



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 21, 2019

R. Ryan Beckman, Administrator
Grangeville Health & Rehabilitation Center
410 East North Second Street
Grangeville, ID 83530-2258

Provider #: 135080

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Mr.. Beckman:

On **August 13, 2019**, a Facility Fire Safety and Construction survey was conducted at **Grangeville Health & Rehabilitation Center** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

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

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you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office. If a State Form with deficiencies was issued, it should be signed, dated and returned along with the CMS-2567 Form.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **September 3, 2019**. Failure to submit an acceptable PoC by **September 3, 2019**, may result in the imposition of civil monetary penalties by **September 25, 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 **September 17, 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 **November 11, 2019**. A change in the seriousness of the deficiencies on **September 27, 2019**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **September 17, 2019**, includes the following:

Denial of payment for new admissions effective **November 13, 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 **February 13, 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 **August 13, 2019**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

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

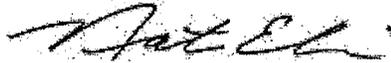
BFS Letters (06/30/11)

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

This request must be received by **September 3, 2019**. If your request for informal dispute resolution is received after **September 3, 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: 08/21/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135080	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 08/13/2019
NAME OF PROVIDER OR SUPPLIER GRANGEVILLE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 410 EAST NORTH SECOND STREET GRANGEVILLE, ID 83530	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The facility is a single story, type V (111) structure originally constructed in 1967. It is fully sprinklered and equipped with an interconnected fire alarm system, including smoke detection in corridors and open spaces. The building has a partial basement housing the boiler, fire suppression system riser and transfer switch to the emergency generator. The facility is currently licensed for 60 SNF/NF beds and had a census of 42 on the dates of the survey. The following deficiencies were cited during the annual Fire/Life Safety survey conducted on August 12 - 13, 2019. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy in accordance with 42 CFR 483.70. The Survey was conducted by: Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction	K 000	"This plan of correction is submitted as required under Federal and State regulations and statutes applicable to skilled nursing facilities. This plan of correction does not constitute an admission of liability, and such liability is hereby specifically denied. The submission of this plan does not constitute agreement by the facility that the surveyor's conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied." Please accept this plan of correction as our credible allegation of compliance.	
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation, operational testing and	K 211		

RECEIVED
SEP 03 2019
FACILITY STANDARDS

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

TITLE

(X6) DATE

[Signature] Administrator 8/29/19

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

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K 211	<p>Continued From page 1</p> <p>interview, the facility failed to ensure means of egress were maintained free of all obstructions to full instant use. Failure to maintain means of egress for full, instant use, could hinder the safe evacuation of residents during an emergency. This deficient practice affected 42 residents and staff on the dates of the survey.</p> <p>Findings include:</p> <p>During the facility tour on August 13, 2019, from approximately 9:00 AM to 11:00 AM, observation and operational testing of exit doors revealed the following:</p> <p>1.) Exit doors at the end of the 100 and 300 hallways required more than 15 lbf. to open to the minimum width.</p> <p>2.) The main entrance/exit doors to the facility had a deadbolt lock, making them non-single operational.</p> <p>When asked, at approximately 9:15 AM during the facility tour, the Maintenance Director stated the facility was not aware the main doors entering the facility could not have a deadbolt lock on them and were required to be single-operational. He further stated, the exit doors at the end of the 100 and 300 hallways are not used often and the facility was aware, that due to varying conditions outside, the doors, on occasion, would drag or catch on the concrete, making them very difficult to open/close.</p> <p>Actual NFPA standard:</p> <p>NFPA 101 19.2 Means of Egress Requirements. 19.2.1 General. Every aisle, passageway, corridor, exit discharge, exit location, and access</p>	K 211	<p>K 211</p> <p>Resident Specific:</p> <p>Please see systemic changes.</p> <p>Other Residents:</p> <p>Please see systemic Changes</p> <p>Systemic Changes:</p> <p>1) Exit doors at the end of the 100 hall and 300 hall have been inspected by "Window's Doors, and More". Parts are on order to replace hinging and thresholds in order to reduce required activation pressure.</p> <p>2) Main entrance doors inspected by "Window's Doors and More". Deadbolt will be removed and replaced with a plug.</p> <p>Monitors:</p> <p>Monthly inspection form added to routine maintenance manual to track and ensure inspections occur. Inspection will ensure doors are free of all obstructions and or impediments. Inspection will also check to ensure required pressure to activate door latch does not exceed 15# and required pressure to move door leaf does not exceed 30#.</p> <p>Date of Compliance:</p> <p>September 17th 2019</p>		

