



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 20, 2020

Dallas Clinger, Administrator
Power County Nursing Home
PO Box 420
American Falls, ID 83211

Provider #: 135066

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

Dear Mr. Clinger:

On **July 8, 2020**, a Facility Fire Safety and Construction survey was conducted at **Power County Nursing Home** 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.

Dallas Clinger, Administrator
July 17, 2020
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Please provide ONLY ONE completion date for each federal and state tag in column (X5) Completion Date to signify when you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office. If a State Form with deficiencies was issued, it should be signed, dated and returned along with the CMS-2567 Form.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **August 3, 2020**. Failure to submit an acceptable PoC by **August 3, 2020**, may result in the imposition of civil monetary penalties by **August 21, 2020**.

Your PoC must contain the following:

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

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

Remedies may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **August 12, 2020**, (Opportunity to Correct). Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **October 6, 2020**. A change in the seriousness of the deficiencies on **August 22, 2020**, may result in a change in the remedy.

Dallas Clinger, Administrator
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The remedy, which will be recommended if substantial compliance has not been achieved by **August 12, 2020**, includes the following:

Denial of payment for new admissions effective **October 8, 2020**.
42 CFR §488.417(a)

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **January 8, 2021**, 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 8, 2020**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

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

BFS Letters (06/30/11)

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

This request must be received by **August 3, 2020**. If your request for informal dispute resolution is received after **August 3, 2020**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosures

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

Printed: 07/16/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135066	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 07/08/2020
NAME OF PROVIDER OR SUPPLIER POWER COUNTY NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 510 ROOSEVELT STREET (83211-1362) AMERICAN FALLS, ID 83211		
(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 located on the first floor, east wing of the county hospital. It was originally constructed in early 1961 and is currently undergoing a large-scale renovation. The fire suppression system was retrofitted in 2010 with a full NFPA 13 sprinkler system and is equipped with an interconnected fire alarm/smoke detection system which includes exit access corridors and open spaces. Emergency power and lighting are provided by a diesel powered, automatic generator that was replaced in 2019. The facility is currently licensed for 18 SNF/NF beds with a census of 17 on the date of the survey. The following deficiencies were cited during the annual life safety code survey conducted on July 8, 2020. 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: Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction	K 000		
K 161 SS=F	Building Construction Type and Height CFR(s): NFPA 101 Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories	K 161	K161 CFR: NFPA101 Building Construction Type & Height <i>What corrective actions will be accomplished for those residents found to be affected by the deficient practice.</i> Director of Engineering will obtain a general contractor to patch the hole above the door header with approved materials; replace the ceiling in the nursing home corridor; and construct rated construction walls to provide separation from the construction area and interstitial spaces above the ceiling for fire and smoke protections.	31Aug2020

RECEIVED
AUG - 3 2020
FACILITY STANDARDS

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

TITLE

(X6) DATE

CEO/ADMINISTRATOR

30 JUL 2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 161	Continued From page 1 non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the fire and smoke resistive properties of the structure were maintained. Failure to maintain penetrations from data sources and ceiling membranes, has the potential to allow smoke, fire and dangerous gases to pass between compartments, into interstitial spaces above, bypassing active protections and allowing fires to grow beyond incipient stages. This	K 161	<i>How will you identify other resident(s) having the potential to be affected and what corrective action(s) will be taken.</i> All residents have the potential to be affected by this deficiency and the planned wall and ceiling fixes will protect them from potential fire, smoke, or gas hazards. <i>What measures will be put in place to ensure that the deficient practice does not recur.</i> Maintenance staff will conduct weekly life safety checks to ensure proper separations are maintained. <i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur.</i> Director of Engineering will review check sheets and perform spot checks to confirm compliance. Deficiencies will be reported monthly to the Safety Committee until construction is completed for further recommended actions. <i>Dates when corrective action will be completed:</i> 8/31/2020	

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K 161	<p>Continued From page 2</p> <p>deficient practice affected 17 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 7/8/20 from 1:00 - 3:00 PM, observation of the door leading from the operations/maintenance corridor into the nursing facility, revealed an approximately two-inch unsealed penetration in the header area with data cabling. Further observation revealed the suspended ceiling membrane of the operations side had been removed, and a two-foot by two-foot ceiling tile on the nursing home side was not in place, exposing the interstitial space above the nursing home and operations/maintenance corridor wall(s).</p> <p>Additionally, an above the ceiling inspection of both areas revealed there was no construction separation between the interstitial spaces of either area. Interview of the Engineering Director conducted at approximately 1:15 PM established this condition and lack of separation was due to the current construction project.</p> <p>Actual NFPA standard::</p> <p>NFPA 101</p> <p>19.1.6 Minimum Construction Requirements. 19.1.6.1 Health care occupancies shall be limited to the building construction types specified in Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7. (See 8.2.1.)</p> <p>8.3.5 Penetrations. The provisions of 8.3.5 shall govern the materials and methods of construction used to protect through-penetrations and membrane penetrations in fire walls, fire barrier</p>	K 161		

