



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

December 14, 2018

Christina Thomas, Administrator
Caribou Memorial Living Center
300 South Third West
Soda Springs, ID 83276-1559

Provider #: 135060

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Ms. Thomas:

On **December 5, 2018**, a Facility Fire Safety and Construction survey was conducted at **Caribou Memorial Living Center** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

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

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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 **December 27, 2018**. Failure to submit an acceptable PoC by **December 27, 2018**, may result in the imposition of civil monetary penalties by **January 18, 2019**.

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 **January 9, 2019**, (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 **March 5, 2019**. A change in the seriousness of the deficiencies on **January 19, 2019**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **January 9, 2019**, includes the following:

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Denial of payment for new admissions effective **March 5, 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 **June 5, 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 **December 5, 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>

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

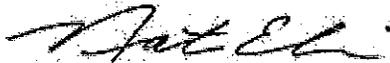
BFS Letters (06/30/11)

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

This request must be received by **December 27, 2018**. If your request for informal dispute resolution is received after **December 27, 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: 12/13/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135060	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 12/05/2018
NAME OF PROVIDER OR SUPPLIER CARIBOU MEMORIAL LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 SOUTH THIRD WEST SODA SPRINGS, ID 83276	
(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 MUST BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) DATE
K 000	INITIAL COMMENTS The facility is a two story, Type II (222) construction, built in the late 1960's. The facility was upgraded in 2011 with a full 13, NFPA compliant fire sprinkler system. The building occupancy consists of a nursing home, hospital, and doctors/clinic offices. Nursing home residents are located on the upper level with exits to finished grade. The Essential Electrical System is supplied by a diesel powered, on-site automatic generator. Medical gas (oxygen) is supplied by a piped system. The facility is currently licensed for 30 SNF/NF beds, and had a census of 24 on the dates of the survey. The following deficiencies were cited during the annual fire/life safety survey conducted on December 4 - 5, 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. The Survey was conducted by: Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction	K 000	K 363 Action Taken: 12/19/2018 Bruce VanPelt, Maintenance Manager installed a smoke/gas seal on the door of room 211 that reduced the gap between the door frame and the door to less than 1/2" when door is fully closed. Identification of others affected: This affected 1 resident, staff, and visitors on the date of the survey with the potential to affect all residents, hospital patients, staff and visitors. Measures/Systemic changes: Bruce VanPelt, Maintenance Manager included in his quarterly rounds an inspection of all resident room doors to assure compliance with the allowable 1/2" gap between door frame and door when fully closed. Monitoring and Tracking: Bruce VanPelt, Maintenance Manager, or designee, will monitor compliance through QA quarterly. The Manager/designee will reassess the needed frequency of the QA after one year. Responsible Party: Bruce VanPelt, Maintenance Manager. Attachments: 1, 2, 8	
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist	K 363		1/9/19

RECEIVED
DEC 31 2018

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE
Christina Thomas *CEO* *12/27/18*

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 363	<p>Continued From page 1</p> <p>the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.</p> <p>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485</p> <p>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, operational testing, and interview the facility failed to maintain doors that protect corridor openings. Failure to maintain corridor doors could allow smoke and dangerous gases to pass freely, preventing defend in place. This deficient practice has the potential to affect 1 resident, staff, and visitors on the dates of the survey.</p>	K 363		

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K 363	Continued From page 2 Findings include: During the facility tour on December 4, 2018, from approximately 2:30 PM to 4:30 PM, observation and operational testing of the resident room doors revealed resident room #211 had an approximately 5/8" gap between the face of the door and the frame of the door when fully closed. When asked, the Maintenance Supervisor stated the facility was unaware the maximum distance between the face and frame of a door when fully closed could not exceed 1/2". Actual NFPA Standards: NFPA 101 19.3.6.3* Corridor Doors. 19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be doors constructed to resist the passage of smoke and shall be constructed of materials such as the following: (1) 1-3/4 in. (44 mm) thick, solid-bonded core wood (2) Material that resists fire for a minimum of 20 minutes Additional Reference: Centers for Medicare/Medicaid Services S&C Letter 07-18, Permittable Door Gaps.	K 363	K 511 Finding 1 Action Taken: 12/5/2018 Bruce VanPelt, Maintenance Manager, removed the zip extension cord from the building. The zip cord has been replaced with a hospital grade power strip with circuit breaker. Staff education on appropriate electrical outlet usage will be added as a agenda line items at both Department Head Meeting to be held on 1/8/2019 and the LTC Staff Meeting to be held on 1/9/2019. Action Taken: 12/5/2018 The toaster was removed from the staff dining room. 12/18/2018 Bear River Electric was on site to install a four-outlet box in the staff dining room. Identification of others affected: This had the potential to affect 24 residents, hospital patients, staff, and visitors. Measures/Systemic Changes: Dillon Liechty, CXO created a handout for residents and families on admission informing them that all decorations, electrical displays, or any other devices that have an electrical plug must be cleared by the Maintenance Department by way of the LTC Director, or designee, prior to use. Current residents and families will have the handout mailed to them to		
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping	K 511		1/9/19	

