



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

September 3, 2020

Jason Jensen, Administrator
Bingham Memorial Skilled Nursing & Rehabilitation
98 Poplar Street
Blackfoot, ID 83221-1758

Provider #: 135007

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

Dear Mr. Jensen:

On **August 27, 2020**, a Facility Fire Safety and Construction survey was conducted at **Bingham Memorial Skilled Nursing & 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.

Jason Jensen, Administrator
September 3, 2020
Page 2 of

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 **September 16, 2020**. Failure to submit an acceptable PoC by **September 16, 2020**, may result in the imposition of civil monetary penalties by **October 8, 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 **October 1, 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 **November 25, 2020**. A change in the seriousness of the deficiencies on **October 11, 2020**, may result in a change in the remedy.

Jason Jensen, Administrator
September 3, 2020
Page 3 of

The remedy, which will be recommended if substantial compliance has not been achieved by **October 1, 2020**, includes the following:

Denial of payment for new admissions effective **November 27, 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 **February 27, 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 **August 27, 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:

Jason Jensen, 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 16, 2020**. If your request for informal dispute resolution is received after **September 16, 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: 09/02/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135007	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE NF B. WING _____		(X3) DATE SURVEY COMPLETED 08/27/2020
NAME OF PROVIDER OR SUPPLIER BINGHAM MEMORIAL SKILLED NURSING & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 98 POPLAR STREET BLACKFOOT, ID 83221		
(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 (III) structure with a partial basement utilized for mechanical/electrical rooms, storage, offices and classrooms. A two-hour fire wall separates the Accredited Hospital and the Accredited Geriatric Psychiatric Hospital from the Skilled Nursing Facility. The facility was originally built in 1963 with a renovation and addition in 1999. The building is fully sprinklered and is protected by a complete fire alarm system with smoke detection in corridors and open spaces. The Essential Electrical System is supplied by a diesel powered, on-site automatic generator. The facility is currently licensed for 53 SNF/NF beds and had a census of 42 on the date of the survey. The following deficiencies were cited during the annual fire/life safety survey conducted on August 27, 2020. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70. The Survey was conducted by: Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction	K 000	This plan of correction is submitted by the facility in accordance with the pertinent terms of provisions of 42CFR Section 488 and/or related State regulations, and is intended to serve as credible allegations of our intent to correct the practices identified as deficient. The Plan of Correction should not be construed or interpreted as an admission that the deficiencies alleged did, in fact, exist; rather, the facility is filing this document in order to comply with its obligations as a provider participating in the Medicare/Medicaid program(s).		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small	K 324	RECEIVED SEP 15 2020 FACILITY STANDARDS K 342 All patients and staff have the potential to be affected.	9/30/20	

