



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

March 16, 2020

Randy Chambers, Administrator  
Temple View Transitional Care Center  
660 South Second Street West  
Rexburg, ID 83440-2300

Provider #: 135105

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

Dear Mr. Chambers:

On **March 5, 2020**, a Facility Fire Safety and Construction survey was conducted at **Temple View Transitional Care Center** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

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

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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 **March 30, 2020**. Failure to submit an acceptable PoC by **March 30, 2020**, may result in the imposition of civil monetary penalties by **April 20, 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 **April 9, 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 **June 3, 2020**. A change in the seriousness of the deficiencies on **April 19, 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 **April 9, 2020**, includes the following:

Denial of payment for new admissions effective **June 5, 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 **September 5, 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 **March 5, 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:

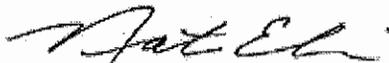
BFS Letters (06/30/11)

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

This request must be received by **March 30, 2020**. If your request for informal dispute resolution is received after **March 30, 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: 03/11/2020  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135105</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE NURSING FACILITY  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/05/2020</b>
NAME OF PROVIDER OR SUPPLIER <b>TEMPLE VIEW TRANSITIONAL CARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>660 SOUTH SECOND STREET WEST REXBURG, ID 83440</b>	
(X4) ID PREFIX TAG <b>K 000</b>	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG <b>K 000</b>	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DEFICIENCY)
<p><b>K 000 INITIAL COMMENTS</b></p> <p>The facility is a single-story type V (111) structure, originally constructed in 1988 and located within a municipal fire district, with both county and state EMS services available. The building is fully sprinklered with an interconnected fire alarm/smoke detection system. Backup emergency power is supplied by an on-site diesel-fired Emergency Power Supply System (EPSS) generator. The facility is currently licensed for 119 SNF/NF beds and had a census of 40 on the date of the survey.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on March 5, 2020. 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> <p><b>K 324</b> Cooking Facilities SS=D 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: * 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,</p>	<p><b>K 000</b></p> <p>The facility is a single-story type V (111) structure, originally constructed in 1988 and located within a municipal fire district, with both county and state EMS services available. The building is fully sprinklered with an interconnected fire alarm/smoke detection system. Backup emergency power is supplied by an on-site diesel-fired Emergency Power Supply System (EPSS) generator. The facility is currently licensed for 119 SNF/NF beds and had a census of 40 on the date of the survey.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on March 5, 2020. 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> <p><b>K 324</b> Cooking Facilities SS=D 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: * 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,</p>	<p><b>K 000</b></p> <p><b>K 324</b></p>	<p><b>RECEIVED</b> SEP 01 2020 <b>FACILITY STANDARDS</b></p> <p><b>K324</b> Corrective Action: The proper documentation was not maintained by the previous owners. We were not able to obtain any of the records from vendors who claimed to have serviced the kitchen hood. We have a signed contract with FSI Fire service of Idaho to perform this hood maintenance. 2nd Quarter service and inspection completed on 4/27/2020.</p> <p>Identification of others affected: The deficiency had the potential to affect staff members in the Kitchen, and with a grease fire could affect everyone in the facility.</p> <p>Systemic changes to ensure deficient practice does not repeat TELS tracking system drives the dates and the documentation capture. A formal agreement with FSI has this service on their radar as well.</p> <p>Monitor of Corrective action: TELS monthly, and quarterly follow through and reporting. Completed 4/27/2020</p>

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

TITLE

(X6) DATE

*[Signature]*

ADMINISTRATOR

9/1/2020

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.

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

Printed: 03/12/2020  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135105</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE NURSING FACILITY  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/05/2020</b>
NAME OF PROVIDER OR SUPPLIER <b>TEMPLE VIEW TRANSITIONAL CARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>660 SOUTH SECOND STREET WEST REXBURG, ID 83440</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 324	<p>Continued From page 1 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. 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, 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:  During review of provided maintenance and inspection records conducted on 3/5/20 from 8:30 - 11:00 AM, only one fire suppression system inspection testing report and one hood cleaning/inspection report was provided for the semi-annual services of the Kitchen UL 300 hood system. When asked at approximately 9:45 AM about the missing documentation, the Maintenance Coordinator stated he was not aware of the missing documentation prior to the date of the survey.</p>	K 324		

