



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 24, 2019

Steve Gannon, Administrator
Quinn Meadows Rehabilitation and Care Center
1033 West Quinn Road
Pocatello, ID 83202-2425

Provider #: 135136

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

Dear Mr. Gannon:

On **July 17, 2019**, a Facility Fire Safety and Construction survey was conducted at **Quinn Meadows Rehabilitation And Care Center** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

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

Steve Gannon, Administrator
July 24, 2019
Page 2 of 4

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 6, 2019**. Failure to submit an acceptable PoC by **August 6, 2019**, may result in the imposition of civil monetary penalties by **August 28, 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 21, 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 **October 15, 2019**. A change in the seriousness of the deficiencies on **August 31, 2019**, may result in a change in the remedy.

Steve Gannon, Administrator
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The remedy, which will be recommended if substantial compliance has not been achieved by **August 21, 2019**, includes the following:

Denial of payment for new admissions effective **October 17, 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 17, 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 17, 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:

Steve Gannon, Administrator
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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:

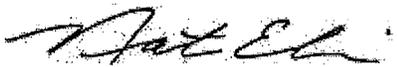
BFS Letters (06/30/11)

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

This request must be received by **August 6, 2019**. If your request for informal dispute resolution is received after **August 6, 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: 07/23/2019
FORM APPROVED
OMB NO. 0938-0391

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135136 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - QUINN MEADOWS B. WING _____ | (X3) DATE SURVEY COMPLETED 07/17/2019 |
|--|---|--|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER QUINN MEADOWS REHABILITATION AND CAF | STREET ADDRESS, CITY, STATE, ZIP CODE 1033 WEST QUINN ROAD POCATELLO, ID 83202 |
|---|--|

| (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 | <p>INITIAL COMMENTS</p> <p>The facility is an approximately 26,000 square foot type V (111) construction, initially licensed in 2009. The building is subdivided into two smoke compartments, with an attached but two-hour separated Physical Therapy section. The building is fully sprinklered and is equipped with an interconnected, manual fire alarm system. Emergency power is provided by an onsite generator system. The facility is currently licensed for 41 beds with a census of 25 on the day of the survey.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on July 17, 2019. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancies, in accordance with 42 CFR, 483.70.</p> <p>The survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction</p> | K 000 | <p style="text-align: center;">RECEIVED AUG 06 2019 FACILITY STANDARDS</p> | |
| K 271 SS=F | <p>Discharge from Exits CFR(s): NFPA 101</p> <p>Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure exit discharges were in</p> | K 271 | | <p>K 271</p> <p>Corrective A pathway will be created from the 200 hall exit which terminates at a public way.</p> <p>Identification There were no residents directly affected by this deficient practice, however all residents in the facility had the potential to be affected.</p> |

| | | |
|--|-------------------------------|----------------------------|
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER/REPRESENTATIVE'S SIGNATURE  | TITLE ADMINISTRATOR | (X6) DATE 8/5/19 |
|--|-------------------------------|----------------------------|