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K 511	<p>Continued From page 3</p> <p>complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure electrical systems were installed in accordance with NFPA 70. Failure to ensure proper electrical installations could result in electrocution or fire. This deficient practice affected 24 residents, staff and visitors on the dates of the survey.</p> <p>Findings include:</p> <p>1.) During the facility tour on December 4, 2018 from approximately 2:30 PM to 4:30 PM, observation of resident room #215 revealed a "zip" extension cord in use. Additionally, observation of the staff dining room revealed a commercial countertop warming unit plugged in to a Relocatable Power Tap (RPT). It was corrected on the spot and plugged directly into a wall outlet. A toaster was also observed, on the shelf below the warming unit, unplugged and not in use. An interview with the Food Service Manager was conducted and education was provided to ensure understanding the toaster would also be required to be plugged into the wall outlet and not the RPT located behind the warming unit. Upon return to the facility on December 5, 2018, at approximately 9:00 AM,</p>	K 511	<p>inform them of the change in policy by 1/9/2019.</p> <p>Measures/Systemic Changes: Delene Barfuss, Dietary Manager, or designee, will monitor and track appropriate outlet usage daily in relation to dietary equipment in the staff dining room. A policy was written addressing appropriate electrical outlet usage. This will be sent to Policy Committee on 1/9/2019 for approval.</p> <p>Monitoring and Tracking: Sherie Alvari, LTC Director, or designee, will monitor compliance through QA monthly. The Director/designee will reassess the needed frequency of the QA after six months.</p> <p>Monitoring and Tracking: Delene Barfuss, Dietary Manager, or designee, will monitor compliance through QA monthly. The Manager/designee will reassess the needed frequency of the QA after six months.</p> <p>Responsible Parties: Sherie Alvari, LTC Director; Dillon Liechty, CXO; Bruce VanPelt, Maintenance Manager; Delene Barfuss, Dietary Manager.</p> <p>Attachments: 9, 10, 11, 3, 14</p>	

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K 511	<p>Continued From page 4 observation of the staff dining room revealed the toaster was plugged in to the RPT.</p> <p>2.) During the facility tour on December 4, 2018 from approximately 2:30 PM to 4:30 PM, observation of the electrical panel labeled, "KP", in the kitchen near the dishwashing area, revealed duct tape had been used to cover two holes where there were missing breakers/blanks. When asked, the Maintenance Supervisor stated the facility was unaware the duct tape was being used to cover openings in the electrical panel.</p> <p>Actual NFPA standard: NFPA 70</p> <p>1.) 400.8 Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of 368.8. (5) Where concealed by walls, floors, or ceilings or located above suspended or dropped ceilings (6) Where installed in raceways, except as otherwise permitted in this Code</p> <p>2.) 110.12 Mechanical Execution of Work. Electrical equipment shall be installed in a neat</p>	K 511	<p>Finding 2</p> <p>Action: 12/18/18 Bear River Electric installed two blank covers in the dietary electrical panel labeled "KP".</p> <p>Identification of others affected: This has the potential to affect 24 residents, hospital patients, staff and visitors.</p> <p>Measures/Systemic Changes: Bruce VanPelt, Maintenance Manager, has completed a sweep of all electrical boxes in the facility to assure all blanks are properly covered. A policy has been written regarding the proper handling of blanks in an electrical panel. This will be sent to Policy Committee on 1/9/19 for approval.</p> <p>Monitoring and Tracking: Bruce VanPelt, Maintenance Manager, or designee, will monitor compliance through QA monthly. The Manager/designee will reassess the needed frequency of the QA after six months.</p> <p>Responsible Party: Bruce VanPelt, Maintenance Manager</p> <p>Attachments: 4, 5, 6, 12, 13, 15</p>	

