



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

August 11, 2020

Landon Taylor, Administrator
Madison Carriage Cove Short Stay Rehabilitation
410 West 1st North
Rexburg, ID 83440-1406

Provider #: 135140

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

Dear Mr. Taylor:

On **July 30, 2020**, a Facility Fire Safety and Construction survey was conducted at **Madison Carriage Cove Short Stay Rehabilitation** 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.

Landon Taylor, Administrator
August 11, 2020
Page 2 of 4

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 24, 2020**. Failure to submit an acceptable PoC by **August 24, 2020**, may result in the imposition of civil monetary penalties by **September 15, 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 **September 3, 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 28, 2020**. A change in the seriousness of the deficiencies on **September 13, 2020**, may result in a change in the remedy.

Landon Taylor, Administrator
August 11, 2020
Page 2 of 4

The remedy, which will be recommended if substantial compliance has not been achieved by **September 3, 2020**, includes the following:

Denial of payment for new admissions effective **October 30, 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 30, 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 30, 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:

Landon Taylor, Administrator
August 11, 2020
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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:

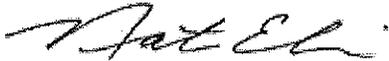
BFS Letters (06/30/11)

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

This request must be received by **August 24, 2020**. If your request for informal dispute resolution is received after **August 24, 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: 08/07/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135140	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - MADISON CARRIAGE COVE SHORT STAY REHABILITATION B. WING _____	(X3) DATE SURVEY COMPLETED 07/30/2020
--	--	---	--

NAME OF PROVIDER OR SUPPLIER MADISON CARRIAGE COVE SHORT STAY REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST 1ST NORTH REXBURG, ID 83440
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	<p>INITIAL COMMENTS</p> <p>The facility is a single-story, Type V (111) construction, built in 2014. There is a partial second floor, with a separated mechanical loft. At approximately 35,874 square feet, the facility is comprised of five smoke compartments, with both fire and smoke dampers in fire-rated wall assemblies. The facility is fully sprinklered, with complete smoke detection and manual fire alarm system. The Type 2, Essential Electrical System is supplied by a diesel powered, on-site automatic generator. Piped in oxygen and vacuum are provided and installed per NFPA Std 99. Currently the facility is licensed for 35 SNF/NF beds, with a census of 27 on the date of the survey.</p> <p>The following deficiencies were cited during the annual fire/life safety code survey conducted on July 30, 2020. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Chapter 19, Existing Healthcare Occupancies, in accordance with 42 CFR 483.70.</p> <p>The survey was conducted by:</p> <p>Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction</p> <p>K 321 SS=E Hazardous Areas - Enclosure CFR(s): NFPA 101</p> <p>Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be</p>	K 000	<p>RECEIVED AUG 25 2020 FACILITY STANDARDS</p>	8/31/20
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE EXECUTIVE DIRECTOR	(X6) DATE
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 321	<p>Continued From page 1</p> <p>separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9</p> <p>Area Automatic Sprinkler Separation N/A</p> <p>a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure hazardous areas were protected with self-closing doors. Failure to provide self-closing doors for hazardous areas could allow smoke and dangerous gases to pass freely into corridors and hinder egress of occupants during a fire event. This deficient practice affected 11 residents and staff on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour on July 30, 2020, from approximately 12:35 PM to 1:35 PM, observation and operational testing of the storage/janitor</p>	K 321			

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K 321	<p>Continued From page 2</p> <p>closet between the resident lounge and the dining room revealed the door was not self-closing. When measured, the room was estimated to be 77 sq. ft. and contained combustible storage items in addition to janitorial supplies. When asked, the Maintenance Supervisor stated the facility was not aware the door was required to be self-closing.</p> <p>Actual NFPA standard:</p> <p>NFPA 101 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.7.1. 19.3.2.1.3 The doors shall be self-closing or automatic-closing. 19.3.2.1.5 Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft² (9.3 m²) (3) Paint shops (4) Repair shops (5) Rooms with soiled linen in volume exceeding 64 gal (242 L) (6) Rooms with collected trash in volume exceeding 64 gal (242 L) (7) Rooms or spaces larger than 50 ft² (4.6 m²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard</p>	K 321		

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K 761 K 761 SS=F	Continued From page 3 Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure fire and smoke rated assemblies were inspected in accordance with NFPA 80 and NFPA 105. Failure to inspect and test fire and smoke rated doors could result in a lack of system performance as designed, impeding defend in place. This deficient practice affected 27 residents and staff on the date of the survey. Findings include: During review of provided facility annual inspection records conducted on July 30, 2020, from approximately 9:35 AM to 12:35 PM, documentation for a current annual inspection and operational testing of fire/smoke rated doors/assemblies could not be produced. The last known inspection was May 2019. When	K 761 K 761		

