



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

August 30, 2018

Steve Lish, Administrator
Discovery Rehabilitation and Living
600 Shanafelt Street
Salmon, ID 83467-4261

Provider #: 135129

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Mr. Lish:

On **August 22, 2018**, a Facility Fire Safety and Construction survey was conducted at **Discovery Rehabilitation and Living** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

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

Steve Lish, Administrator
August 30, 2018
Page 2 of 4

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 **September 12, 2018**. Failure to submit an acceptable PoC by **September 12, 2018**, may result in the imposition of civil monetary penalties by **October 4, 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 **September 26, 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 **September 26, 2018**. A change in the seriousness of the deficiencies on **September 26, 2018**, may result in a change in the remedy.

Steve Lish, Administrator
August 30, 2018
Page 3 of 4

The remedy, which will be recommended if substantial compliance has not been achieved by **September 26, 2018**, includes the following:

Denial of payment for new admissions effective **November 22, 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 **February 22, 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 **August 22, 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 Lish, Administrator

August 30, 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)

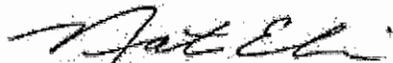
2001-10 Long Term Care Informal Dispute Resolution Process

2001-10 IDR Request Form

This request must be received by **September 12, 2018**. If your request for informal dispute resolution is received after **September 12, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135129	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 08/22/2018
NAME OF PROVIDER OR SUPPLIER DISCOVERY REHABILITATION AND LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 600 SHANAFELT STREET SALMON, ID 83467		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The facility is a type V(II) fully sprinkled, single story structure originally constructed in 1997. It is equipped with an interconnected fire alarm/smoke detection system, which includes both corridors and open areas. The building is two-hour separated to the connected Assisted Living and is equipped with a Type 1, spark-ignited propane Emergency Power Supply System (EPSS) generator. The facility is currently licensed for 45 SNF/NF beds with a census of 28 on the date of the survey. The following deficiencies were cited during the annual fire/life safety survey conducted on August 22, 2018. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70 The survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	K 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Discovery Care Center does not admit that the deficiency listed on this form exist, 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."	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked b) Who provided system test	K 353	A. Corrective Actions: The findings listed during the survey pertaining to NFPA 25 and the inspection, testing and maintenance of the fire suppression system had not been fully undertaken.	

RECEIVED
 SEP 12 2018
 FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE **Executive Director** (X8) DATE **9/10/2018**

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

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

Printed: 08/29/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135129	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 08/22/2018
NAME OF PROVIDER OR SUPPLIER DISCOVERY REHABILITATION AND LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 600 SHANAFELT STREET SALMON, ID 83467		
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K 353	<p>Continued From page 1</p> <p><u>o) Water system supply source</u></p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to ensure that fire suppression systems were maintained in accordance with NFPA 25. Failure to inspect system components has the potential to hinder system performance during a fire event and/or render the facility not fully sprinklered after an activation or repair. This deficient practice affected 28 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>1) During review of provided facility inspection and testing records conducted on 8/22/18 from 8:30 - 10:00 AM, no records were available indicating the dry system gauges were inspected on a weekly basis.</p> <p>2) During review of provided facility inspection and testing records conducted on 8/22/18 from 8:30 AM - 10:00 AM, no records were available demonstrating a waterflow alarm test was conducted during the second quarter of 2018.</p> <p>Actual NFPA standard:</p> <p>NFPA 25</p> <p>5.2.4 Gauges. 5.2.4.2 Gauges on dry, preaction, and deluge systems shall be inspected weekly to ensure that</p>	K 353	<p>B. Identification of others affected and corrective actions: The facility's Plant Operations Manager inspected the facility further and both aspects cited under NFPA 25 did not identify any others as being affected.</p> <p>C. Measures to ensure that the deficient practice does not happen again: The facility's Plant Operations Manager has conducted both the dry system gauge inspection as well as the water flow alarm test. The former will be tested and documented on a weekly basis and the latter on a quarterly basis and documented.</p> <p>D. Monitor corrective actions: The Executive Director or his designee will conduct an audit review of the required scheduled checklist/log for a period of one quarter or three months. The results will be reported to the QAA committee which meets monthly. The QAA Committee will then determine if the implemented testing/inspection system is effective to ensure ongoing compliance.</p> <p>E. Corrective action(s) were completed on: 09/04/18</p>	

