



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 29, 2018

Briar Heisler, Administrator  
Life Care Center of Idaho Falls  
2725 East 17th Street  
Idaho Falls, ID 83406-6601

Provider #: 135091

**RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER**

Dear Ms. Heisler:

On **October 16, 2018**, an Emergency Preparedness survey was conducted at **Life Care Center of Idaho Falls** 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.

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

The remedy, which will be recommended if substantial compliance has not been achieved by **November 20, 2018**, includes the following:

Denial of payment for new admissions effective **January 16, 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.

Briar Heisler, Administrator

October 29, 2018

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We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **April 16, 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 16, 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 **November 11, 2018**. If your request for informal dispute resolution is received after **November 11, 2018**, the request will not be granted.

Briar Heisler, Administrator

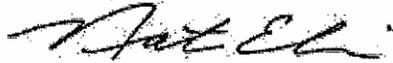
October 29, 2018

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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".

Nate Elkins, Supervisor  
Facility Fire Safety and Construction

NE/lj

Enclosures

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

Printed: 10/21/2018  
FORM APPROVED  
OMB NO. 0938-0391

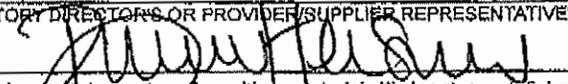
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135091	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  10/16/2018
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NAME OF PROVIDER OR SUPPLIER <b>LIFE CARE CENTER OF IDAHO FALLS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2725 EAST 17TH STREET IDAHO FALLS, ID 83406</b>
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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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E 000	Initial Comments  The facility is a single story Type V (III) building with partial basement, which is used for records storage and houses the facility water heaters. The facility was built in 1978 with a major renovation completed in 1998. The facility is fully sprinklered with a new smoke detection system installed throughout in 2011. It is equipped with emergency backup power, supplied by a diesel-fired generator and is situated in a municipal fire district, with both county and state emergency management support services available. Currently the facility is licensed for 109 SNF/NF beds with a census of 73 on the date of the survey.  The following deficiencies were cited during the annual Emergency Preparedness survey conducted on October 16, 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	This Plan of correction is submitted as required under Federal and State regulations and statutes applicable to long-term care providers. The Plan of Correction does not constitute an admission of liability on part of the facility, and such liability is specifically denied. The submission of this Plan of Correction does not constitute agreement by the facility that the surveyors findings and/or conclusions constitute a deficiency, or that the scope and severity of the deficiencies cited are correctly applied.	
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		

**RECEIVED**  
NOV 08 2018  
**FACILITY STANDARDS**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE ED	(X6) DATE 11/07/2018
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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 73 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>1) On 10/16/18 from 8:30 - 10:30 AM, review of the provided emergency plan, policies and procedures, revealed the facility HVA (Hazard Vulnerability Analysis) failed to demonstrate</p>	E 006	<p>E 006 Specific Resident: No specific resident affected.</p> <p>Other Resident: Residents, staff and visitors present in the facility have the potential to be affected.</p> <p>Systemic Changes: Bonneville County Multi-Jurisdiction All Hazard Mitigation Plan and Bonneville County Emergency Operations Plan obtained and reviewed for comparison of the facility risk assessment to ensure hazards identified are site specific. Hazard Vulnerability Analysis will include facility and community based risk assessment in the form of the Bonneville County Multi-Jurisdiction All Hazard Mitigation Plan review for comparison. Written documentation placed in emergency preparedness manual that task occurred.</p> <p>Monitoring: Maintenance Director and/or designee will audit to ensure the Annual Hazard Vulnerability Analysis includes facility based and community based risk assessment analysis.</p>	11/19/2018

