barrier CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that	K 374	K 374 Resident Specific: Please see systemic changes. Other Residents: Please see systemic Changes Systemic Changes: Fusible links set to be inspected on May 14 by Fisher Systems. Annual inspections have been added to Fisher Systems schedule as well. Monitors: Administrator will maintain record of inspection for drop down fire door. Administrator will add drop down fire door inspection to regular scheduled maintenance list for building and ensure that annually scheduled inspections are complete Administrator will report findings at QA and make changes to the above plan of correction as needed. Date of compliance: May 14th 2018	

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K 374	<p>Continued From page 2</p> <p>resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors.</p> <p>19.3.7.6, 19.3.7.8, 19.3.7.9</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and observation, the facility failed to ensure smoke and fire barriers were maintained to limit the transfer of smoke, fire and dangerous gases between compartments. Failure to maintain installed fire rated assemblies that limit transfer of combustion products, has the potential to hinder egress and the ability to shelter in place. This deficient practice potentially affected residents using the main dining, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>1) During review of facility maintenance and inspection records conducted on 4/10/18 from approximately 8:30 - 10:00 AM, no records were provided indicating automatic roll-down fire doors equipped with fusible links were inspected and tested annually in accordance with NFPA 80 guidelines.</p> <p>2) During the facility tour conducted on 4/10/18 from 2:45 - 3:30 PM, observation of the pass-thru door at the Kitchen revealed the door was equipped with a fusible link and tagged as to the requirement of annual testing in accordance with NFPA 80.</p>	K 374		

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K 374	Continued From page 3 Actual NFPA standard: 19.3.7.7 Reserved. 19.3.7.8* Doors in smoke barriers shall comply with 8.5.4 and all of the following: (1) The doors shall be self-closing or automatic-closing in accordance with 19.2.2.2.7. (2) Latching hardware shall not be required (3) The doors shall not be required to swing in the direction of egress travel. 8.5.4.4* Doors in smoke barriers shall be self-closing or automatic-closing in accordance with 7.2.1.8 and shall comply with the provisions of 7.2.1. 7.2.1.15.2 Fire-rated door assemblies shall be inspected and tested in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Smoke door assemblies shall be inspected and tested in accordance with NFPA 105, Standard for Smoke Door Assemblies and Other Opening Protectives. NFPA 80 5.2* Inspections. 5.2.1* Fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ.	K 374		
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	K 911	K 911 Resident Specific: Please see systemic changes. Other Residents: Please see systemic Changes Systemic Changes: Annunciator panel with remote manual stop to be installed by Cummins on May 14th 2018 at the nurse's station. If additional materials required for install will install as soon as items arrive. Monitors: Staff will be in serviced on function and use of the new annunciator/stop system. Alarm system will be monitored during regular in house generator tests as well as regularly scheduled maintenance by Cummins. Administrator will report findings at QA and make changes to the above plan of correction as needed. Date of Compliance: May 15th	

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K 911	<p>Continued From page 4 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 station in accordance with NFPA 110. Failure to provide a remote stop potentially hinders staff ability to shut down the generator if required during an emergency. This deficient practice affected 42 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 4/10/18 from approximately 1:30 - 2:30 PM, observation of the facility and the generator location failed to reveal a remote manual stop station for the EES generator. When asked, the Maintenance Director stated he was not aware of the location of a remote manual stop for the generator.</p> <p>Actual NFPA standard:</p> <p>NFPA 110</p> <p>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.</p>	K 911	<p>K 916</p> <p>Resident Specific:</p> <p>Please see systemic changes.</p> <p>Other Residents:</p> <p>Please see systemic Changes</p> <p>Systemic Changes:</p> <p>Annunciator panel with remote manual stop to be installed by Cummins on May 14th 2018 at the nurse's station. If additional materials required for install will install as soon as items arrive.</p> <p>Monitors:</p> <p>Staff will be in serviced on function and use of the new annunciator/stop system. Alarm system will be monitored during regular in house generator tests as well as regularly scheduled maintenance by Cummins.</p> <p>Administrator will report findings at QA and make changes to the above plan of correction as needed.</p> <p>Date of Compliance: May 15th</p>	
K 916 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101	K 916		

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K 916	<p>Continued From page 5</p> <p>Electrical Systems - Essential Electric System Alarm Annunciator</p> <p>A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, the facility failed to ensure the Essential Electrical System (EES) was equipped with a remote annunciator readily observed at a regular work station in accordance with NFPA 99. Failure to provide a readily observed remote annunciator has the potential to hinder staff awareness to system failures during a power outage or other emergency. This deficient practice affected 42 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on April 10, 2018 from approximately 2:45 - 3:30 PM, no location was found for a remote annunciator for the EES generator.</p> <p>Actual NFPA standard:</p> <p>NFPA 99 6.4.1.1.17 Alarm Annunciator. A remote annunciator that is storage battery powered shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station (see 700.12 of NFPA 70, National Electrical Code). The</p>	K 916		