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K 161	Continued From page 3 walls, and fire resistance-rated horizontal assemblies. The provisions of 8.3.5 shall not apply to approved existing materials and methods of construction used to protect existing through-penetrations and existing membrane penetrations in fire walls, fire barrier walls, or fire resistance-rated horizontal assemblies, unless otherwise required by Chapters 11 through 43. 8.3.5.1* Firestop Systems and Devices Required. Penetrations for cables, cable trays, conduits, pipes, tubes, combustion vents and exhaust vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a fire barrier shall be protected by a firestop system or device. The firestop system or device shall be tested in accordance with ASTM E 814, Standard Test Method for Fire Tests of Through Penetration Fire Stops, or ANSI/UL 1479, Standard for Fire Tests of Through-Penetration Firestops, at a minimum positive pressure differential of 0.01 in. water column (2.5 N/m ²) between the exposed and the unexposed surface of the test assembly.	K 161		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by:	K 345	K345 CFR: NFPA101 Fire Alarm System- Testing & Maintenance <i>What corrective actions will be accomplished for those residents found to be affected by the deficient practice.</i> Director of Engineering verified with fire alarm contractor that devices labeled as "removed for construction" on sensitivity test conducted on 2/25/2020 have been replaced with addressable devices. Sensitivity testing will be conducted on portion of construction that has been completed on 8/3/2020.	3Aug2020

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K 345	<p>Continued From page 4</p> <p>Based on record review and interview, the facility failed to ensure fire alarm systems were maintained in accordance with NFPA 72. Failure to ensure fire alarm systems are inspected and tested at least annually has the potential to hinder system response and notification of residents during a fire event. This deficient practice affected 17 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During review of provided fire alarm maintenance and inspection records conducted on 7/8/20 from 8:45 - 11:00 AM, documentation revealed seven (7) initiating devices installed in the long-term care corridor(s) were not tested for sensitivity during the annual inspection and sensitivity test conducted on 2/25/20, due to these devices having been removed during construction. Interview of the Engineering Director at approximately 10:45 AM failed to establish if these devices had been re-installed and then tested as required.</p> <p>Actual NFPA standard:</p> <p>19.3.4 Detection, Alarm, and Communications Systems. 19.3.4.1 General. Health care occupancies shall be provided with a fire alarm system in accordance with Section 9.6.</p> <p>9.6 Fire Detection, Alarm, and Communications Systems. 9.6.1.3 A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72,</p>	K 345	<p><i>How will you identify other resident(s) having the potential to be affected and what corrective action(s) will be taken.</i></p> <p>All residents have the potential to be affected by this deficiency and the planned device verification and testing of the system by the contractor will protect them from potential fire hazards.</p> <p><i>What measures will be put in place to ensure that the deficient practice does not recur.</i></p> <p>Maintenance staff will review documentation from the fire alarm contractor prior to completing inspections and installations to ensure compliance with devices and sensitivity testing.</p> <p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur.</i></p> <p>Director of Engineering will review contractor documentation to confirm compliance. Deficiencies will be reported monthly to the Safety Committee until construction is completed for further recommended actions.</p> <p><i>Dates when corrective action will be completed:</i> 8/3/2020</p>	

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K 345	Continued From page 5 National Fire Alarm and Signaling Code, unless it is an approved existing installation, which shall be permitted to be continued in use. 14.3 Inspection. 14.3.1* Unless otherwise permitted by 14.3.2 visual inspections shall be performed in accordance with the schedules in Table 14.3.1 or more often if required by the authority having jurisdiction. 14.3.4 The visual inspection shall be made to ensure that there are no changes that affect equipment performance.	K 345			
K 351 SS=F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure the structure was fully sprinklered as required in accordance with NFPA 101 and NFPA 13.	K 351	K351 CFR: NFPA101 Sprinkler System- Installation <i>What corrective actions will be accomplished for those residents found to be affected by the deficient practice.</i> Director of Engineering will obtain a fire sprinkler contractor to identify vulnerable areas and install appropriate fire sprinkler system heads where needed. <i>How will you identify other resident(s) having the potential to be affected and what corrective action(s) will be taken.</i> All residents have the potential to be affected by this deficiency and the additional fire sprinkler heads in vulnerable areas will protect them from potential fire hazards. <i>What measures will be put in place to ensure that the deficient practice does not recur.</i> Maintenance staff will conduct weekly life safety checks to ensure vulnerable areas have proper sprinkler head coverage.	7Aug2020	

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K 351	Continued From page 6 Eliminating fire suppression system coverage in corridors during the course of construction projects without alternative protection measures in place, has the potential for fires to expand rapidly in a compartment, endangering the lives of residents, staff and visitors and eliminating means of egress for evacuation. This deficient practice affected 17 residents, staff and visitors on the date of the survey. Findings include: During the facility tour conducted on 7/8/20 from 1:00 - 3:00 PM, the following areas were observed to be absent of sprinkler protection: - Approximately twenty feet of the east/west corridor directly in front of the nurse's station - At the intersection of the east/west corridor and the transition heading north toward room 18, a suppression system pendant had been removed and an approximately ten-foot square area of the dietary station and that section of the corridor was unsprinklered. Actual NFPA standard: 19.3.5 Extinguishment Requirements. 19.3.5.1 Buildings containing nursing homes shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7, unless otherwise permitted by 19.3.5.5.	K 351	<i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur.</i> Director of Engineering will review maintenance staff documentation to confirm compliance with checks. Deficiencies will be reported to the Safety Committee for the duration of construction for further recommended actions. <i>Dates when corrective action will be completed:</i> 8/7/2020	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection,	K 353	K353 CFR: NFPA101 Sprinkler System- Maintenance & Testing <i>What corrective actions will be accomplished for those residents found to be affected by the deficient practice.</i> Maintenance staff will conduct required quarterly tests of the fire sprinkler system and document the test details.	30Jul2020