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135136 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - QUINN MEADOWS B. WING _____ | (X3) DATE SURVEY COMPLETED 07/17/2019 |
|--|---|--|---|---|
| NAME OF PROVIDER OR SUPPLIER QUINN MEADOWS REHABILITATION AND CARE | | STREET ADDRESS, CITY, STATE, ZIP CODE 1033 WEST QUINN ROAD POCATELLO, ID 83202 | | |
| (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 271 | Continued From page 1 accordance with NFPA 101. Failure to ensure exit discharges meet the provisions for a means of egress and terminate at the public way has the potential to hinder safe evacuation of residents during emergencies. This deficient practice affected all residents and staff needing the use of the exit discharge from the 200 hall. Findings include: During the facility tour conducted on 7/17/19 from 11:00 AM - 12:00 PM, observation of the 200 hall exit discharge revealed the discharge did not have a path which terminated at the public way. Interview of the Maintenance Supervisor at 11:15 AM established he was aware of the missing pathway. When asked if he felt the facility would be able to evacuate residents in wheelchairs or beds to the public way from this exit discharge, he stated "No". Actual NFPA standard: 19.2.7 Discharge from Exits. Discharge from exits shall be arranged in accordance with Section 7.7. 7.7 Discharge from Exits. 7.7.1* Exit Termination. Exits shall terminate directly, at a public way or at an exterior exit discharge, unless otherwise provided in 7.7.1.2 through 7.7.1.4. | K 271 | K 271 continued... Measure No measures are needed as the path will be a permanent addition that will not change and all other emergency exits have pathways that terminate at a public way. Monitor No monitoring needed as the correction is a one time fix for the path to be a permanent addition that will not change. | 8/16/19 |
| K 511 SS=D | Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no | K 511 | K 511 Corrective 2-1 non grounded extension cord that was used to supply power to a hair dryer was removed from the Salon located on the 200 Hall immediately upon it being found. | |

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| K 511 | <p>Continued From page 2 hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the use of safe electrical installations in accordance with NFPA 70. Use of flexible cords as a substitute for the fixed wiring of the facility has been historically linked to arc fires and electrical shock hazards in facilities. This deficient practice affected those residents using salon services and staff on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 7/17/19 from 10:00 - 11:00 AM, observation of the Salon located in the 200 hall, revealed a 2-1 non-grounded extension cord in use to supply power to a hair dryer. Interview of the Maintenance Supervisor at approximately 10:45 AM established he was not aware the Salon was using an extension cord for the hair dryer.</p> <p>Actual NFPA standard:</p> <p>NFPA 70 400.8 Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors</p> | K 511 | <p>K 511 continued...</p> <p>Identification There were no residents directly affected by this deficient practice, however all residents in the facility had the potential to be affected.</p> <p>Measure In-service education will be given to all staff that use the salon to ensure there are no 2-1 non-grounded extension cords used in the Salon.</p> <p>Monitor The Maintenance Director will check the Salon to ensure there are no 2-1 non-grounded extension cords being used.</p> <p>Monitoring will begin on 8/9/2019 and will continue weekly for 4 weeks, then every other week for 4 weeks, then monthly for 3 months.</p> | 7/17/2019 |

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| K 511 | Continued From page 3 (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces Exception to (4): Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of 368.56(B) (5) Where concealed by walls, floors, or ceilings or located above suspended or dropped ceilings (6) Where installed in raceways, except as otherwise permitted in this Code (7) Where subject to physical damage | K 511 | | |



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July 24, 2019

Steve Gannon, Administrator
Quinn Meadows Rehabilitation and Care Center
1033 West Quinn Road
Pocatello, ID 83202-2425

Provider #: 135136

RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER

Dear Mr. Gannon:

On **July 17, 2019**, an Emergency Preparedness survey was conducted at Quinn Meadows Rehabilitation And Care Center by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. Your facility was found to be in substantial compliance with Federal regulations during this survey.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, which states that the facility complies with the requirements of CFR 42, 483.70(a) of the federal requirements. This form is for your records only and does not need to be returned.

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

Sincerely,

Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135136 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 07/17/2019 |
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| E 000 | <p>Initial Comments</p> <p>The facility is an approximately 26,000 square foot type V (111) construction, initially licensed in 2009. The building is subdivided into two smoke compartments, with an attached Physical Therapy section which includes both inpatient, facility use as well as outpatient services. The building is fully sprinklered and is equipped with a manual fire alarm system. Emergency power is provided by an onsite, dual-fuel generator system. The facility is located within a municipal fire district, with both regional and state EMS support services available. The facility is currently licensed for 41 SNF/NF beds, with a census of 25 on the day of the survey.</p> <p>The facility was found to be in substantial compliance during the Emergency Preparedness Survey conducted on July 17, 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 and Construction</p> | E 000 | | |

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

TITLE

(X6) DATE

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.