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K 211	Continued From page 2 shall be in accordance with Chapter 7, unless otherwise modified by 19.2.2 through 19.2.11. 1.) 7.1.10 Means of Egress Reliability. 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. 2.) 7.2.1.4.5 Door Leaf Operating Forces. 7.2.1.4.5.1 The forces required to fully open any door leaf manually in a means of egress shall not exceed 15 lbf (67 N) to release the latch, 30 lbf (133 N) to set the leaf in motion, and 15 lbf (67 N) to open the leaf to the minimum required width, unless otherwise specified as follows: (1) The opening forces for interior side-hinged or pivoted-swinging door leaves without closers shall not exceed 5 lbf (22 N). (2) The opening forces for existing door leaves in existing buildings shall not exceed 50 lbf (222 N) applied to the latch stile. (3) The opening forces for horizontal-sliding door leaves in detention and correctional occupancies shall be as provided in Chapters 22 and 23. (4) The opening forces for power-operated door leaves shall be as provided in 7.2.1.9.	K 211		
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9.18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure	K 291		

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K 291	<p>Continued From page 3</p> <p>doors equipped with special locking arrangements, were provided with battery powered emergency lighting. Failure to provide emergency lighting for doors equipped with delayed egress potentially hinders identification of exits utilized for resident egress during low light conditions. This deficient practice affected 42 residents and staff on the dates of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on August 13, 2019, from approximately 9:00 AM - 11:00 AM, observation of the exit doors at the end of all three resident sleeping corridors, revealed all were equipped with magnetic locking arrangements, which included a delayed egress component, but none had the required emergency lighting.</p> <p>Actual NFPA standard:</p> <p>19.2.9 Emergency Lighting. 19.2.9.1 Emergency lighting shall be provided in accordance with Section 7.9.</p> <p>7.9 Emergency Lighting. 7.9.1 General. 7.9.1.1* Emergency lighting facilities for means of egress shall be provided in accordance with Section 7.9 for the following: (1) Buildings or structures where required in Chapters 11 through 43 (2) Underground and limited access structures as addressed in Section 11.7 (3) High-rise buildings as required by other sections of this Code (4) Doors equipped with delayed-egress locks (5) Stair shafts and vestibules of smokeproof</p>	K 291	<p>K 291</p> <p>Resident Specific:</p> <p>Please see systemic changes.</p> <p>Other Residents:</p> <p>Please see systemic Changes</p> <p>Systemic Changes:</p> <p>Exit lights with 90-minute battery backup emergency lights have been ordered to replace current exit signs on all three halls. Signs will be installed when received.</p> <p>Monitors:</p> <p>Backup lights will be included in monthly 30-second and quarterly 90-minute testing of existing battery backup lights upon installation.</p> <p>Date of Compliance:</p> <p>September 17th 2019</p>		