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K 761	<p>Continued From page 4</p> <p>asked, the Maintenance Supervisor stated the facility was aware the annual inspection was due but had been distracted with COVID-19 pandemic responsibilities.</p> <p>Actual NFPA standard:</p> <p>NFPA 101</p> <p>19.2.2.2 Doors. 19.2.2.2.1 Doors complying with 7.2.1 shall be permitted.</p> <p>7.2.1 Door Openings. 7.2.1.15 Inspection of Door Openings. 7.2.1.15.1* Where required by Chapters 11 through 43, the following door assemblies shall be inspected and tested not less than annually in accordance with 7.2.1.15.2 through 7.2.1.15.8: (1) Door leaves equipped with panic hardware or fire exit hardware in accordance with 7.2.1.7 (2) Door assemblies in exit enclosures (3) Electrically controlled egress doors (4) Door assemblies with special locking arrangements subject to 7.2.1.6</p> <p>7.2.1.15.2 Fire-rated door assemblies shall be inspected and tested in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Smoke door assemblies shall be inspected and tested in accordance with NFPA 105, Standard for Smoke Door Assemblies and Other Opening Protectives.</p> <p>NFPA 80 5.2* Inspections. 5.2.1* Fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept</p>	K 761			

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K 761	Continued From page 5 for inspection by the AHJ. NFPA 105 5.2 Specific Requirements. 5.2.1* Inspections. 5.2.1.1 Smoke door assemblies shall be inspected annually. 5.2.1.2 Doors shall be operated to confirm full closure. 5.2.1.3 Hardware and gaskets shall be inspected annually, and any parts found to be damaged or inoperative shall be replaced.	K 761			

DATE OF COMPLIANCE

8/31/20

K-321

SPECIFIC RESIDENT

NO RESIDENTS WERE DIRECTLY AFFECTED BY THIS PRACTICE.

OTHER RESIDENTS

11 RESIDENTS HAD THE POTENTIAL TO BE AFFECTED BY THIS DEFICIENT PRACTICE.

SYSTMATIC CHANGES

THE STORAGE/JANITOR DOOR LOCATED ON THE SOUTH HALL NEAR THE NURSES STATION WILL HAVE A SELF CLOSING MECHANISM INSTALLED TO COMPLY WITH HAZARDOUS AREAS- ENCLOSURES AS OUTLINED IN NFPA 101.

MONITOR

MAINTENANCE DIRECTOR OR DESIGNEE WILL INSPECT ALL FACILITY STORAGE AREAS THAT DO NOT CURRENTLY HAVE SELF CLOSING MECHANISMS AND ARE NOT IN COMPLIANCE WITH K-321 HAZARDOUS AREAS AND ENCLOSURES.

K-761

SPECIFIC RESIDENT

NO RESIDENTS WERE DIRECTLY AFFECTED BY THIS PRACTICE.

OTHER RESIDENTS

27 RESIDENTS HAD THE POTENTIAL TO BE AFFECTED BY THIS DEFICIENT PRACTICE.

SYSTMATIC CHANGES

THE ANNUAL DOOR INSPECTIONS FOR OPERATIONAL TESTING OF FIRE/SMOKE RATED DOORS/ASSEMBLIES WAS COMPLETED ON JULY 31ST, 2020.

MONITOR

MAINTENANCE DIRECTOR OR DESIGNEE WILL ENSURE THAT ANNUAL DOOR INSPECTIONS FOR OPERATIONAL TESTING OF FIRE/SMOKE RATED DOORS/ASSEMBLIES IS CONDUCTED ANNUALLY IN COMPLIANCE WITH K-761.



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK – ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
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3232 Elder Street
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August 11, 2020

Landon Taylor, Administrator
Madison Carriage Cove Short Stay Rehabilitation
410 West 1st North
Rexburg, ID 83440-1406

Provider #: 135140

RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER

Dear Mr. Taylor:

On **July 30, 2020**, an Emergency Preparedness survey was conducted at **Madison Carriage Cove Short Stay Rehabilitation** 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"

Landon Taylor, Administrator
August 11, 2020
Page 2 of 4

(located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **August 24, 2020**. Failure to submit an acceptable PoC by **August 24, 2020**, may result in the imposition of civil monetary penalties by **September 15, 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;
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- 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 **September 3, 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 **September 25, 2020**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **September 3, 2020**, includes the following:

Landon Taylor, Administrator
August 11, 2020
Page 3 of 4

Denial of payment for new admissions effective **October 30, 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 30, 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.

