



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

May 31, 2019

Lori Bentzler, Administrator  
Twin Falls Center  
674 Eastland Drive  
Twin Falls, ID 83301-6846

Provider #: 135104

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

Dear Ms. Bentzler:

On **May 14, 2019**, a Facility Fire Safety and Construction survey was conducted at **Twin Falls Center** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

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

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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 **June 13, 2019**. Failure to submit an acceptable PoC by **June 13, 2019**, may result in the imposition of civil monetary penalties by **July 5, 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 **June 18, 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 **August 12, 2019**. A change in the seriousness of the deficiencies on **June 28, 2019**, 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 **June 18, 2019**, includes the following:

Denial of payment for new admissions effective **August 14, 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 **November 14, 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 **May 14, 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:

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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:

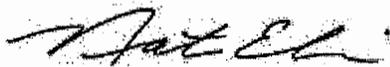
BFS Letters (06/30/11)

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

This request must be received by **June 13, 2019**. If your request for informal dispute resolution is received after **June 13, 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: 05/29/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135104	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  05/14/2019
NAME OF PROVIDER OR SUPPLIER  TWIN FALLS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 674 EASTLAND DRIVE TWIN FALLS, ID 83301	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS  The facility is a single-story Type V (111) structure, comprised of six (6) smoke compartments, built in 1987. The building is protected throughout by an automatic fire extinguishing system and a fire alarm/smoke detection system. The Essential Electrical System is supplied by a natural gas powered, on-site automatic generator. The facility is currently licensed for 116 SNF/NF beds with a census of 48 on the dates of the survey.  The following deficiencies were cited during the annual fire/life safety survey conducted on May 13 -14, 2019. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.  The Survey was conducted by:  Linda Chaney Health Facility Surveyor Facility Fire Safety and Construction	K 000	“This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Genesis HealthCare Twin Falls Center, does not admit that the deficiencies listed on this form exists, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiencies. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiencies, statements, facts, and conclusions that form the basis for the deficiencies.”	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101  Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____	K 353	<u>K353</u>  <u>Specific Residents Identified</u>  The three year full trip test of the dry system was completed on or before 6/17/19. The 3 sprinkler heads in the air handling room were replaced on or before 6/17/19. The corroded sprinkler head in the access room behind the dryers was replaced on or before 6/17/19. The two corroded sprinkler heads outside of the exit doors on the 100 and 400 hallways were replaced on or before 6/17/19. All of the work was completed by Delta Fire systems.	

RECEIVED  
JUN 11 2019

FACILITY STANDARDS

RECEIVED  
JUN 12 2019

FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Lain Bentley* TITLE *Center Executive Director* (X6) DATE *6/10/19*

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.

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K 353	<p>Continued From page 1</p> <p>b) Who provided system test</p> <hr/> <p>c) Water system supply source</p> <hr/> <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 record review, observation and interview, the facility failed to inspect, test and maintain the fire suppression system in accordance with NFPA 25. Failure to maintain fire suppression systems could hinder system performance during a fire event. This deficient practice affected 48 residents, staff and visitors on the dates of the survey.</p> <p>Findings include:</p> <p>1.) During the review of facility records on May 13, 2019, from approximately 10:30 AM to 1:30 PM, documentation for a three-year full-trip test of the dry system was last recorded in September 2015. When asked, the Maintenance Supervisor stated the facility was aware the full-trip test of the dry system was due. The sprinkler company decided to push the full-trip test from September 2018 to the summer of 2019 to ensure the weather was warm enough to prevent freezing.</p> <p>2.) During the facility tour on May 14, 2019, from approximately 8:30 AM to 11:00 AM, observation revealed three (3) sprinkler heads in the air handler room with non-factory paint.</p> <p>3.) During the facility tour on May 14, 2019, from approximately 8:30 AM to 11:00 AM, observation revealed a corroded sprinkler head in the access room behind the dryers. Two (2) additional</p>	K 353	<p><b><u>Identification of Other Residents</u></b></p> <p>The three year full trip test of the dry system was completed on or before 6/17/19. The additional sprinkler heads in the facility were inspected on or before 6/17/19 for leakage, corrosion, physical damage and paint and any findings were corrected by Delta Fire systems.</p> <p>The Maintenance Supervisor has a copy of this inspection.</p> <p><b><u>Systemic Changes</u></b></p> <p>The Maintenance Supervisor was educated on or before 6/17/19 by the Center Executive Director regarding the requirement that the three year full trip test of the dry system be completed timely and that the sprinkler heads in the facility must be free of corrosion, foreign materials, paint and physical damage and not show signs of leakage.</p>

