



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

January 31, 2020

Casey Kemmerer, Administrator
Teton Post Acute Care & Rehabilitation
3111 Channing Way
Idaho Falls, ID 83404-7534

Provider #: 135138

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

Dear Mr. Kemmerer:

On **January 22, 2020**, a Facility Fire Safety and Construction survey was conducted at **Teton Post Acute Care & Rehabilitation** 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 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 **February 13, 2020**. Failure to submit an acceptable PoC by **February 13, 2020**, may result in the imposition of civil monetary penalties by **March 6, 2020**.

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 26, 2020**, (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 21, 2020**. A change in the seriousness of the deficiencies on **March 7, 2020**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **February 26, 2020**, includes the following:

Denial of payment for new admissions effective **April 22, 2020**.
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 22, 2020**, 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 22, 2020**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

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

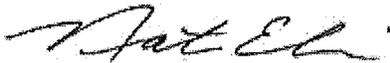
BFS Letters (06/30/11)

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

This request must be received by **February 13, 2020**. If your request for informal dispute resolution is received after **February 13, 2020**, 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: 01/31/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135138	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - TETON POST ACUTE CARE & REHABILITATION B. WING _____	(X3) DATE SURVEY COMPLETED 01/22/2020
NAME OF PROVIDER OR SUPPLIER TETON POST ACUTE CARE & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 3111 CHANNING WAY IDAHO FALLS, ID 83404	
(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	INITIAL COMMENTS The facility is a single story Type V (111) structure originally built in 1988. The building is fully sprinklered, with an interconnected fire alarm/smoke detection system. There is an on-site, natural gas, spark ignited Emergency Power Supply System (EPSS) generator. The facility is currently licensed for 88 SNF/NF beds with a census of 58 on the date of the survey. The following deficiencies were cited during the annual fire/life safety survey conducted on January 22, 2020. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Chapter 19 Existing Health Care Occupancy in accordance with 42 CFR 483.70 The Survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	K 000	<p style="text-align: center;">RECEIVED FEB 12 2020 FACILITY STANDARDS</p> <p>K Tag 211</p> <p>Corrective Action: The path of egress that had the ice dam near the dining room was cleared of obstructions on 1/22/2020.</p> <p>Identifications of others: All other paths of egress were checked on 1/22/2020 to validate that the paths of egress were clear. All paths of egress were free of obstruction on 1/22/2020.</p> <p>Systematic Change: An in-service will be conducted by NHA or Designees no later than 2/25/2020. The in-service will educate the department manager team that all paths of egress are required to be free of-obstruction at all times.</p>	
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11, 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure means of egress were maintained free of obstructions to allow full,	K 211		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Casey Kemmerer TITLE: Administrator (X6) DATE: 2/11/2020

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 211	<p>Continued From page 1</p> <p>instant use in an emergency. Failure to eliminate obstacles such as ice dams across exit discharge paths to the public way, has the potential to hinder the safe evacuation of residents during emergencies. This deficient practice affected residents and staff using the main dining room on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 1/22/20 from 2:00 - 3:00 PM, observation of the exit discharge from the main dining room leading to the southwest, revealed the path was obstructed by an ice dam approximately four feet long, twelve inches wide and four inches tall. Interview of the Maintenance Supervisor at approximately 2:15 PM, established he was not aware of the ice dam prior to the survey.</p> <p>Findings include:</p> <p>7.1.6 Walking Surfaces in the Means of Egress. 7.1.6.3 Level. Walking surfaces shall comply with all of the following: (1) Walking surfaces shall be nominally level. (2) The slope of a walking surface in the direction of travel shall not exceed 1 in 20, unless the ramp requirements of 7.2.5 are met. (3) The slope perpendicular to the direction of travel shall not exceed 1 in 48. 7.1.6.4* Slip Resistance. Walking surfaces shall be slip resistant under foreseeable conditions. The walking surface of each element in the means of egress shall be uniformly slip resistant along the natural path of travel. 7.1.10 Means of Egress Reliability. 7.1.10.1* General. Means of egress shall be continuously maintained free of all obstructions or</p>	K 211	<p>Monitor: An audit tool will be developed by the maintenance director or designee no later than 2/25/2020. The tool will be utilized to monitor that all paths of egress are free from obstruction which includes snow, ice, or large objects. The audit will be done daily for 1 month-weekly for 2 months, and results will be brought to the monthly Quality assurance meeting for review and recommendation for 3 months and as needed.</p> <p>Date of Compliance: 2/25/2020</p>	
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K 211 K 324 SS=D	<p>Continued From page 2</p> <p>impediments to full instant use in the case of fire or other emergency.</p> <p>Cooking Facilities CFR(s): NFPA 101</p> <p>Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:</p> <ul style="list-style-type: none"> * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. <p>Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure kitchen hood systems were maintained in accordance with NFPA 96 and NFPA 17A. Failure to document testing and inspection of UL 300 hood systems,</p>	K 211 K 324	<p>K Tag 324</p> <p>Corrective Action: The maintenance director educated our vendors to provide service reports from them rather than invoices. We received the kitchen exhaust systems cleaning report from D and T Power and have it on-site. The reports are dated for 6/22/2019 and 9/28/19. 20-North Refrigeration Inc. completed the kitchen hood filter gap repair on 2/5/2020 by adding a spacer end plate.</p> <p>Identifications of others: There is only one kitchen hood system in the building.</p>	

