



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

July 10, 2019

James Hayes, Administrator  
Payette Center  
1019 Third Avenue South  
Payette, ID 83661-2832

Provider #: 135015

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

Dear Mr. Hayes:

On **July 2, 2019**, a Facility Fire Safety and Construction survey was conducted at **Payette 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 **July 23, 2019**. Failure to submit an acceptable PoC by **July 23, 2019**, may result in the imposition of civil monetary penalties by **August 14, 2019**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.
- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567. If a State Form was issued as well, it should also be signed, dated and returned.

All references to federal regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Remedies may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **August 6, 2019**, (Opportunity to Correct). Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **September 30, 2019**. A change in the seriousness of the deficiencies on **August 16, 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 **August 6, 2019**, includes the following:

Denial of payment for new admissions effective **October 2, 2019**.  
42 CFR §488.417(a)

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **January 2, 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 **July 2, 2019**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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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:

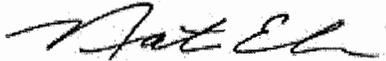
BFS Letters (06/30/11)

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

This request must be received by **July 23, 2019**. If your request for informal dispute resolution is received after **July 23, 2019**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626, option 3.

Sincerely,



Nate Elkins, Supervisor  
Facility Fire Safety and Construction

NE/lj  
Enclosures

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

Printed: 07/09/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b> - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/02/2019</b>
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NAME OF PROVIDER OR SUPPLIER <b>PAYETTE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1019 THIRD AVENUE SOUTH PAYETTE, ID 83661</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	<p><b>INITIAL COMMENTS</b></p> <p>The facility is a single story, type V (111) structure, located within a municipal fire district, originally constructed in 1961. The building is fully sprinklered with an interconnected fire alarm/smoke detection system and is equipped with an on-site, spark ignited natural gas Emergency Power Supply System (EPSS) generator. Currently the facility is licensed for 80 SNF/NF beds, with a census of 43 on the date of the survey.</p> <p>The following deficiencies were cited during the annual life safety code survey conducted on July 2, 2019. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Chapter 19, 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 &amp; Construction</p>	K 000	<p>“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.”</p>	
K 325 SS=F	<p>Alcohol Based Hand Rub Dispenser (ABHR) CFR(s): NFPA 101</p> <p>Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room</p>	K 325	<p><b>K 325</b></p> <p><b>AFFECTED:</b></p> <p>On July 2, 2019, all AHBR units were re-inspected by the Housekeeping Manager to insure all were functioning properly.</p> <p><b>POTENTIAL:</b></p> <p>On July 2, 2019, all AHBR units were re-inspected By the housekeeping Supervisor to insure all are functioning properly.</p> <p><b>RECEIVED</b></p> <p><b>JUL 23 2019</b></p> <p><b>FACILITY STANDARDS</b></p>	08/06/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>John A. Doyke</i>	TITLE <b>Executive Director</b>	(X6) DATE <b>07/23/19</b>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 325	<p>Continued From page 1</p> <ul style="list-style-type: none"> <li>* Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30</li> <li>* Dispensers are not installed within 1 inch of an ignition source</li> <li>* Dispensers over carpeted floors are in sprinklered smoke compartments</li> <li>* ABHR does not exceed 95 percent alcohol</li> <li>* Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11)</li> <li>* ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485</li> </ul> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure Alcohol-Based Hand Rub (ABHR) dispensers were maintained in accordance with NFPA 101. Failure to test and document operation of ABHR dispensers under manufacturer's recommendations and in accordance with the standard, has the potential of increasing the risk of fires from flammable liquids. This deficient practice affected 43 residents and staff on the dates of the survey.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1) During review of provided maintenance and inspection records conducted on 7/2/19 from 9:30 - 11:00 AM, no records were available for the inspection and testing of ABHR dispensers during the refill process.</li> <li>2) During the facility tour conducted on 7/2/19 from 1:00 - 3:00 PM, observation of installed ABHR dispensers revealed manual dispensers were primarily installed throughout the facility.</li> </ol> <p>Prior to the exit conference at approximately 3:30</p>	K 325	<p><b>SYSTEMIC: Changes and Measures put in place</b></p> <p>On July 19, 2019, The Housekeeping Manager received inservice from the Center Executive Director regarding the need to maintain the Alcohol-Based Hand Rub dispensers in accordance with NFPA requirements and facility policy, which includes inspection of the ABHR units when refilled, and the policy regarding completion of the inspection forms.</p> <p>On or before July 26, the AHBR inspection logs will be reviewed in the monthly Safety Committee Meeting.</p> <p><b>MONITOR:</b></p> <p>On or before August 6, 2019, the AHBR inspection reports will be reported in the monthly QAPI meeting as part of the Safety Committee presentation agenda. The Executive Director will be responsible for monitoring compliance.</p>	

