



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

Dennis Carlson, Administrator
Bear Lake Memorial Skilled Nursing Facility
164 South Fifth Street
Montpelier, ID 83254-1557

FILE COPY

Provider #: 135070

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Mr. Carlson:

On **October 2, 2018**, a Facility Fire Safety and Construction survey was conducted at **Bear Lake Memorial Skilled Nursing Facility** 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

Dennis Carlson, Administrator
October 12, 2018
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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 6, 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 6, 2018**. A change in the seriousness of the deficiencies on **November 6, 2018**, may result in a change in the remedy.

Dennis Carlson, Administrator
October 12, 2018
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The remedy, which will be recommended if substantial compliance has not been achieved by **November 6, 2018**, includes the following:

Denial of payment for new admissions effective **January 2, 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 2, 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 2, 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:

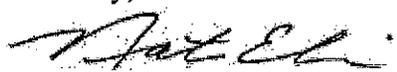
BFS Letters (06/30/11)

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

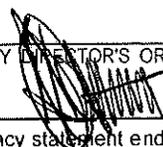
Printed: 10/11/2018
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135070	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE NF B. WING _____		(X3) DATE SURVEY COMPLETED 10/02/2018
NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL SKILLED NURSING F			STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83254		
(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	<p>INITIAL COMMENTS</p> <p>The facility is a single-story type V (111) construction, originally constructed in 1977. The nursing facility is attached to the main hospital and separated by two-hour construction. The nursing facility is comprised of two (2) smoke compartments with separated administration offices abutting the conference room. The facility is equipped with piped medical gases in some residential rooms and emergency power is supplied from the hospital on-site diesel generator. The facility is currently licensed for 36 SNF/NF beds and had a census of 35 on the date of the survey.</p> <p>The following deficiencies were cited during the annual Fire/Life Safety survey conducted on October 2, 2018. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.</p> <p>The Survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety & 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> <p>K511 – This alleged deficiency had the potential to affect 15 residents in the north hall smoke compartment. No residents were harmed by this alleged deficiency.</p> <p>The facility AIT removed the 6-2 multiple plug adapter and returned it to the residents family member on October 3rd, 2018. Staff received education at in-service on October 11th regarding the use of appropriate electrical equipment in healthcare facilities meeting UL 1363 standards. Admin will conduct walking safety rounds to ensure resident rooms are safe from electrical hazards. Walking rounds will be conducted bi-weekly for one month, then weekly ongoing. Any concerns will be reported to the QA committee, along with the appropriate department to correct.</p>		
K 511 SS=E	<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>	K 511			

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

TITLE

(X6) DATE



Sam Burbank

10/22/18

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

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K 511	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure safe electrical equipment installations in accordance with NFPA 70. Failure to provide approved electrical installations has the potential of exposing residents to electrical shock and/or arc fires. This deficient practice affected 15 residents, staff and visitors in 1 of 2 smoke compartments on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 10/2/18 from approximately 1:30 - 3:00 PM, observation of the installed electrical installations, revealed room 106 was using a 6-2 multiple plug adapter to supply power to a clock and a fan.</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. 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</p>	K 511		

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K 511	Continued From page 2 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 may be marked on the equipment, included in the product instructions, or included in the appropriate listing and labeling 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 923 SS=D	Gas Equipment - Cylinder and Container Storage CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or	K 923		

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K 923	<p>Continued From page 3</p> <p>within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating.</p> <p>Less than or equal to 300 cubic feet</p> <p>In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING."</p> <p>Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather.</p> <p>11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, the facility failed to ensure medical gas storage was in accordance with NFPA 99. Failure to secure pressurized medical gas cylinders by either a chain or a rack has the potential to expose residents to the increased risks of explosions or fire. This deficient practice affected staff and visitors on the date of the survey.</p>	K 923	<p>K923 – The alleged deficiency had the potential to affect all residents. No residents were harmed by this alleged deficient practice.</p> <p>Staff received education at in-service on October 11th regarding proper storage of oxygen cylinders. Staff also receive annual education on fire safety and safe oxygen handling. A sign indicating the proper storage method of oxygen cylinders will be posted near the oxygen storage rack on October 22nd, 2018. Proper storage of cylinders in the oxygen storage rack will be monitored by admin during routine walking rounds bi-weekly for one month, then weekly ongoing.</p>	