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K 353	Continued From page 2 corroded sprinkler heads were also observed on the exterior of the building outside of exit doors in the 100 and 400 hallways. When asked, the Maintenance Supervisor stated the facility was unaware of the painted and corroded sprinkler heads.  Actual NFPA standard:  NFPA 25 1.) 13.4.4.2.2.2* Every 3 years and whenever the system is altered, the dry pipe valve shall be trip tested with the control valve fully open and the quick-opening device, if provided, in service. 2.) 5.2.1.1.1* Sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., upright, pendent, or sidewall). 5.2.1.1.2 Any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical damage (4) Loss of fluid in the glass bulb heat responsive element (5) *Loading (6) Painting unless painted by the sprinkler manufacturer	K 353	<b>Monitoring</b>  Starting the week of 6/18/19, inspections of the sprinkler heads will be completed weekly by the Maintenance Supervisor or designee. One hall of the facility will be inspected per week. Audits of the inspections will be completed weekly for 4 weeks and then monthly for 2 months by the Maintenance Supervisor or designee to ensure that the sprinkler heads do not have any leakage, physical damage, paint or corrosion and any findings addressed.  Audits will be reviewed monthly for three months by the Safety Committee for compliance. A report will be submitted to the Performance Improvement Committee monthly for three months. The Maintenance Supervisor is responsible for monitoring and follow up.  <b>Date of Compliance</b>  6/17/19	
K 911 SS=F	Electrical Systems - Other CFR(s): NFPA 101  Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard	K 911		

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K 911	Continued From page 3 citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the Essential Electrical System (EES) generator was equipped with a remote manual stop station in accordance with NFPA 110. Failure to provide a remote manual stop station has the potential to prevent shutdown of the emergency generator during a system malfunction, or unintentional operation. This deficient practice affected 48 residents and staff on the dates of the survey.  Findings include:  During the facility tour on May 14, 2019, from approximately 8:30 AM to 11:00 AM, a remote manual stop station for the EES generator could not be located. When asked, the Maintenance Supervisor stated the facility was not equipped with a remote stop station.  Actual NFPA standard:  NFPA 110 5.6.5.6* All installations shall have a remote manual stop station of a type to prevent inadvertent or unintentional operation located outside the room housing the prime mover, where so installed, or elsewhere on the premises where the prime mover is located outside the building.	K 911	<b><u>K911</u></b>  <b><u>Specific Residents Identified and Identification of Other Residents</u></b>  The Essential Electrical System generator was equipped with a remote manual stop station on or before 6/17/19 by Power Systems West.  <b><u>Systemic Changes</u></b>  The Maintenance Supervisor was educated on or before 6/17/19 by the Center Executive Director regarding the requirement that a remote manual stop be placed on the electrical generator.  <b><u>Monitoring</u></b>  Starting the week of 6/18/19, an inspection and test of the remote manual stop station will be completed weekly x 4 weeks and then monthly for 2 months by the Maintenance Supervisor or designee to ensure that the remote stop is in place and is working.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101  Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed	K 914		

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K 914	Continued From page 4 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. 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 48 residents and staff members to the risks of arc fires on the dates of survey.  Findings include:  1.) During review of facility maintenance and inspection records provided on May 13, 2019, from approximately 10:30 AM - 1:30 PM, no records were available to demonstrate non-hospital grade outlets in resident rooms were inspected and tested annually. Additionally,	K 914	Audits will be reviewed monthly for three months by the Safety Committee for compliance. A report will be submitted to the Performance Improvement Committee monthly for three months. The Maintenance Supervisor is responsible for monitoring and follow up.  <u>Date of Compliance</u>  6/17/19  <u>K914</u>  <u>Specific Residents Identified and Identification of Other Residents</u>  Non hospital grade outlets in resident rooms have been inspected and tested by the Maintenance Supervisor or designee on or before 6/17/19. An inspection and testing protocol based on performance data was developed and inspection/testing completed for Hospital grade outlets in resident rooms by the Facility Maintenance Supervisor or designee on or before 6/17/19.	

