



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

October 12, 2018

Dallas Clinger, Administrator
Power County Nursing Home
PO Box 420
American Falls, ID 83211-0420

Provider #: 135066

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

Dear Mr. Clinger:

On **October 1, 2018**, a Facility Fire Safety and Construction survey was conducted at **Power County Nursing Home** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

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

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **October 25, 2018**. Failure to submit an acceptable PoC by **October 25, 2018**, may result in the imposition of civil monetary penalties by **November 16, 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 **November 5, 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 **November 5, 2018**. A change in the seriousness of the deficiencies on **November 5, 2018**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **November 5, 2018**, includes the following:

Denial of payment for new admissions effective **January 1, 2019**.
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 **April 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 **October 1, 2018**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

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<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

Go to the middle of the page to Information Letters section and click on State and select the following:

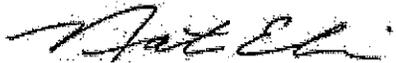
BFS Letters (06/30/11)

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

This request must be received by **October 25, 2018**. If your request for informal dispute resolution is received after **October 25, 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

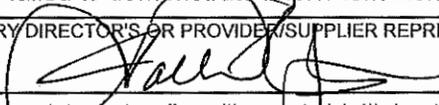
Printed: 10/11/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135066	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2018
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NAME OF PROVIDER OR SUPPLIER POWER COUNTY NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 510 ROOSEVELT STREET (83211-1362) AMERICAN FALLS, ID 83211
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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 facility is located on the first floor, east wing of the county hospital. It is two-hour separated and originally constructed in early 1961. The structure was retrofitted in 2010 with a full NFPA 13 sprinkler system and is equipped with an interconnected fire alarm/smoke detection system which includes exit access corridors and open spaces. Emergency power and lighting are provided by the hospital's diesel powered, automatic generator. The facility is currently licensed for 20 SNF/NF beds with a census of 15 on the date of the survey.</p> <p>The following deficiencies were cited during the annual life safety code survey conducted on October 10, 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>Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction</p>	K 000	<p style="text-align: center;">RECEIVED</p> <p style="text-align: center;">OCT 26 2018</p> <p style="text-align: center;">FACILITY STANDARDS</p>	
K 100 SS=F	<p>General Requirements - Other CFR(s): NFPA 101</p> <p>General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to demonstrate implementation of a water</p>	K 100	<p>K100 NFPA 101 25Oct2018 General Requirements- Other</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The Infection Control Preventionist (ICP) updated the facility water management program risk assessment with control measures to identify the where, what, and how for each hazard and its risk level. The updated assessment also assigns responsibility for tracking and compliance.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE CEO/ADMINISTRATOR	(X6) DATE 23 OCT 2018
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 100	<p>Continued From page 1</p> <p>management program for waterborne pathogens such as Legionella, in accordance with 42 CFR 483.80. Failure to implement a water management program with consideration for the ASHRAE 188 standard and utilizing those parameters as defined in the CDC toolkit, has the potential to limit relevant facility awareness and expose residents to Legionella and other water source bacterium based on inconclusive data. This deficient practice affected 15 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During review of provided water management documentation conducted on 10/1/18 from 1:30 - 2:30 PM with the Infection Control nurse, documentation provided indicated the facility Water Management Plan included policies for how to implement a plan and those persons responsible for its development, but did not define or identify a facility risk assessment or control measures.</p> <p>When asked if the ASHRAE 188 standard or the CDC toolkit was used during the development of the water management plan, the Infection Control nurse stated she was not aware of the ASHRAE standard and was not fully understanding how to incorporate the CDC toolkit into the plan.</p> <p>CFR standard: 42 CFR 483.80</p> <p>§ 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.</p>	K 100	<p>How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents, staff, and visitors have the potential to be affected by this deficiency.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Housekeeping, Maintenance, Nursing and Physical Therapy department staffs will conduct and perform the control measures as outlined in the risk assessment for checking hazards.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what QA program will be put into place? The ICP will review each assigned department hazards checklists each quarter for compliance; The ICP will also review the water management program and risk assessment annually and report any discrepancies or findings to the Water Management Committee.</p> <p>Completion date 10/25/18</p>	