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K 353	<p>Continued From page 7</p> <p>Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure fire suppression systems were maintained in accordance with NFPA 25. Failure to ensure fire suppression systems are inspected as required, has the potential to hinder system performance during a fire event. This deficient practice affected 17 residents and staff on the date of the survey.</p> <p>Findings include:</p> <p>During review of provided maintenance and inspection records conducted on 7/8/20 from 8:45 - 11:00 AM, no records were available for the quarterly waterflow alarm testing for 3 of 4 quarters: The first and second quarter of 2020 and the third quarter of 2019.</p> <p>Interview of the Engineering Director conducted on 7/8/20 at approximately 11:15 AM revealed he was not aware of the missing documentation prior to the date of the survey.</p>	K 353	<p><i>How will you identify other resident(s) having the potential to be affected and what corrective action(s) will be taken.</i></p> <p>All residents have the potential to be affected by this deficiency and improving documentation of the quarterly system tests will protect residents from potential fire system problems.</p> <p><i>What measures will be put in place to ensure that the deficient practice does not recur.</i></p> <p>Preventative maintenance schedules will be reviewed and updated to reflect missing required testing and documentation. Preventative maintenance checks and testing will be completed by Maintenance staff.</p> <p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur.</i></p> <p>Director of Engineering will maintain and review the maintenance staff documentation monthly for compliance. Deficiencies will be reported to the Safety Committee for three months for further recommended actions.</p> <p><i>Dates when corrective action will be completed:</i> 7/30/2020</p>	

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K 353	Continued From page 8 Actual NFPA standard: NFPA 25 5.3.3 Waterflow Alarm Devices. 5.3.3.1 Mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly.	K 353		
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 performed in accordance with NFPA 101. Failure to conduct fire drills for each shift quarterly, has the potential to hinder staff response during a fire event. This deficient practice affected 17 residents, staff and visitors on the date of the survey. Findings include: During review of provided fire drill documentation conducted on 7/8/20 from 8:45 - 11:00 AM, no documentation was provided demonstrating a fire drill was conducted during the following shifts:	K 712	K712 CFR: NFPA101 Fire Drills <i>What corrective actions will be accomplished for those residents found to be affected by the deficient practice.</i> Safety Officer will conduct a fire drill for each shift. The first drill will be conducted 7/29/20 for the day shift and a drill will be conducted 7/30/20 for the evening shift. Dates and times will be established with the Safety Officer and not shared with general staff. The second round of fire drills will be conducted the first week in August when different crew members are present to practice. <i>How will you identify other resident(s) having the potential to be affected and what corrective action(s) will be taken.</i> All residents have the potential to be affected by this deficiency and planning fire drills during all shifts will help them and staff to be better prepared to respond during a fire emergency. <i>What measures will be put in place to ensure that the deficient practice does not recur.</i> Fire drill completion will be added to the preventative maintenance schedule with updated forms that better reflect staff participation and steps taken during a fire drill.	30Jul2020

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K 712	Continued From page 9 - Evening shift in the first quarter of 2020 - Evening shift for the second quarter of 2020 - Day shift and Evening shift for the third quarter of 2019 - Evening shift for the fourth quarter of 2019 Interview of the Engineering Director conducted at approximately 11:15 AM confirmed he was aware of some missing fire drills.	K 712	<i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur.</i> Director of Engineering will maintain and review quarterly fire drill checksheets to verify shifts and documentation is complete. Deficiencies will be reported quarterly to the Safety Committee for further action. <i>Dates when corrective action will be completed:</i> 7/30/2020		
K 791 SS=F	Construction, Repair, and Improvement Operati CFR(s): NFPA 101 Construction, Repair, and Improvement Operations Construction, repair, and improvement operations shall comply with 4.6.10. Any means of egress in any area undergoing construction, repair, or improvements shall be inspected daily to ensure its ability to be used instantly in case of emergency and compliance with NFPA 241. 18.7.9, 19.7.9, 4.6.10, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on record review observation and operational testing, the facility failed to ensure construction activities were performed in accordance with NFPA 101. Failure to ensure alternative fire life safety measures are in place and followed when required life safety systems are reduced or eliminated, has the potential to expose residents to those elevated hazards and risks associated with such activities. This deficient practice affected 17 residents, staff and visitors on the date of the survey. Findings include: 1) During the facility tour conducted on 7/8/20 from 1:00 - 3:00 PM, observation of both the operations/maintenance corridor and the entire	K 791	K791 CFR: NFPA101 Construction, Repair, & Improvement Operations <i>What corrective actions will be accomplished for those residents found to be affected by the deficient practice.</i> 1) Director of Engineering will obtain a general contractor to replace the ceiling in the nursing home corridor; install 1-hour rated fire separation from the nursing home to the construction area; and relocate temporary sprinkler heads to cover all areas. 2) Director of Engineering will ensure contractors are informing staff of any egress blocking that may need to occur. Designated personnel will inform nursing staff as well as hang signage to indicate blockage and alternate exit routes. 3) The Safety Officer will conduct two additional fire drills per shift during construction and update the ILSM matrix accordingly. Fire Drills will be conducted 7/29/20, 7/30/20, and the first week in August ensuring a variety of staff members are present to practice.	7 Aug 2020	