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K 511	Continued From page 5 and workmanlike manner. (A) Unused Openings. Unused cable or raceway openings in boxes, raceways, auxiliary gutters, cabinets, cutout boxes, meter socket enclosures, equipment cases, or housings shall be effectively closed to afford protection substantially equivalent to the wall of the equipment. Where metallic plugs or plates are used with nonmetallic enclosures, they shall be recessed at least 6 mm (¼ in.) from the outer surface of the enclosure. (B) Subsurface Enclosures. Conductors shall be racked to provide ready and safe access in underground and subsurface enclosures into which persons enter for installation and maintenance. (C) Integrity of Electrical Equipment and Connections. Internal parts of electrical equipment, including busbars, wiring terminals, insulators, and other surfaces, shall not be damaged or contaminated by foreign materials such as paint, plaster, cleaners, abrasives, or corrosive residues. There shall be no damaged parts that may adversely affect safe operation or mechanical strength of the equipment such as parts that are broken; bent; or deteriorated by corrosion, chemical action, or overheating.	K 511	K 911 Action: 11/7/2018A remote manual stop (Communication Kit) was ordered through Power Systems West. This will be installed by a Power Systems West Serviceman in the room adjacent to the generator room. Projected completion date 1/30/2019. Identification of others affected: This has the potential to affect 24 residents, hospital patients, staff and visitors. Measuring/Systemic Changes: The emergency stop will be included in the scheduled weekly testing of our generator. Precision Power, our third party generator testing company, will also include the emergency stop per current agreement.		
K 911 SS=F	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems 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, Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced	K 911	Monitoring and Tracking: Bruce VanPelt, Maintenance Manager, or designee, will monitor compliance through QA monthly. The Manager/designee will reassess the needed frequency of the QA after six months. Responsible Party: Bruce VanPelt, Maintenance Manager Attachments: 7, 17	1/9/19	

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K 911	Continued From page 6 by: Based on observation and interview, the facility failed to ensure the Essential Electrical System (EES) generator was equipped with a remote manual stop station in accordance with NFPA 110. Failure to provide a remote manual stop station has the potential to prevent shutdown of the emergency generator during a system malfunction, or unintentional operation. This deficient practice affected 24 residents, staff and visitors on the dates of the survey. Findings include: During the facility tour on December 4, 2018 from approximately 2:30 PM to 4:30 PM, a remote manual stop station for the EES generator could not be located. When asked, the Maintenance Supervisor stated the facility was not equipped with a remote stop station. Actual NFPA standard: NFPA 99 6.4.1.1.16.2 Safety indications and shutdowns shall be in accordance with Table 6.4.1.1.16.2. (SEE TABLE) NFPA 110 5.6.5.6* All installations shall have a remote manual stop station of a type to prevent inadvertent or unintentional operation located outside the room housing the prime mover, where so installed, or elsewhere on the premises where the prime mover is located outside the building.	K 911	K916 Action Taken: 11/7/2018 A remote annunciator panel (Communication Kit) was ordered through Power Systems West. This will be installed by a Power Systems West Serviceman in the hospital floor nurses station. Projected completion date 1/30/2018. Identification of others affected: This had the potential to affect 24 residents, hospital patients, staff, and visitors. Measuring/Systemic Changes: the annunciator panel will be included in the scheduled weekly testing of our generator. Precision Power, our third party generator testing company, will also include the annunciator panel per current agreement. Monitoring and Tracking: Bruce VanPelt, Maintenance Manager, or designee, will monitor compliance through QA monthly. The Manager/designee will reassess the needed frequency of the QA after six months. Responsible Party: Bruce VanPelt, Maintenance Manager	
K 916 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101	K 916	Attachments: 7, 17	1/9/19