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K 325	<p>Continued From page 2</p> <p>PM, Interview with the Administrator revealed the Housekeeping department had developed a form for the documentation process, but had yet to implement it during refilling procedures.</p> <p>Actual NFPA standard:</p> <p>NFPA 101</p> <p>19.3.2.6* Alcohol-Based Hand-Rub Dispensers. Alcohol-based hand-rub dispensers shall be protected in accordance with 8.7.3.1, unless all of the following conditions are met:</p> <p>(1) Where dispensers are installed in a corridor, the corridor shall have a minimum width of 6 ft (1830 mm).</p> <p>(2) The maximum individual dispenser fluid capacity shall be as follows:</p> <p>(a) 0.32 gal (1.2 L) for dispensers in rooms, corridors, and areas open to corridors</p> <p>(b) 0.53 gal (2.0 L) for dispensers in suites of rooms</p> <p>(3) Where aerosol containers are used, the maximum capacity of the aerosol dispenser shall be 18 oz. (0.51 kg) and shall be limited to Level 1 aerosols as defined in NFPA30B, Code for the Manufacture and Storage of Aerosol Products.</p> <p>(4) Dispensers shall be separated from each other by horizontal spacing of not less than 48 in. (1220 mm).</p> <p>(5) Not more than an aggregate 10 gal (37.8 L) of alcohol-based hand-rub solution or 1135 oz (32.2 kg) of Level 1 aerosols, or a combination of liquids and Level 1 aerosols not to exceed, in total, the equivalent of 10 gal (37.8 L) or 1135 oz (32.2 kg), shall be in use</p>	K 325		
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 325	Continued From page 3 outside of a storage cabinet in a single smoke compartment, except as otherwise provided in 19.3.2.6(6). (6) One dispenser complying with 19.3.2.6 (2) or (3) per room and located in that room shall not be included in the aggregated quantity addressed in 19.3.2.6(5). (7) Storage of quantities greater than 5 gal (18.9 L) in a single smoke compartment shall meet the requirements of NFPA 30, Flammable and Combustible Liquids Code. (8) Dispensers shall not be installed in the following locations: (a) Above an ignition source within a 1 in. (25 mm) horizontal distance from each side of the ignition source (b) To the side of an ignition source within a 1 in. (25mm) horizontal distance from the ignition source (c) Beneath an ignition source within a 1 in. (25 mm) vertical distance from the ignition source (9) Dispensers installed directly over carpeted floors shall be permitted only in sprinklered smoke compartments. (10) The alcohol-based hand-rub solution shall not exceed 95 percent alcohol content by volume. (11) Operation of the dispenser shall comply with the following criteria: (a) The dispenser shall not release its contents except when the dispenser is activated, either manually or automatically by touch-free activation. (b) Any activation of the dispenser shall occur only when an object is placed within 4 in. (100 mm) of the sensing device. (c) An object placed within the activation zone and left in place shall not cause more than one activation. (d) The dispenser shall not dispense more solution than the amount required for hand	K 325		