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K 324	<p>Continued From page 2 Actual NFPA standard:</p> <p>NFPA 96</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.</p> <p>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 recommendations, shall be filed with the owner or with the owner ' s representative. 7.3.3.5.1 The owner or owner ' s representative</p>	K 324		

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K 324	Continued From page 3 shall retain all maintenance reports for a period of 1 year after the next maintenance of that type required by the standard.	K 324		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101  Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure that fire alarm systems were maintained in accordance with NFPA 72. Failure to test and maintain fire alarm systems as required, has the potential to limit early detection of fires and hinder system response during these events. This deficient practice affected 40 residents and staff on the date of the survey.  Findings include:  During review of provided fire alarm system maintenance and inspection records conducted on 3/5/20 from 8:30 - 11:00 AM, records indicated the fire alarm report dated August 9, 2019 did not indicate the quantity of the following devices having been visually inspected or functionally tested: - The report indicates installed heat detectors, but not the quantity of devices tested. Observation of installed devices during the facility tour conducted on 3/5/20 from 12:30 - 4:00 PM,	K 345		

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K 345	<p>Continued From page 4</p> <p>did determine heat detectors were installed in the facility.</p> <ul style="list-style-type: none"> <li>- The report indicates under "Alarm initiating devices and CKT Info" installed magnetic locking systems, but does not demonstrate or identify the number of devices tested.</li> <li>- The report indicates under "Alarm notification devices and CKT info" "Door Holders" under the section marked "other", but no indication of the number of installed devices.</li> </ul> <p>When asked at approximately 10:45 AM about the lack of documentation on the report, the Maintenance Coordinator stated he was not aware of the missing documentation for designation of all devices.</p> <p>Additionally, during review of provided fire alarm system maintenance and inspection records conducted on 3/5/20 from 8:45 - 11:00 AM, no records were available demonstrating the date the last sensitivity testing was conducted.</p> <p>Actual NFPA standard:</p> <p>NFPA 72</p> <p>14.4.5.3* In other than one- and two-family dwellings, sensitivity of smoke detectors and single- and multiple-station smoke alarms shall be tested in accordance with 14.4.5.3.1 through 14.4.5.3.7.</p> <p>14.4.5.3.1 Sensitivity shall be checked within 1 year after installation.</p> <p>14.4.5.3.2 Sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with 14.4.5.3.3.</p> <p>14.4.5.3.3 After the second required calibration test, if sensitivity tests indicate that the device has remained within its listed and marked sensitivity</p>	K 345	<p>K345</p> <p>Corrective Action: The proper documentation was not maintained by the previous owners. A contract with OMNI Security is now in place, Omni Security provided a full sensitivity test on 3-9-2020. 19 smoke detectors did not pass the sensitivity test. All of the 19 smoke detectors have been replaced with new smoke detectors on July 29th, sensitivity testing has been completed on August 11, 2020.</p> <p>The Number of devices installed and evaluated, (magnetic door locks-9, door Holders-16, Heat detective devices- none and Sensitivity testing on 60 smoke detector devices)</p> <p>Identification of others affected: The deficiency had the potential to affect staff members and residents in the facility.</p> <p>Systemic changes to ensure deficient practice does not repeat Deficiencies are repaired properly, and monitored annually through TELS driven dates for inspection.</p> <p>Monitor of Corrective action: Annual testing is being completed by OMNI Security.</p> <p>Completion date : August 11, 2020</p>	

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NAME OF PROVIDER OR SUPPLIER <b>TEMPLE VIEW TRANSITIONAL CARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>660 SOUTH SECOND STREET WEST REXBURG, ID 83440</b>		
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K 345	<p>Continued From page 5</p> <p>range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years.</p> <p>14.6.2.4* A record of all inspections, testing, and maintenance shall be provided that includes the following information regarding tests and all the applicable information requested in Figure 14.6.2.4:</p> <ul style="list-style-type: none"> <li>(1) Date</li> <li>(2) Test frequency</li> <li>(3) Name of property</li> <li>(4) Address</li> <li>(5) Name of person performing inspection, maintenance, tests, or combination thereof, and affiliation, business address, and telephone number</li> <li>(6) Name, address, and representative of approving agency(ies)</li> <li>(7) Designation of the detector(s) tested</li> <li>(8) Functional test of detectors</li> <li>(9)*Functional test of required sequence of operations</li> <li>(10) Check of all smoke detectors</li> <li>(11) Loop resistance for all fixed-temperature, line-type heat detectors</li> <li>(12) Functional test of mass notification system control units</li> <li>(13) Functional test of signal transmission to mass notification systems</li> <li>(14) Functional test of ability of mass notification system to silence fire alarm notification appliances</li> <li>(15) Tests of intelligibility of mass notification system speakers</li> <li>(16) Other tests as required by the equipment manufacturer ' s published instructions</li> <li>(17) Other tests as required by the authority having jurisdiction</li> </ul>	K 345		

