



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – 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

RECEIVED

JAN 22 2019

FACILITY STANDARDS

January 10, 2019

Melissa Truesdell, Administrator
Owyhee Health & Rehabilitation Center
PO Box A
Homedale, ID 83628-2040

Provider #: 135087

RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER

Dear Ms. Truesdell:

On **January 2, 2019**, an Emergency Preparedness survey was conducted at **Owyhee Health & Rehabilitation 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 an isolated 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.

Melissa Truesdell, Administrator

January 10, 2019

Page 2 of 4

Your Plan of Correction (PoC) for the deficiencies must be submitted by **January 23, 2019**. Failure to submit an acceptable PoC by **January 23, 2019**, may result in the imposition of civil monetary penalties by **February 14, 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 **February 6, 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 **February 24, 2019**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **February 6, 2019**, includes the following:

Denial of payment for new admissions effective **April 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.

Melissa Truesdell, Administrator

January 10, 2019

Page 3 of 4

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **July 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 **January 2, 2019**, 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

Melissa Truesdell, Administrator

January 10, 2019

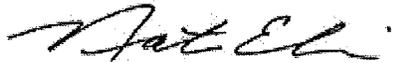
Page 4 of 4

This request must be received by **January 23, 2019**. If your request for informal dispute resolution is received after **January 23, 2019**, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135087	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/02/2019
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NAME OF PROVIDER OR SUPPLIER OWYHEE HEALTH & REHABILITATION CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 108 WEST OWYHEE HOMEDALE, ID 83628
---	--

(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	<p>Initial Comments</p> <p>The facility is a single story, type V(111) construction originally constructed in 1959. The latest addition was completed in June of 2018 and included the installation of a new diesel-fired generator system. The facility is fully sprinklered and is equipped with smoke detection in common areas and corridors. The facility is located in a rural fire district with county, state and federal response services available. Currently the facility is licensed for 49 SNF/NF beds with a census of 44 on the date of the survey.</p> <p>The following deficiency was cited during the Emergency Preparedness Survey conducted on January 2, 2019. 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>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	E 000	<p>"The plan of correction is prepared and submitted as required by law. By submitting this Plan of Correction, Owyhee Health & Rehabilitation Center does not admit that the deficiency listed on this form exists, nor does the center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.</p>	
E 004 SS=D	<p>Develop EP Plan, Review and Update Annually CFR(s): 483.73(a)</p> <p>[The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.]</p> <p>* [For hospitals at §482.15 and CAHs at §485.625(a):] The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness</p>	E 004	<p>RECEIVED JAN 22 2019 FACILITY STANDARDS</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Melissa Truesen</i>	TITLE <i>Administrator</i>	(X6) DATE <i>1/22/2019</i>
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A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135087	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/02/2019
NAME OF PROVIDER OR SUPPLIER OWYHEE HEALTH & REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE 108 WEST OWYHEE HOMEDALE, ID 83628		
(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 004	<p>Continued From page 1</p> <p>program that meets the requirements of this section, utilizing an all-hazards approach.</p> <p>The emergency preparedness program must include, but not be limited to, the following elements:]</p> <p>(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least annually.</p> <p>* [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least annually.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, the facility failed to demonstrate the Emergency Plan (EP) had been updated annually. Failure to update the EP annually has the potential to provide information not relevant to the facility and hinder emergency response during a disaster. This deficient practice affected 44 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During review of the provided EP conducted on 1/2/19 from 11:00 AM to 3:00 PM, observation of the following documentation demonstrated lack of an annual :</p> <p>On the page identified as "ii", both local AHJ (Authority Having Jurisdiction) agencies documented a review of the EP on 12/21/17, with no subsequent review.</p> <p>The Volunteer Policy on page 33 directed staff to request additional staff through "LA County</p>	E 004	<p>E004</p> <p><u>Corrective Action:</u></p> <p>On 1/3/2019 Owyhee Health & Rehabilitation thoroughly reviewed its facility's emergency preparedness plan and has removed any reference to agencies not pertaining to the local area or Idaho as a whole.</p> <p><u>Identification of others affected:</u></p> <p>This deficiency had the potential to affect all residents, new admissions, staff including new hires, and visitors.</p> <p><u>Systemic Changes to ensure Deficient Practice Doesn't Repeat</u></p> <p>Owyhee Health & Rehabilitation will continue to review the emergency preparedness plan no less than quarterly and as needed to ensure the plan is a living document to include applicable city, county, and state responding agencies as well as any other pertinent updates to maintain safe and effective protocols in the event of an actual emergency.</p> <p><u>Monitor of corrective action</u></p> <p>QAPI will continue to follow emergency preparedness no less than quarterly and as needed to ensure there are no concerns from the IDT regarding processes in the event of an emergency.</p> <p><u>Corrective Action Completed:</u></p>	

1/3/2019

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

Printed: 01/07/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135087	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/02/2019
NAME OF PROVIDER OR SUPPLIER OWYHEE HEALTH & REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 108 WEST OWYHEE HOMEDALE, ID 83628		
(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 004	<p>Continued From page 2</p> <p>Department of Public Health (DPH), Health Facilities Inspection Division (HFID)" which is not related to the facility or connected to any Idaho Agency.</p> <p>Page 126 of the EP is identified as "Appendix W - Return to Facility" and listed multiple references from LA County; DPH; HFID; LA County EMS; and California Long Term Care Ombudsman", all of which are not related to operations or requirements relevant to Idaho facilities.</p> <p>The included 24/7 Emergency Reporting contact information located in the front of the EP was for reporting to the North Dakota Health Department.</p> <p>Reference: 42 CFR 483.73 (a)</p>	E 004			



