



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 29, 2019

Steve Lish, Administrator  
Discovery Rehabilitation and Living  
600 Shanafelt Street  
Salmon, ID 83467-4261

Provider #: 135129

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

Dear Mr. Lish:

On **August 21, 2019**, a Facility Fire Safety and Construction survey was conducted at **Discovery Rehabilitation And Living** 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

Steve Lish, Administrator  
August 29, 2019  
Page 2 of 4

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 11, 2019**. Failure to submit an acceptable PoC by **September 11, 2019**, may result in the imposition of civil monetary penalties by **October 3, 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 25, 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 19, 2019**. A change in the seriousness of the deficiencies on **October 5, 2019**, may result in a change in the remedy.

Steve Lish, Administrator  
August 29, 2019  
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The remedy, which will be recommended if substantial compliance has not been achieved by **September 25, 2019**, includes the following:

Denial of payment for new admissions effective **November 21, 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 21, 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 21, 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 Lish, 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:

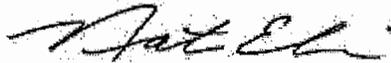
BFS Letters (06/30/11)

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

This request must be received by **September 11, 2019**. If your request for informal dispute resolution is received after **September 11, 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: 08/28/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135129</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/21/2019</b>
NAME OF PROVIDER OR SUPPLIER <b>DISCOVERY REHABILITATION AND LIVING</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>600 SHANAFELT STREET SALMON, ID 83467</b>		
(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><b>INITIAL COMMENTS</b></p> <p>The facility is a type V(III) fully sprinkled, single story structure originally constructed in 1997. It is equipped with an interconnected fire alarm/smoke detection system, which includes both corridors and open areas. The building is two-hour separated to the connected Assisted Living and is equipped with a Type 1, spark-ignited propane Emergency Power Supply System (EPSS) generator. The facility is currently licensed for 45 SNF/NF beds with a census of 28 on the date of the survey.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on August 21, 2019. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70</p> <p>The survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	K 000	<p><b>A. Corrective Actions</b> The smoke detectors in question that failed the sensitivity check(s), in accordance with NFPA 72, have been ordered through Western States Fire Protection.</p> <p><b>B. Identification of others affected and corrective actions:</b> The facility's Plant Operations Manager upon further inspection of the facility and the specific aspects cited under NFPA 72 did not identify an others as being affected.</p> <p><b>C. Measures to ensure that the deficient practice does not happen again:</b> The facility will have Western States conduct a sensitivity check on the newly installed smoke detectors as well as the new smoke detectors being subject to the sensitivity check with its' next annual inspection.</p> <p><b>D. Monitor corrective actions:</b> The Executive Director or his designee(s) will immediately begin conducting a modified fire watch, each shift, in the specific areas affected by the. The results will be recorded and reported to the QAA committee which meets monthly. Any identified concerns will be addressed as found for continued compliance until the replacement smoke detectors are installed and the sensitivity testing complete.</p> <p><b>E. Corrective action(s) will be completed by:</b> 09/24/19</p>	
K 345 SS=F	<p><b>Fire Alarm System - Testing and Maintenance</b> CFR(s): NFPA 101</p> <p><b>Fire Alarm System - Testing and Maintenance</b> A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility</p>	K 345		

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SEP 11 2019  
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE 9/10/19

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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NAME OF PROVIDER OR SUPPLIER <b>DISCOVERY REHABILITATION AND LIVING</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>600 SHANAFELT STREET SALMON, ID 83467</b>		
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K 345	<p>Continued From page 1</p> <p>failed to ensure fire alarm systems were maintained in accordance with NFPA 72. Failure to address smoke detection system repairs due to failures identified on sensitivity testing, has the potential to hinder response of installed systems and notification to local emergency response personnel. This deficient practice affected 26 residents and staff on the date of the survey.</p> <p>Findings include:</p> <p>During review of provided fire alarm inspection records conducted on 8/21/19 from 8:15 - 10:00 AM, records indicated that a total of 12 smoke detectors had failed sensitivity testing during the fire alarm inspection conducted on 8/27/18 and no indication the failed detectors had been cleaned, re-calibrated or replaced.</p> <p>Interview of the Maintenance Director on 8/21/19 at approximately 11:00 AM established that these failed smoke detectors had not been replaced as of the date of the survey.</p> <p>Actual NFPA standard:</p> <p>NFPA 72 14.4.5.3.1 Sensitivity shall be checked within 1 year after installation. 14.4.5.3.2 Sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with 14.4.5.3.3. 14.4.5.3.3 After the second required calibration test, if sensitivity tests indicate that the device has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years.</p>	K 345		