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K 923	<p>Continued From page 4</p> <p>Findings include:</p> <p>During the initial tour conducted on 10/2/18 from 8:00 - 8:30 AM and the facility tour conducted from 1:30 - 3:00 PM, observation of the Staff Lounge area revealed one (1) "A" cylinder laying horizontally on top of, and being supported by, two (2) "A" cylinders in a rack abutting the staff lockers.</p> <p>Actual NFPA standard:</p> <p>NFPA 99</p> <p>11.6 Operation and Management of Cylinders. 11.6.2.3 Cylinders shall be protected from damage by means of the following specific procedures:</p> <p>(1) Oxygen cylinders shall be protected from abnormal mechanical shock, which is liable to damage the cylinder, valve, or safety device. (2) Oxygen cylinders shall not be stored near elevators or gangways or in locations where heavy moving objects will strike them or fall on them. (3) Cylinders shall be protected from tampering by unauthorized individuals. (4) Cylinders or cylinder valves shall not be repaired, painted, or altered. (5) Safety relief devices in valves or cylinders shall not be tampered with. (6) Valve outlets clogged with ice shall be thawed with warm - not boiling - water. (7) A torch flame shall not be permitted, under any circumstances, to come in contact with a cylinder, cylinder valve, or safety device. (8) Sparks and flame shall be kept away from cylinders. (9) Even if they are considered to be empty, cylinders shall not be used as rollers, supports, or</p>	K 923		

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K 923	Continued From page 5 for any purpose other than that for which the supplier intended them. (10) Large cylinders (exceeding size E) and containers larger than 45 kg (100 lb) weight shall be transported on a proper hand truck or cart complying with 11.4.3.1. (11) Freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. (12) Cylinders shall not be supported by radiators, steam pipes, or heat ducts.	K 923		
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: 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. Findings include:	K 926	K 946 - 926 SS 11/13/18 The alleged deficiency had the potential to affect all residents. No residents were harmed by this alleged deficient practice Staff were educated at in-service on October 11 th , 2018 regarding the proper use and storage of oxygen cylinders. Annual education on fire safety in healthcare facilities (including oxygen use and storage) is required for all facility staff which includes a competency testing component. Administration will conduct random "on-the-spot" testing to ensure staff are competent in the safe storage, handling, and use of medical gases such as oxygen. Results of testing will be shared with the QA committee.	

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K 926	<p>Continued From page 6</p> <p>During review of provided training records on 10/2/18 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.</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. 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.</p>	K 926		



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RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER

Dear Mr. Carlson:

On **October 2, 2018**, an Emergency Preparedness survey was conducted at **Bear Lake Memorial Skilled Nursing Facility** 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.

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- 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.
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The remedy, which will be recommended if substantial compliance has not been achieved by **November 6, 2018**, includes the following:

Denial of payment for new admissions effective **January 2, 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 2, 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 2, 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 **October 25, 2018**. If your request for informal dispute resolution is received after **October 25, 2018**, the request will not be granted. An incomplete

Dennis Carlson, Administrator

October 12, 2018

Page 4 of 4

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 fluid and cursive, with the first name "Nate" being more prominent than the last name "Elkins".

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: 135070	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2018
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NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL SKILLED NURSING F	STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83254
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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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E0D0	Initial Comments The facility is a single-story type V (111) construction, originally constructed in 1977 and is supported by both county and state EMS services. The nursing facility is attached to the main hospital and separated by two-hour construction. The nursing facility is comprised of two (2) smoke compartments with separated administration offices abutting the conference room. The facility is equipped with piped medical gases in some residential rooms and emergency power is supplied from the hospital on-site diesel generator. The facility is currently licensed for 36 SNF/NF beds and had a census of 35 on the date of the survey. The following deficiencies were cited during the annual Emergency Preparedness survey conducted on October 2, 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 ODO	E006 – All residents have the potential to be affected by this alleged deficiency. No residents were harmed by this alleged deficient practice. Facility HVA was reviewed and did not identify a hurricane or tsunami as a likely risk, however a policy & procedure did exist in the emergency plan binder at the time of the survey. These two policies and procedures were removed from the emergency plan on October 3 rd , 2018. The facility HVA will be reviewed annually to ensure the deficient practice does not recur. The emergency plan will be reviewed and amended as needed based on findings from the HVA. Any findings will be reported to the QA committee.	
E 006 SS=F	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.*	E 006	RECEIVED OCT 26 2018 FACILITY SURVEILLANCE	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE 	TITLE ADMINISTRATOR	(X6) DATE 10/22/18
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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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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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to develop an Emergency Preparedness program that included a relevant facility based and community based risk assessment. Failure to provide a relevant facility and community based risk assessment, has the potential to focus staff training and resources on hazards that are not site specific. This deficient practice affected 35 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>1) On 10/2/18 from 8:30 - 10:30 AM, review of the provided emergency plan, policies and procedures, revealed the facility HVA (Hazard Vulnerability Analysis) provided information of the</p>	E 006		
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E 006	Continued From page 2 impact of Hurricanes and Tsunami's, which are not geographically relevant to the facility. 2) Interview with the facility Emergency Coordinator revealed he was not aware these risks were included as part of the HVA. Reference: 42 CFR 483.73 (a) (1) - (2)	E 006		
E 013 SS=D	Development of EP Policies and Procedures CFR(s): 483.73(b) (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and	E 013	E013 - All residents have the potential to be affected by this alleged deficiency. No residents were harmed by this alleged deficient practice. The policies and procedures for a hurricane and tsunami were removed from the emergency plan on October 3 rd , 2018. The emergency plan will be reviewed annually and amended as needed based on findings from the HVA. Any findings will be reported to the QA committee	