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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>

Landon Taylor, Administrator
August 11, 2020
Page 4 of 4

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

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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
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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135140	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2020
NAME OF PROVIDER OR SUPPLIER MADISON CARRIAGE COVE SHORT STAY REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST 1ST NORTH REXBURG, ID 83440		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
E 000	Initial Comments The facility is a single-story, Type V (111) construction, built in 2014. There is a partial second floor, with a separated mechanical loft. At approximately 35,874 square feet, the facility is comprised of five smoke compartments, with both fire and smoke dampers in fire-rated wall assemblies. The facility is fully sprinklered, with complete smoke detection and manual fire alarm system. The Type 2, Essential Electrical System is supplied by a diesel powered, on-site automatic generator. Piped in oxygen and vacuum are provided and installed per NFPA Std 99. Currently the facility is licensed for 35 SNF/NF beds, with a census of 27 on the date of the survey. The following deficiencies were cited during the annual Emergency Preparedness Survey conducted on July 30, 2020. The facility was surveyed under the Emergency Preparedness Rule, in accordance with 42 CFR 483.73. The survey was conducted by: Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction 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.*	E 000			
E 006 SS=F		E 006		8.31.20	

RECEIVED
AUG 25 2020
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____
[Signature] *EXECUTIVE DIRECTOR*

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 006	Continued From page 1 (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 assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[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. * [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,	E 006			

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E 006	Continued From page 2 including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to utilize a community-based element in the development of the facility Hazard Vulnerability Assessment (HVA). The facility also failed to provide strategies to address all hazards identified on the HVA. Failure to utilize community resources has the potential to exclude hazards relevant to the facility's geographical area. Absence of strategies for response to all hazards, could hinder the facility's ability to respond to emergencies. This deficient practice affected residents and staff on the date of the survey. Findings include: On July 30, 2020, from approximately 12:30 PM to 1:30 PM, review of the provided Emergency Preparedness Plan, including the facility HVA, revealed the facility did not have strategies to address all of the hazards identified on the HVA. When asked, the Administrator stated the facility had not taken into consideration or reviewed local community emergency preparedness documents when developing the facility HVA. The Administrator further stated the facility was not aware strategies for response were required for all hazards identified on the HVA. Reference: 42 CFR 483.73 (a) (1) - (2)	E 006			
E 023	Policies/Procedures for Medical Documentation	E 023			

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E 023 SS=D	Continued From page 3 CFR(s): 483.73(b)(5) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years (annually for LTC).] At a minimum, the policies and procedures must address the following:] [(5) or (3),(4),(6)] A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. *[For RNHCIs at §403.748(b):] Policies and procedures. (5) A system of care documentation that does the following: (i) Preserves patient information. (ii) Protects confidentiality of patient information. (iii) Secures and maintains the availability of records. *[For OPOs at §486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to provide a current policy and procedure for a system of medical documentation that preserves patient information, protects confidentiality of patient information, and	E 023			

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E 023	Continued From page 4 secures and maintains availability of records. Lack of a current policy and procedure for medical documentation has the potential to leave residents and staff without resources to continue care during an emergency. This deficient practice could affect residents and staff on the date of the survey Findings include: On July 30, 2020, from approximately 12:30 PM to 1:30 PM, review of provided policies, procedures and emergency planning records, failed to demonstrate current and annually reviewed policies and procedures for a system of medical documentation that would preserve resident information, protect confidentiality and maintain the availability of records. Interview of the Administrator revealed the facility was unaware the Emergency Preparedness Plan did not include policies and procedures for medical documentation during an emergency. Reference: 42 CFR 483.73 (b) (5)	E 023			
E 033 SS=D	Methods for Sharing Information CFR(s): 483.73(c)(4)-(6) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years (annually for LTC).] The communication plan must include all of the following: (4) A method for sharing information and medical documentation for patients under the [facility's]	E 033			

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E 033	<p>Continued From page 5</p> <p>care, as necessary, with other health providers to maintain the continuity of care.</p> <p>(5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.102(c), CORFs under §485.68(c)]</p> <p>(6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4).</p> <p>*[For RNHCs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative.</p> <p>*[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to document a current plan for sharing information and medical documentation for residents as necessary to maintain continuity of care during an emergency. Lack of a current plan for sharing information with other health care providers has the potential to hinder the facility's ability to continue care during a disaster. This deficient practice could affect residents and staff on the date of the survey.</p>	E 033			

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E 033	<p>Continued From page 6</p> <p>Findings include:</p> <p>On July 30, 2020, from approximately 12:30 PM to 1:30 PM, review of provided policies, procedures and emergency planning records failed to demonstrate a current policy which could be implemented by the facility to share information for the care of residents with other healthcare providers, release resident information as permitted in the event of an evacuation, or provide information about the general condition and location of residents during/after an emergency. When asked, the Administrator stated the facility was unaware the Emergency Preparedness Plan did not include a plan for sharing information.</p> <p>Reference:</p> <p>42 CFR 483.73 (c) (4) - (6)</p>	E 033		

DATE OF COMPLIANCE

8/31/20

E-006

SPECIFIC RESIDENT

NO RESIDENTS WERE DIRECTLY AFFECTED BY THIS PRACTICE.