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K 353	Continued From page 2 normal air and water pressures are being maintained.	K 353		
K 511 SS=D	<p>5.3.3 Waterflow Alarm Devices. 5.3.3.1 Mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly.</p> <p>Utilities - Gas and Electric CFR(s): NFPA 101</p> <p>Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain safe electrical installations in accordance with NFPA 70 and equipment listing. Use of multiple plug adapters (MPAs) to supply power to heat-producing appliances such as microwaves, has been historically linked to the increased potential of arc fires. This deficient practice affected 4 residents in 1 of 3 smoke compartments, staff and visitors on the date of the survey.</p> <p>Findings include: During the facility tour conducted on 8/22/18 from approximately 1:30 PM to 3:30 PM, observation of the Nurse's station, revealed a microwave</p>	K 511		

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K 511	<p>Continued From page 3 plugged into a surge-protected multiple plug adapter (MPA).</p> <p>Interview of the Maintenance Director revealed he was not aware the microwave was plugged into a MPA. Additional interview with the nurse present at that time revealed the microwave was used to warm up some types of liquids needed for medications for resident care.</p> <p>Actual NFPA standard: NFPA 70</p> <p>110.2 Approval. The conductors and equipment required or permitted by this Code shall be acceptable only if approved.</p> <p>Informational Note: See 90.7, Examination of Equipment for Safety, and 110.3, Examination, Identification, Installation, and Use of Equipment. See definitions of Approved, Identified, Labeled, and Listed.</p> <p>110.3 Examination, Identification, Installation, and Use of Equipment. (A) Examination. In judging equipment, considerations such as the following shall be evaluated: (1) Suitability for installation and use in conformity with the provisions of this Code Informational Note: Suitability of equipment use may be identified by a description marked on or provided with a product to identify the suitability of the product for a specific purpose, environment, or application. Special conditions of use or other limitations and other pertinent information. Suitability of equipment may be evidenced by listing or labelling. (2) Mechanical strength and durability, including,</p>	K 511		

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K 511	Continued From page 4 for parts designed to enclose and protect other equipment, the adequacy of the protection thus provided (3) Wire-bending and connection space (4) Electrical insulation (5) Heating effects under normal conditions of use and also under abnormal conditions likely to arise in service (6) Arcing effects (7) Classification by type, size, voltage, current capacity, and specific use (8) Other factors that contribute to the practical safeguarding of persons using or likely to come in contact with the equipment (B) Installation and Use. Listed or labeled equipment shall be installed and used in accordance with any instructions included in the listing or labeling.	K 511	<p>A. Corrective Actions The facility's Plant Operations Manager promptly removed and relocated the microwave in accordance with NFPA 70.</p> <p>B. Identification of others affected and corrective actions: The facility's Plant Operations Manager subsequently inspected the unit and identified no further (MPA) issues or others affected.</p> <p>C. Measures to ensure that the deficient practice does not happen again: The facility's Plant Operations Manager will add a routine monthly safe electrical installation inspection (MPA) to his monthly checklist. This to safeguard against such type of situations in the future. The outcome will be documented accordingly for continued compliance.</p> <p>D. Monitor corrective actions: The Executive Director or his designee will conduct an audit review of the required scheduled checklist/log for a period of one quarter or three months. The results will be reported to the QAA committee which meets monthly. The QAA Committee will then determine if the implemented testing/inspection system is effective to ensure ongoing compliance.</p> <p>E. Corrective action(s) were completed on: 08/23/18</p>	



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August 30, 2018

Steve Lish, Administrator
Discovery Rehabilitation and Living
600 Shanafelt Street
Salmon, ID 83467-4261

Provider #: 135129

RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER

Dear Mr. Lish:

On **August 22, 2018**, an Emergency Preparedness survey was conducted at **Discovery Rehabilitation And Living** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with 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. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. Please provide **ONLY ONE** completion date for each federal and state tag in column (X5) Completion Date to signify when you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office.