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K 325	Continued From page 4 hygiene consistent with label instructions. (e) The dispenser shall be designed, constructed, and operated in a manner that ensures that accidental or malicious activation of the dispensing device is minimized. (f) The dispenser shall be tested in accordance with the manufacturer ' s care and use instructions each time a new refill is installed.	K 325		
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101  Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked  b) Who provided system test  c) Water system supply source  Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that fire suppression sprinkler pendants were maintained free of leakage and obstructions such as paint, dirt and corrosion. Failure to maintain fire suppression pendants to ensure their proper operation, has the potential to hinder system response during a fire event. This deficient practice affected staff on the date of the	K 353	<b>K 353</b>  <b>AFFECTED:</b>  On or before August 6, 2019, the fire suppression sprinkler pendants identified by the Surveyor will be replaced by our fire suppression system contractor.  <b>POTENTIAL:</b>  On or before August 6, 2019, all fire suppression pendants will be inspected by the Maintenance Director to identify other pendants in need of service or repair.  On or before August 6, 2019, identified pendants will be replaced as necessary.  <b>SYSTEMIC:</b>  On or Before August 6, 2019, the Maintenance Director will receive in-service from the Executive Director regarding the need to inspect fire system pendants monthly/  On or before August 6, 2019, fire suppression pendants will be inspected monthly by the Maintenance Director.  On or before August 6 2019, fire system pendant inspections will be reported in the Safety Committee Meeting.	<b>08/06/19</b>

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K 353	<p>Continued From page 5 survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 7/2/19 from 11:30 AM - 2:00 PM, observation of installed fire suppression pendants revealed the following:</p> <ol style="list-style-type: none"> <li>1) In the Utility room across from the dining area, observation revealed one (1) painted sprinkler pendant.</li> <li>2) In the main Kitchen, the sprinkler pendant above the dishwasher was revealed to be corroded and the sprinkler pendant to the right of the main cookline was observed to be leaking.</li> </ol> <p>Interview of the Plant Operations Manager at approximately 1:00 PM established he was not aware of these pendant impediments prior to the date of the survey.</p> <p>Actual NFPA standard:</p> <p><b>NFPA 25</b> 5.2* Inspection. 5.2.1 Sprinklers. 5.2.1.1* Sprinklers shall be inspected from the floor level annually.  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</p>	K 353	<p><b>MONITOR:</b></p> <p>On or before August 6, 2019, Pendant inspection results will be reported in the Monthly QAPI meeting as part of the Safety Committee presentation. The Executive Director will be responsible for monitoring compliance.</p>	

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K 353	Continued From page 6 (4) Loss of fluid in the glass bulb heat responsive element (5)*Loading (6) Painting unless painted by the sprinkler manufacturer	K 353	<b>K 712</b>  <b>AFFECTED:</b> On July 3, 2019, fire drills are conducted in a timely manner in accordance with NFPA requirements.  <b>POTENTIAL:</b> On July 3, 2019, fire drills are conducted in a timely manner in accordance with NFPA requirements.  <b>SYSTEMIC:</b> On or before August 6, 2019 the Maintenance Director will receive in-service from the Executive Director regarding the fire drill requirements.  On or before August 6, 2019, orientation of temporary or newly hired Maintenance personnel will include ensuring timely access to the TELS preventive maintenance program which provides alerts of impending drills and PM tasks.  On or before August 6, 2019, fire drills will be reported and monitored in the monthly Safety Committee meeting.	<b>08/06/19</b>
K 712 SS=F	Fire Drills CFR(s): NFPA 101  Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure fire drills were conducted in accordance with NFPA 101. Failure to perform fire drills quarterly for each shift has the potential to hinder staff response in the event of a fire. This deficient practice affected 43 residents and staff on the date of the survey.  Findings include:  During review of provided facility fire drill records conducted on 7/2/19 from 9:30 - 11:00 AM, records revealed the facility had missed the fire drills for the day shift during the first quarter of 2019 and the noc shift during the fourth quarter of 2018.  Interview of the Plant Operations Manager	K 712		