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K 232	<p>Continued From page 3</p> <p>them to be seven feet and six inches wide, with only 36 inches of space remaining after placement of these chairs. Additionally, the placement of the chair outside room 3 blocked direct access to the exit door. Interview of the Maintenance Supervisor indicated that he was not aware of the requirement for furniture to be affixed and that the Physical Therapy department had placed the chair outside of room 3 which blocked the door.</p> <p>Actual NFPA standard:</p> <p>19.2.3.4* Any required aisle, corridor, or ramp shall be not less than 48 in. (1220 mm) in clear width where serving as means of egress from patient sleeping rooms, unless otherwise permitted by one of the following:</p> <p>(1) Aisles, corridors, and ramps in adjunct areas not intended for the housing, treatment, or use of inpatients shall be not less than 44 in. (1120 mm) in clear and unobstructed width.</p> <p>(2)*Where corridor width is at least 6 ft (1830 mm), noncontinuous projections not more than 6 in. (150 mm) from the corridor wall, above the handrail height, shall be permitted.</p> <p>(3) Exit access within a room or suite of rooms complying with the requirements of 19.2.5 shall be permitted.</p> <p>(4) Projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met:</p> <p>(a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in.(1525 mm).</p> <p>(b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar</p>	K 232	<p>documentation will be checked monthly by the Director of Engineering.</p> <p>Completion date 10/25/18</p>	

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K 232	Continued From page 4 emergency. (c)*The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment (5)*Where the corridor width is at least 8 ft (2440 mm), projections into the required width shall be permitted for fixed furniture, provided that all of the following conditions are met: (a) The fixed furniture is securely attached to the floor or to the wall. (b) The fixed furniture does not reduce the clear unobstructed corridor width to less than 6 ft (1830 mm), except as permitted by 19.2.3.4(2). (c) The fixed furniture is located only on one side of the corridor. (d) The fixed furniture is grouped such that each grouping does not exceed an area of 50 ft ² (4.6 m ²). (e) The fixed furniture groupings addressed in 19.2.3.4(5)(d) are separated from each other by a distance of at least 10 ft (3050 mm). (f)*The fixed furniture is located so as to not obstruct access to building service and fire protection equipment. (g) Corridors throughout the smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the fixed furniture spaces are arranged and located to allow direct supervision by the facility staff from a nurses ' station or similar space. (h) The smoke compartment is protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.8.	K 232		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing	K 353		

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K 353	<p>Continued From page 5</p> <p>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.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</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 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 15 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During review of provided facility inspection and testing records conducted on 10/1/18 from 8:30 - 10:30 AM, records were not available for the annual inspection and second quarter of 2018 waterflow alarm flow test.</p> <p>Actual NFPA standard:</p>	K 353	<p>K353 NFPA 101 25Oct2018 Sprinkler System- Maintenance and Testing</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The Maintenance staff contacted the fire suppression inspection company and copies of the second quarter and annual report were not available, due to company consolidation and reorganization. The new company came to the facility on 10/9/18 and completed the annual test of the facility fire suppression system.</p> <p>How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents, staff, and visitors have the potential to be affected by this deficiency.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? The Director of Engineering will review the contract of the current inspection company for better compliance with reporting. The Maintenance staff will require that for all future fire suppression systems tests and inspections that the company inspectors leave a preliminary report or receipt of testing to keep for our record tracking and follow-up.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what QA program will be put into place? Maintenance staff will continue to schedule the required fire suppression system quarterly and annual testing and maintain the</p>	

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K 353	Continued From page 6 NFPA 25 5.2* Inspection. 5.2.1 Sprinklers. 5.2.1.1* Sprinklers shall be inspected from the floor level annually. 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.	K 353	corresponding documentation as required. Documentation will be checked quarterly by the Director of Engineering or the Administrator. Completion date 10/25/18	
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101 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 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. Failure to provide safe electrical installations has been historically linked to the increased potential of arc fires. This deficient practice affected staff and visitors on the date of the survey. Findings include: During the facility tour conducted on 10/01/18	K 511	K511 NFPA 101 Utilities- Gas and Electric What corrective action will be accomplished for those residents found to have been affected by the deficient practice? An electrical contractor replaced the existing light fixture connections on 10/18/18 in the Housekeeping office to be in compliance with NFPA 70 Section 110. The Director of Engineering also spoke with the gift shop staff and removed all extension cords on 10/19/18. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents, staff, and visitors have the potential to be affected by this deficiency.	25Oct2018