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K 353	<p>Continued From page 5</p> <p>render the facility not fully sprinklered after an activation or repair. This deficient practice affected 42 residents and staff on the dates of the survey.</p> <p>Findings include:</p> <p>1.) During review of provided facility inspection and testing records on August 12, 2019, from approximately 11:00 AM - 4:30 PM, no documentation could be produced for a monthly visual inspection of wet sprinkler system gauges and control valves. When asked on August 12, 2019, at approximately 3:00 PM, the Maintenance Director stated the facility was performing weekly, if not daily, checks of the sprinkler system gauges and control valves, but was unaware visual inspections of the sprinkler system were required to be documented.</p> <p>2.) During the facility tour on August 13, 2019, from approximately 10:20 AM to 10:40 AM, observation of the kitchen revealed a total of two (2) corroded sprinkler heads. When discovered, interview of the Maintenance Director revealed the facility was unaware of the corroded sprinkler heads.</p> <p>Actual NFPA standard:</p> <p>NFPA 25</p> <p>1.) 5.24 Gauges. 5.2.4.1 Gauges on wet pipe sprinkler systems shall be inspected monthly to ensure that they are in good condition and that normal water supply pressure is being maintained. Chapter 13 Valves, Valve Components, and Trim 13.3.2 Inspection</p>	K 353			

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K 353	Continued From page 6 13.3.2.1 Valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly. 13.3.2.2 The valve inspection shall verify that the valves are in the following condition: (1) In the normal open or closed position (2) Sealed, locked, or supervised (3) accessible (4) Provided with correct wrenches (5) free from external leaks (6) Provided with applicable identification 14.4.1.1 Alarm valves and system riser check valves shall be externally inspected monthly and shall verify the following: (1) The gauges indicate normal supply water pressure is being maintained (2) The valve is free of physical damage (3) All valves are in the appropriate open or closed position (4) The retarding chamber or alarm drains are not leaking. 2.) 5.2.1 Sprinklers. 5.2.1.1* Sprinklers shall be inspected from the floor level annually. 5.2.1.1.1* Sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., upright, pendent, or sidewall). 5.2.1.1.2 Any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical damage (4) Loss of fluid in the glass bulb heat responsive element (5) *Loading (6) Painting unless painted by the sprinkler manufacturer	K 353			
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101	K 363			

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K 363	Continued From page 7 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.	K 363	K 363 Resident Specific: Please see systemic changes. Other Residents: Please see systemic Changes Systemic Changes: Doors have been inspected by "Window's Doors and More". All three doors will be adjusted and smoke seal will be applied to correct gapping and manual operation of doors. Gapping and manual operation of all three doors will be within compliance upon completion of work. Monitors: Monthly inspection form added to routine maintenance manual to track and ensure inspections occur. Inspection will check for proper fit and operation as well as identifying doors that have a greater than 3/4" gap between the door slab and frame. 1/2" <i>u</i> Date of Compliance September 17th 2019 <i>pen & ink 9-6-19</i>	

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K 363	<p>Continued From page 8</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, operational testing, and interview the facility failed to maintain doors that protect corridor openings. Failure to maintain corridor doors could allow smoke and dangerous gases to pass freely, preventing defend in place. This deficient practice has the potential to affect 3 residents and staff on the dates of the survey.</p> <p>Findings include:</p> <p>During the facility tour on August 13, 2019, from approximately 9:00 AM to 11:00 AM, observation and operational testing of the resident room doors revealed room #106 had a 1" gap, and room #308 had a 3/4" gap between the face of the door and the frame of the door when fully closed. Room #302 was very difficult to close/open and did not latch without great force. When asked during the facility tour at approximately 10:50 AM, the Maintenance Director stated the facility was unaware of the door gaps but had just repaired door #302 and was unaware it was having problems operating again.</p> <p>Actual NFPA Standards:</p> <p>NFPA 101 19.3.6.3* Corridor Doors. 19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be doors constructed to resist the passage of smoke and shall be constructed of materials such as the following: (1) 1-3/4 in. (44 mm) thick, solid-bonded core wood (2) Material that resists fire for a minimum of 20</p>	K 363		

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135080	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 08/13/2019
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NAME OF PROVIDER OR SUPPLIER GRANGEVILLE HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 410 EAST NORTH SECOND STREET GRANGEVILLE, ID 83530
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 363	Continued From page 9 minutes	K 363		
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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 21, 2019

R. Ryan Beckman, Administrator
Grangeville Health & Rehabilitation Center
410 East North Second Street
Grangeville, ID 83530-2258

Provider #: 135080

RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER

Dear Mr. Beckman:

On **August 13, 2019**, an Emergency Preparedness survey was conducted at **Grangeville Health & Rehabilitation Center** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. Please provide **ONLY ONE** completion date for each federal and state tag in column (X5) Completion Date to signify when you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office.

