



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

February 7, 2019

Darin Dransfield, Administrator
Franklin County Transitional Care
44 North 100 East
Preston, ID 83263-1326

Provider #: 135059

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Mr. Dransfield:

On **January 30, 2019**, a Facility Fire Safety and Construction survey was conducted at **Franklin County Transitional Care** 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

Darin Dransfield, Administrator
February 7, 2019
Page 2 of 4

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 20, 2019**. Failure to submit an acceptable PoC by **February 20, 2019**, may result in the imposition of civil monetary penalties by **March 13, 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 **March 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 30, 2019**. A change in the seriousness of the deficiencies on **March 16, 2019**, may result in a change in the remedy.

Darin Dransfield, Administrator
February 7, 2019
Page 3 of 4

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

Denial of payment for new admissions effective **April 30, 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 30, 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 30, 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:

Darin Dransfield, Administrator
February 7, 2019
Page 4 of 4

<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:

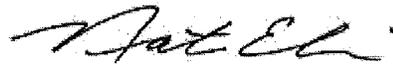
BFS Letters (06/30/11)

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

This request must be received by **February 20, 2019**. If your request for informal dispute resolution is received after **February 20, 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

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

Printed: 02/06/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135059	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE NF BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 01/30/2019
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NAME OF PROVIDER OR SUPPLIER FRANKLIN COUNTY TRANSITIONAL CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 44 NORTH 100 EAST PRESTON, ID 83263
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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 II (111) structure, originally constructed in 1971. The building is fully sprinklered with an interconnected fire alarm/smoke detection system protecting corridors and open spaces. The facility is connected to the Critical Access Hospital and is two-hour separated. There is an on-site, diesel-fired Emergency Power Supply System (EPSS) generator which supplies backup emergency power. Currently the facility is licensed for 35 SNF/NF beds and had a census of 27 on the date of the survey.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on January 30, 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 & Construction</p>	K 000		
K 325 SS=F	<p>Alcohol Based Hand Rub Dispenser (ABHR) CFR(s): NFPA 101</p> <p>Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single</p>	K 325	<p>1. All staff and residents in the facility could have been affected by use of hand sanitizers.</p> <p>2. A sweep was conducted and all original forms were removed from use and new forms were put in place. Please see attached form as evidence of correction.</p> <p>Continued next page...</p>	02/28/19

RECEIVED
FEB 20 2018
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE <i>[Signature]</i>	(X8) DATE <i>2-17-19</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER FRANKLIN COUNTY TRANSITIONAL CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 44 NORTH 100 EAST PRESTON, ID 83263		
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K 325	<p>Continued From page 1</p> <p>smoke compartment outside a storage cabinet, excluding one individual dispenser per room</p> <ul style="list-style-type: none"> * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, observation and interview, the facility failed to ensure automatically operated Alcohol Based Hand Rub Dispensers (ABHR), were maintained in accordance with NFPA 101. Failure to install, test and document operation of ABHR dispensers under manufacturer's recommendations and in accordance with the standard, has the potential of increasing the risk of fires from flammable liquids. This deficient practice affected 27 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1) During review of provide maintenance and inspection records conducted on 1/30/19 from 8:30 - 10:00 AM, records for refilling of ABHR dispensers failed to indicate what procedures or operational testing was being performed during the process. 2) During the facility tour conducted on 1/30/19 from 11:00 AM - 2:00 PM, observation of installed ABHR dispensers revealed automatically 	K 325	<ol style="list-style-type: none"> 3. A new form was created with required inspection elements listed. Staff were trained on new form and inspection process at staff in service on February 4th. 2 staff members were not present for staff meeting and will be trained by February 28th. 4. To monitor for compliance, Housekeeping Manager will monitor for correct use of form on a monthly basis and provide further instruction if compliance is not achieved. He will report to QM Committee after one quarter of observations. 5. February 28, 2019 	