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K 791	<p>Continued From page 10</p> <p>long-term care facility, revealed both areas were undergoing substantial renovation and construction, impacting all means of egress. Further observation of the ceiling area of the long-term care, revealed an approximately six-inch separation in height, with a single layer of plastic, secured intermittently along the vertical line.</p> <p>In addition, the east side area, across from the main nurses's station had a temporary wall in place separating the demolition of approximately four (4) existing rooms. This temporary wall was confirmed to terminate at the ceiling grid and not to the upper level sub-structure. It was also observed to be constructed out of one (1) layer of drywall on one (1) side, the corridor of the long-term care.</p> <p>Further observation of the east-west corridor revealed two (2) areas of the section directly in front of the nurse's station that were not equipped with fire suppression:</p> <ul style="list-style-type: none"> - The area of the hall from the dietary station in front of the nurse's station to the intersection at room 11, the sprinkler piping was observed to enter into the demolition area, but no sprinklers were observed for approximately twenty feet of the main corridor. - The area at the intersection of the main hall to the path of travel into the north/south corridor toward room 18, was observed to have a fire suppression pendant removed and capped at the location of the demolition area, leaving approximately a ten-foot separation, or gap between pendants. <p>2) During the facility tour conducted on 7/8/20 from 1:00 - 3:00 PM, observation of the exit door</p>	K 791	<p>4) A review of the fire sprinkler system will be added and updated in the ILSM matrix.</p> <p><i>How will you identify other resident(s) having the potential to be affected and what corrective action(s) will be taken.</i></p> <p>All residents have the potential to be affected by these deficiencies and the planned fire separation, additional egress monitoring, fire drills and sprinkler system checks will reduce the risk of potential resident hazards.</p> <p><i>What measures will be put in place to ensure that the deficient practice does not recur.</i></p> <p>Maintenance staff will conduct weekly life safety checks to ensure proper separations and egress areas are maintained during construction.</p> <p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur.</i></p> <p>Director of Engineering will review check sheets, drills and perform spot checks to confirm compliance. Director of engineering will review the ILSM matrix prior to commencing construction projects in other areas. Deficiencies will be reported monthly to the Safety Committee while active construction is underway for further recommended actions.</p> <p><i>Dates when corrective action will be completed:</i> 8/7/2020</p>	

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K 791	<p>Continued From page 11</p> <p>abutting rooms 18 and 19, revealed the exit discharge was blocked by a construction scissor-lift. Operational testing of this door revealed it was not locked and opened approximately four inches and directly into the lift equipment.</p> <p>Further observation revealed no signs or other notifications informing as to the obstruction of this exit were in place.</p> <p>3) During review of the provide Interim Life Safety Measure (ILSM) Matrix conducted on 7/8/20 from 3:00 - 3:15 PM, it was determined that areas of temporary barrier maintenance and obstruction of egress were to be evaluated, along with documentation of two (2) drills per shift area, depending on duration of the project. Further documentation review did not establish those areas of evaluation and protections in place were completed and in accordance with required standards, as approved by the authority having jurisdiction.</p> <p>4) During review of the provide Interim Life Safety Measure (ILSM) Matrix conducted on 7/8/20 from 3:00 - 3:15 PM, documentation did not provide information or review of the fire suppression system, the removal of the fire suppression pendants or the lack of full sprinkler protection in the main corridor.</p> <p>Actual NFPA standard:</p> <p>NFPA 101</p> <p>19.7.9 Construction, Repair, and Improvement Operations. 19.7.9.1 Construction, repair, and improvement operations shall comply with 4.6.10.</p>	K 791		

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K 791	Continued From page 12 4.6.10 Construction, Repair, and Improvement Operations. 4.6.10.1* Buildings, or portions of buildings, shall be permitted to be occupied during construction, repair, alterations, or additions only where required means of egress and required fire protection features are in place and continuously maintained for the portion occupied or where alternative life safety measures acceptable to the authority having jurisdiction are in place.	K 791		
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 program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and	K 918	K918 CFR: NFPA101 Electrical Systems- Essential Electric System <i>What corrective actions will be accomplished for those residents found to be affected by the deficient practice.</i> Maintenance staff will continue to complete required EPSS generator testing at required intervals. <i>How will you identify other resident(s) having the potential to be affected and what corrective action(s) will be taken.</i> All residents are affected by this deficiency and ensuring that the generator tests and exercises are performed will protect them during a power loss. <i>What measures will be put in place to ensure that the deficient practice does not recur.</i> Maintenance staff and Director of Engineering will update and enforce a Preventative Maintenance program to ensure appropriate generator tests are being completed and documented to meet NFPA regulations. <i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur.</i>	30Jul2020

