



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

RECEIVED

AUG - 1 2018

FACILITY STANDARDS

July 19, 2018

Steve Gannon, Administrator  
Quinn Meadows Rehabilitation and Care Center  
1033 West Quinn Road  
Pocatello, ID 83202-2425

Provider #: 135136

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

Dear Mr. Gannon:

On **July 12, 2018**, a Facility Fire Safety and Construction survey was conducted at **Quinn Meadows Rehabilitation and Care 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

Steve Gannon, Administrator

July 19, 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 **August 1, 2018**. Failure to submit an acceptable PoC by **August 1, 2018**, may result in the imposition of civil monetary penalties by **August 23, 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 **August 16, 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 **August 16, 2018**. A change in the seriousness of the deficiencies on **August 16, 2018**, may result in a change in the remedy.

Steve Gannon, Administrator  
July 19, 2018  
Page 3 of 4

The remedy, which will be recommended if substantial compliance has not been achieved by **August 16, 2018**, includes the following:

Denial of payment for new admissions effective **October 12, 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 **January 12, 2019**, 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 **July 12, 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:

Steve Gannon, Administrator  
July 19, 2018  
Page 4 of 4

<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 **August 1, 2018**. If your request for informal dispute resolution is received after **August 1, 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: 07/18/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135136</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/12/2018</b>
NAME OF PROVIDER OR SUPPLIER <b>QUINN MEADOWS REHABILITATION AND CARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1033 WEST QUINN ROAD POCATELLO, ID 83202</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
E 000	<p>Initial Comments</p> <p>The facility is an approximately 26,000 square foot type V (111) construction, initially licensed in 2009. The building is subdivided into two smoke compartments, with an attached but two-hour separated Physical Therapy section. The building is fully sprinklered and is equipped with a manual fire alarm system. Emergency power is provided by an onsite, dual-fuel generator system. The facility is located within a municipal fire district, with both regional and state emergency management support services available. The facility is currently licensed for 41 SNF/NF beds, with a census of 32 on the day of the survey.</p> <p>The facility was found to be in substantial compliance during the emergency preparedness survey conducted on July 11 and 12, 2018. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.</p> <p>The survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety &amp; Construction</p>	E 000	<p style="text-align: center;">RECEIVED AUG - 1 2018 FACILITY STANDARDS</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

*Steve Gaudin* (STEVE GAUDIN) EXECUTIVE DIRECTOR 7/31/18

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.

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

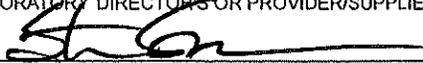
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NAME OF PROVIDER OR SUPPLIER <b>QUINN MEADOWS REHABILITATION AND CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1033 WEST QUINN ROAD POCATELLO, ID 83202</b>
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K 000	<p><b>INITIAL COMMENTS</b></p> <p>The facility is an approximately 26,000 square foot type V (111) construction, initially licensed in 2009. The building is subdivided into two smoke compartments, with an attached but two-hour separated Physical Therapy section. The building is fully sprinklered and is equipped with a manual fire alarm system. Emergency power is provided by an onsite generator system. The facility is currently licensed for 41 beds with a census of 32 on the day of the survey.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on July 11 and 12, 2018. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancies, in accordance with 42 CFR, 483.70.</p> <p>The survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety &amp; Construction</p>	K 000	<p>Preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the accuracy or truthfulness of any facts alleged or any conclusions set forth in this allegation of deficiencies by the State Licensing Authority.</p> <p>Accordingly, the facility has drafted this Plan of Correction in accordance with Federal and State Laws which mandate the submission of a Plan of Correction as a condition for participation in the Medicare and Medicaid program. This Plan of Correction shall constitute this facility's credible allegation compliance with this section.</p> <p style="text-align: center;"><b>RECEIVED</b> <b>AUG - 1 2018</b> <b>FACILITY STANDARDS</b></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: 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</p>	K 100	<p>K-100 General Requirements SS=F CFR(s); NFPA 101</p> <p><b>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</b></p> <p>No residents were directly affected by this deficiency.</p> <p><b>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:</b></p>	07/27/2018