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NAME OF PROVIDER OR SUPPLIER GRANGEVILLE HEALTH & REHABILITATION C		STREET ADDRESS, CITY, STATE, ZIP CODE 410 EAST NORTH SECOND STREET GRANGEVILLE, ID 83630		
(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 916	Continued From page 6 annunciator shall be hard-wired to indicate alarm conditions of the emergency or auxiliary power source as follows: (1) Individual visual signals shall indicate the following: (a) When the emergency or auxiliary power source is operating to supply power to load (b) When the battery charger is malfunctioning (2) Individual visual signals plus a common audible signal to warn of an engine?generator alarm condition shall indicate the following: (a) Low lubricating oil pressure (b) Low water temperature (below that required in 8.4.1.1.11) (c) Excessive water temperature (d) Low fuel when the main fuel storage tank contains less than a 4-hour operating supply (e) Overcrank (failed to start) (f) Overspeed	K 916		

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E 000	Initial Comments The facility is a single story, type V(111) structure originally constructed in 1967. It is fully sprinklered with an interconnected fire alarm/smoke detection system. The building has a partial basement housing the boiler, fire suppression system riser and transfer switch to the emergency generator. The facility is located in a municipal fire district with both voluntary and community served responders. The facility is currently licensed for 60 SNF/NF beds and had a census of 42 on the day of the survey. The following deficiencies were cited during the Emergency Preparedness survey conducted on April 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: Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction	E 000	<p style="text-align: center;">RECEIVED</p> <p style="text-align: center;">MAY 14 2018</p> <p style="text-align: center;">FACILITY STANDARDS</p> <p>E 006 Resident Specific: Please see systemic changes. Other Residents: Please see systemic Changes Systemic Changes: Reviewed county multi-hazard mitigation plan with Jerry Zumalt (Idaho County Disaster Management Coordinator). He agreed with our threat analysis based on geographic location with the exception of possibly increasing severe weather's threat level. Both Severe weather and High winds have been moved to top five risk scale and highlighted in our policy.</p>		
E 006 SS=F	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,	E 006	Monitors: Maintaining membership in the North Central Healthcare Coalition and open communications with the Idaho County Disaster Coordinator will allow us to maintain a more up to date picture for current risk assessment. Risk assessment will be reviewed in our QAPI at least yearly to reevaluate and adjust if needed. Administrator will report findings at QA and make changes to the above plan of correction as needed. Date of Compliance:		

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

May 9th 2018 TITLE

(X8) DATE

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

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

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FORM APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135080	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/10/2018
NAME OF PROVIDER OR SUPPLIER GRANGEVILLE HEALTH & REHABILITATION C			STREET ADDRESS, CITY, STATE, ZIP CODE 410 EAST NORTH SECOND STREET GRANGEVILLE, ID 83530		
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E 006	<p>Continued From page 1 including missing residents.</p> <p>*[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients.</p> <p>(2) Include strategies for addressing emergency 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: Based on record review and interview, it was determined the facility failed to develop an Emergency Preparedness program that included a facility based and community based risk assessment. Failure to use available data for localized risks from such resources as the local county all-hazards mitigation strategies, has the potential to hinder resident continuity of care during a disaster based on insufficient data. This deficient practice potentially affected 42 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>On 4/10/18 from 10:00 AM - 12:00 PM, review of the provided emergency plan, policies and procedures, revealed the facility HVA (Hazard Vulnerability Analysis) provided information inconsistent with the local, documented Idaho County multi-jurisdictional all-hazards mitigation</p>	E 006			

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E 006	Continued From page 2 plan developed in 2015. Interview of the Administrator demonstrated the HVA was developed internally only and not with developed information provided by the county mitigation plan. Reference: 42 CFR 483.73 (a) (1) - (2)	E 006			
E 013 SS=F	Development of EP Policies and Procedures CFR(s): 483.73(b) (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §480.84(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	E 013	E 013 Resident Specific: Please see systemic changes. Other Residents: Please see systemic Changes Systemic Changes: Upon review of the "Hurricane" policy it is noted that it is actually the "Hurricane/High Wind" policy. High winds is a risk factor that was taken into consideration under the severe weather section of our facility assessment. The actions and responses under this policy are accurate for any high wind emergency situation. Monitors: We will continue to include this policy as it pertains to our facility risk assessment. Administrator will report findings at QA and make changes to the above plan of correction as needed. Date of Compliance:		