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K 918	<p>Continued From page 13</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 Emergency Power Supply System (EPSS) generators were maintained in accordance with NFPA 110. Failure to conduct weekly inspections and monthly load testing, has the potential to hinder continuity of care for residents during an extended power loss. This deficient practice affected 17 residents and staff on the date of the survey.</p> <p>Findings include:</p> <p>During review of provided maintenance and inspection records for the installed EPSS generator conducted on 7/8/20 from 8:45 - 11:00 AM, the facility failed to demonstrate documentation for the following weekly inspection(s) and monthly exercises:</p> <ul style="list-style-type: none"> - No weekly inspection documented during the months of April 2019, May 2019 and October 2019. - No monthly load exercises documented during the months of April 2019, May 2019, October 2019 and November 2019. <p>Interview of the Engineering Director conducted on 7/8/20 at approximately 11:15 AM, revealed he was not aware of any missing documentation for the weekly inspection(s) and monthly exercises.</p>	K 918	<p>Director of Engineer will maintain and review documentation monthly for compliance. Deficiencies will be reported monthly to the Safety Committee for further recommended actions.</p> <p><i>Dates when corrective action will be completed:</i> 7/30/2020</p>	

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K 918	Continued From page 14 Actual NFPA standard: NFPA 110 8.3 Maintenance and Operational Testing. 8.3.8 A fuel quality test shall be performed at least annually using tests approved by ASTM standards. 8.4 Operational Inspection and Testing. 8.4.1* EPSSs, including all appurtenant components, shall be inspected weekly and exercised under load at least monthly.	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,	K 923	K923 CFR: NFPA101 Gas Equipment- Cylinder & Container Storage <i>What corrective actions will be accomplished for those residents found to be affected by the deficient practice.</i> Maintenance staff has removed excess oxygen "E" cylinders from the storage area. A new storage cylinder cart was ordered on 7/28/20 to separate the storage of full and empty oxygen cylinders. This area will also be labeled for staff to store correctly after use. <i>How will you identify other resident(s) having the potential to be affected and what corrective action(s) will be taken.</i> All residents using oxygen may be affected by this deficiency and maintaining a safe storage system for the cylinders will ensure their safety. <i>What measures will be put in place to ensure that the deficient practice does not recur.</i> Maintenance staff will conduct weekly life safety checks for three months to ensure proper quantities of bottles and storage separations of full and empty bottles are maintained.	7Aug2020

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K 923	<p>Continued From page 15</p> <p>where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING."</p> <p>Storage is planned so cylinders are used in order 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.</p> <p>11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, the facility failed to ensure storage of medical gas cylinders such as oxygen, were maintained in accordance with NFPA 99. Failure to secure cylinders with either a rack or chain and segregate storage of empty cylinders from full cylinders, has an increased risk for explosions and 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 dates of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 7/8/20 from 1:00 - 3:00 PM, observation of the storage room located behind and to the right of the main nurse's station, revealed the room had a rack with twelve "E" size cylinders, one "E" cylinder loose and unsecured on the floor and three (3) "E" cylinders in crash carts stored directly adjacent.</p> <p>Further observation revealed that of the twelve cylinders stored in the rack, five (5) of them had</p>	K 923	<p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur.</i></p> <p>Director of Engineering will review the check sheets and perform spot checks to confirm compliance. Deficiencies will be reported monthly to the Safety Committee for further recommended actions.</p> <p><i>Dates when corrective action will be completed:</i></p> <p>8/7/2020</p>	

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K 923	<p>Continued From page 16</p> <p>no valve protective plastic on top and seven (7) still had the protective cap intact. Additionally, no identifying signs or labeling demonstrating the separation of full and empty cylinders was observed in this location.</p> <p>Interview of a a nurse on duty at approximately 1:15 PM, when asked about the determination of which cylinders were considered "Full" and which cylinders were considered "Empty", she stated the absence of the protective cap would indicate "Empty" and the presence of a cap would indicate "Full".</p> <p>Actual NFPA standard:</p> <p>NFPA 99</p> <p>11.6.2.3 Cylinders shall be protected from damage by means of the following specific procedures:</p> <ol style="list-style-type: none"> (1) Oxygen cylinders shall be protected from abnormal mechanical shock, which is liable to damage the cylinder, valve, or safety device. (2) Oxygen cylinders shall not be stored near elevators or gangways or in locations where heavy moving objects will strike them or fall on them. (3) Cylinders shall be protected from tampering by unauthorized individuals. (4) Cylinders or cylinder valves shall not be repaired, painted, or altered. (5) Safety relief devices in valves or cylinders shall not be tampered with. (6) Valve outlets clogged with ice shall be thawed with warm - not boiling - water. (7) A torch flame shall not be permitted, under any circumstances, to come in contact with a cylinder, cylinder valve, or safety device. (8) Sparks and flame shall be kept away from 	K 923		