OTHER RESIDENTS

27 RESIDENTS HAD THE POTENTIAL TO BE AFFECTED BY THIS DEFICIENT PRACTICE.

SYSTEMATIC CHANGES

THE EMERGENCY PREPARADNESS PLAN WAS REVISED TAKING INTO CONSIDERATION THE COMMUNITY EMERGENCY PREPARADNESS DOCUMENTS INCLUDING ADDING STRATEGIES FOR EACH VULNERBILITY LISTED ON THE HVA.

MONITOR

THE EMERGENCY PREPARADNESS PLAN SPECIFIC TO THE HVA WILL BE REVIEW ANNUALLY BY MAINTENANCE DIRECTOR AND ADMINISTRATION TO REVISE AS NEEDED. THE EMERGENCY PREPARADNESS PLAN WILL BE REVIEWED IN THE NEXT FACILITY QAPI MEETING.

E-023

SPECIFIC RESIDENT

NO RESIDENTS WERE DIRECTLY AFFECTED BY THIS PRACTICE.

OTHER RESIDENTS

27 RESIDENTS HAD THE POTENTIAL TO BE AFFECTED BY THIS DEFICIENT PRACTICE.

SYSTEMATIC CHANGES

THE FACILITY DEVELOPED A POLICY FOR MEDICAL RECORD PRESERVATION IN THE EVENT OF AN EMERGENCY THAT WOULD ALLOW FOR REMOTE ACCESS TO THE EMAR AND/OR HARD COPIES TO MADE AVAILABLE DEPENDING ON THE STATE OF EMERGENCY WHILE STILL MAINTAIN THE PRIVACY AND CONFIDENTIALITY OF PATIENT INFORMATION.

MONITOR

THE MAINTENANCE DIRECTOR OR ADMINISTRATION WILL INTRODUCE THE NEW POLICY OF THE MEDICAL RECORD PRESERVATION IN THE EVENT OF AN EMERGENCY THAT WOULD ALLOW FOR REMOTE ACCESS TO THE EMAR AND/OR HARD COPIES TO MADE AVAILABLE DEPENDING ON THE STATE OF EMERGENCY WHILE STILL MAINTAIN THE PRIVACY AND CONFIDENTIALITY OF PATIENT INFORMATION. THIS POLICY

WILL BE TESTED ON A TABLETOP EXERCISE AND PRESENTED TO ALL STAFF FOR EDUCATION ONCE IT IS REVIEWED BY THE QAPI TEAM.

E-033

SPECIFIC RESIDENT

NO RESIDENTS WERE DIRECTLY AFFECTED BY THIS PRACTICE.

OTHER RESIDENTS

27 RESIDENTS HAD THE POTENTIAL TO BE AFFECTED BY THIS DEFICIENT PRACTICE.

SYSTEMATIC CHANGES

THE FACILITY DEVELOPED A POLICY FOR THE SHARING OF MEDICAL RECORD IN THE EVENT OF AN EMERGENCY THAT WOULD RECORDS BEING TRANSFERRED TO RECEIVING HEALTHCARE PROVIDERS CARING FOR RESIDENTS WHILE STILL MAINTAINING THE PRIVACY AND CONFIDENTIALITY OF PATIENT INFORMATION.

MONITOR

THE MAINTENANCE DIRECTOR OR ADMINISTRATION WILL INTRODUCE THE NEW POLICY OF THE METHODS OF SHARING MEDICAL RECORD IN THE EVENT OF AN EMERGENCY THAT WOULD RECORDS BEING TRANSFERRED TO RECEIVING HEALTHCARE PROVIDERS CARING FOR RESIDENTS WHILE STILL MAINTAINING THE PRIVACY AND CONFIDENTIALITY OF PATIENT INFORMATION. THIS POLICY WILL BE TESTED ON A TABLETOP EXERCISE AND PRESENTED TO ALL STAFF FOR EDUCATION ONCE IT IS REVIEWED BY THE QAPI TEAM.