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K 324	<p>Continued From page 3</p> <p>and ensure grease laden vapors do not bypass the installed filters, has the potential to allow grease build-up inside the exhaust system, increasing the risk of grease fires. This deficient practice affected staff of the main Kitchen on the date of the survey.</p> <p>Findings include:</p> <p>1) During review of provided maintenance and inspection records conducted on 1/22/20 from 8:45 - 10:00 AM, only 1 fire suppression system inspection testing reports was provided for the semi-annual services of the Kitchen UL 300 hood system. Further review of documentation provided demonstrated only invoices were available for the second fire suppression system testing and both of the cleaning/inspection reports. When asked at approximately 9:45 AM about the missing documentation, the Maintenance Supervisor stated he was not aware his service contractors had not provided the reports as required.</p> <p>2) During the facility tour conducted on 1/22/20 from approximately 11:00 AM - 2:00 PM, observation of the main Kitchen hood system revealed two gaps on the south side of the hood, one in between the filters and one between the face of the filters and the frame of the housing. The gap between the filters was approximately 1/2 inch wide from top to bottom, and the gap at the top of the second filter measured approximately 1/2 inch wide at the top and tapered down until it touched the framework at the bottom.</p> <p>Actual NFPA standard:</p>	K 324	<p>Systematic Change: An in-service will be conducted by Maintenance Director with our vendor no later than 2/25/2020. The in-service will educate the vendors that the kitchen hood maintenance is a semi-annual test and that we need service reports from them instead of invoices. An in-service with Dietary will be conducted by Maintenance Director no later than 2/25/2020. The in-service will educate the dietary staff that there cannot be any gaps in the hood filters and if one is discovered, it must be reported to the Maintenance Director.</p>

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K 324	<p>Continued From page 4 NFPA 96</p> <p>6.2.3 Grease Filters. 6.2.3.3 Grease filters shall be arranged so that all exhaust air passes through the grease filters.</p> <p>11.2 Inspection, Testing, and Maintenance of Fire-Extinguishing Systems. 11.2.1* Maintenance of the fire-extinguishing systems and listed exhaust hoods containing a constant or fire-activated water system that is listed to extinguish a fire in the grease removal devices, hood exhaust plenums, and exhaust ducts shall be made by properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction at least every 6 months.</p> <p>11.4* Inspection for Grease Buildup. The entire exhaust system shall be inspected for grease buildup by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction and in accordance with Table 11.4.</p> <p>11.6.14 After cleaning or inspection is completed, the exhaust cleaning company and the person performing the work at the location shall provide the owner of the system with a written report that also specifies areas that were inaccessible or not cleaned. 11.6.15 Where required, certificates of inspection and cleaning and reports of areas not cleaned shall be submitted to the authority having jurisdiction.</p> <p>NFPA 17A</p> <p>7.3 Maintenance. 7.3.3.5 The maintenance report, including any</p>	K 324	<p>Monitor: An service log will be developed by the maintenance director or designee no later than 2/25/2020. The service log will be utilized to monitor that all services that are rendered in the building have service reports instead of invoices. A weekly audit tool will be developed by the maintenance director to validate that there are no gaps in the hood filter system. Weekly audits will be conducted and results reported to the monthly Quality assurance meeting for review and recommendation for 3 months and as needed.</p> <p>Date of compliance: 2/25/2020</p>	
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K 324	Continued From page 5 recommendations, shall be filed with the owner or with the owner ' s representative. 7.3.3.5.1 The owner or owner ' s representative shall retain all maintenance reports for a period of 1 year after the next maintenance of that type required by the standard.	K 324	K353 Corrective Action: The maintenance director contacted Viking Fire Protection to validate what type of head was on the dry system in the attic. The heads that are in the attic are a standard response sprinkler head that needs to be tested every 50 years. We inspected the control valves on the fire sprinkler suppression system on 1/22/2020. The fire sprinkler pendant in the business office manager office, the 300 hall shower room, and the walk in fridge and freezer, will be replaced by 2/25/2020. Identifications of others: We only have one fire sprinkler suppression system so it was checked on 1/22/2020. All fire sprinkler pendants will be checked to validate that the pendants are free of corrosion, foreign material, and paint & physical damaged. The audit will be conducted no later than 2/25/2020.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure fire suppression systems were maintained in accordance with NFPA 25. Failure to ensure fire suppression systems were maintained free of obstructions and inspected as required, has the potential to hinder system performance during a fire event. This deficient practice affected 58	K 353		