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K 923	Continued From page 17 cylinders. (9) Even if they are considered to be empty, cylinders shall not be used as rollers, supports, or for any purpose other than that for which the supplier intended them. (10) Large cylinders (exceeding size E) and containers larger than 45 kg (100 lb) weight shall be transported on a proper hand truck or cart complying with 11.4.3.1. (11) Freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. (12) Cylinders shall not be supported by radiators, steam pipes, or heat ducts. 11.6.5 Special Precautions - Storage of Cylinders and Containers. 11.6.5.1 Storage shall be planned so that 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135066	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 07/08/2020
NAME OF PROVIDER OR SUPPLIER POWER COUNTY NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 510 ROOSEVELT STREET (83211-1362) AMERICAN FALLS, ID 83211		
(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) COMPLETE DATE
C 000	<p>INITIAL COMMENTS</p> <p>The facility is located on the first floor, east wing of the county hospital. It was originally constructed in early 1961 and is currently undergoing a large-scale renovation. The fire suppression system was retrofitted in 2010 with a full NFPA 13 sprinkler system and is equipped with an interconnected fire alarm/smoke detection system which includes exit access corridors and open spaces. Emergency power and lighting are provided by a diesel powered, automatic generator that was replaced in 2019. The facility is currently licensed for 18 SNF/NF beds with a census of 17 on the date of the survey.</p> <p>The following deficiencies were cited during the annual life safety code survey conducted on July 8, 2020. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70 and IDAPA 16.03.02 Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities.</p> <p>The Survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction</p>	C 000	<p style="text-align: center;">RECEIVED AUG - 3 2020 FACILITY STANDARDS</p>	
C 442	<p>02.120,12,b Prohibited Use of Personal Comfort Heating</p> <p>b. Portable comfort heating devices shall not be used. This RULE: is not met as evidenced by: Based on observation, the facility failed to ensure that portable heating devices, that are historically linked to facility fires, were not used as a supplemental heat source. Failure to ensure that</p>	C 442	<p>C442 02.120,12,b Prohibited Use of Personal Comfort Heating</p> <p><i>What corrective actions will be accomplished for those residents found to be affected by the deficient practice.</i> The heater that was located in the DON office was removed by Maintenance staff on 7/30/20.</p>	1Aug2020

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

TITLE

(X6) DATE

CEO / ADMINISTRATOR

30 JUL 2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135066	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 07/08/2020
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C 442	<p>Continued From Page 1</p> <p>portable heaters are not used for supplemental heat, potentially increases the risk of facility fires from these devices. This deficient practice affected staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 7/8/20 from 1:00 - 3:00 PM, observation of the DON office revealed a portable heater in use.</p> <p>Actual State IDAPA requirements: 16.03.02.120 120. EXISTING BUILDINGS. These standards shall be applied to all currently licensed health care facilities. Any minor alterations, repairs, and maintenance shall meet these standards. In the event of a change in ownership of a facility, the entire facility shall meet these standards prior to issuance of a new license.</p> <p>12. Heating. A heating system shall be provided for the facility that is capable of maintaining a temperature of seventy-five degrees (75F) to eighty degrees (80F) Fahrenheit in all weather conditions.</p> <p>b. Portable comfort heating devices shall not be used.</p>	C 442	<p><i>How will you identify other resident(s) having the potential to be affected and what corrective action(s) will be taken.</i></p> <p>Maintenance staff will conduct a walk through to ensure no additional portable heaters are located in the unit.</p> <p><i>What measures will be put in place to ensure that the deficient practice does not recur.</i></p> <p>Maintenance staff will conduct weekly fire and life safety rounding and will ensure portable heaters are not located in the Skilled Nursing Facility.</p> <p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur.</i></p> <p>Director of Engineering will review the weekly checks. Deficiencies will be reported monthly to the Safety Committee for three months or until compliance is met.</p> <p><i>Dates when corrective action will be completed:</i> 8/1/2020</p>	

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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 20, 2020

Dallas Clinger, Administrator
Power County Nursing Home
PO Box 420
American Falls, ID 83211

Provider #: 135066

RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER

Dear Mr. Clinger:

On **July 8, 2020**, an Emergency Preparedness survey was conducted at **Power County Nursing Home** 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.

Dallas Clinger, Administrator
July 20, 2020
Page 2 of 4

Your Plan of Correction (PoC) for the deficiencies must be submitted by **August 3, 2020**. Failure to submit an acceptable PoC by **July 30, 2020**, may result in the imposition of civil monetary penalties by **August 21, 2020**.