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K 712	Continued From page 7 conducted at approximately 10:30 AM, revealed he was unaware the facility had missed fire drills.  Actual NFPA standard:  19.7* Operating Features. 19.7.1 Evacuation and Relocation Plan and Fire Drills.  19.7.1.6 Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions.	K 712	<b>MONITOR:</b>  On or before August 6, 2019, fire drills will be reported in the monthly QAPI Meeting as part of the Safety Committee presentation. The Executive Director will be responsible for monitoring compliance.	
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 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	K 918	<b>K 918</b>  <b>AFFECTED:</b>  On July 17, 2019, a 4 hour load test was completed on the generator by the EC Power Company, our electrical contractor. The unit passed.  <b>POTENTIAL:</b>  On July 17, 2019, a 4 hour load test was completed on the generator by the EC Power Company, our electrical contractor. The unit passed.	<b>06/06/19</b>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/02/2019</b>
NAME OF PROVIDER OR SUPPLIER <b>PAYETTE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1019 THIRD AVENUE SOUTH PAYETTE, ID 83661</b>		
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K 918	<p>Continued From page 8</p> <p>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 that the Essential Electrical System (EES) generator was maintained in accordance with NFPA 110. Failure to perform required load tests for Level 1 generators in accordance with their Class, has the potential to hinder system readiness during emergency events such as a full power loss. This deficient practice affected 43 residents and staff on the date of the survey.</p> <p>Findings include:</p> <p>During review of the EES generator maintenance and testing logs conducted on 7/2/19 from 9:30 - 11:00 AM, documentation failed to demonstrate a 4-hour load test was completed within the past 36 months. When asked about the missing load documentation at approximately 10:00 AM, the Plant Operations Manager stated he was not aware his generator was required to have a 4 hour load test.</p> <p>Actual NFPA standard:</p> <p>8.4.9* Level 1 EPSS shall be tested at least once</p>	K 918	<p><b>SYSTEMIC:</b></p> <p>On July 19, 2019, the facility Maintenance Director received inservice from the Center Executive Director regarding the requirement for a 4 hour generator load test to be completed each 36 months.</p> <p>On or before August 6, 2019, the facility Life Safety Inspection Record will be revised to eliminate the "Diesel Only" inspection instruction, continue the annual 2-hour test, and add the 36-month 4-hour test.</p> <p>On or before August 6, 2019, the safety Committee meeting agenda will be revised to include the generator weekly, monthly, and 36-month test results.</p> <p><b>MONITOR:</b></p> <p>On or before August 6, 2019, the results of the generator inspections will be presented by the Maintenance Director in the Safety Committee Meeting and included in the full monthly QAPI meetings. The Executive Director will be responsible for monitoring compliance.</p>	

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K 918	Continued From page 9 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). 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.  Additional Reference E-0041	K 918		
K 923 SS=E	Gas Equipment - Cylinder and Container Storage CFR(s): NFPA 101  Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order	K 923	<b>K923</b>  <b>AFFECTED:</b>  On July 2, 2019 the Full "E" cylinders were moved by the Maintenance Director from the "Empty" side of the Oxygen Storage room to the "Full" side.  <b>POTENTIAL:</b>  On July 2, 2019 the Full "E" cylinders were moved by the Maintenance Director from the "Empty" side of the Oxygen Storage room to the "Full" side.  <b>SYSTEMIC:</b>  On July 5, 2019, at the request of the Maintenance Director, the oxygen supply company delivered new-style oxygen tanks which come with regulators and gauges installed which can be quickly and visually verified as empty or full.  On July 17, all staff received inservice from the Maintenance Director regarding the new tanks and the requirement for separated storage in the empty or full locations.  On or Before August 6, 2019, the oxygen room will be inspected and logged daily by the Maintenance Director.	<b>08/06/19</b>