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K 353	<p>Continued From page 6 residents and staff on the date of the survey.</p> <p>Findings include:</p> <p>1) During review of provided fire suppression system maintenance and inspection records conducted on 1/22/20 from 8:45 - 10:00 AM, no records were available indicating the last ten-year replacement or UL testing completed for dry sprinklers installed. Interview of the Maintenance Supervisor established he was unaware of any missing documentation from the time the facility was re-opened in 2012.</p> <p>2) During review of provided fire suppression system maintenance and inspection records conducted on 1/22/20 from 8:45 - 10:00 AM, no records were available indicating the facility was conducting monthly control valve inspections.</p> <p>3) During the facility tour conducted on 1/22/20 from 11:00 AM - 2:30 PM, observation of installed fire suppression system pendants revealed the pendant installed in the shower room across from room 307 and the pendant installed in the business office, both had non-factory applied paint on both the upright and deflector(s). Further observation at 1:45 PM of the main riser spare sprinkler box, revealed standard response, upright pendants that were dated 1987.</p> <p>When asked at the time of the observation which area these sprinkler pendants controlled, the Maintenance Director stated he believed these were installed in the attic. An above the ceiling inspection of the attic space conducted at approximately 2:15 PM, confirmed the upright sprinklers dated 1987 were installed in the attic.</p>	K 353	<p>Systematic Changes: An in-service will be conducted by NHA or designees no later than 2/25/2020. The in-service will educate the maintenance director on the fire sprinkler pendants, and monthly monitoring of control valves. The fire sprinkler pendants need to be free of corrosion, foreign materials, paint and physical</p> <p>damage. The fire suppression system control values need to be checked monthly for correct positioning of the valve and ensure it's functional.</p>		

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K 353	<p>Continued From page 7</p> <p>4) During the facility tour conducted on 1/22/20 from 11:00 AM - 2:30 PM, observation of installed fire suppression system pendants revealed both the walk-in freezer and the walk-in cooler dry-barrel pendants were dated 1988.</p> <p>Actual NFPA standard:</p> <p>NFPA 25</p> <p>5.2* Inspection.</p> <p>5.2.1 Sprinklers.</p> <p>5.2.1.1* Sprinklers shall be inspected from the floor level annually.</p> <p>5.2.1.1.1* Sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., upright, pendent, or sidewall).</p> <p>5.2.1.1.2 Any sprinkler that shows signs of any of the following shall be replaced:</p> <p>(1) Leakage (2) Corrosion (3) Physical damage (4) Loss of fluid in the glass bulb heat responsive element (5)*Loading (6) Painting unless painted by the sprinkler manufacturer</p> <p>5.2.1.1.3* Any sprinkler that has been installed in the incorrect orientation shall be replaced.</p> <p>5.3 Testing.</p> <p>5.3.1* Sprinklers.</p> <p>5.3.1.1* Where required by this section, sample sprinklers shall be submitted to a recognized testing laboratory acceptable to the authority having jurisdiction for field service testing.</p>	K 353	<p>Monitor: Audit tools will be developed by the maintenance director or designee no later than 2/25/2020. The tools will be utilized to monitor the fire sprinkler pendants to validate that the pendants are free of corrosion, foreign materials, and paint & physical damage. Another audit tool will be developed to validate that the inspection of the control values is done monthly. The audit will be done monthly for 3 months and the results of the audit will be brought to the monthly Quality assurance meeting for review and recommendation for 3 months and as needed.</p> <p>Date of Compliance:</p> <p>2/25/2020</p>