Steve Lish, Administrator

August 30, 2018

Page 2 of 4

Your Plan of Correction (PoC) for the deficiencies must be submitted by **September 12, 2018**. Failure to submit an acceptable PoC by **September 12, 2018**, may result in the imposition of civil monetary penalties by **October 4, 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 **September 26, 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 **September 26, 2018**. A change in the seriousness of the deficiencies on **September 26, 2018**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **September 26, 2018**, includes the following:

Denial of payment for new admissions effective **November 22, 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.

Steve Lish, Administrator
August 30, 2018
Page 3 of 4

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **February 22, 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 **August 22, 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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BFS Letters (06/30/11)

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

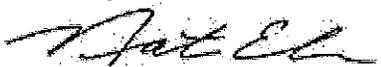
Steve Lish, Administrator
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will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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,

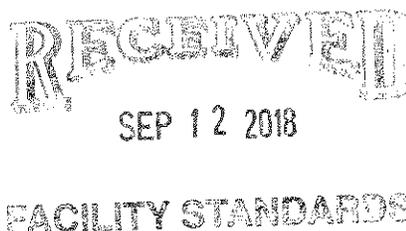


Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosures

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/22/2018
NAME OF PROVIDER OR SUPPLIER DISCOVERY REHABILITATION AND LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 800 SHANAFELT STREET SALMON, ID 83467		
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E 000	Initial Comments The facility is a type V(III) fully sprinkled, single story structure originally constructed in 1997. It is equipped with an interconnected fire alarm/smoke detection system, which includes both corridors and open areas. The building is two-hour separated to the connected Assisted Living facility and is equipped with a Type 1, spark-ignited propane Emergency Power Supply System (EPSS) generator. The facility is located in a rural fire district with both state and federal EMS support services available. The facility is currently licensed for 45 SNF/NF with a census of 28 on the day of the survey. The following deficiencies were cited during the Emergency Preparedness survey conducted on August 22, 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 and Construction	E 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Discovery Care Center does not admit that the deficiency listed on this form exist, 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." 	
E 007 SS=D	EP Program Patient Population CFR(s): 483.73(a)(3) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.**	E 007	A. Corrective Actions The facility has reviewed the existing emergency plan, policy and procedures and re-assessed the types of services the facility has the ability to provide during an emergency. B. Identification of others affected and corrective actions: As noted in the citation, facility residents, staff and visitors could have been affected in the event of an actual emergency or disaster. The facility's Executive Director has re-evaluated and identified no others affected at this time.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE Executive Director (X6) DATE 9/10/2018

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

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

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FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER DISCOVERY REHABILITATION AND LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 600 SHANAFELT STREET SALMON, ID 83467		
(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 007	Continued From page 1 *Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the facility failed to provide an emergency plan, policies and procedures which addressed the types of services the facility has the ability to provide during an emergency. Failure to address the types of services the facility has the ability to provide, has the potential to hinder continuity of care and emergency management response during an emergency. This deficient practice affected 28 residents, staff and visitors on the date of the survey. Findings include: On 8/22/18 from 1:30 - 3:00 PM, review of provided emergency plan, policies and procedures, revealed the plan failed to define what types of services the facility had the ability to provide during an emergency. Reference: 42 CFR 483.73 (a) (3)	E 007	C. Measures to ensure that the deficient practice does not happen again: The facility plan will be reviewed and updated as necessary but not less than annually in order to avert the potential to hinder the continuity of care, other services and management response during an actual emergency. D. Monitor corrective actions: The Executive Director or his designee will conduct a monthly audit review for three months. The results will be reported to the QAA committee which meets monthly. The QAA Committee will review until it has been determined that the system is effective to assure continued compliance. E. Corrective action(s) will be completed by: 09/25/18	
E 015 SS=D	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and	E 015		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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E 015	<p>Continued From page 2 procedures must address the following:</p> <p>(1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal.</p> <p>*[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by:</p>	E 015	<p>A. Corrective Actions: The facility has reviewed the existing emergency plan, policy and procedure of subsistence to ensure sewage and waste disposal is provided and better addressed how the facility will provide those services in the event of an actual emergency or disaster.</p> <p>B. Identification of others affected and corrective actions: As noted in the citation, facility residents, staff and visitors could have been affected in the event of an actual emergency or disaster. The facility's Executive Director and Plant Operations Manager Supervisor have re-evaluated and identified no others affected at this time.</p> <p>C. Measures to ensure that the deficient practice does not happen again: The facility plan will be reviewed and updated as necessary but not less than annually in order to avert potentially limiting the facility's ability to provide safe and sanitary continuity of care and other services during an actual emergency or disaster.</p>	