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE **EXECUTIVE DIRECTOR** (X6) DATE **7/31/18**

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 1 483.80, that includes control measures for identified risks. Failure to provide control measures for known risks of waterborne pathogens, has the potential to increase the probability of exposure to bacterium, as a result of insufficient prevention measures in place. This deficient practice affected 32 residents, staff and visitors on the date of the survey.  Findings include:  During review of provided water management documentation conducted on 7/11/18 from approximately 1:30 - 2:00 PM, documentation failed to identify control measures in place for the risks identified in the facility risk assessment.  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 QSO 17-30	K 100	<b>K100 cont...</b> All residents, staff and visitors may have the potential to be affected by this deficiency; hence by 07/27/2018 the administrator and Maintenance Director will document control measures for identified risk areas within the facility water management program for waterborne pathogens.  <b>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</b>  Water testing control measures will be added to the monthly maintenance checklist to ensure all water testing is being done according to the control measures.  <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</b>  The Administrator or designee will audit control measure implementation documentation to ensure control measures have been completed.	
K 222 SS=F	Egress Doors CFR(s): NFPA 101  Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements:	K 222	Monitoring will start on 08/10/2018. This will be done monthly. The Administrator or designee will present to the quarterly QA&A Committee meeting the findings and/or corrective actions taken. Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.	

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K 222	<p>Continued From page 2</p> <p><b>CLINICAL NEEDS OR SECURITY THREAT LOCKING</b> Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6</p> <p><b>SPECIAL NEEDS LOCKING ARRANGEMENTS</b> Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4</p> <p><b>DELAYED-EGRESS LOCKING ARRANGEMENTS</b> Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4</p> <p><b>ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS</b> Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be</p>	K 222	<p>K - 222 Egress Doors SS=F CFR(s); NFPA 101</p> <p><b>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</b></p> <p>No residents were directly affected by this deficiency.</p> <p><b>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:</b></p> <p>All residents, staff and visitors have the potential to be affected by this deficiency.</p> <p>By 8/13/2018 The front exit doors will have a sensor installed and the back patio doors will be rewired to allow a 30 second delay before the doors re-magnetize during night hours when the doors are secured for the safety of our residents and staff. There is no magnetization of the doors during the day when the doors remain unlocked.</p> <p>NOTE: Even though the magnetization of the egress doors does not currently have a 30 second delay before re-magnetizing when locked at night for the safety of our residents and staff, there is no impediment to exiting the building. Weather the doors are magnetized or not, pushing the door handles will immediately de-magnetize the doors and allow for immediate and safe exit out of the facility with no delays.</p>	07/31/2018

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K 222	<p>Continued From page 3 permitted. 18.2.2.2.4, 19.2.2.2.4 <b>ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS</b> Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure controlled egress locking arrangements were installed in accordance with NFPA 101. Failure to provide a delay of 30 seconds or more to re-energize the magnetic locking component inherent to the system, has the potential for hindering safe evacuation of residents during emergencies. This deficient practice affected 32 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 7/12/18 from 9:00 - 11:00 AM, observation of the front door and the rear door accessing the patio on the south side of the facility, revealed these doors were each equipped with controlled egress magnetic locking arrangements. Further observation and operational testing revealed the doors would re-engage/energize the magnetic locks instantly upon contact of the magnet and would not remain unlocked for a minimum of 30 seconds.</p> <p>When asked, the Maintenance Director stated he was not aware these doors were not in compliance with the standard for controlled</p>	K 222	<p><b>K 222 cont...</b></p> <p><b>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</b></p> <p>The front exit doors and the patio exit doors will be tested monthly by the maintenance director to ensure the 30 second delay before re-magnetization occurs when the doors are locked at night for the security of our residents and staff.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</b></p> <p>The Administrator or designee will audit monthly maintenance logs to ensure 30 second delay before magnetization of the facility exit doors has been completed.</p> <p>Monitoring will start on 08/20/2018. This will be done monthly.</p> <p>The Administrator or designee will present to the quarterly QA&amp;A Committee meeting the findings and/or corrective actions taken.</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&amp;A Committee quarterly meeting.</p>