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E 006	Continued From page 2 incorporation of a community based risk assessment, by utilizing relevant data from the local authority hazard mitigation plan.  2) Interview with the facility Administrator revealed she had input the data of the HVA, but had not compared the local mitigation plan and taken that into consideration when developing the facility plan risk assessment.  Reference: 42 CFR 483.73 (a) (1) - (2)	E 006	E009 Specific Resident: No specific resident affected.  Other Resident: Residents, staff and visitors present in the facility have the potential to be affected.  Systemic Changes: Executive Director (ED) and/or Facility Management will attend annual meeting with local fire marshal to review disaster preparedness manual and facility risk assessment in effort to maintain an integrated response during a disaster or emergency situation. Facility to keep documentation of facility's efforts to contact and contact completed with local fire marshal. Local fire marshal contacted and reviewed evaluation of recent community drill, 09/05/2018, with signature to verify/document collaboration was completed during preparation, fire exercise and the evaluation. ED contacted Eastern Idaho Public Health via e-mail regarding disaster preparedness. E-mail response from Holly Peterson, Healthcare Liaison, confirming her facilitation of the Regional	
E 009 SS=F	Local, State, Tribal Collaboration Process CFR(s): 483.73(a)(4)  [(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:]  (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts.  * [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the dialysis facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. The dialysis facility must contact	E 009		

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E 009	<p>Continued From page 3</p> <p>the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, it was determined the facility failed to document collaboration with local, tribal, regional, State and Federal EP officials and integrated emergency response efforts. Failure to develop a collaborative planning effort with multi-jurisdictional entities, has the potential to limit the facilities options during a disaster. This deficient practice affected 73 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>On 10/16/18 from 8:30 AM - 12:30 PM, review of provided policies, procedures and the emergency plan, failed to establish documentation indicating collaborative involvement with local, tribal, regional State and Federal EP officials, including such involvement as participation in county EMS or regional healthcare coalition meetings.</p> <p>Reference: 42 CFR 483.73 (a) (4)</p>	E 009	<p>Healthcare Coalition (HCC). ED and/or facility management will attend local Regional Healthcare Coalition at a minimum of bi-annually with first conference scheduled 11/15/18.</p> <p>Monitoring: ED and/or designee to audit the attendance at the upcoming Regional Healthcare Coalition, November 15, 2018, to ensure facility ED and/or facility management is present.</p>	11/19/2018
E:026 SS=D	<p>Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8)</p> <p>[(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</p>	E 026		

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E 026	<p>Continued From page 4 procedures must address the following:]</p> <p>(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.</p> <p>*[For RNHCs at §403.748(b):] Policies and procedures. (8) The role of the RNHC under a waiver declared by the Secretary, in accordance 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 73 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 10/16/18 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>	E 026	<p>E026 Specific Resident: No specific resident affected.</p> <p>Other Resident: Residents, staff and visitors present in the facility have the potential to be affected.</p> <p>Systemic Changes: "1135 Waiver-At A Glance" and "Requesting an 1135 Waiver" documents obtained/printed from Idaho Department of Health and Welfare website and placed in Emergency Preparedness Manual to document facility's role under 1135 waiver as declared by the Secretary and the provisions of care as required under this action if identified by emergency management officials.</p> <p>Monitoring: Maintenance Director and/or designee will audit the annual review of the facility's Emergency Preparedness Program (EPP) to include documentation of the facility's role under an 1135 waiver.</p>	11/19/2018
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E 026	Continued From page 5 Interview of the Administrator revealed she was not aware the facility had not included any policies or procedures on the role assumed by the facility under an 1135 waiver.	E 026		
E 031 SS=D	<p>Reference: 42 CFR 483.73 (b) (8)</p> <p>Emergency Officials Contact Information CFR(s): 483.73(c)(2)</p> <p>[(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:</p> <p>(2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance.</p> <p>*[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.</p> <p>*[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:</p>	E 031	<p>E031 Specific Resident: No specific resident affected.</p> <p>Other Resident: Residents, staff and visitors present in the facility have the potential to be affected.</p> <p>Systemic Changes: Current contact information obtained and documentation updated to reflect accurate contact for Idaho Department of Health and Welfare in the facility's Emergency Preparedness manual.</p> <p>Monitoring: Maintenance Director and/or designee will audit the annual EPP review to include reviewing and/or updating communications lists and phone numbers.</p>	<p>11/19/2018</p>