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E 015	Continued From page 3 Based on record review, the facility failed to provide an emergency plan, policy and procedure of subsistence to ensure sewage and waste disposal was provided in the event of loss of those services. Failure to provide sewage and waste disposal in the event of a disaster has the potential to limit the facility's ability of providing safe and sanitary continuity of care in an emergency. This deficient practice affected 28 residents, staff and visitors on the date of the survey. Findings include: On 8/22/18 from 1:30 - 3:00 PM, review of provided emergency plan, policies and procedures for the facility did not indicate the means the facility chose to employ to provide sewage and waste disposal for residents and staff in the event of a disaster. Reference: 42 CFR 483.73 (b) (1)	E 015	D. Monitor corrective actions: The Executive Director or his designee will conduct a monthly audit review for three months. The results will be reported to the QAA committee which meets monthly. The QAA Committee will review until it has been determined that the system is effective to assure continued compliance. E. Corrective action(s) will be completed by: 09/25/18	
E 030 SS=D	Names and Contact Information CFR(s): 483.73(c)(1) [(c) The [facility, except RNHCs, hospices, transplant centers, and HHAs] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities].	E 030		

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E 030	<p>Continued From page 4 (v) Volunteers.</p> <p>*[For RNHCI at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers.</p> <p>*[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers.</p> <p>*[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices.</p> <p>*[For OPOs at §486.360(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs.</p>	E 030	<p>A. Corrective Actions: The facility has reviewed the existing emergency plan, policies and procedures and re-assessed the communication plan to better identify contact information for volunteers in the event of an actual emergency or disaster.</p> <p>B. Identification of others affected and corrective actions: As noted in the citation, facility residents, staff and visitors could have been affected in the event of an actual emergency or disaster. The facility's Executive Director and Plant Operations Manager Supervisor have re-evaluated and identified no others affected at this time.</p> <p>C. Measures to ensure that the deficient practice does not happen again: The facility plan will be reviewed and updated as necessary but not less than annually in order to avert potentially limiting the facility's ability to provide a communication plan that better identifies the contact information for volunteers during an actual emergency or disaster.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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E 030	Continued From page 5 (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the facility failed to document a communication plan which included contact information for volunteers. Failure to have a communication plan which includes contact information for those parties who may assist in the facility's response and recovery during a disaster, has the potential to hinder both internal and external emergency response efforts. This deficient practice affected 28 residents, staff and visitors on the date of the survey. Findings include: On 8/22/18 from 1:30 - 3:00 PM, review of provided emergency plan, policies and procedures, failed to reveal a communication plan that included contact information for volunteers. Reference: 42 CFR 483.73 (c) (1)	E 030	D. Monitor corrective actions: The Executive Director or his designee will conduct a monthly audit review for three months. The results will be reported to the QAA committee which meets monthly. The QAA Committee will review until it has been determined that the system is effective to assure continued compliance. E. Corrective action(s) will be completed by: 09/25/18	
E 031 SS=D	Emergency Officials Contact Information CFR(s): 483.73(c)(2) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance.	E 031	A. Corrective Actions: The facility has reviewed the existing emergency plan, policies and procedures and addressed the need to include contact information for the State Licensing and Certification Agency and the State Ombudsman.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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E 031	<p>Continued From page 6</p> <p>*[For LTC Facilities at §483.73(c):] (2) Contact information for the following:</p> <p>(i) Federal, State, tribal, regional, or local emergency preparedness staff.</p> <p>(ii) The State Licensing and Certification Agency.</p> <p>(iii) The Office of the State Long-Term Care Ombudsman.</p> <p>(iv) Other sources of assistance.</p> <p>*[For ICF/IIDs at §483.475(c):] (2) Contact information for the following:</p> <p>(i) Federal, State, tribal, regional, and local emergency preparedness staff.</p> <p>(ii) Other sources of assistance.</p> <p>(iii) The State Licensing and Certification Agency.</p> <p>(iv) The State Protection and Advocacy Agency.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, the facility failed to ensure current contact information for emergency management officials and other resources of assistance was provided in the emergency communication plan. Failure to provide information for resources available to the facility has the potential to hinder facility response and continuity of care for the 28 residents, staff and visitors in the facility on the date of the survey.</p> <p>Findings include:</p> <p>On 8/22/18 from 1:30 - 3:00 PM, review of the emergency plan, policies and procedures, revealed the plan did not include contact information for State Licensing and Certification Agency and the State Ombudsman.</p> <p>Reference: 42 CFR 483.73 (c) (2)</p>	E 031	<p>B. Identification of others affected and corrective actions:</p> <p>As noted in the citation facility residents, staff and visitors could have been affected in the event of an actual emergency or disaster. The facility's Executive Director and Plant Operations Manager Supervisor have re-evaluated and identified no others affected at this time.</p> <p>C. Measures to ensure that the deficient practice does not happen again:</p> <p>The facility plan will be reviewed and updated as necessary but not less than annually in order to avert the potential hindrance of facility response and the continuity of care and other services during an actual emergency or disaster.</p> <p>D. Monitor corrective actions:</p> <p>The Executive Director or his designee will conduct a monthly audit review for three months. The results will be reported to the QAA committee which meets monthly. The QAA Committee will review until it has been determined that the system is effective to assure continued compliance.</p> <p>E. Corrective action(s) will be completed by: 09/25/18</p>		
E 039 SS=F	EP Testing Requirements CFR(s): 483.73(d)(2)	E 039			