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E 013	<p>Continued From page 3 updated at least annually.</p> <p>*[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the facility failed to develop policies and procedures based on the Emergency Plan, that aligned with a facility and community based risk assessment. Failure to provide policies and procedures based on a relevant facility and community based risk assessment, has the potential to focus training and resources to non-applicable hazards. This deficient practice affected 35 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>On 10/2/18 from 8:30 - 10:30 AM, review of provided policies and procedures revealed the risk of Hurricanes was not included in the HVA, but the facility procedures included policies for risks associated with Hurricanes and Tsunamis, neither of which are referenced as geographically relevant by county or state EMS (Emergency Management Services).</p>	E 013		

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E 013	Continued From page 4 Reference: 42 CFR 483.73 (b)	E 013		
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]. (v) Volunteers. *[For RNHCs 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 RNHCs. (v) Volunteers. *[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.	E 030	E030 – All residents have the potential to be affected by this alleged deficiency. No residents were harmed by this alleged deficient practice. The emergency plan contained a list of contact information for all facility staff, including physicians. Physician contact information will be revised and listed on a separate page that contains only physician contact information on October 22, 2018. The facility doesn't utilize any regular/consistent volunteers. As part of the annual emergency plan review, contact information will also be reviewed & updated. Changes in contact information that occur prior to the annual review will be updated as necessary in the event of a change of physicians at the facility.	

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E 030	<p>Continued From page 5</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. (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 resident physicians and volunteers. Failure to have a communication plan which includes contact information for those parties assisting 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 35 residents, staff and visitors on the date of the survey.</p> <p>Findings include: On 10/2/18 from 8:30 - 10:30 AM, review of provided emergency plan, policies and procedures, failed to reveal a communication</p>	E 030		

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E 030	Continued From page 6 plan that included contact information for resident physicians and volunteers.	E 030		
E 031 SS=D	Reference: 42 CFR 483.73 (c) (1) 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. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, or local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to ensure current contact information for emergency	E 031	E031- All residents have the potential to be affected by this alleged deficiency. No residents were harmed by this alleged deficient practice. The emergency plan was updated to include contact information for Federal, State, and County emergency management, and the phone number was corrected for the State Licensing and Certification Agency on October 22, 2018. Contact information will be reviewed as part of the annual emergency plan review.	

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E 031	Continued From page 7 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 35 residents, staff and visitors in the facility on the date of the survey. Findings include: On 10/2/18 from 8:30 - 10:30 AM, review of the emergency plan, policies and procedures, revealed the plan did not include contact information for Federal, State, and County emergency management, as well as the number listed for State Licensing and Certification Agency was incorrect. Reference: 42 CFR 483.73 (c) (2)	E 031		
E 035 SS=D	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 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	E 035	E035 - All residents have the potential to be affected by this alleged deficiency. No residents were harmed by this alleged deficient practice. Information was added to the emergency plan stating that the plans existence is both publicly posted in the facility and included in the admission packet for new residents on October 22, 2018.	

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E 035	Continued From page 8 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 35 residents, staff and visitors on the date of the survey. Findings include: On 10/2/18 from 8:30 - 10:30 AM, during review of provided emergency plan, policies and procedures, no documentation was provided demonstrating 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		
E 036 SS=D	EP Training and Testing CFR(s): 483.73(d) (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk	E 036	E036 - All residents have the potential to be affected by this alleged deficiency. No residents were harmed by this alleged deficient practice. Training will continue to take place regularly at staff in-service meetings. Training modules will be developed based on the top risks identified in the facility HVA. Competency testing will be developed and implemented to coincide with the training modules. Training and testing modules will be developed by November 5 th , 2018. Training and testing methods will be reviewed as part of the annual emergency plan review.	

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E 036	<p>Continued From page 9</p> <p>assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICFIID must meet the requirements for evacuation drills and training at §483.470(h).</p> <p>*[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, it was determined the facility failed to provide an emergency prep training and testing program. Lack of a facility emergency training and testing program covering the emergency preparedness plan, policies and procedures, has the potential to hinder staff response during a disaster. This deficient practice affected 35 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>On 10/2/18 from 8:30 - 9:30 AM, review of provided emergency plan, policies and procedures, along with associated inservices, found no documentation demonstrating the facility had a current testing program for staff based on</p>	E 036		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135070	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2018
NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL SKILLED NURSING F		STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83254		
(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 036	Continued From page 10 training conducted over the contents of the emergency plan. Interview of 3 of 3 staff members conducted on 10/2/18 from 9:30 - 11:45 AM, established the facility had not yet implemented a testing program for staff on the contents of the Emergency Plan. Reference: 42 CFR 483.73 (d)	E 036		