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E 013	<p>Continued From page 3 updated at least annually.</p> <p>*[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to develop policies and procedures based on the Emergency Plan, that aligned with a facility and community based risk assessment. Development of policies and procedures based on non-geographically relevant hazards, creates purposeless facility training of non-localized events. This deficient practice potentially affected 42 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>On 4/10/18 from 10:00 AM - 12:00 PM, review of provided policies and procedures revealed procedures contained in the plan for the risk of a Hurricane, which is not geographically relevant to the facility location and not identified as a risk in the HVA. Further evaluation of the local county all-hazard mitigation plan found no indication the county EMS (Emergency Management Services) considered this a likely occurrence for the area.</p>	E 013			

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E 013	Continued From page 4 Interview of the Administrator revealed he was not aware the policies and procedures included a plan for Hurricanes. Reference: 42 CFR 483.73 (b) Additional Reference: E - 0006	E 013	E 036 Resident Specific: Please see systemic changes. Other Residents: Please see systemic Changes		
E 036 SS=C	EP Training and Testing CFR(s): 483.73(d) (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and 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	E 036	Systemic Changes: All Staff in-service on new EOP Manual was given on January 5th 2018. All staff were trained on contents and location of the new manual. All new staff are instructed on contents and location of manual on hire and going forward a form will be created for them to acknowledge receipt of that information. The evacuation portion of the drill was tested in January with an unannounced drill. We also tested the active shooter policy with our Table top drill in October 2017. We have also conducted multiple fire drills testing that section of the policy. EOP will be reviewed quarterly at All Staff in-service. We will continue to perform random unannounced drills that target alternate sections of the EOP in order to test it. We will also continue to perform at least one table top scenario each year to test our EOP. Administrator will report findings at QA and make changes to the above plan of correction as needed. Date of Compliance: May 7th 2018		

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E 036	<p>Continued From page 5</p> <p>develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, it was determined the facility failed to provide a emergency prep testing program for provided staff training. Lack of a facility emergency testing program covering the emergency preparedness plan, policies and procedures, has the potential to hinder staff response during a disaster. This deficient practice affected 42 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>On 4/10/18 from 10:00 AM - 12:00 PM, review of provided emergency plan, policies and procedures, found no documentation demonstrating the facility had a current testing program for staff based on training conducted of the emergency plan.</p> <p>Interview of 3 of 3 staff conducted on 4/10/18 from 1:45 - 3:00 PM, established staff had not participated in any specific testing program on the emergency plan contents.</p> <p>Additional interview of the Administrator established the emergency plan was recently updated and staff had been inserviced as to the new plan implementation, but no testing over the</p>	E 036			

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E 036	Continued From page 6 contents of the plan had been conducted.	E 036			
E 039 SS=F	<p>Reference: 42 CFR 483.73 (d)</p> <p>EP Testing Requirements CFR(s): 483.73(d)(2)</p> <p>(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:</p> <p>*[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:]</p> <p>(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 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: (A) A second full-scale exercise that is community-based or individual, facility-based. (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>	E 039	<p>E 039</p> <p>Resident Specific:</p> <p>Please see systemic changes.</p> <p>Other Residents:</p> <p>Please see systemic Changes</p> <p>Systemic Changes:</p> <p>We have joined the North Central Healthcare Coalition and our full scale live action community exorcise with Grangeville, Cottonwood and surrounding area hospitals, dispatch, EMS, fire, local police, state police, and life flight is scheduled for Saturday May 12th 2018.</p> <p>Monitors:</p> <p>Administrator will continue to work with the North Central Health care coalition to be involved in at least yearly full scale community exorcises.</p> <p>Administrator will report findings at QA and make changes to the above plan of correction as needed.</p> <p>Date of Compliance:</p> <p>May 12th 2018</p>		

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E 039	<p>Continued From page 7</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, it was determined the facility failed to complete two full-scale exercises which tested the emergency preparedness readiness of the facility. Failure to participate in full-scale or tabletop events has the potential to reduce the facility's effectiveness to provide continuation of care to residents during an emergency. This deficient practice affected 42 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>On 4/10/18 from 10:00 AM - 12:00 PM, review of provided emergency plan documents, documentation revealed the facility failed to</p>	E 039		

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E 039	Continued From page 8 document required full-scale exercises, testing the effectiveness of the emergency preparedness plan, policies and procedures. Reference: 42 CFR 483.73 (d) (1)	E 039			