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K 511	<p>Continued From page 7 from approximately 1:30 PM to 3:30 PM, observation of electrical installations in the facility revealed the following:</p> <p>The Housekeeping office was using two (2) non-grounded plug adapters, plugged into non-grounded plug to light socket adapters, to supply power to two (2) fluorescent light fixtures in the ceiling.</p> <p>The gift shop was using an extension cord connected in series (daisy-chained) with a relocatable power tap (RPT).</p> <p>Interview of the Maintenance Director revealed he was not aware these installations were in place prior to the date of the survey.</p> <p>Actual NFPA standard:</p> <p>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</p>	K 511	<p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? The Director of Engineering reminded the gift shop staff not to use extension cords. The Maintenance staff added a check of electrical components to their daily checklist and will conduct routine checks of department areas to identify and address compliance with electrical connections and fixtures.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what QA program will be put into place? The Maintenance staff daily checklist documentation will be checked monthly by the Director of Engineering.</p> <p>Completion date 10/25/18</p>	

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K 511	Continued From page 8 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 labeling. (2) Mechanical strength and durability, including, 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		
K 926 SS=E	Gas Equipment - Qualifications and Training CFR(s): NFPA 101 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 926	K926 NFPA 101 Gas Equipment- Qualifications and Training What corrective action will be accomplished for those residents found to have been affected by the deficient practice?	25Oct2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135066	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2018
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K 926	<p>Continued From page 9</p> <p>Based on record review, and interview, the facility failed to ensure continuing education and staff training was provided on the risks associated with the storage, handling and use of medical gases and their cylinders. Failure to provide training of safety and the risks associated with medical gases, potentially increases risks associated, hindering staff response on the use and handling of oxygen. This deficient practice potentially affected oxygen dependent residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During review of provided training records on 10/1/18 from 8:30 - 10:30 AM, records provided did not demonstrate continuing training was performed on an annual basis for the risks associated with oxygen and its use.</p> <p>Interview of 3 of 3 staff members revealed none had participated in a facility provided, continuing education program, on the risks associated with the storage, handling or use of medical gases such as oxygen. Further interview of the DON and HR Director confirmed this training was not conducted annually.</p> <p>Actual NFPA standard:</p> <p>NFPA 99 11.5.2 Gases in Cylinders and Liquefied Gases in Containers. 11.5.2.1 Qualification and Training of Personnel. 11.5.2.1.1* Personnel concerned with the application and maintenance of medical gases and others who handle medical gases and the cylinders that contain the medical gases shall be trained on the risks associated with their handling and use.</p>	K 926	<p>The Director of Human Resources and Director of Engineering will create a training that will be required by all staff that handles or uses oxygen or other compressed gases to be reviewed on an annual basis and at orientation for new applicable staff. A med gas training was also reviewed with staff at the 10/24/18 Long Term Care department meeting.</p> <p>How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents, visitors, and staff that utilize oxygen services have the potential to be affected by this deficiency.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Annual staff training will be mandatory for all staffs that handle oxygen or other compressed gases. At the conclusion of the training, staff will be required to pass a written or electronic test with documentation maintained by Human Resources. This training and testing will be held in conjunction with other annual and orientation mandatory training and testing.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what QA program will be put into place? All mandatory training documentation, including oxygen/gas safety, will be kept by Human Resources and reports reviewed biannually by Department Managers for staff compliance.</p> <p>Completion date 10/25/18</p>	

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

Printed: 10/11/2018
FORM APPROVED
OMB NO. 0938-0391

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K 926	Continued From page 10 11.5.2.1.2 Health care facilities shall provide programs of continuing education for their personnel. 11.5.2.1.3 Continuing education programs shall include periodic review of safety guidelines and usage requirements for medical gases and their cylinders.	K 926		



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

October 12, 2018

Dallas Clinger, Administrator
Power County Nursing Home
PO Box 420
American Falls, ID 83211-0420

Provider #: 135066

RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER

Dear Mr. Clinger:

On **October 1, 2018**, an Emergency Preparedness survey was conducted at **Power County Nursing Home** 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.