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K 222	Continued From page 4 egress arrangements.  Actual NFPA standard:  NFPA 101  7.2.1.6.2* Access-Controlled Egress Door Assemblies. Where permitted in Chapters 11 through 43, door assemblies in the means of egress shall be permitted to be equipped with electrical lock hardware that prevents egress, provided that all of the following criteria are met: (1) A sensor shall be provided on the egress side, arranged to unlock the door leaf in the direction of egress upon detection of an approaching occupant. (2) Door leaves shall automatically unlock in the direction of egress upon loss of power to the sensor or to the part of the access control system that locks the door leaves. (3) Door locks shall be arranged to unlock in the direction of egress from a manual release device complying with all of the following criteria: (a) The manual release device shall be located on the egress side, 40 in. to 48 in. (1015 mm to 1220 mm ) vertically above the floor, and within 60 in. (1525 mm) of the secured door openings. (b) The manual release device shall be readily accessible and clearly identified by a sign that reads as follows: PUSH TO EXIT. (c) When operated, the manual release device shall result in direct interruption of power to the lock-independent of the locking system electronics-and the lock shall remain unlocked for not less than 30 seconds. (4) Activation of the building fire-protective signaling system, if provided, shall automatically unlock the door leaves in the direction of egress, and the door leaves shall remain unlocked until	K 222		

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K 222	Continued From page 5 the fire-protective signaling system has been manually reset. (5) The activation of manual fire alarm boxes that activate the building fire-protective signaling system specified in 7.2.1.6.2(4) shall not be required to unlock the door leaves. (6) Activation of the building automatic sprinkler or fire detection system, if provided, shall automatically unlock the door leaves in the direction of egress, and the door leaves shall remain unlocked until the fire-protective signaling system has been manually reset. (7) The egress side of access-controlled egress doors, other than existing access-controlled egress doors, shall be provided with emergency lighting in accordance with Section 7.9.	K 222		
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 station in accordance with NFPA 110. Failure to provide a remote stop located outside of the room housing the prime mover, potentially hinders staff ability to shut down the generator if required during an emergency. This deficient practice affected 32 residents, staff and visitors on the date of the survey.	K 911	K - 911 Electrical Systems - Other SS=F CFR(s): NFPA 101  <b>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</b>  No residents were directly affected by this deficiency.  <b>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:</b>  All residents, staff and visitors have the potential to be affected by this deficiency.  By 7/27/2018, a remote manual stop station will be installed on the facility generator. EXTENSION HOUSING 8/2/18 STJ	07/27/2018

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135136</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - QUINN MEADOWS</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/12/2018</b>
NAME OF PROVIDER OR SUPPLIER <b>QUINN MEADOWS REHABILITATION AND CAF</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1033 WEST QUINN ROAD POCATELLO, ID 83202</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 911	Continued From page 6 Findings include:  During the facility tour conducted on 7/12/18 from approximately 11:00 AM - 12:00 PM, a remote manual stop for the EES generator was not located.  When asked if he was aware if the generator was equipped with a remote manual stop, the Maintenance Director stated he was not aware of a remote stop being installed on the EES.  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.	K 911	<b>K 911 cont...</b> <b>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</b>  By 7/27/2018, the remote manual stop station will be added to the monthly generator testing log to ensure the manual stop station is functioning correctly.  <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</b>  The Administrator or designee will audit the monthly generator log to ensure testing has been completed on the manual stop station.  Monitoring will start on 08/10 /2018. This will be done monthly.  The Administrator or designee will present to the quarterly QA&A Committee meeting the findings and/or corrective actions taken.  Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.	
K 927 SS=D	Gas Equipment - Transfilling Cylinders CFR(s): NFPA 101  Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99)	K 927		