Your PoC must contain the following:

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

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

Remedies may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **August 12, 2020**, (Opportunity to Correct). Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on . A change in the seriousness of the deficiencies on **August 31, 2020**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **August 12, 2020**, includes the following:

Denial of payment for new admissions effective **October 8, 2020**.
42 CFR §488.417(a)

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

Dallas Clinger, Administrator
July 20, 2020
Page 3 of 4

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **January 8, 2021**, 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 8, 2020**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

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

BFS Letters (06/30/11)

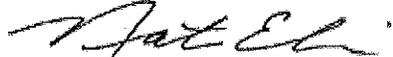
2001-10 Long Term Care Informal Dispute Resolution Process
2001-10 IDR Request Form

Dallas Clinger, Administrator
July 20, 2020
Page 4 of 4

This request must be received by **July 30, 2020**. If your request for informal dispute resolution is received after **July 30, 2020**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosures

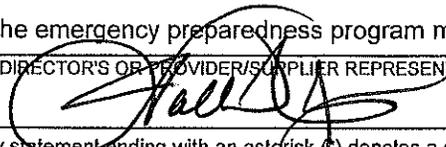
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 07/16/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135066	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/08/2020
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E 000	Initial Comments The facility is located on the first floor, east wing of the county hospital. Both the Skilled Nursing Facility and the Hospital are supported by county and state EMS services. It was originally constructed in early 1961 and is currently undergoing a large-scale renovation. The fire suppression system was retrofitted in 2010 with a full NFPA 13 sprinkler system and is equipped with an interconnected fire alarm/smoke detection system which includes exit access corridors and open spaces. Emergency power and lighting are provided by a diesel powered, automatic generator that was replaced in 2019. The facility is currently licensed for 18 SNF/NF beds with a census of 17 on the date of the survey. The following deficiencies were cited during the annual Emergency Preparedness survey conducted on July 8, 2020. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73. The Survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction	E 000		
E 004 SS=F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must	E 004	E004 CFR: 483.73(a) Develop EP Plan, Review & Update Annually <i>What corrective actions will be accomplished for those residents found to be affected by the deficient practice.</i> Power County Hospital District Emergency Plan (EP) will be updated with required information that was identified to be lacking during this survey. The EP will then be submitted to Power County Hospital District administration and board for approval.	24Aug2020

RECEIVED
AUG - 3 2020
FACILITY STANDARDS

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



TITLE

CEO/ADMINISTRATOR

(X6) DATE

30 JUL 2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 004	<p>Continued From page 1 include, but not be limited to, the following elements:</p> <p>(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following:</p> <p>* [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.</p> <p>* [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed and updated at least annually.</p> <p>* [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to demonstrate the Emergency Plan (EP) had been reviewed and updated annually. Failure to review the EP annually to ensure it is relevant to identified facility risks, has the potential to provide information not relevant to the facility procedures and hinder staff emergency response and training during a disaster. This deficient practice affected 17 residents, staff and visitors</p>	E 004	<p><i>How will you identify other resident(s) having the potential to be affected and what corrective action(s) will be taken.</i> All residents have the potential to be affected by this deficiency and updating and reviewing the EP annually will better ensure their safety during a potential emergency.</p> <p><i>What measures will be put in place to ensure that the deficient practice does not recur.</i> Director of Engineering will add the EP to a Preventative Maintenance schedule for annual review and approval.</p> <p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur.</i> Administrative Assistant will monitor and send reminders for the annual review date of the EP to the Director of Engineering and Safety Officer to ensure compliance. Deficiency to complete the review will be reported to the Safety Committee for further recommended actions.</p> <p><i>Dates when corrective action will be completed:</i> Corrective Action complete 8/10/2020; Board approval of Plan 8/24/2020</p>		

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E 004	Continued From page 2 on the date of the survey. Findings include: During review of the provided EP conducted on 7/8/20 from 8:45 - 11:00 AM, documentation failed to demonstrate the plan was reviewed to ensure continuity of the information provided was relevant to current facility risks, geographical location and emergency conditions. Interview of the facility Engineering Director conducted at approximately 10:00 AM, established the facility had failed to meet the deadline for submission of approval on the Emergency plan by the governing body board, for both 2019 and 2020. Reference: 42 CFR 483.73 (a)	E 004			
E 006 SS=F	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. *[For LTC facilities at §483.73(a)(1):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk	E 006	E006 CFR: 483.73(a)(1-2) Plan Based on All Hazards Risk Assessment <i>What corrective actions will be accomplished for those residents found to be affected by the deficient practice.</i> Power County Hospital District EP HVA will be updated to identify the current COVID-19 pandemic and similar diseases as highly likely. The EP HVA will then be submitted to Power County Hospital District board for approval. <i>How will you identify other resident(s) having the potential to be affected and what corrective action(s) will be taken.</i> All residents have the potential to be affected by this deficiency and updating and reviewing the EP HVA annually will better ensure their safety for likely emergency threats.	24Aug2020	

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E 006	<p>Continued From page 3 assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment.</p> <p>*[For ICF/IIDs at §483.475(a)(1):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment.</p> <p>* [For Hospices at §418.113(a)(2):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to develop a Hazard Vulnerability Analysis (HVA) that utilized current data on community and facility-specific risks. Failure to identify and plan for risks identified by local, state authorities as specific not only to the facility location, but the healthcare industry, has the potential to expose</p>	E 006	<p><i>What measures will be put in place to ensure that the deficient practice does not recur.</i> Director of Engineering will add the review of the EP HVA to a Preventative Maintenance schedule for annual review and approval.</p> <p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur.</i> Administrative Assistant will monitor and send reminders for the annual review date of the EP HVA to the Director of Engineering and Safety Officer to ensure compliance. Deficiency to complete the review will be reported to the Safety Committee for further recommended actions.</p> <p><i>Dates when corrective action will be completed:</i> Corrective Action complete 8/10/2020; Board approval of Plan 8/24/2020</p>	