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K 345	Continued From page 6 (18) Signatures of tester and approved authority representative (19) Disposition of problems identified during test (e.g., system owner notified, problem corrected/successfully retested, device abandoned in place)	K 345	
K 353 SS=F	<p><b>Sprinkler System - Maintenance and Testing</b> CFR(s): NFPA 101</p> <p>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.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</p> <p>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 observation and interview, the facility failed to ensure fire suppression systems were maintained in accordance with NFPA 25. Failure to provide the required amount of spare replacement pendants has the potential to impede the ability for repairs and leave the facility not fully sprinklered in the event of a fire. This deficient practice affected 40 residents and staff on the date of the survey.</p>	K 353	<p>K353 Corrective Action: All fire sprinkler pendant spares required to reach the total of 12 spare pendants were received on April 15th, 2020. 3-D Fire installed the pendants that were not to code on August 5th, 2020</p> <p>Identification of others affected: The deficiency had the potential to affect staff members and residents in the facility.</p> <p>Systemic changes to ensure deficient practice does not repeat TELS drives the bi-annual test dates, and spares are in place for quick change needs.</p> <p>Monitor of Corrective action: Bi-annual testing is being completed by 3-D Fire.</p> <p>Completion date: August 5th, 2020</p>

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NAME OF PROVIDER OR SUPPLIER <b>TEMPLE VIEW TRANSITIONAL CARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>660 SOUTH SECOND STREET WEST REXBURG, ID 83440</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5) COMPLETION DATE
K 353	<p>Continued From page 7</p> <p>Findings include:</p> <p>During the facility tour conducted on 3/5/20 from 12:30 - 4:00 PM, observation of the spare pendant box for the fire suppression system, revealed only eight (8) spare pendants available. Interview of the Maintenance at the time of this observation established he was unaware of the number of spare pendants the facility was required to keep on hand.</p> <p>Actual NFPA standard:</p> <p>NFPA 25</p> <p>5.4.1.4* A supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have operated or been damaged in any way can be promptly replaced.</p> <p>5.4.1.5 The stock of spare sprinklers shall include all types and ratings installed and shall be as follows:</p> <p>(1) For protected facilities having under 300 sprinklers-no fewer than 6 sprinklers</p> <p>(2) For protected facilities having 300 to 1000 sprinklers - no fewer than 12 sprinklers</p> <p>(3) For protected facilities having over 1000 sprinklers - no fewer than 24 sprinklers</p>	K 353	
K 521 SS=F	<p>HVAC</p> <p>CFR(s): NFPA 101</p> <p>HVAC</p> <p>Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications.</p> <p>18.5.2.1, 19.5.2.1, 9.2</p>	K 521	