R. Ryan Beckman, Administrator

August 21, 2019

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Your Plan of Correction (PoC) for the deficiencies must be submitted by **September 3, 2019**. Failure to submit an acceptable PoC by **September 3, 2019**, may result in the imposition of civil monetary penalties by **September 25, 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 **September 17, 2019**, (Opportunity to Correct). Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on . A change in the seriousness of the deficiencies on **October 5, 2019**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **September 17, 2019**, includes the following:

Denial of payment for new admissions effective **November 13, 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.

R. Ryan Beckman, Administrator

August 21, 2019

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We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **February 13, 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 **August 13, 2019**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

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

BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process

2001-10 IDR Request Form

R. Ryan Beckman, Administrator

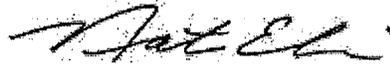
August 21, 2019

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This request must be received by **September 3, 2019**. If your request for informal dispute resolution is received after **September 3, 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

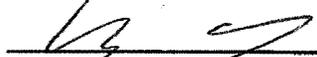
PRINTED: 08/21/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135080	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/13/2019
NAME OF PROVIDER OR SUPPLIER GRANGEVILLE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 410 EAST NORTH SECOND STREET GRANGEVILLE, ID 83530	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments The facility is a single story, type V (111) structure originally constructed in 1967. It is fully sprinklered and equipped with an interconnected fire alarm system, including smoke detection in corridors and open spaces. The building has a partial basement housing the boiler, fire suppression system riser and transfer switch to the emergency generator. The facility is currently licensed for 60 SNF/NF beds and had a census of 42 on the dates of the survey. The following deficiency was cited during the emergency preparedness survey conducted on August 12 - 13, 2019. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73. The Survey was conducted by: Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction	E 000	"This plan of correction is submitted as required under Federal and State regulations and statutes applicable to skilled nursing facilities. This plan of correction does not constitute an admission of liability, and such liability is hereby specifically denied. The submission of this plan does not constitute agreement by the facility that the surveyor's conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied." Please accept this plan of correction as our credible allegation of compliance. RECEIVED SEP 03 2019 FACILITY STANDARDS	
E 039 SS=F	EP Testing Requirements CFR(s): 483.73(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the	E 039		

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

TITLE

(X6) DATE



Admin. Staff

8/29/19

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

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E 039	Continued From page 1 following:] (I) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an	E 039	E 039 Resident Specific: Please see systemic changes. Other Residents: Please see systemic Changes Systemic Changes: Live action drill with [REDACTED] Coalition scheduled for September 12th 2019. Monitors: Grangeville Health and Rehab will Maintain membership in the [REDACTED] Coalition and ensure Live action drills are conducted within 365 days of previous drills and or actual activation of the facility emergency plan. Administrator will report findings at QA and make changes to the above plan of correction as needed. Date of Compliance: September 17th 2019		

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E 039	<p>Continued From page 2</p> <p>emergency plan.</p> <p>(ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, it was determined the facility failed to test the emergency preparedness plan annually. Failure to test the emergency preparedness plan annually, has the potential to hinder staff response during a disaster. This deficient practice affected 42 residents and staff on the dates of the survey.</p> <p>Findings Include:</p> <p>Review of the facility Emergency Preparedness (EP) plan on August 12 - 13, 2019, from approximately 12:00 PM to 4:30 PM, revealed a written EP testing program, and a facility-based tabletop exercise. However, there had not been a full-scale, community-based exercise since May 12, 2018. When the Maintenance Director was questioned on August 12, 2019, at approximately 3:00 PM, he stated the facility was planning to participate in a community-based full-scale exercise next month, September 2019.</p> <p>Reference:</p> <p>42 CFR 483.73 (d) (2)</p>	E 039		