FILE COPY

Dallas Clinger, Administrator

October 12, 2018

Page 2 of 4

Your Plan of Correction (PoC) for the deficiencies must be submitted by **October 25, 2018**. Failure to submit an acceptable PoC by **October 25, 2018**, may result in the imposition of civil monetary penalties by **November 16, 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 **November 5, 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 **November 5, 2018**. A change in the seriousness of the deficiencies on **November 5, 2018**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **November 5, 2018**, includes the following:

Denial of payment for new admissions effective **January 1, 2019**.
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.

Dallas Clinger, Administrator

October 12, 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 **April 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 **October 1, 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

Dallas Clinger, Administrator
October 12, 2018
Page 4 of 4

This request must be received by **October 25, 2018**. If your request for informal dispute resolution is received after **October 25, 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,

A handwritten signature in black ink, appearing to read "Nate Elkins", with a small star or asterisk at the end of the signature.

Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosures

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

Printed: 10/11/2018
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OMB NO. 0938-0391

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E 000	Initial Comments The facility is located on the first floor, east wing of the county hospital. Both the Skilled Nursing Facility and the Hospital are supported by county and state EMS services. It is two-hour separated and originally constructed in early 1961. The structure was retrofitted in 2010 with a full NFPA 13 sprinkler system and is equipped with an interconnected fire alarm/smoke detection system which includes exit access corridors and open spaces. Emergency power and lighting are provided by the hospital's diesel powered, automatic generator. The facility is currently licensed for 20 SNF/NF beds with a census of 15 on the date of the survey. The following deficiencies were cited during the annual Emergency Preparedness survey conducted on October 1, 2018. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73. The Survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction	E 000	RECEIVED OCT 26 2018 FACILITY STANDARDS	
E 006 SS=D	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.*	E 006	E006 CFR: 483.73(a)(1)-(2) 15Nov2018 Plan Based on All Hazards Risk Assessment What corrective action will be accomplished for those residents found to have been affected by the deficient practice? PCHD staff is working with staff and area community agencies to develop a more comprehensive facility based and community based Hazard Vulnerability Assessment (HVA) utilizing the recommended all-hazards approach. The updated HVA will be completed by 11/15/18. How you will identify other residents having the potential to be affected by the same deficient	

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

TITLE

(X6) DATE

CEO/ADMINISTRATOR

23 OCT 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.

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E 006	<p>Continued From page 1</p> <p>*[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents.</p> <p>*[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients.</p> <p>(2) Include strategies for addressing emergency events identified by the risk assessment.</p> <p>* [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to develop an EP plan that included both a facility based and community based risk assessment. Failure to include relevant community information when developing the risk assessment, has the potential to shift focus of resources on hazards that are not consistent with the facility location or community impact from localized disasters. This deficient practice affected 15 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>On 10/1/18 from 8:30 - 10:00 AM, review of the provided emergency plan, policies and procedures, revealed the facility HVA (Hazard</p>	E 006	<p>practice and what corrective action will be taken? All residents, staff, and visitors have the potential to be affected by this deficiency.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? The HVA will be reviewed and shared at the 11/15/18 Safety Committee meeting for any additional changes and then posted on the District's network for review by staff. A notice will also be posted for residents, their representatives or visitors to request the HVA information.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what QA program will be put into place? An annual review of the HVA will be completed by the Emergency Preparedness Coordinator and reported to the Safety Committee.</p> <p>Completion date 11/15/18</p>	

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E 006	Continued From page 2 Vulnerability Analysis) failed to provide information for flooding, dam failure and tornadoes, that was consistent with local community and state hazard mitigation plans, as well as a FEMA (Federal Emergency Management Agency) discovery reporting conducted in February of 2014. Interview of the facility Safety Officer revealed the facility HVA was developed during a management staff meeting, but had not consulted outside resources or data for the establishment of probability and impact of localized events. Reference: 42 CFR 483.73 (a) (1) - (2)	E 006		
E 026 SS=F	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) [(b) Policies and procedures. The [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 procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance	E 026	E026 CFR: 483.73(b)(8) Roles Under Waiver Declared by Secretary What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Documentation on the role of PCHD under an 1135 waiver has been added to the facility Emergency Operations Plan (EOP). How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents, staff, and visitors have the potential to be affected by this deficiency. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Updated copies of the EOP with 1135 waiver information will be available on the District public network for review by staff and departments. It will also be reviewed at the 11/15/18 Safety Committee meeting.	15Nov2018