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NAME OF PROVIDER OR SUPPLIER <b>QUINN MEADOWS REHABILITATION AND CARE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1033 WEST QUINN ROAD POCATELLO, ID 83202</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 927	<p>Continued From page 7</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure liquid oxygen transfilling was conducted in accordance with NFPA 99. Failure to transfill liquid oxygen in rated assemblies as required under the standard, has the potential to create an oxygen rich environment, increasing the risk of combustion. This deficient practice affected staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 7/12/18 from approximately 10:30 AM to 12:00 PM, observation of the oxygen storage/transfill area abutting the back service corridor, revealed the space designed for transfilling had two (2) transfer grilles approximately sixteen inch by sixteen inch, installed over a hole of the same size which was cut through the 1-hour fire rated assembly, into the abutting storage room.</p> <p>Further observation of the area designated for transfilling, established the space did not provide sufficient room for staff conducting transfilling to stand inside, requiring staff to have to prop the transfill space door open during while filling portable tanks. This action placed transfilling operations in direct exposure to combustible linens stacked inside the storage room, approximately two feet from the doorway to the transfill space.</p> <p>Actual NFPA standard:</p> <p>NFPA 99</p> <p>11.3.2.3 Oxidizing gases such as oxygen and nitrous oxide shall be separated from</p>	K 927	<p><b>K - 927 Gas Equipment - Transfilling Cylinders SS=D</b> <b>CFR(s): NFPA 101</b></p> <p><b>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</b></p> <p>No Residents were directly affected by this deficiency.</p> <p><b>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:</b></p> <p>All residents, staff and visitors had the potential to be affected.</p> <p>The (2) 16 inch transfer grilles that were installed over holes cut through the 1 hour fire rated assembly have been removed and the holes patched to repair the integrity of the 1 hour fire rated assembly wall.</p> <p>All combustible items have been removed from the storage area surrounding the oxygen transfilling room thus allowing transfilling operations to commence without exposure to combustible materials.</p>	07/27/2018

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135136</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - QUINN MEADOWS  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/12/2018</b>
NAME OF PROVIDER OR SUPPLIER <b>QUINN MEADOWS REHABILITATION AND CARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1033 WEST QUINN ROAD POCATELLO, ID 83202</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 927	Continued From page 8 combustibles or materials by one of the following: (1) Minimum distance of 6.1 m (20 ft) (2) Minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) Enclosed cabinet of noncombustible construction having a minimum fire protection rating of 1.2 hour  11.5.2.3 Transfilling Liquid Oxygen. Transfilling of liquid oxygen shall comply with 11.5.2.3.1 or 11.5.2.3.2, as applicable. 11.5.2.3.1 Transfilling to liquid oxygen base reservoir containers or to liquid oxygen portable containers over 344.74 kPa (50 psi) shall include the following: (1) A designated area separated from any portion of a facility wherein patients are housed, examined, or treated by a fire barrier of 1 hour fire-resistive construction. (2) The area is mechanically ventilated, is sprinklered, and has ceramic or concrete flooring. (3) The area is posted with signs indicating that transfilling is occurring and that smoking in the immediate area is not permitted. (4) The individual transfilling the container(s) has been properly trained in the transfilling procedures.	K 927	<b>K 927 cont...</b> <b>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</b>  The maintenance director will perform weekly checks of the oxygen transfilling station to ensure there are no penetrations in the 1 hour fire rated wall and to ensure there are no combustible materials are stored around the oxygen transfilling room.  <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</b>  The Administrator or designee will audit to ensure the 1 hour fire rated wall has no penetrations in it to compromise its integrity; and to ensure no combustible materials are stored in or around the oxygen transfilling room.  Monitoring will start on 8/10/2018 This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.  The Administrator or designee will present their findings and/or corrective actions taken to the Administrator his/her designee and to the QA&A Committee, during their quarterly QA&A meeting.  Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.	