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135138	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - TETON POST ACUTE CARE & REHABILITATION B. WING _____	(X3) DATE SURVEY COMPLETED 01/22/2020
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K 511	<p>Continued From page 9</p> <p>shock. This deficient practice affected staff on the date of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on 1/22/20 from 11:00 AM - 2:30 PM, observation of the Maintenance Office revealed a microwave plugged into a RPT and not directly into the fixed wiring of the facility.</p> <p>2) During the facility tour conducted on 1/22/20 from 11:00 AM - 2:30 PM, observation of the main Laundry revealed a full-sized refrigerator plugged into a surge-protected multiple plug adapter and not directly into the fixed wiring of the facility.</p> <p>3) During the facility tour conducted on 1/22/20 from 11:00 AM - 2:30 PM, an above the ceiling inspection in the attic revealed a furnace power supply with a main hot lead outside of the attached junction box. Further observation revealed the cover of the junction box was screwed in at the top and pressing against the power supply wiring and the junction box housing. Interview of the Maintenance Supervisor revealed he was not aware of the exposed wiring being installed in this manner.</p> <p>Findings include:</p> <p>NFPA 70</p> <p>110.3 Examination, Identification, Installation, and Use of Equipment.</p> <p>(A) Examination. In judging equipment, considerations such as the following shall be evaluated:</p> <p>(1) Suitability for installation and use in conformity</p>	K 511	<p>Systematic Changes: An in-service will be conducted by NHA or designee no later than 2/25/2020. The in-service will educate staff on proper items that can be plugged into a power strip and proper items that need to be plugged straight into the power source. A second in-service will educate the maintenance director that when work is being performed on furnaces, he will inspect after work is completed that wires and junction boxes are routed and closed up correctly.</p>

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K 511	<p>Continued From page 10</p> <p>with the provisions of this Code Informational Note: Suitability of equipment use may be identified by a description marked on or provided with a product to identify the suitability of the product for a specific purpose, environment, or application. Special conditions of use or other limitations and other pertinent information may be marked on the equipment, included in the product instructions, or included in the appropriate listing and labeling information. Suitability of equipment may be evidenced by listing or labeling.</p> <p>(2) Mechanical strength and durability, including, for parts designed to enclose and protect other equipment, the adequacy of the protection thus provided</p> <p>(3) Wire-bending and connection space</p> <p>(4) Electrical insulation</p> <p>(5) Heating effects under normal conditions of use and also under abnormal conditions likely to arise in service</p> <p>(6) Arcing effects</p> <p>(7) Classification by type, size, voltage, current capacity, and specific use</p> <p>(8) Other factors that contribute to the practical safeguarding of persons using or likely to come in contact with the equipment.</p> <p>(B) Installation and Use. Listed or labeled equipment shall be installed and used in accordance with any instructions included in the listing or labeling.</p> <p>110.27 Guarding of Live Parts.</p> <p>(A) Live Parts Guarded Against Accidental Contact.</p> <p>Except as elsewhere required or permitted by this Code, live parts of electrical equipment operating at 50 volts or more shall be guarded against accidental contact by approved</p>	K 511	<p>Monitor: Audit tools will be developed by the maintenance director or designee no later than 2/25/2020. The tools will be utilized to monitor power strips usage and validate that correct items are plugged into power strips. A service log will be created by the maintenance director or designee no later than 2/25/2020. The log will have the date of service upon furnaces and that the visual check was performed on the furnace following service, and to validate that wires and junction boxes are put back correctly. The power strip audit will be done weekly for 4 weeks then monthly for 2 months. and log will be utilized as needed and the results of the log will be brought to the monthly Quality Assurance meeting for review and recommendations for 3 months and as needed.</p> <p>Date of Compliance: 2/25/2020</p>	

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K 511	Continued From page 11 enclosures or by any of the following means: (1) By location in a room, vault, or similar enclosure that is accessible only to qualified persons. (2) By suitable permanent, substantial partitions or screens arranged so that only qualified persons have access to the space within reach of the live parts. Any openings in such partitions or screens shall be sized and located so that persons are not likely to come into accidental contact with the live parts or to bring conducting objects into contact with them. (3) By location on a suitable balcony, gallery, or platform elevated and arranged so as to exclude unqualified persons. (4) By elevation of 2.5 m (8 ft) or more above the floor or other working surface. (B) Prevent Physical Damage. In locations where electrical equipment is likely to be exposed to physical damage, enclosures or guards shall be so arranged and of such strength as to prevent such damage. 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 to (4): Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of 368.56(B) (5) Where concealed by walls, floors, or ceilings or located above suspended or dropped ceilings	K 511			