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K 914	<p>Continued From page 5</p> <p>documentation was not available for facility requirements for inspection and testing of hospital-grade outlets as defined by documented performance data.</p> <p>2.) During the facility tour on May 14, 2019, from approximately 8:30 AM to 11:00 AM, observation of the facility electrical outlets in resident rooms revealed the facility had a mix of non-hospital grade and hospital grade outlets in resident rooms. When asked if the facility was inspecting and testing non-hospital-grade outlets annually, or if an inspection and testing protocol had been developed for hospital-grade outlets based on performance data, the Maintenance Supervisor stated the facility had not yet implemented a documented procedure for the inspection and testing of electrical outlets in resident rooms.</p> <p>Actual NFPA standard:</p> <p>NFPA 99 6.3.3.2 Receptacle Testing in Patient Care Rooms. 6.3.3.2.1 The physical integrity of each receptacle shall be confirmed by visual inspection. 6.3.3.2.2 The continuity of the grounding circuit in each electrical receptacle shall be verified. 6.3.3.2.3 Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed. 6.3.3.2.4 The retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 g (4 oz). 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 administered, testing shall be performed after initial installation, replacement, or servicing of the</p>	K 914	<p><b><u>Systemic Changes</u></b></p> <p>The Maintenance Supervisor was educated by the Center Executive Director on or before 6/17/19 on the requirement that non hospital grade outlets and hospital grade outlets are inspected and tested annually.</p> <p><b><u>Monitoring</u></b></p> <p>Starting the week of 6/18/19, non hospital grade and hospital grade outlets will be inspected and tested in 8 resident rooms weekly.</p> <p>Audits will be completed weekly x 4 weeks and then monthly for two months by the Facility Maintenance Supervisor or designee to ensure that outlets are working properly.</p> <p>Audits will be reviewed monthly by the Safety Committee for compliance. A report will be submitted to the Performance Improvement Committee monthly for three months. The Maintenance Supervisor is responsible for monitoring and follow up.</p> <p><b><u>Date of Compliance</u></b></p> <p>6/17/19</p>



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K 918	<p>Continued From page 7</p> <p>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 the generator for the Essential Electrical System (EES) was maintained in accordance with NFPA 110. Failure to test EES generators as required could result in a lack of system reliability during a power loss. This deficient practice affected 48 residents and staff on the dates of the survey.</p> <p>Findings include:</p> <p>During review of the facility generator inspection and testing records on May 13, 2019, from approximately 10:30 AM to 1:30 PM, the facility failed to provide documentation for a three-year, four-hour load test for the natural gas powered EES generator with the available load. When asked, the Maintenance Supervisor stated the facility was unaware of the three-year, four-hour load test requirement.</p> <p>Actual NFPA standard:</p> <p>NFPA 110 8.4.9* Level 1 EPSS shall be tested at least once within every 36 months. 8.4.9.1 Level 1 EPSS shall be tested continuously for the duration of its assigned class (see Section 4.2).</p>	K 918	<p>was completed and any findings addressed.</p> <p>Audits will be reviewed monthly for three months by the Safety Committee for compliance. A report will be submitted to the Performance Improvement Committee monthly for three months. The Maintenance Supervisor is responsible for monitoring and follow up.</p> <p><u>Date of Compliance</u></p> <p>6/17/19</p>	

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K 918	Continued From page 8 8.4.9.2 Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 continuous hours. 8.4.9.3 The test shall be initiated by operating at least one transfer switch test function and then by operating the test function of all remaining ATSS, or initiated by opening all switches or breakers supplying normal power to all ATSS that are part of the EPSS being tested. 8.4.9.4 A power interruption to non-EPSS loads shall not be required. 8.4.9.5 The minimum load for this test shall be as specified in 8.4.9.5.1, 8.4.9.5.2, or 8.4.9.5.3. 8.4.9.5.3 For spark-ignited EPSs, loading shall be the available EPSS load.	K 918		



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

May 31, 2019

Lori Bentzler, Administrator  
Twin Falls Center  
674 Eastland Drive  
Twin Falls, ID 83301-6846

Provider #: 135104

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

Dear Ms. Bentzler:

On **May 14, 2019**, an Emergency Preparedness survey was conducted at **Twin Falls 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.

Lori Bentzler, Administrator

May 31, 2019

Page 2 of 4

Your Plan of Correction (PoC) for the deficiencies must be submitted by **June 13, 2019**. Failure to submit an acceptable PoC by **June 13, 2019**, may result in the imposition of civil monetary penalties by **July 5, 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 **June 18, 2019**, (Opportunity to Correct). Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on . A change in the seriousness of the deficiencies on **July 15, 2019**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **June 18, 2019**, includes the following:

Denial of payment for new admissions effective **August 14, 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.