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

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K 521	<p>Continued From page 8</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to ensure maintenance of installed fire dampers in accordance with NFPA 101, NFPA 90A and NFPA 80. Failure to test installed fire dampers as designed has the potential to hinder system performance during a fire event. This deficient practice affected 40 residents and staff on the date of the survey.</p> <p>Findings include:</p> <p>During review of the maintenance and inspection records conducted on 3/5/20 from 8:30 - 11:00 AM, no records were available for the last four-year testing completing on installed fire dampers.</p> <p>During the facility tour conducted on 3/5/20 from 12:30 - 4:00 PM, observation of installed HVAC systems, revealed fire dampers equipped with fusible links were installed throughout the facility on both the supply and return air installation(s).</p> <p>Actual NFPA standard:</p> <p>NFPA 101</p> <p>9.2 Heating, Ventilating, and Air-Conditioning. 9.2.1 Air-Conditioning, Heating, Ventilating Ductwork, and Related Equipment. Air conditioning, heating, ventilating ductwork, and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems, or NFPA 90B, Standard for the Installation of Warm Air Heating and Air-Conditioning Systems, as applicable, unless such installations are approved</p>	K 521	<p>K521 Corrective Action: Most motors in the fire dampers had not been maintained by the previous owners, and require being repaired or replaced. After inspection, all 17 dampers had faulty motors and actuators, needed to be replaced. Each of these motors and actuators, have been replaced. Completed August 27th, 2020.</p> <p>The deficiency had the potential to affect all staff members and residents in the facility.</p> <p>Systemic changes to ensure deficient practice does not repeat TELS drives the monthly fire alarm tests that enable the dampers, and the dampers are inspected every 4 years for full functionality.</p> <p>Monitor of Corrective action: TELS drives the dates and documentation for fire alarm and Damper testing.</p> <p>Completion date: August 27th, 2020</p>	

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K 521	Continued From page 9 existing installations, which shall be permitted to be continued in service.  NFPA 90A  5.4.8 Maintenance. 5.4.8.1 Fire dampers and ceiling dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives.  NFPA 80  19.4* Periodic Inspection and Testing. 19.4.1 Each damper shall be tested and inspected 1 year after installation. 19.4.1.1 The test and inspection frequency shall then be every 4 years, except in hospitals, where the frequency shall be every 6 years.	K 521		
K 918 SS=F	Electrical Systems - Essential Electric System CFR(s): NFPA 101  Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by	K 918		

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K 918	<p>Continued From page 10</p> <p>competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.</p> <p>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure Emergency Power Supply System (EPSS) generators were maintained in accordance with NFPA 110. Failure to maintain EPSS generator sets as required, has the potential to hinder continuity of care for residents during an extended power loss. This deficient practice affected 40 residents and staff on the date of the survey.</p> <p>Findings include:</p> <p>1) During review of provided maintenance and inspection records for the installed EPSS generator conducted on 3/5/20 from 8:30 - 11:00 AM, the facility failed to demonstrate documentation for the following weekly inspection(s) and monthly exercises:</p> <p>- No weekly inspections completed during the 2019 calendar year for the weeks of March 10 and 17; July 13, 20 and 27; August (entire</p>	K 918	<p>K918</p> <p>Corrective Action:</p> <p>Temple View Transitional Care has a contract with Western States caterpillar to perform all our annual generator testing including the 4 hour load testing. The maintenance supervisor is now using the TELS system, to keep weekly, monthly and annual inspections up to date. Fuel test completed 5/1/2020.</p> <p>Identification of others affected:</p> <p>The deficiency had the potential to affect all staff members and residents in the facility.</p> <p>Systemic changes to ensure deficient practice does not repeat</p> <p>TELS drives the weekly, monthly quarterly and annual tests.</p> <p>Monitor of Corrective action:</p> <p>TELS drives the dates and documentation for generator weekly monthly and annual tests and load testing.</p> <p>Completion 5/1/2020</p>	

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K 918	<p>Continued From page 11 month) and December 29.</p> <ul style="list-style-type: none"> <li>- No weekly inspection completed during the week of January 26, 2020.</li> <li>- No monthly load exercises completed during the 2019 calendar year for the months of March, July and August.</li> </ul> <p>Interview of the Maintenance Coordinator conducted on 3/5/20 at approximately 10:15 AM, revealed he was not aware of any missing documentation for the weekly inspection(s) and monthly exercises.</p> <p>2) During review of provided maintenance and inspection records for the installed EPSS generator conducted on 3/5/20 from 8:45 - 11:00 AM, no documentation was available demonstrating an annual fuel test had been conducted within the past twelve months.</p> <p>Actual NFPA standard:</p> <p>NFPA 110</p> <p>8.3 Maintenance and Operational Testing. 8.3.8 A fuel quality test shall be performed at least annually using tests approved by ASTM standards.</p> <p>8.4 Operational Inspection and Testing. 8.4.1* EPSSs, including all appurtenant components, shall be inspected weekly and exercised under load at least monthly.</p>	K 918		
K 926 SS=E	<p>Gas Equipment - Qualifications and Training CFR(s): NFPA 101</p> <p>Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities</p>	K 926		