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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

January 10, 2019

Melissa Truesdell, Administrator
Owyhee Health & Rehabilitation Center
PO Box A
Homedale, ID 83628-2040

Provider #: 135087

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Ms. Truesdell:

On **January 2, 2019**, a Facility Fire Safety and Construction survey was conducted at **Owyhee Health & Rehabilitation 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 an isolated 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

Melissa Truesdell, Administrator

January 10, 2019

Page 2 of 4

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 **January 23, 2019**. Failure to submit an acceptable PoC by **January 23, 2019**, may result in the imposition of civil monetary penalties by **February 14, 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 **February 6, 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 **April 2, 2019**. A change in the seriousness of the deficiencies on **February 16, 2019**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **February 6, 2019**, includes the following:

Melissa Truesdell, Administrator
January 10, 2019
Page 3 of 4

Denial of payment for new admissions effective **April 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 **July 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 **January 2, 2019**, 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>

Melissa Truesdell, Administrator
January 10, 2019
Page 4 of 4

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

BFS Letters (06/30/11)

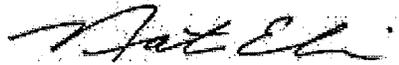
2001-10 Long Term Care Informal Dispute Resolution Process

2001-10 IDR Request Form

This request must be received by **January 23, 2019**. If your request for informal dispute resolution is received after **January 23, 2019**, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135087	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - ENTIRE NF STRUCTURE B. WING _____	(X3) DATE SURVEY COMPLETED 01/02/2019
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NAME OF PROVIDER OR SUPPLIER OWYHEE HEALTH & REHABILITATION CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 108 WEST OWYHEE HOMEDALE, ID 83628
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	<p>INITIAL COMMENTS</p> <p>The facility is a single story, type V(111) construction originally constructed in 1959. The latest addition was completed in June of 2018 and included the installation of a new diesel-fired generator system. The facility is fully sprinklered and is equipped with smoke detection in common areas and corridors. Currently the facility is licensed for 49 SNF/NF beds with a census of 44 on the date of the survey.</p> <p>The following deficiency was cited during the annual fire/life safety survey conducted on January 2, 2019. 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 and Construction</p>	K 000	<p>"The plan of correction is prepared and submitted as required by law. By submitting this Plan of Correction, Owyhee Health & Rehabilitation Center does not admit that the deficiency listed on this form exists, nor does the center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.</p> <p style="text-align: center;">RECEIVED JAN 22 2019 FACILITY STANDARDS</p>	
K 321 SS=D	<p>Hazardous Areas - Enclosure CFR(s): NFPA 101</p> <p>Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of</p>	K 321		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Missa Truesden</i>	TITLE <i>Administrator</i>	(X6) DATE <i>1/22/2019</i>
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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 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135087	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - ENTIRE NF STRUCTURE B. WING _____	(X3) DATE SURVEY COMPLETED 01/02/2019
NAME OF PROVIDER OR SUPPLIER OWYHEE HEALTH & REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE 108 WEST OWYHEE HOMEDALE, ID 83628		
(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 321	<p>Continued From page 1 hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9</p> <p>Area Automatic Sprinkler Separation N/A</p> <p>a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and operational testing, the facility failed to ensure hazardous areas were equipped with self-closing doors. Failure to provide self-closing doors on soiled linen rooms has the potential to allow fire, smoke and dangerous gases to pass into corridors, hindering the safe egress of residents during evacuation. This deficient practice affected 9 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 1/2/19 from 11:00 AM to 3:00 PM, observation and operational testing of the door entering the soiled linen storage adjacent to the riser room in the new wing, revealed the door was not equipped to self-close.</p> <p>Actual NFPA standard:</p> <p>19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas</p>	K 321	<p>K 321</p> <p><u>Corrective Action:</u> Owyhee Health & Rehabilitation Installed the self-closing mechanism to the soiled linen storage on 01/03/2019.</p> <p><u>Identification of others affected:</u> The deficiency had the potential to affect all residents, new admissions, staff including new hires, and visitors may be affected.</p> <p><u>Systemic Changes to ensure Deficient Practice Doesn't Repeat</u> The Administrator and Maintenance Director were educated on the requirements of NFPA standard 19.3.2 and 19.3.2.1. All hazardous areas were evaluated for compliance.</p> <p><u>Monitor of corrective action</u> Administrator and/or designee will continue to do weekly maintenance rounds reporting and addressing issues of concern. QAPI will review overall plant/maintenance findings no less than quarterly and as needed to ensure all areas of concern are resolved or a corrective action plan is in place.</p> <p><u>Corrective Action Completed:</u></p>	1/3/2019

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

Printed: 01/07/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135087	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - ENTIRE NF STRUCTURE B. WING _____	(X3) DATE SURVEY COMPLETED 01/02/2019
NAME OF PROVIDER OR SUPPLIER OWYHEE HEALTH & REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE 108 WEST OWYHEE HOMEDALE, ID 83628		
(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 321	Continued From page 2 shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.7.1. 19.3.2.1.5 Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft ² (9.3 m ²) (3) Paint shops (4) Repair shops (5) Rooms with soiled linen in volume exceeding 64 gal (242 L) (6) Rooms with collected trash in volume exceeding 64 gal (242 L) (7) Rooms or spaces larger than 50 ft ² (4.6 m ²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard	K 321		