Lori Bentzler, Administrator

May 31, 2019

Page 3 of 4

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **November 14, 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 **May 14, 2019**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

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

BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process

2001-10 IDR Request Form

Lori Bentzler, Administrator

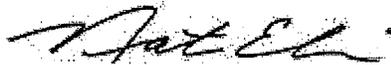
May 31, 2019

Page 4 of 4

This request must be received by **June 13, 2019**. If your request for informal dispute resolution is received after **June 13, 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,

A handwritten signature in black ink, appearing to read "Nate Elkins".

Nate Elkins, Supervisor  
Facility Fire Safety and Construction

NE/lj

Enclosures

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

PRINTED: 05/29/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135104	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  05/14/2019
NAME OF PROVIDER OR SUPPLIER  TWIN FALLS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 674 EASTLAND DRIVE TWIN FALLS, ID 83301	
(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	Initial Comments  The facility is a single-story Type V (111) structure, comprised of six (6) smoke compartments, built in 1987. The building is protected throughout by an automatic fire extinguishing system and a fire alarm/smoke detection system. The Essential Electrical System is supplied by a natural gas powered, on-site automatic generator. The facility is currently licensed for 116 SNF/NF beds with a census of 48 on the dates of the survey.  The following deficiency was cited during the annual Emergency Preparedness survey conducted on May 13 - 14, 2019. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.  The Survey was conducted by:  Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction	E 000	<b>RECEIVED</b> JUN 11 2019 FACILITY STANDARDS  <b>RECEIVED</b> JUN 12 2019 FACILITY STANDARDS	
E 022 SS=F	Policies/Procedures for Sheltering in Place CFR(s): 483.73(b)(4)  [(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 annually. At a minimum, the policies and procedures must address the following:]	E 022	<u>E022</u>  <u>Specific Residents Identified and Identification of Other Residents</u>  The facility Emergency Preparedness Plan has been updated on or before 6/17/19 by the Center Executive Director to include a policy and procedure for residents, staff and volunteers to shelter in place when evacuation is not possible or advised during a disaster.	

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

TITLE

(X6) DATE

*Joan Bentley*

*Center Executive Director*

6/10/19

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.

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E 022	<p>Continued From page 1</p> <p>(4) A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility].</p> <p>*[For Inpatient Hospices at §418.113(b):] Policies and procedures.</p> <p>(6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following:</p> <p>(i) A means to shelter in place for patients, hospice employees who remain in the hospice. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to provide a policy and procedure for residents, staff and volunteers to shelter-in-place when evacuation is not possible or advised during a disaster. Lack of a policy and procedure for sheltering in place has the potential to leave residents, staff and volunteers without resources to continue care during an emergency. This deficient practice affected 48 residents and staff on the dates of the survey.</p> <p>Findings include:</p> <p>On May 13, 2019, from approximately 1:30 PM to 4:30 PM, review of provided policies, procedures and emergency planning records failed to demonstrate current and annually reviewed policies and procedures for sheltering in place. Interview of the Administrator revealed the facility did not yet have a comprehensive shelter-in-place policy or procedure. The facility had identified areas of refuge within the facility, but had not defined how, why or when these areas would be</p>	E 022	<p><b><u>Systemic Changes</u></b></p> <p>The facility Maintenance Supervisor and Safety Committee members were educated by the Center Executive Director on or before 6/17/19 that a shelter in place policy/procedure for residents, staff and volunteers when evacuation is not possible or advised during a disaster is required.</p> <p><b><u>Monitoring</u></b></p> <p>Starting the week of 6/18/19, a review of the Emergency Preparedness Plan will be completed weekly x 4 week and then monthly x 2 months by the Center Executive Director to ensure that the books are complete and include the new shelter in place policy.</p> <p>Audits will be reviewed monthly for three months by the Safety Committee for compliance. A report will be submitted to the Performance Improvement Committee monthly for three months. The Center Executive Director is responsible for monitoring and follow up.</p> <p><b><u>Date of Compliance</u></b></p> <p>6/17/19</p>	

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

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E 022	Continued From page 2 utilized in a disaster.  Reference:  42 CFR 483.73 (b) (4)	E 022		