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K 926	<p>Continued From page 12</p> <p>provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to ensure staff participation in training on the risks associated with the storage, handling and use of medical gases and their cylinders. Failure to ensure the training of all direct-care staff involved with the safe use, application, maintenance and handling of medical gases, including the procedures for transfilling of liquid oxygen (LOX), has the potential to expose residents to those hazards. This deficient practice potentially affected oxygen dependent residents and staff on the date of the survey.</p> <p>Findings include:</p> <p>During review of provided inservice training records conducted on 3/5/20 from 8:30 - 11:00 AM, no documentation was available demonstrating all direct-care staff completed training on oxygen safety and the risks associated with medical gases, such as transfilling of LOX used by the facility.</p> <p>Additionally, during the facility tour conducted on 3/5/20 from 12:30 - 4:00 PM, observation and interview of the DON at the oxygen storage room located in 100 hall, established the facility primarily used portable oxygen units, transfilled from the main LOX cylinders.</p> <p>Actual NFPA standard:  NFPA 99</p>	K 926	<p>K926 Corrective Action: Medical oxygen use and handling training for employees, Completed on 7/9/2020 during all-staff meeting, training provided by our oxygen providing vendor, SMS. Any new hires are trained during the new hire orientation, starting 7/2020. Annual retraining for all staff is scheduled with the facility training coordinator.</p> <p>Identification of others affected: The deficiency had the potential to affect all staff members and residents using oxygen in the facility.</p> <p>Systemic changes to ensure deficient practice does not repeat New details for new hire orientation augmented to include Oxygen use and safety instruction, and added as a module for the monthly all staff meetings.</p> <p>Monitor of Corrective action: Semi-annual audit to be completed to ensure this topic is covered with adequate detail during employee training. Initial re-training complete by 7/9/2020.</p>		

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K 926	<p>Continued From page 13</p> <p>11.5.2 Gases in Cylinders and Liquefied Gases in Containers.</p> <p>11.5.2.1 Qualification and Training of Personnel.</p> <p>11.5.2.1.1* Personnel concerned with the application and maintenance of medical gases and others who handle medical gases and the cylinders that contain the medical gases shall be trained on the risks associated with their handling and use.</p> <p>11.5.2.1.2 Health care facilities shall provide programs of continuing education for their personnel.</p> <p>11.5.2.1.3 Continuing education programs shall include periodic review of safety guidelines and usage requirements for medical gases and their cylinders.</p>	K 926	



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

March 16, 2020

Randy Chambers, Administrator  
Temple View Transitional Care Center  
660 South Second Street West  
Rexburg, ID 83440-2300

Provider #: 135105

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

Dear Mr. Chambers:

On **March 5, 2020**, an Emergency Preparedness survey was conducted at **Temple View Transitional Care Center** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. Please provide **ONLY ONE** completion date for each federal and state tag in column (X5) Completion Date to signify when you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office.

Randy Chambers, Administrator

March 16, 2020

Page 2 of 4

Your Plan of Correction (PoC) for the deficiencies must be submitted by **March 30, 2020**. Failure to submit an acceptable PoC by **March 30, 2020**, may result in the imposition of civil monetary penalties by **April 20, 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 **April 9, 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 . A change in the seriousness of the deficiencies on **April 30, 2020**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **April 9, 2020**, includes the following:

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

Randy Chambers, Administrator  
March 16, 2020  
Page 3 of 4

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **September 5, 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 **March 5, 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:

<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

Randy Chambers, Administrator  
March 16, 2020  
Page 4 of 4

This request must be received by **March 30, 2020**. If your request for informal dispute resolution is received after **March 30, 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,

A handwritten signature in black ink, appearing to read "Nate Elkins". The signature is fluid and cursive, with a prominent initial "N" and a long, sweeping underline.