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K 511	Continued From page 12 (6) Where installed in raceways, except as otherwise permitted in this Code (7) Where subject to physical damage	K 511	K Tag 927		
K 927 SS=F	Further reference: UL 1363 XBYS Gas Equipment - Transfilling Cylinders CFR(s): NFPA 101 Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and operational testing, the facility failed to ensure mechanical ventilation was provided for transfilling procedures in accordance with NFPA 99. Failure to provide sufficient mechanical ventilation for liquid oxygen transfilling operations, has the potential to increase the exposure to fires and explosions associated with medical gases. This deficient practice affected 23 residents and staff on the date of the survey. Findings include: During the facility tour conducted on 1/22/20 from 11:00 AM - 2:30 PM, observation and operational	K 927	Corrective Action: The Maintenance Director contacted 20 North Refrigeration and they replaced the ventilation fan in the oxygen room on 2/5/2020. Identification of others: The oxygen room on the 200 hall is the only location where trans filling of oxygen occurs in the building. There is only the one ventilation fan. Systematic Changes: An in-service will be conducted by NHA or designee no later than 2/25/2020. The in-service will educate the maintenance director that exhaust fans are on, required to be operational, and have sufficient exhaust air flow to discharge gasses from the space where oxygen is transferred and / or stored.		

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K 927	Continued From page 13 testing of the exhaust fan in the oxygen transfill room located at the entrance to the 300 hall, revealed the fan was on and operational, but lacked sufficient exhaust to discharge gases from the space when tested placing a standard sheet of note paper against the face of the exhaust fan grille. NFPA 99 9.3.7.5.3.2 Mechanical exhaust shall be at a rate of 1 L/sec of airflow for each 300 L (1 cfm per 5 ft3 of fluid) designed to be stored in the space and not less than 24 L/sec (50 cfm) nor more than 235 L/sec (500 cfm). 11.5.2.2 Transfilling Cylinders. 11.5.2.2.1 Mixing of compressed gases in cylinders shall be prohibited. 11.5.2.2.2 Transfilling of gaseous oxygen from one cylinder to another shall be in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen to be Used for Respiration. 11.5.2.2.3 Transfilling of any gases from one cylinder to another in patient care rooms of health care facilities shall be prohibited. 11.5.2.3 Transfilling Liquid Oxygen. Transfilling of liquid oxygen shall comply with 11.5.2.3.1 or 11.5.2.3.2, as applicable. 11.5.2.3.1 Transfilling to liquid oxygen base reservoir containers or to liquid oxygen portable containers over 344.74 kPa (50 psi) shall include the following: (1) A designated area separated from any portion of a facility wherein patients are housed, examined, or treated by a fire barrier of 1 hour fire-resistive construction. (2) The area is mechanically ventilated, is sprinklered, and has ceramic or concrete flooring.	K 927	Monitor: A audit tool will be created by the Maintenance Director or Designee no later than 2/25/2020. The audit-tool will validate that the ventilation fan is on, operational, and has sufficient exhaust airflow to discharge gasses from the space. The audit will be done weekly for 4 weeks then monthly for 2 months. The results of the audits will be brought to the monthly Quality Assurance meeting for review and recommendation for 3 months and as needed. Date of Compliance: 2/25/2020		

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K 927	Continued From page 14 (3) The area is posted with signs indicating that transfilling is occurring and that smoking in the immediate area is not permitted. (4) The individual transfilling the container(s) has been properly trained in the transfilling procedures.	K 927			



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

January 31, 2020

Casey Kemmerer, Administrator
Teton Post Acute Care & Rehabilitation
3111 Channing Way
Idaho Falls, ID 83404-7534

Provider #: 135138

RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER

Dear Mr. Kemmerer:

On **January 22, 2020**, an Emergency Preparedness survey was conducted at Teton Post Acute Care & Rehabilitation by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with 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
Enclosure

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

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E 000	<p>Initial Comments</p> <p>The facility is a single story Type V (111) structure originally built in 1988 and located within a municipal fire district, with both county and state EMS services available. There is an on-site, natural gas Emergency Power Supply System (EPSS) generator. The building is fully sprinklered, with an interconnected fire alarm/smoke detection system. The facility is currently licensed for 88 SNF/NF beds with a census of 58 on the date of the survey.</p> <p>The facility was found to be in substantial compliance during the Emergency Preparedness survey conducted on January 22, 2020. 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			

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.