



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

September 7, 2018

Bonnie Sorensen, Administrator
Countryside Care & Rehabilitation
1224 Eighth Street
Rupert, ID 83350-1527

Provider #: 135064

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Ms. Sorensen:

On **August 29, 2018**, a Facility Fire Safety and Construction survey was conducted at Countryside Care & Rehabilitation by the Bureau of Facility Standards/Department of Health & Welfare 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. Your facility was found to be in substantial compliance with Federal regulations during this survey.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, which states that the facility complies with the requirements of CFR 42, 483.70(a) of the federal requirements. This form is for your records only and does not need to be returned.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact this office at (208) 334-6626, option 3.

Sincerely,

Nate Elkins, Supervisor
Facility Fire Safety and Construction

FILE COPY

NE/lj
Enclosures

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

PRINTED: 09/07/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135064	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 08/29/2018
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NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE CARE & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 1224 EIGHTH STREET RUPERT, ID 83350
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(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
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K 000	<p>INITIAL COMMENTS</p> <p>The main skilled nursing facility is a single story, type V (111) construction, with a two-hour wall at the original hospital building constructed in 1960. The short-term portion of the nursing facility occupies the West wing of the Hospital building and is separated by a smoke barrier from the remaining hospital building which is type I construction. The entire facility is fully sprinklered with corridor smoke detection and manual fire alarm system. The Essential Electrical System is supplied by a diesel powered, on-site automatic generator. The facility is licensed for 46 SNF beds and had a census of 33 on the date of the survey.</p> <p>The facility was found to be in substantial compliance during the annual fire/life safety survey conducted on August 29, 2018. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70, and 42 CFR 483.80.</p> <p>The Survey was conducted by:</p> <p>Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction</p>	K 000	<p>RECEIVED</p> <p>SEP 12 2018</p> <p>FACILITY STANDARDS</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Bonnie Larsen</i>	TITLE <i>Admin</i>	(X6) DATE <i>9-11-18</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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September 7, 2018

Bonnie Sorensen, Administrator
Countryside Care & Rehabilitation
1224 8th St.
Rupert, ID 83350-1527

FILE COPY

Provider #: 135064

RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER

Dear Ms. Sorensen:

On **August 29, 2018**, an Emergency Preparedness survey was conducted at **Countryside Care & Rehabilitation** 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 no more than minimal harm, 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.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **September 20, 2018**. Failure to submit an acceptable PoC by **September 20, 2018**, may result in the imposition of civil monetary penalties by **October 12, 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 **October 3, 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 **October 3, 2018**. A change in the seriousness of the deficiencies on **October 3, 2018**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **October 3, 2018**, includes the following:

Denial of payment for new admissions effective **November 29, 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 **March 1, 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 29, 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:

<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

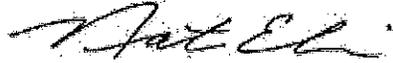
This request must be received by **September 20, 2018**. If your request for informal dispute resolution is received after **September 20, 2018**, the request will not be granted.

Bonnie Sorensen, Administrator
September 7, 2018
Page 4 of 4

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,

A handwritten signature in black ink, appearing to read "Nate Elkins". The signature is written in a cursive style with a horizontal line underneath.

Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosures

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NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE CARE & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 1224 EIGHTH STREET RUPERT, ID 83350
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E 000	Initial Comments The main skilled nursing facility is a single story, type V (111) construction, with a two-hour wall at the original hospital building constructed in 1960. The short-term portion of the nursing facility occupies the West wing of the Hospital building and is separated by a smoke barrier from the remaining hospital building which is type I construction. The entire facility is fully sprinklered with corridor smoke detection and manual fire alarm system. The Essential Electrical System is supplied by a diesel powered, on-site automatic generator. The facility is licensed for 46 SNF beds and had a census of 33 on the date of the survey. The following deficiency was cited during the emergency preparedness survey conducted on August 29, 2018. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73. The Survey was conducted by: Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction	E 000	RECEIVED SEP 12 2018 FACILITY STANDARDS	
E 035 SS=C	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (8) A method for sharing information from the	E 035	1. A letter will be sent to the residents and/or their representative along with the monthly billing statement stating that the facility does have an Emergency Preparedness Plan (EPP). The emergency plan is available to view upon request. 2. All residents have the potential to be affected by the deficient practice. 3. A letter stating that we have an Emergency Preparedness Plan will be	09/30/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Bonnie Sorenson</i>	TITLE <i>Admin</i>	(X6) DATE <i>9-11-18</i>
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E 035	<p>Continued From page 1</p> <p>emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, it was determined the facility failed to provide current information on the facility emergency preparedness plan with residents, families and representatives. Not sharing information with residents, families and representatives on the EP plan, has the potential to create confusion and lack of understanding of the facility's response during a disaster. This deficient practice could potentially affect 48 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>On August 8, 2018 from approximately 10:00 AM to 11:30 AM, review of the facility Emergency Preparedness (EP) Plan and related documents revealed the facility did not have a plan to share information with residents, families and representatives on the emergency preparedness plan. When asked, the Administrator stated the facility was unaware of this requirement.</p> <p>Reference:</p> <p>42 CFR 483.73 (c) (8)</p>	E 035	<p>added to the admission paperwork and that it is available to view upon request. The resident's in resident council will be notified in the quarterly resident council meeting.</p> <p>4. The DON or the DON's representative will complete a QA of the admission paperwork to see if the appropriate notification of anEPP was recieved by the resident or the resident's representative. The information will be sent to the Quality Assurance Committee for review. The Administrator will be notified of the fidings through the Quality Committee.</p>	