DR

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K 325	<p>Continued From page 2</p> <p>activated dispensers were installed throughout the facility. During the tour at approximately 11:30 AM, housekeeping staff present and performing rounds on the floor was asked what steps were taken during the refill process. Staff produced a log which established only the date and the name of the staff performing the refill were the items being documented.</p> <p>Further interview of both the Housekeeping Supervisor and the Maintenance Supervisor revealed they were not aware of any documentation of functional tests required.</p> <p>Actual NFPA standard:</p> <p>NFPA 101</p> <p>19.3.2.6* Alcohol-Based Hand-Rub Dispensers. Alcohol-based hand-rub dispensers shall be protected in accordance with 8.7.3.1, unless all of the following conditions are met:</p> <p>(1) Where dispensers are installed in a corridor, the corridor shall have a minimum width of 6 ft (1830 mm).</p> <p>(2) The maximum individual dispenser fluid capacity shall be as follows:</p> <p>(a) 0.32 gal (1.2 L) for dispensers in rooms, corridors, and areas open to corridors</p> <p>(b) 0.53 gal (2.0 L) for dispensers in suites of rooms</p> <p>(3) Where aerosol containers are used, the maximum capacity of the aerosol dispenser shall be 18 oz. (0.51 kg) and shall be limited to Level 1 aerosols as defined in NFPA30B, Code for the Manufacture and Storage of Aerosol Products.</p> <p>(4) Dispensers shall be separated from each</p>	K 325		

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K 325	Continued From page 3 other by horizontal spacing of not less than 48 in. (1220 mm). (5) Not more than an aggregate 10 gal (37.8 L) of alcohol-based hand-rub solution or 1135 oz (32.2 kg) of Level 1 aerosols, or a combination of liquids and Level 1 aerosols not to exceed, in total, the equivalent of 10 gal (37.8 L) or 1135 oz (32.2 kg), shall be in use outside of a storage cabinet in a single smoke compartment, except as otherwise provided in 19.3.2.6(6). (6) One dispenser complying with 19.3.2.6 (2) or (3) per room and located in that room shall not be included in the aggregated quantity addressed in 19.3.2.6(5). (7) Storage of quantities greater than 5 gal (18.9 L) in a single smoke compartment shall meet the requirements of NFPA 30, Flammable and Combustible Liquids Code. (8) Dispensers shall not be installed in the following locations: (a) Above an ignition source within a 1 in. (25 mm) horizontal distance from each side of the ignition source (b) To the side of an ignition source within a 1 in. (25mm) horizontal distance from the ignition source (c) Beneath an ignition source within a 1 in. (25 mm) vertical distance from the ignition source (9) Dispensers installed directly over carpeted floors shall be permitted only in sprinklered smoke compartments. (10) The alcohol-based hand-rub solution shall not exceed 95 percent alcohol content by volume. (11) Operation of the dispenser shall comply with the following criteria: (a) The dispenser shall not release its contents except when the dispenser is activated, either manually or automatically by touch-free activation.	K 325		

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K-325	Continued From page 4 (b) Any activation of the dispenser shall occur only when an object is placed within 4 in. (100 mm) of the sensing device. (c) An object placed within the activation zone and left in place shall not cause more than one activation. (d) The dispenser shall not dispense more solution than the amount required for hand hygiene consistent with label instructions. (e) The dispenser shall be designed, constructed, and operated in a manner that ensures that accidental or malicious activation of the dispensing device is minimized. (f) The dispenser shall be tested in accordance with the manufacturer's care and use instructions each time a new refill is installed.	K 325		
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results.	K 914	1. All residents were identified as having been affected by this. 2. Any new admission during the time a plan was not in place would be affected as well. 3. To ensure compliance, a plan was put in place to perform testing of all receptacles in patient rooms at least one time in every 12 months. 4. Testing was performed on 2/12/19 compliance with this regulation and will be performed as part of regular maintenance duties every 12 months. It is and will be recorded in maintenance documentation. 5. Date completed 2/12/19	Date: 2/12/19