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E 031	<p>Continued From page 6</p> <p>Based on record review, the facility failed to ensure current contact information for emergency management officials and other resources of assistance was provided in the emergency communication plan. Failure to provide information for resources available to the facility has the potential to hinder facility response and continuity of care for the 73 residents, staff and visitors in the facility on the date of the survey.</p> <p>Findings include:</p> <p>On 10/16/18 from 8:30 - 10:30 AM, review of the emergency plan, policies and procedures, revealed the plan Emergency Contact List located on page 4 in Chapter 5, had left the number for the State Licensing and Certification Agency blank.</p> <p>Reference: 42 CFR 483.73 (c) (2)</p>	E 031	<p>E036 Specific Resident: No specific resident affected.</p> <p>Other Resident: Residents, staff and visitors present in the facility have the potential to be affected.</p> <p>Systemic Change: "Emergency Preparedness Program Compliance Calendar" completed for annual training requirements including follow up testing to determine staff knowledge of presented information. Will conduct training at next all staff meeting, November 14<sup>th</sup> 2018, followed by testing documentation to determine staff knowledge of the education presented. Documentation of demonstrating knowledge will be present for all facility employees annually and upon orientation for new employees for the EPP.</p> <p>Monitoring: ED and/or Maintenance Director to audit presence of documentation regarding testing for demonstration knowledge for active facility employees/newly hired employees regarding EPP weekly for 12 weeks.</p>	
E 036 SS=D	<p>EP Training and Testing CFR(s): 483.73(d)</p> <p>(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.</p> <p>*[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</p>	E 036		11/19/2018

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NAME OF PROVIDER OR SUPPLIER <b>LIFE CARE CENTER OF IDAHO FALLS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2725 EAST 17TH STREET IDAHO FALLS, ID 83406</b>
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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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E 036	<p>Continued From page 7</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 ICF/IID 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 73 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>On 10/16/18 from 8:30 - 10:30 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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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135091	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  10/16/2018	
NAME OF PROVIDER OR SUPPLIER <b>LIFE CARE CENTER OF IDAHO FALLS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2725 EAST 17TH STREET IDAHO FALLS, ID 83406</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 036	<p>Continued From page 8</p> <p>training conducted over the contents of the emergency plan (EP).</p> <p>Interview of 3 of 3 staff members conducted on 10/16/18 from 1:30 - 2:45 PM, established the facility had not yet implemented a testing program for staff on the contents of the EP. Further interview with the Staff Development Coordinator established he had not yet implemented any testing program for the staff knowledge of the EP.</p> <p>Reference: 42 CFR 483.73 (d)</p>	E 036		



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 29, 2018

Briar Heisler, Administrator  
Life Care Center of Idaho Falls  
2725 East 17th Street  
Idaho Falls, ID 83406-6601

Provider #: 135091

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

Dear Ms. Heisler:

On **October 16, 2018**, a Facility Fire Safety and Construction survey was conducted at Life Care Center Of Idaho Falls by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. Your facility was found to be in substantial compliance with Federal regulations during this survey.

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

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

Sincerely,

Nate Elkins, Supervisor  
Facility Fire Safety and Construction

NE/lj

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

Printed: 10/21/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135091</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02 - ENTIRE BUILDING</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/16/2018</b>
NAME OF PROVIDER OR SUPPLIER <b>LIFE CARE CENTER OF IDAHO FALLS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2725 EAST 17TH STREET IDAHO FALLS, ID 83406</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	<p><b>INITIAL COMMENTS</b></p> <p>The facility is a single story Type V (III) building with partial basement, which is used for records storage and houses the facility water heaters. The facility was built in 1978 with a major renovation completed in 1998. The facility is fully sprinklered with a new smoke detection system installed throughout in 2011. Currently the facility is licensed for 109 SNF/NF beds with a census of 73 on the date of the survey.</p> <p>The facility was found to be in substantial compliance during the annual Fire/Life Safety survey conducted on October 16, 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 483.65.</p> <p>The Survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety &amp; Construction</p>	K 000		

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

TITLE

(X6) DATE

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.