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K 916	<p>Continued From page 7</p> <p>Electrical Systems - Essential Electric System Alarm Annunciator</p> <p>A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, the facility failed to ensure the EES (Essential Electrical System) was installed in accordance with NFPA 99. Failure to provide an alarm annunciator for the EES could hinder early notification of equipment failures, leaving the facility without emergency power during an outage. This deficient practice affected 24 residents, staff and visitors on the dates of the survey.</p> <p>Findings include:</p> <p>During the facility tour on December 4, 2018 from approximately 2:30 PM to 4:30 PM, observation revealed no alarm annunciator for the EES within the facility. When asked, the Maintenance Supervisor stated that the facility was aware they needed an alarm annunciator for the generator. The facility was working with the generator service company to find an annunciator that would work with their generator. He further stated the facility would be installing an annunciator panel soon.</p> <p>Actual NFPA standard:</p>	K 916			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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K 916	Continued From page 8 NFPA 99 Chapter 6 Electrical Systems 6-4 Essential Electrical System Requirements - Type 1. 6.4.1.1.17 Alarm Annunciator. A remote annunciator that is storage battery powered shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station (see 700.12 of NFPA 70, National Electrical Code). The annunciator shall be hard-wired to indicate alarm conditions of the emergency or auxiliary power source as follows: (1) Individual visual signals shall indicate the following: (a) When the emergency or auxiliary power source is operating to supply power to load (b) When the battery charger is malfunctioning (2) Individual visual signals plus a common audible signal to warn of an engine generator alarm condition shall indicate the following: (a) Low lubricating oil pressure (b) Low water temperature (below that required in 6.4.1.1.11) (c) Excessive water temperature (d) Low fuel when the main fuel storage tank contains less than a 4-hour operating supply (e) Overcrank (failed to start) (f) Overspeed	K 916	K918 Action: 12/5/2018 Bruce VanPelt, Maintenance Manager added weekly generator testing to the electronic record system, which alerts for scheduled testing. Identification of others affected: This had the potential to affect 24 residents, hospital patients, staff, and visitors. Measuring/Systemic Changes: 12/19/18 Bruce VanPelt, Maintenance Manager conducted training on generator testing procedures within the Maintenance Department. A policy has been written regarding generator testing. This will be sent to Policy Committee on 1/9/2018 for approval. Monitoring and Tracking: Bruce VanPelt, Maintenance Manager, or designee, will monitor compliance through QA monthly. The Manager/designee will reassess the needed frequency of the QA after six months. Responsible Party: Bruce VanPelt, Maintenance Manager Attachments: 17, 18, 19	1/9/19
K 918 SS=F	Electrical Systems - Essential Electric System CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second	K 918		

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K 918	<p>Continued From page 9</p> <p>criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.</p> <p>Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.</p> <p>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure Emergency Power Supply Systems (EPSS) were maintained in accordance to NFPA 110. Failure to inspect the generator weekly could result in a lack of system reliability during a power loss. This deficient practice affected 24 residents, staff and visitors on the dates of the survey.</p>	K 918		

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K 918	Continued From page 10 Findings Include: During review of the facility generator inspection and testing records on December 4, 2018, from approximately 10:00 AM to 2:30 PM, the facility failed to provide weekly generator inspection logs for the weeks of 12/31/17 - 1/6/18, 2/4/18-2/10/18, 7/15/18 - 7/21/18. When asked, the Maintenance Supervisor stated he was out on leave during the first week of January and was unaware of the missing documentation in February and July. (See E-41) Actual NFPA standard: NFPA 110 8.4 Operational Inspection and Testing. 8.4.1* EPSSs, including all appurtenant components, shall be inspected weekly and exercised under load at least monthly.	K 918			



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

December 14, 2018

Christina Thomas, Administrator
Caribou Memorial Living Center
300 South Third West
Soda Springs, ID 83276-1559

Provider #: 135060

RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER

Dear Ms. Thomas:

On **December 5, 2018**, an Emergency Preparedness survey was conducted at **Caribou Memorial Living Center** 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 **December 27, 2018**. Failure to submit an acceptable PoC by **December 27, 2018**, may result in the imposition of civil monetary penalties by **January 18, 2019**.

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 **January 9, 2019**, (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 . A change in the seriousness of the deficiencies on **January 28, 2019**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **January 9, 2019**, includes the following:

Denial of payment for new admissions effective **March 5, 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.