Nate Elkins, Supervisor  
Facility Fire Safety and Construction

NE/lj  
Enclosures

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

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E 000	Initial Comments  The facility is a single-story type V (111) structure, originally constructed in 1988 and located within a municipal fire district, with both county and state EMS services available. The building is fully sprinklered with an interconnected fire alarm/smoke detection system. Backup emergency power is supplied by an on-site diesel-fired Emergency Power Supply System (EPSS) generator. The facility is currently licensed for 119 SNF/NF beds and had a census of 40 on the date of the survey.  The following deficiencies were cited during the annual Emergency Preparedness Survey conducted on March 5, 2020. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.  The Survey was conducted by:  Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	E 000		
E 004 SS=F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a)  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.  The emergency preparedness program must include, but not be limited to, the following elements:  (a) Emergency Plan. The [facility] must develop	E 004		

RECEIVED  
JUL - 6 2020  
FACILITY STANDARDS

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

TITLE

(X6) DATE

*[Handwritten Signature]*

ADMINISTRATOR

7/2/2020

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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E 004	<p>Continued From page 1</p> <p>and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following:</p> <p>* [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. 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 program that meets the requirements of this section, utilizing an all-hazards approach.</p> <p>* [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC 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 every 2 years.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to ensure the Emergency Plan (EP) was reviewed and updated annually. Failure to ensure data compiled in the EP is current and relevant to the facility location and identifiable risks, has the potential to hinder response and continuity of care for residents, staff and visitors during emergencies. This deficient practice affected 40 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p>	E 004	<p>E004</p> <p>Corrective Action: Temple View EOP plan has been reviewed, a new plan defined, with Madison County Public Health Department being the contact location, with phone numbers corrected. Updated 6/15.</p> <p>Identification of others affected: The deficiency had the potential to affect all Residents and employees that may have been impacted by an emergency event in the facility or community.</p> <p>Systemic changes to ensure deficient practice does not repeat Formalize a portion of the safety meeting to review EP annually.</p> <p>Completed June 15, 2020</p>		

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NAME OF PROVIDER OR SUPPLIER <b>TEMPLE VIEW TRANSITIONAL CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>660 SOUTH SECOND STREET WEST REXBURG, ID 83440</b>		
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E 004	Continued From page 2 During review of the provided EP conducted on 3/5/20 from 8:30 AM - 1:00 PM, documentation indicated multiple references for a facility located approximately 77 miles away and in another county jurisdiction. These references included, but were not limited to:  - "Staffing during an Emergency" located on page 31 of the EP - Phone numbers located on page(s) 5-21, directing the caller to the City of Pocatello Behavioral Health. - Appendix V for "Emergency Shutdown", the number for the vendor listed was for the City of Pocatello. - "Resource Management" located on page 34, references Bannock County, not Madison County, the facility's county AHJ.  Reference: 42 CFR 483.73 (a)	E 004			
E 006 SS=F	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2)  [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:]  (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.*  (2) Include strategies for addressing emergency events identified by the risk assessment.  *[For LTC facilities at §483.73(a)(1):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan	E 006			

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E 006	<p>Continued From page 3 must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment.</p> <p>*[For ICF/IIDs at §483.475(a)(1):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment.</p> <p>* [For Hospices at §418.113(a)(2):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to develop a Hazard Vulnerability Analysis (HVA) that considered local risks and the available county all-hazard mitigation plan. Failure</p>	E 006	<p>E006 Corrective Action: EOP updated to include Madison County's HVA and reassessed facility HVA to identify any potentially new higher risk emergencies. Updated 6/29.</p> <p>Identification of others affected: The deficiency had the potential to affect all Residents and employees that may have been impacted by an emergency event in the facility or community.</p> <p>Systemic changes to ensure deficient practice does not repeat Formalize a portion of the safety meeting to review EP annually.</p> <p>Monitor of Corrective action: Completed June 29, 2020, review annually.</p>	

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E 006	Continued From page 4 to identify and plan for localized risks as identified to the facility location, has the potential to develop and plan for disasters and emergencies not within the geographical area, hindering staff preparedness and response. This deficient practice affected 40 residents, staff and visitors on the date of the survey.  Findings include:  During review of the provided EP HVA conducted on 3/5/20 from 8:30 AM - 1:00 PM, documentation was not available for the local county all-hazard mitigation plan. At approximately 2:30 PM, when asked how the facility developed the HVA used in the EP, the Administrator stated he did not have or use the local county all-hazard mitigation plan and took information from another facility when developing the HVA.  Reference: 42 CFR 483.73 (a) (1) - (2)	E 006			
E 013 SS=F	Development of EP Policies and Procedures CFR(s): 483.73(b)  (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years.  *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set	E 013			