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K 923	<p>Continued From page 10</p> <p>of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, the facility failed to ensure oxygen cylinders were maintained in accordance with NFPA 99. Failure to segregate oxygen cylinders in storage has the potential to inadvertently use the incorrect cylinder during an emergency requiring supplemental oxygen. This deficient practice affected those residents requiring supplemental oxygen treatment and staff on the date of the survey.</p> <p>During the facility tour conducted on 7/2/19 from 1:00 - 3:00 PM, observation of the oxygen storage adjacent to the Business Office, revealed two (2) "E" cylinders stored on the side marked "Empty" which had the protective plastic caps still intact. Interview at the time of observation of both the Director of Nursing Services (DNS) and an on-duty care staff member as to the condition of these cylinders, both individuals stated these two (2) cylinders were "full" and stored on the empty side.</p> <p>Actual NFPA standard:</p> <p>NFPA 99</p> <p>11.6.5 Special Precautions - Storage of Cylinders and Containers.</p> <p>11.6.5.1 Storage shall be planned so that</p>	K 923	<p>On or Before August 6, 2019, the oxygen room inspection logs will be presented in the Safety Committee meeting by the Maintenance Director</p> <p><b>MONITOR:</b></p> <p>On or before August 9, 2019 the oxygen room inspection results will be reported during the Safety Committee presentation in the monthly QAPI meeting. The Executive Director will be responsible for monitoring compliance.</p>		

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

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FORM APPROVED  
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K 923	Continued From page 11 cylinders can be used in the order in which they are received from the supplier. 11.6.5.2 If empty and full cylinders are stored within the same enclosure, empty cylinders shall be segregated from full cylinders. 11.6.5.3 Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed in a rapid manner.	K 923		



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

July 10, 2019

James Hayes, Administrator  
Payette Center  
1019 Third Avenue South  
Payette, ID 83661-2832

Provider #: 135015

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

Dear Mr. Hayes:

On **July 2, 2019**, an Emergency Preparedness survey was conducted at **Payette 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.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **July 23, 2019**. Failure to submit an acceptable PoC by **July 23, 2019**, may result in the imposition of civil monetary penalties by **August 14, 2019**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.
- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567. If a State Form was issued as well, it should also be signed, dated and returned.

All references to federal regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Remedies may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **August 6, 2019**, (Opportunity to Correct). Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on . A change in the seriousness of the deficiencies on **August 24, 2019**, may result in a change in the remedy.

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

Denial of payment for new admissions effective **October 2, 2019**.  
42 CFR §488.417(a)

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **January 2, 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 **July 2, 2019**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

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

BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process

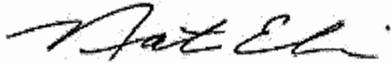
2001-10 IDR Request Form

James Hayes, Administrator  
July 10, 2019  
Page 4 of 4

This request must be received by **July 23, 2019**. If your request for informal dispute resolution is received after **July 23, 2019**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626, option 3.

Sincerely,

A handwritten signature in black ink, appearing to read "Nate Elkins". The signature is written in a cursive, slightly slanted style.

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	<p>Initial Comments</p> <p>The facility is a single story, type V (111) structure, located within a municipal fire district, originally constructed in 1961. The facility has both county and state EMS services available. The building is fully sprinklered with an interconnected fire alarm/smoke detection system and is equipped with an on-site, spark ignited natural gas Emergency Power Supply System (EPSS) generator. Currently the facility is licensed for 80 SNF/NF beds, with a census of 43 on the date of the survey.</p> <p>The following deficiencies were cited during the Emergency Preparedness Survey conducted on July 2, 2019. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.</p> <p>The Survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety &amp; Construction</p>	E 000	<p>“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.”</p>	
E 024 SS=D	<p>Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6)</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 annually. At a minimum, the policies and procedures must address the following:]</p> <p>(6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency</p>	E 024	<p>E024 <b>AFFECTED</b></p> <p>On or before August 6, 2019, the Emergency Operations Plan will be updated by the Center Executive Director to include provision for the use of volunteers during an emergency.</p> <p>On or before August 6, 2019, the updated Emergency Plan will be presented by the Center Executive Director the Safety Committee for approval.</p>	<p>08/06/19</p> <p><b>RECEIVED</b></p> <p><b>JUL 23 2019</b></p> <p><b>FACILITY STANDARDS</b></p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Jan H. B. G.</i>	TITLE <b>Executive Director</b>	(X6) DATE <b>07/23/19</b>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 024	<p>Continued From page 1</p> <p>staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.</p> <p>*[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency.</p> <p>*[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the facility failed to develop policies and procedures which address the use of volunteers during an emergency. Lack of a plan, policy and procedure specific to the use of volunteers, potentially hinders the facility's ability to provide continuity of care during a disaster. This deficient practice had the potential to affect the 43 residents and staff in the facility on the date of the survey.</p> <p>Findings include:</p> <p>Review of provided emergency operation plan (EOP), policies and procedures conducted on 07/02/19 from 9:30 - 11:00 AM, revealed no policy or procedure for the use of volunteers during an emergency was documented in the EOP.</p> <p>Reference: 42 CFR 483.73 (b) (6)</p>	E 024	<p><b>POTENTIAL:</b></p> <p>On or before August 6, 2019, the Emergency Operations Plan will be updated by the Center Executive Director to include provision for the use of volunteers during an emergency.</p> <p>On or before August 6, 2019, the updated Emergency Plan will be presented by the Center Executive Director the Safety Committee for approval.</p> <p><b>SYSTEMIC:</b></p> <p>On or Before August 6, 2019, the Emergency Operations Plan will be calendared by the Center Executive Director for annual review by the Safety Committee.</p> <p><b>MONITOR:</b></p> <p>On or before August 6, 2019, the QAPI agenda will be revised by the Center Executive Director to include provision for Emergency Operations Plan changes in the Safety Committee presentation section of the meeting.</p>	