Christina Thomas, Administrator

December 14, 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 **June 5, 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 **December 5, 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

Christina Thomas, Administrator

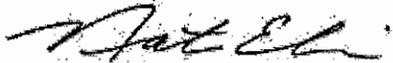
December 14, 2018

Page 4 of 4

This request must be received by **December 27, 2018**. If your request for informal dispute resolution is received after **December 27, 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

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NAME OF PROVIDER OR SUPPLIER CARIBOU MEMORIAL LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 300 SOUTH THIRD WEST SODA SPRINGS, ID 83276
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E 000	<p>Initial Comments</p> <p>The facility is a two story, Type II (222) construction, built in the late 1960's. The facility was upgraded in 2011 with a full 13, NFPA compliant fire sprinkler system. The building occupancy consists of a nursing home, hospital, and doctors/clinic offices. Nursing home residents are located on the upper level with exits to finished grade. The Essential Electrical System is supplied by a diesel powered, on-site automatic generator. Medical gas (oxygen) is supplied by a piped system. The facility is currently licensed for 30 SNF/NF beds, and had a census of 24 on the dates of the survey.</p> <p>The following deficiencies were cited during the emergency preparedness survey conducted on December 4 - 5, 2018. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.</p> <p>The Survey was conducted by:</p> <p>Linda Chaney Health Facility Surveyor Facility Fire Safety and Construction</p>	E 000	E 006	
E 006 SS=F	<p>Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2)</p> <p>[(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:]</p> <p>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.*</p>	E 006	<p>Action Taken: 12/24/2018 Preliminary procedures were established based off of the current HVA to bring the EOP into compliance. These procedures will be communicated at the Department Head Meeting on 1/8/2019. 1/9/2019 Emergency Preparedness Committee will meet to evaluate and update the current HVA and construct updated policies and procedures related to the top identified HVA events as determined by the probability and risk scores. This team is made up of interdisciplinary members which include: administration, medical staff, ancillary staff, charge nurses and clinical staff.</p> <p>Identification of other affected: This has the potential to affect 24 residents, hospital patients, staff, and visitors.</p> <p>Measures/Systemic changes: The Emergency Preparedness Committee will meet monthly and conduct an annual review of the facility EOP and HVA as well as a review with any identified community and facility changes or events that would impact the HVA. If a significant hazard is found in the HVA, a procedure will be</p>	1/9/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Christina Thomas</i>	TITLE CEO	(X6) DATE 12/27/18
--	------------------	---------------------------

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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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 include strategies to address all hazards identified on the facility-based/community-based risk assessment. Failure to include strategies for response to all hazards could hinder the facility's ability to respond to localized disasters and emergencies. This deficient practice affected 24 residents, staff and visitors on the dates of the survey.</p> <p>Findings include:</p> <p>On December 5, 2018, from approximately 9:00 AM to 3:30 PM, review of the provided emergency preparedness plan, including the facility Hazard Vulnerability Assessment (HVA)</p>	E 006	<p>developed and communicated to staff at scheduled monthly Safety and Department Head Meetings.</p> <p>Monitoring and Tracking: Emergency Preparedness Committee will reassess the HVA yearly and make changes to strategy as needed to accommodate any inefficiencies that are found in either drills or real scenarios. If a new significant hazard is found in the HVA, a new strategy will be built for each of the new hazards identified.</p> <p>Responsible: Dillon Liechty, CXO, Team Lead Emergency Preparedness Committee; Emergency Preparedness Committee</p> <p>Attachments: 1</p>	

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E 006	Continued From page 2 revealed some of the hazards identified on the HVA did not have strategies for response. They were; Severe Thunderstorm, Snowfall, Blizzard, Ice Storm, Flood - Internal & External, Dam Inundation, Epidemic, HVAC Failure, Information Systems Failure, Hazmat Exposure - Internal - Mass Casualty & Small Casualty, Chemical Exposure - External, Small - Medium Sized Internal Spill, Terrorism - Radiologic, Supply Shortage, Structural Damage, Mass Casualty Incident - Trauma, Mass Casualty Incident - Medical/Infectious, Terrorism - Biological, Labor Action, Forensic Admission. Additionally, some strategies for response were in the EP plan, but not listed on the HVA. They were; Patient/Resident Elopement, Intruder/Weapon Situation and Natural Gas Failure. These were corrected on the spot and added to the HVA. When asked, the Chief Operating Officer stated the facility was not aware of the discrepancies on the HVA.	E 006	E 007 Action Taken: 12/27/18 Sherie Alvari, LTC Director extracted information addressing resident profiles and continuation of care information from the LTC Facility Assessment. This was entered into the facility-wide EOP and will be reviewed during the Emergency Preparedness Committee Meeting to be held 1/9/19. Identification of others affected: This has the potential to affect 24 residents, hospital patients, staff, and visitors. Measures/Systemic Changes: As the Facility Assessment is updated, it will be reviewed quarterly by the Emergency Preparedness Committee to reflect changes in the EOP.		
E 007 SS=F	Reference: 42 CFR 483.73 (a) (1) - (2) EP Program Patient Population CFR(s): 483.73(a)(3) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.**	E 007	Monitoring and Tracking: The LTC Director sits on the Emergency Preparedness Committee and will inform them of any changes that occur to the Facility Assessment that need immediate review. All other reviews will happen on a quarterly basis within regular committee meetings. All reviews and/or changes will be reflected in the meeting minutes and the EOP. Responsible: Sherie Alvari, LTC Director Attachments: 4	1/9/19	