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E 006	Continued From page 4 residents, staff and visitors to increased risks associated. This deficient practice affected 17 residents, staff and visitors on the date of the survey. Findings include: During review of the provided EP HVA conducted on 7/8/20 from 8:30 AM - 1:00 PM, documentation provided indicated the risk of "infectious disease outbreak" for the facility was "least likely", however at the time of the survey, local, state, federal and even global authorities have identified the COVID-19 pandemic as systemic and highly likely in all areas. Reference: 42 CFR 483.73 (a) (1) - (2)	E 006		
E 013 SS=F	Development of EP Policies and Procedures CFR(s): 483.73(b) (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set 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.	E 013	E013 CFR: 483.73(b) Development of EP Policies & Procedures <i>What corrective actions will be accomplished for those residents found to be affected by the deficient practice.</i> Power County Hospital District Emergency Preparedness Coordinator will consult with appropriate regional and local authorities to help facilitate updating the EP HVA. The EP HVA will then be submitted to Power County Hospital District board for approval. <i>How will you identify other resident(s) having the potential to be affected and what corrective action(s) will be taken.</i> All residents have the potential to be affected by this deficiency and updating and reviewing the EP HVA with area authorities annually will better ensure their safety for likely local or regional emergency threats.	24Aug2020

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135066	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/08/2020
NAME OF PROVIDER OR SUPPLIER POWER COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 510 ROOSEVELT STREET (83211-1362) AMERICAN FALLS, ID 83211		
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E 013	Continued From page 5 *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to utilize current community information and risk assessment when developing the facility HVA. Failure to consider both community and regional information on significant risks that would affect the facility, has the potential to hinder and divert focus in the development of policies and procedures that would be relevant to the facility plan. This deficient practice affected 17 residents, staff and visitors on the date of the survey. Findings include: On 7/5/20 from 8:30 AM - 1:00 PM, review of the provided emergency plan, revealed the facility HVA did not represent level considerations of the available county, state and federal identified risk of COVID-19. Further review established the facility had identified "Infectious Disease Outbreak" to the facility location as "least likely". Reference: 42 CFR 483.73 (b)	E 013	<i>What measures will be put in place to ensure that the deficient practice does not recur.</i> Director of Engineering will add the review of the EP HVA to a Preventative Maintenance schedule for annual review and approval. <i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur.</i> Administrative Assistant will monitor and send reminders for the annual review date of the EP HVA to the Director of Engineering and Safety Officer to ensure compliance. Deficiency to complete the review will be reported to the Safety Committee for further recommended actions. <i>Dates when corrective action will be completed:</i> Corrective Action complete 8/10/2020; Board approval of Plan 8/24/2020		

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E 041 E 041 SS=F	Continued From page 6 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	E041 CFR: 483.73(e) Hospital CAH & LTC Emergency Power <i>What corrective actions will be accomplished for those residents found to be affected by the deficient practice.</i> Maintenance staff will continue to complete required EPSS generator testing at required intervals. <i>How will you identify other resident(s) having the potential to be affected and what corrective action(s) will be taken.</i> All residents are affected by this deficiency and ensuring that the generator tests and exercises are performed will protect them during a power loss and emergency situation. <i>What measures will be put in place to ensure that the deficient practice does not recur.</i> Maintenance staff and Director of Engineering will update and enforce a Preventative Maintenance program to ensure appropriate generator tests are being completed and documented to meet NFPA regulations. <i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur.</i> Director of Engineer will maintain and review documentation monthly for compliance. Deficiencies will be reported monthly to the Safety Committee for further recommended actions. <i>Dates when corrective action will be completed:</i> 7/30/2020	30Jul2020	

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E 041	<p>Continued From page 7</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):]</p> <p>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: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. 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			

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E 041	<p>Continued From page 8</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 Emergency Power Supply System (EPSS) generators were maintained in accordance with NFPA 110. Failure to maintain EPSS generator sets, has the potential to hinder continuity of care for residents during emergencies creating an extended power loss. This deficient practice affected 17 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During review of provided maintenance and inspection records for the installed EPSS generator conducted on 7/8/20 from 8:45 - 11:00 AM, the facility failed to demonstrate documentation for the following weekly inspection(s) and monthly exercises:</p> <ul style="list-style-type: none"> - No weekly inspection documented during the months of April 2019, May 2019 and October 2019. - No monthly load exercises documented during the months of April 2019, May 2019, October 2019 and November 2019. <p>Interview of the Engineering Director conducted on 7/8/20 at approximately 11:15 AM, revealed he</p>	E 041			

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E 041	Continued From page 9 was not aware of any missing documentation for the weekly inspection(s) and monthly exercises. Actual NFPA standard: NFPA 110 8.3 Maintenance and Operational Testing. 8.4 Operational Inspection and Testing. 8.4.1* EPSSs, including all appurtenant components, shall be inspected weekly and exercised under load at least monthly.	E 041			