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E 013	<p>Continued From page 5</p> <p>forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.</p> <p>*[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, the facility failed to ensure policies and procedures were aligned with a community-based and facility-based HVA. Failure to develop policies based on relevant facility and community based risks, has the potential to confuse staff and result in irrelevant training on hazards that are not consistent with the facility location. This deficient practice affected 40 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>On 3/5/20 from 8:30 AM - 1:00 PM, review of the provided emergency plan, policies and procedures, revealed the facility HVA did not utilize and consider the available county all-hazard mitigation plan and known, identified</p>	E 013	<p>E013</p> <p>Corrective Action: EOP updated to include Madison County's HVA and reassessed facility HVA to identify new higher risk emergencies. Updated 6/29.</p> <p>Identification of others affected: The deficiency had the potential to affect all Residents and employees that may have been impacted by an emergency event in the facility or community. Systemic changes to ensure deficient practice does not repeat Formalize a portion of the safety meeting to review EP annually.</p> <p>Monitor of Corrective action: Completed June 29, 2020, review annually.</p>	

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E 013	Continued From page 6 risks to the facility location. Asked at approximately 2:30 PM what information was used to generate the HVA and the policies and procedures for the EP, the Administrator stated the information was brought from another facility not within the local or county geographical area.  Reference: 42 CFR 483.73 (b)	E 013		
E 015 SS=D	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1)  [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years (annually for LTC). At a minimum, the policies and procedures must address the following:  (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal.  *[For Inpatient Hospice at §418.113(b)(6)(iii):]	E 015		

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E 015	<p>Continued From page 7 Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the facility failed to develop policies and procedures in the Emergency Plan (EP), which identified the steps or methods for providing sewage and waste disposal should those utilities become compromised in a disaster requiring the need to shelter in place. Lack of policies and procedures for sewage and waste disposal during a disaster, has the potential to limit the ability to provide continuing care for residents housed in the facility. This deficient practice affected 40 residents, staff and visitors on the date of the survey.  Findings include:  On 3/5/20 from 8:30 AM - 1:00 PM, review of provided policies and procedures did not reveal a</p>	E 015	<p>E015 Corrective Action: Agreement in process with A-1 Rentals to provide emergency portable toilets to be used for the facility, staff and a place to dispose of resident waste. A-1 Rentals also will provide a generator for use if our backup generator fails.  Identification of others affected: The deficiency had the potential to affect all Residents and employees that may have been impacted by an emergency event in the facility or community.  Monitor of Corrective action: Verify contractual agreement completed by July 31st, 2020.</p>	

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E 015	Continued From page 8 policy or procedure for utilities loss that was relevant to the loss of sewage and waste disposal during a disaster.	E 015	
E 026 SS=F	<p>Reference: 42 CFR 483.73 (b) (1)</p> <p>Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8)</p> <p>[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years (annually for LTC).] At a minimum, the policies and procedures must address the following:]</p> <p>(8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.</p> <p>*[For RNHCs at §403.748(b):] Policies and procedures. (8) The role of the RNHCl under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to document their role under an 1135 waiver as declared by the Secretary and the provisions of care as required</p>	E 026	

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E 026	Continued From page 9 under this action if identified by emergency management officials. Failure to plan for alternate means of care and the role under an 1135 waiver has the potential to limit facility options during an emergency. This deficient practice potentially affects reimbursement and continuity of care for the 40 residents, staff and visitors housed on the date of the survey along with the available surge needs of the community during a disaster.  Findings include:  On 3/5/20 from 8:30 AM - 1:00 PM, review of the provided EP, did not document the role of the facility under the declaration of an 1135 waiver, should that condition be enacted by the Secretary.  Interview of the Administrator conducted at approximately 4:00 PM during the exit conference revealed he was not aware the procedural requirement of and under an 1135 waiver.  Reference: 42 CFR 483.73 (b) (8)	E 026	E026 Corrective Action: In times of an emergency an 1135 waiver, the following steps will be followed if needed. In the event of evacuation from the Facility to an alternate site that normally does not practice medical services the facility will provide proper care at alternate site in compliance to the 1135 waiver. •Supplies from central supply, medical carts, Oxygen Concentrators would be transported from facility to alternate site by facilities owned van and all staff vehicles that are available. •Local O2 supplier to deliver O2 tanks alternate site. •Extra supplies will be ordered through preferred vendors that has emergency agreements with facility. •Medical Charts will be available at the alternate site with internet access for proper resident care. •We have two company vans both can fit 10-11 passenger.		
E 039 SS=F	EP Testing Requirements CFR(s): 483.73(d)(2)  *[For RNCHI at §403.748, ASCs at §416.54, HHAs at §484.102, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHC at §485.920, RHC/FQHC at §491.12, ESRD Facilities at §494.62]:  (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is	E 039	Identification of others affected: The deficiency had the potential to affect all Residents and employees that may have been impacted by an emergency event in the facility or community.  Monitor of Corrective action: Complete 6/29/2020		