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K 345	Continued From page 2	K 345		
K 353 SS=F	<p>14.4.5.3.5 Unless otherwise permitted by 14.4.5.3.6, smoke detectors or smoke alarms found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced.</p> <p>Sprinkler System - Maintenance and Testing CFR(s): NFPA 101</p> <p>Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure that installed fire suppression systems were maintained in accordance with NFPA 25. Failure to maintain dry sprinklers and high temperature sprinklers through UL testing or replacement, has the potential to hinder system response during a fire. This deficient practice affected 26 residents and staff on the date of the survey.</p>	K 353		

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K 353	<p>Continued From page 3 Findings include:</p> <p>1) During review of the provided maintenance and inspection records of the installed fire suppression system conducted on 8/21/19 from 8:15 - 10:00 AM, records did not indicate the last performed testing or replacement of the following fire suppression system sprinklers:</p> <ul style="list-style-type: none"> <li>- The main Kitchen hood suppression system was identified as being part of a high-temp wet system, but no records were available demonstrating this high-temp sprinkler had been tested or replaced.</li> <li>- Dry sprinklers installed in the attic were not identified as having been tested or replaced within the past 10 years.</li> </ul> <p>2) During review the provided maintenance and inspection records of the installed fire suppression system conducted on 8/21/19 from 8:15 - 10:00 AM and interview of the Maintenance Director at that time, established that the dry barrel sprinkler installed in the freezer had been replaced on 7/6/17, but the walk-in cooler had no record of testing or replacement.</p> <p>Actual NFPA standard:</p> <p>5.3.1.1.1.4* Representative samples of solder-type sprinklers with a temperature classification of extra high [325°F (163°C)] or greater that are exposed to semicontinuous to continuous maximum allowable ambient temperature conditions shall be tested at 5-year intervals.</p> <p>5.3.1.1.1.6* Dry sprinklers that have been in service for 10 years shall be replaced or representative samples shall be tested and then</p>	K 353	<p><b>A. Corrective Actions:</b> The findings listed during the survey pertaining to NFPA 25 concerning the inspection, testing and maintenance of the fire suppression system had not been fully undertaken. Western States Fire Inspection Company conducted the dry suppression system inspection on 07/7/2017. From this, the dry sprinkler heads in the attic were good. It is an air pressurized dry system that is active by air release on a wet valve. Additionally, the Dry Sprinkler Heads in the cooler and freezer were changed in 2018. Further, the 360 degree high temperature sprinkler heads located in the range hood will both be changed out during the same time as the smoke detector replacement.</p> <p><b>B. Identification of others affected and corrective actions:</b> The facility's Plant Operations Manager upon further inspection of the facility and the aspects cited under NFPA 25 did not identify any others as being affected.</p> <p><b>C. Measures to ensure that the deficient practice does not happen again:</b> The facility's Plant Operations Manager will provide documentation from Western States Fire Protection and will conduct, on an annual basis, a documented checklist/log as to what required areas are to be included in the Western States Fire Protection's annual inspection.</p>	

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K 353	Continued From page 4 retested at 10-year intervals.	K 353	<p><b>D. Monitor corrective actions:</b> The Executive Director or his designee will conduct an audit review of this checklist/log one month prior to Western States Fire Protection's scheduled annual inspection. The results will be reported to the QAA committee which meets monthly. The QAA Committee will then determine if the system is effective to ensure ongoing compliance.</p> <p><b>E. Corrective action(s) will be completed or substantially completed by: 09/24/19</b></p>	



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

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August 29, 2019

Steve Lish, Administrator  
Discovery Rehabilitation and Living  
600 Shanafelt Street  
Salmon, ID 83467-4261

Provider #: 135129

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

Dear Mr. Lish:

On **August 21, 2019**, an Emergency Preparedness survey was conducted at Discovery Rehabilitation And Living 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

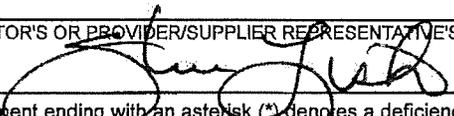
NE/lj  
Enclosure

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135129</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/21/2019</b>
NAME OF PROVIDER OR SUPPLIER <b>DISCOVERY REHABILITATION AND LIVING</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>600 SHANAFELT STREET SALMON, ID 83467</b>		
(X4) ID PREFIX TAG <b>E 000</b>	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG <b>E 000</b>	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p><b>Initial Comments</b></p> <p>The facility is a type V(III) fully sprinkled, single story structure originally constructed in 1997. It is equipped with an interconnected fire alarm/smoke detection system, which includes both corridors and open areas. The building is two-hour separated to the connected Assisted Living facility and is equipped with a Type 1, spark-ignited propane Emergency Power Supply System (EPSS) generator. The facility is located in a rural fire district with both state and federal EMS support services available. The facility is currently licensed for 45 SNF/NF with a census of 26 on the day of the survey.</p> <p>The facility was found in substantial compliance during the Emergency Preparedness survey conducted on August 21, 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>			

**RECEIVED**  
SEP 11 2019  
**FACILITY STANDARDS**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE **Executive Director** (X6) DATE **9/10/19**

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.