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E 026	<p>Continued From page 3 with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to document their role under an 1135 waiver as declared by the Secretary and the provisions of care as required under this action if identified by emergency management officials. Failure to plan for alternate means of care and the role under an 1135 waiver has the potential to limit facility options during an emergency. This deficient practice potentially affects reimbursement and continuity of care for the 15 residents, staff and visitors housed on the date of the survey along with the available surge needs of the community during a disaster.</p> <p>Findings include:</p> <p>On 10/1/18 from 8:30 -10:30 AM, review of the provided emergency plan, policies and procedures, did not demonstrate the role of the facility under the declaration of an 1135 waiver, should that condition be enacted by the Secretary.</p> <p>Interview of the facility Safety Officer revealed he was not aware the facility had not included any policies or procedures on the role assumed by the facility under an 1135 waiver.</p> <p>Reference: 42 CFR 483.73 (b) (8)</p>	E 026	<p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what QA program will be put into place? An annual review of the EOP and 1135 waiver documentation will be completed by the Emergency Preparedness Coordinator and reported to the Safety Committee.</p> <p>Completion date 11/15/18</p>	
E 035 SS=D	<p>LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8)</p> <p>[(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness</p>	E 035		

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E 035	Continued From page 4 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 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: Based on record review, it was determined the facility failed to provide policies, procedure or plan identifying the method of sharing information on the emergency plan with residents, families, or representatives. Failure to share the emergency plan and its contents with residents, families, or representatives, has the potential to create confusion and lack of understanding of the facility's response during a disaster. This deficient practice potentially affected 15 residents, staff and visitors on the date of the survey. Findings include: On 10/1/18 from 8:30 - 10:30 AM, review of provided emergency plan, policies and procedures, failed to demonstrate the facility policy and method for sharing information with residents, their families or representatives on the contents of the emergency plan, or the facility's procedures during such events. Reference: 42 CFR 483.73 (c) (8)	E 035	E035 CFR: 483.73(c)(8) LTC and ICF/IID Sharing Plan with Patients What corrective action will be accomplished for those residents found to have been affected by the deficient practice? A letter was sent on 10/24/18 to all residents or their representatives with information about how to obtain a copy of the District's EOP or whom to contact with questions about the facility EOP. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents, staff, and visitors have the potential to be affected by this deficiency. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? The Social Services Director has added a copy of the EOP notice letter and information to the admission packets to distribute to all new residents. The letter notice was also posted near the facility survey copies in a public area for residents, families, or visitors to view. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what QA program will be put into place? The Long Term Care Director of Nursing and Social Services Director will do annual reviews of resident admission packets to check for EOP documentation. Completion date 10/25/18	25Oct2018
E 039 SS=F	EP Testing Requirements CFR(s): 483.73(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to	E 039		

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E 039	<p>Continued From page 5</p> <p>test the emergency plan at least annually. The [facility, except for RNHCIs 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 RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the</p>	E 039	<p>E039 CFR: 483.73(d)(2) EP Testing Requirements</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The Safety Officer is working on a full scale facility exercise with help from area agency for assessment of activities. The plans will be reviewed at the upcoming 11/15/18 Safety Committee and the exercise done on or before 11/30/18.</p> <p>How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents, staff, and visitors have the potential to be affected by this deficiency.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? The Safety Officer or Administrator will attend available community emergency planning meetings to coordinate annual community-based exercise options to participate in. The Safety Committee will schedule the two required facility exercises with required follow-up documentation on an annual basis to be in compliance with CFR(s): 483.73(d)(2).</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what QA program will be put into place? The Administrator will review and approve the Safety Committee's annual schedule of the</p>	30Nov2018

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

Printed: 10/11/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135066	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2018
NAME OF PROVIDER OR SUPPLIER POWER COUNTY NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 510 ROOSEVELT STREET (83211-1362) AMERICAN FALLS, ID 83211		
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E 039	<p>Continued From page 6 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: 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 15 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>On 10/1/18 from 8:30 - 10:30 AM, 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 facility Safety Officer on 10/1/18 from 10:30 - 11:00 AM substantiated the facility had only documented one (1) actual event which followed a procedure identified in the emergency plan.</p>	E 039	<p>two required facility exercises to ensure compliance.</p> <p>Completion date 11/30/18</p>	

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E 039	Continued From page 7 Reference: 42 CFR 483.73 (d) (1)	E 039			