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E 039	<p>Continued From page 7</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> <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 RNHCs at §403.748 and OPOs at</p>	E 039			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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E 039	<p>Continued From page 8</p> <p>§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 failed to participate in two exercises which tested the emergency preparedness readiness of the facility. Failure to participate in full-scale, actual, or tabletop events has the potential to reduce the facility's effectiveness to provide continuity of care to residents during an emergency. This deficient practice affected 28 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>On 8/22/17 from 1:30 - 3:00 PM, review of provided emergency plan documents revealed documentation demonstrating the facility had participated in one (1) of the required two (2) exercises of the emergency preparedness plan, policies and procedures.</p> <p>Interview of the Administrator on 8/22/18 from 2:30 - 3:00 PM substantiated the facility had only</p>	E 039	<p>A. Corrective Actions:</p> <p>The facility has reviewed the existing emergency plan, policies and procedures and better defined the participation requirement including that of a documented "tabletop" exercise that challenges the "plan" and the effectiveness of how the facility will provide those emergent services in the event of an actual disaster.</p> <p>B. Identification of others affected and corrective actions:</p> <p>As noted in the citation facility residents, staff and visitors could have been affected in the event of an actual emergency or disaster. The facility's Executive Director and Plant Operations Manager Supervisor have re-evaluated and identified no others affected at this time.</p>	

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E 039	Continued From page 9 documented one (1) actual event which followed a procedure identified in the emergency plan. Reference: 42 CFR 483.73 (d) (1)	E 039	C. Measures to ensure that the deficient practice does not happen again: The facility plan will be reviewed and updated as necessary but not less than annually in order to address the actual participation requirement of a community based full-scale exercise, an individual facility based exercise or that of a documented "tabletop" exercise. The latter, that challenges the "plan" and how the facility will provide those emergent services in the event of an actual disaster. The results of which analyze and document facility responses with respect to revising the plan as to what works and what doesn't. D. Monitor corrective actions: The Executive Director or his designee will conduct a monthly audit review for three months. The results will be reported to the QAA committee which meets monthly. The QAA Committee will review until it has been determined that the system is effective to assure continued compliance. E. Corrective action(s) will be completed by: 09/25/18		