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E 007	Continued From page 3 *Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to provide an emergency plan that addressed the resident population, including persons at risk and the type of services the facility would be able to provide in an emergency. Failure to provide information on the resident population served within the facility, their unique vulnerabilities in the event of a disaster, and services the facility has the ability to provide in an emergency, could potentially hinder evacuation, continuation of resident care and a community integrated response during an emergency. This deficient practice affected 24 residents, staff and visitors on the dates of the survey. Findings include: On December 5, 2018, from approximately 9:00 AM to 3:30 PM, review of the provided emergency preparedness plan revealed the resident population, including persons at risk was not addressed in the plan. Additionally, the facility had not identified all of the services they could provide in an emergency. When asked, the Chief Operating Officer stated the facility was unaware the EP was deficient in this area. Reference: 42 CFR 483.73 (a) (3) Hospital CAH and LTC Emergency Power CFR(s): 483.73(e)	E 007			
E 041 SS=F		E 041			

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E 041	Continued From page 4 (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source	E 041	E 041 Action: 11/7/2018 a remote manual stop (Communication Kit) was ordered through Power Systems West. This will be installed by a Power Systems West Serviceman in the room adjacent to the generator room. Projected completion date 1/30/2019. Identification of others affected: This has the potential to affect 24 residents, hospital patients, staff and visitors. Measuring/Systemic Changes: The emergency stop will be included in the scheduled weekly testing of our generator. Precision Power, our third party generator testing company, will also include the emergency stop per current agreement. Monitoring and Tracking: Bruce VanPelt, Maintenance Manager, or designee, will monitor compliance through QA monthly. The Manager/designee will reassess the needed frequency of the QA after six months. Responsible Party: Bruce VanPelt, Maintenance Manager Attachments: 2, 3	1/9/19

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

PRINTED: 12/13/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135060	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2018
NAME OF PROVIDER OR SUPPLIER CARIBOU MEMORIAL LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 SOUTH THIRD WEST SODA SPRINGS, ID 83276		
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E 041	<p>Continued From page 5</p> <p>to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates.</p> <p>*[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes.</p> <p>(1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000.</p> <p>(i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011.</p> <p>(ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011.</p> <p>(iii) TIA 12-3 to NFPA 99, issued August 9, 2012.</p> <p>(iv) TIA 12-4 to NFPA 99, issued March 7, 2013.</p> <p>(v) TIA 12-5 to NFPA 99, issued August 1, 2013.</p> <p>(vi) TIA 12-6 to NFPA 99, issued March 3, 2014.</p> <p>(vii) NFPA 101, Life Safety Code, 2012 edition,</p>	E 041			

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E 041	<p>Continued From page 6 issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure the generator for the EES (Essential Electrical System) was maintained in accordance with NFPA 110. Failure to provide an alarm annunciator, emergency stop station and inspect and test EES generators could hinder early notification of equipment failures, prevent shutdown of the emergency generator during a system malfunction, or unintentional operation and result in a lack of system reliability during a power loss. This deficient practice affected 24 residents, staff and visitors on the dates of the survey.</p> <p>Findings Include:</p> <p>During review of the facility generator inspection and testing records on December 4, 2018, from approximately 10:00 AM to 2:30 PM, the facility failed to provide weekly generator inspection logs for the weeks of 12/31/17 - 1/6/18, 2/4/18-2/10/18, 7/15/18 - 7/21/18. When asked, the Maintenance Supervisor stated he was out on leave during the first week of January and was unaware of the missing documentation in</p>	E 041			

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E 041	Continued From page 7 February and July. (See K-918) Reference: 42 CFR 483.73 (e) (2)	E 041			