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K 914	<p>Continued From page 5 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure outlets in resident care areas were maintained and tested. Failure to perform maintenance and testing on electrical systems has the potential of electrical outlet failure, exposing residents to the risks of arc fires. This deficient practice affected 27 residents staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>1) During review of facility maintenance and inspection records provided on 1/30/19 from approximately 8:45 - 10:00 AM, records revealed testing of hospital grade outlets in resident rooms ceased on 10/16/17.</p> <p>2) During the facility tour conducted on 1/30/19 from 10:30 AM to 2:00 PM, observation of resident rooms throughout the facility revealed all were equipped with hospital-grade outlets. When asked why the testing of these outlets ceased in 2017, the Maintenance Supervisor stated he was not aware annual testing documentation was required.</p> <p>Actual NFPA standard:</p> <p>NFPA 99 6.3.4.1 Maintenance and Testing of Electrical Systems 6.3.4.1.1 Where hospital-grade receptacles are required at patient bed locations and in locations where deep sedation or general anesthesia is</p>	K 914		

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K 914	Continued From page 6 administered, testing shall be performed after initial installation, replacement, or servicing of the device. 6.3.4.1.2 Additional testing of receptacles in patient care rooms shall be performed at intervals defined by documented performance data. 6.3.4.1.3 Receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months.	K 914		
K 927 SS=E	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, the facility failed to ensure liquid oxygen transfilling was conducted in accordance with NFPA 99. Transfilling liquid oxygen without sufficient mechanical ventilation has the potential to increase the risks of combustion and explosions. This deficient practice affected 12 residents, staff and visitors on the date of the survey. Findings include:	K 927	1. 12 residents on "A Hall" were identified as having been affected by this. 2. Any new admission on "A Hall" during the time a plan was not in place would be affected as well. 3. To ensure compliance, a new fan was purchased on 2/6/19 and installed on 2/15/19. Final wiring and testing was completed on 2/19/19. 4. Fan has a capacity of 200cfs which meets the NFPA 99 conditions. 5. Date completed 2/19/19	Date: 2/19/19

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NAME OF PROVIDER OR SUPPLIER FRANKLIN COUNTY TRANSITIONAL CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 44 NORTH 100 EAST PRESTON, ID 83283
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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
K 927	<p>Continued From page 7</p> <p>During the facility tour conducted on 1/30/19 from 10:00 - 11:00 AM, observation of the oxygen storage/transfill area in the east hall, revealed a static vent was installed in the ceiling, but the space was not equipped with mechanical ventilation.</p> <p>Actual NFPA standard:</p> <p>NFPA 99</p> <p>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).</p>	K 927		

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3232 Elder Street
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February 7, 2019

Darin Dransfield, Administrator
Franklin County Transitional Care
44 North 100 East,
Preston, ID 83263-1326

Provider #: 135059

RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER

Dear Mr. Dransfield:

On **January 30, 2019**, an Emergency Preparedness survey was conducted at Franklin County Transitional Care 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
Enclosures

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

Printed: 02/06/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135059	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/30/2019
NAME OF PROVIDER OR SUPPLIER FRANKLIN COUNTY TRANSITIONAL CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 44 NORTH 100 EAST PRESTON, ID 83263		
(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 000	<p>Initial Comments</p> <p>The facility is a single story Type II (111) structure, originally constructed in 1971. The building is fully sprinklered with an interconnected fire alarm/smoke detection system protecting corridors and open spaces. The facility is connected to the Critical Access Hospital and is two-hour separated. The facility is located within a rural fire district with county, state and federal EMS support available. There is an on-site, diesel-fired Emergency Power Supply System (EPSS) generator which supplies backup emergency power. Currently the facility is licensed for 35 SNF/NF beds and had a census of 27 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 30, 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 & Construction</p>	E 000		

RECEIVED
FEB 20 2018
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *David Quam* TITLE: CEO (X6) DATE: 2-19-19

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.