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E 039	<p>Continued From page 10</p> <p>not accessible, conduct a facility-based functional exercise every 2 years; or</p> <p>(B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event.</p> <p>(ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.</p> <p>*[For Hospices at 418.113(d):]</p> <p>(2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following:</p> <p>(i) Participate in a full-scale exercise that is community based every 2 years; or</p> <p>(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or</p>	E 039	<p>E039</p> <p>Corrective Action:</p> <p>1st formal Emergency plan being exercised. Emergency plan has been evoked with regards to Covid-19 Pandemic since March 2020. A second emergency event will be conducted prior to the end of 2020. This will either be a Table Top discussion, or an in house mock disaster.</p> <p>Identification of others affected: The deficiency had the potential to affect all Residents and employees that may have been impacted by an emergency event in the facility or community.</p> <p>Monitor of Corrective action: Complete 6/29/2020.</p>		

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E 039	<p>Continued From page 11</p> <p>(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d) (2)(i) of this section is conducted, that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or</p> <p>(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event.</p>	E 039		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135105</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/05/2020</b>
NAME OF PROVIDER OR SUPPLIER <b>TEMPLE VIEW TRANSITIONAL CARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>660 SOUTH SECOND STREET WEST REXBURG, ID 83440</b>		
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E 039	<p>Continued From page 12</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.</p> <p>*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]</p> <p>(2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or</p> <p>(B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the</p>	E 039		

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E 039	<p>Continued From page 13 following:</p> <p>(A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed.</p> <p>*[For LTC Facilities at §483.73(d):]</p> <p>(2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.</p> <p>(B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility based</p>	E 039		

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E 039	<p>Continued From page 14</p> <p>functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed.</p> <p>*[For ICF/IIDs at §483.475(d):</p> <p>(2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or</p> <p>(B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated,</p>	E 039			

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E 039	<p>Continued From page 15</p> <p>clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.</p> <p>*[For OPOs at §486.360]</p> <p>(d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following:</p> <p>(i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event.</p> <p>(ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCl's and OPO's] emergency plan, as needed. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, it was determined the facility failed to complete two (2) full scale exercises as required. Failure to complete two full-scale exercises testing the effectiveness of the activation of the EP, has the potential to hinder staff performance during an actual emergency. This deficient practice affected 40 residents and staff on the date of the survey.</p>	E 039			

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E 039	Continued From page 16 Findings include:  During review of the provided facility EP conducted on 3/5/20 from 8:30 AM - 1:00 PM, records demonstrated the facility had not documented two (2) exercises testing the activation of the EP.  Reference: 42 CFR 483.73 (d) (1)	E 039			
E 041 SS=F	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e)  (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section.  §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section.  §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated.  482.15(e)(2), §483.73(e)(2), §485.625(e)(2)	E 041			

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E 041	<p>Continued From page 17</p> <p>Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code.</p> <p>482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates.</p> <p>*[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: <a href="http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html">http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html</a>. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes.</p> <p>(1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012</p>	E 041	<p>E041</p> <p>Corrective Action: 4 hour load test of generator completed on 5/1/2020 by Western States. The maintenance supervisor is now set up on TELS and uses this tool to keep weekly, monthly, and annual inspections current. Diesel Fuel testing now being completed by Western States Caterpillar as part of annual contract.</p> <p>Identification of others affected: The deficiency had the potential to affect all Residents and employees that may have been impacted by an emergency event in the facility or community.</p> <p>Monitor of Corrective action: Complete 5/1/2020.</p>