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E 041 E 041 SS=F	Continued From page 2 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) 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.  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	E 041 E 041	<b>E 041</b>  <b>AFFECTED:</b>  On <b>July 17, 2019</b> , a 4 hour load test was completed on the generator by the EC Power Company, our electrical contractor. The unit passed.  <b>POTENTIAL:</b>  On July 17, 2019, a 4 hour load test was completed on the generator by the EC Power Company, our electrical contractor. The unit passed.  <b>SYSTEMIC:</b>  On July 19, 2019, the facility Maintenance Director received inservice from the Center Executive Director regarding the requirement for a 4 hour generator load test to be completed each 36 months. On or before August 6, 2019, the facility Life Safety Inspection Record will be revised to eliminate the "Diesel Only" inspection instruction, continue the annual 2-hour test, and add the 36-month 4-hour test. On or before July 26, 2019, the safety Committee meeting agenda will be revised to include the generator weekly, monthly, and 36-month test results.	<b>08/06/19</b>

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

Printed: 07/09/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/02/2019</b>
NAME OF PROVIDER OR SUPPLIER <b>PAYETTE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1019 THIRD AVENUE SOUTH PAYETTE, ID 83661</b>		
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E 041	<p>Continued From page 3</p> <p>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.</p> <p>(i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011.</p> <p>(ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011.</p> <p>(iii) TIA 12-3 to NFPA 99, issued August 9, 2012.</p> <p>(iv) TIA 12-4 to NFPA 99, issued March 7, 2013.</p> <p>(v) TIA 12-5 to NFPA 99, issued August 1, 2013.</p> <p>(vi) TIA 12-6 to NFPA 99, issued March 3, 2014.</p> <p>(vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011.</p> <p>(viii) TIA 12-1 to NFPA 101, issued August 11,</p>	E 041	<p><b>MONITOR:</b></p> <p>On or before August 6, 2019, the results of the generator inspections will be presented by the Maintenance Director in the Safety Committee Meeting and included in the full monthly QAPI meetings. The Executive Director will be responsible for monitoring compliance.</p>	

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E 041	<p>Continued From page 4</p> <p>2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure the emergency and standby power systems were maintained and available to provide subsistence as required under the rule. Failure to ensure emergency generators are maintained and tested in accordance with NFPA 99 and NFPA 110, potentially hinders the facility's ability to provide continuity of care during an emergency to the 43 residents and staff on the date of the survey.</p> <p>Findings include:</p> <p>During review of the EES generator maintenance and testing logs conducted on 7/2/19 from 9:30 - 11:00 AM, documentation failed to demonstrate a 4-hour load test was completed within the past 36 months. When asked about the missing load documentation at approximately 10:00 AM, the Plant Operations Manager stated he was not aware his generator was required to have a 4 hour load test.</p> <p>Reference: 42 CFR 483.73 (e) (1)</p> <p>Additional Reference CMS 2567 K tag 918</p>	E 041			