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



TITLE

Administrator

(X6) DATE

9/14/20

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 324	<p>Continued From page 1</p> <p>appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2</p> <p>* cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or</p> <p>* cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.</p> <p>Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor.</p> <p>18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the kitchen hood system, specifically, grease filters, in accordance with NFPA 96. Failure to maintain grease filters could increase the risk of fires due to excessive build-up of grease laden vapors. This deficient practice affected staff in the kitchen on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour on August 27, 2020, from approximately 2:00 PM to 4:00 PM, inspection of the hood system revealed several of the baffle filters were damaged, preventing them from fitting together tightly and leaving gaps of one (1) inch or more in several places on both sides of the</p>	K 324	<p>K 324 con't</p> <p>Root-cause analysis revealed lack of communication or identification of damage causing gaps in the hood system.</p> <p>We believe education/training is the best prevention. Staff in the kitchen and engineering were educated on evaluating and identifying the hood system for proper functioning/ damage, and to then communicate the need for any repairs/ replacements. Replacement of the identified damaged hood parts have been ordered and will be replaced when delivered.</p> <p>We will maintain this through scheduled reviews, by engineering, of equipment for damage or not functioning properly during rounds.</p> <p>Audit of this during monthly rounds by engineering manager or designee.</p> <p>Areas of concern will be addressed immediately and discussed at QA (Quality Assurance) meeting, quarterly and PRN.</p> <p>Date of completion: 9/30/20</p>	9/30/20
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 324	<p>Continued From page 2</p> <p>hood system. The numerous gaps were allowing grease laden vapors to enter the duct system unfiltered. When asked, the Director of Engineering stated the facility was unaware the grease filters were damaged.</p> <p>Actual NFPA standard:</p> <p>NFPA 96</p> <p>4.1 General.</p> <p>4.1.1 Cooking equipment used in processes producing smoke or grease-laden vapors shall be equipped with an exhaust system that complies with all the equipment and performance requirements of this standard.</p> <p>4.1.2 All such equipment and its performance shall be maintained in accordance with the requirements of this standard during all periods of operation of the cooking equipment.</p> <p>4.1.3 The following equipment shall be kept in working condition:</p> <p>(1) Cooking equipment (2) Hoods (3) Ducts (if applicable) (4) Fans (5) Fire-extinguishing equipment (6) Special effluent or energy control equipment</p> <p>4.1.3.1 Maintenance and repairs shall be performed on all components at intervals necessary to maintain good working condition.</p> <p>6.2.3 Grease Filters.</p> <p>6.2.3.2 Grease filters shall be of rigid construction that will not distort or crush under normal operation, handling, and cleaning conditions.</p> <p>6.2.3.3 Grease filters shall be arranged so that all exhaust air passes through the grease filters.</p>	K 324		9/30/20
K 353	Sprinkler System - Maintenance and Testing	K 353		

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K 353 SS=D	<p>Continued From page 3 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 observation and interview, the facility failed to ensure fire suppression system pendants were maintained free of obstructions such as loading or corrosion. Failure to maintain fire sprinkler pendants free of obstructions could insulate thermal elements and delay operation, affect water distribution patterns, or otherwise render the sprinkler inoperable or ineffectual during a fire event. This deficient practice affected staff in the kitchen on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour on August 27, 2020, from approximately 2:00 PM to 4:00 PM, observation</p>	K 353	<p>K 353</p> <p>All patients and staff have the potential to be affected.</p> <p>Root-cause analysis revealed lack of communication or identification of damaged or corroded/dirty sprinkler heads.</p> <p>We believe education/training is the best prevention. Staff in the kitchen and engineering were educated on evaluating and identifying the sprinkler system for proper function and to then communicate the need for any repairs/replacements/cleaning. Replacement/repair of the identified sprinkler heads have been scheduled for repair/replacement.</p> <p>We will maintain this through scheduled reviews, by engineering, of equipment for damage or not working properly during weekly rounds.</p> <p>Audit of this will be done during monthly rounds by engineering manager or designee.</p> <p>Areas of concern will be addressed immediately and discussed at QA (Quality Assurance meeting, quarterly and PRN.</p> <p>Date of Completion: 9/30/20</p>	9/30/20

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K 353	<p>Continued From page 4</p> <p>of the sprinkler heads in the kitchen near the range revealed one sprinkler head was corroded and three (3) were loaded with grease, and dust. When asked, the Director of Engineering stated the facility was unaware the sprinkler heads were loaded and corroded.</p> <p>Actual NFPA standard:</p> <p>NFPA 25</p> <p>5.2.1 Sprinklers.</p> <p>5.2.1.1* Sprinklers shall be inspected from the floor level annually.</p> <p>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., up-right, pendent, or sidewall).</p> <p>5.2.1.1.2 Any sprinkler that shows signs of any of the following shall be replaced:</p> <p>(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</p> <p>5.2.1.1.4 Any sprinkler shall be replaced that has signs of leakage; is painted, other than by the sprinkler manufacturer, corroded, damaged, or loaded; or is in the improper orientation.</p>	K 353		9/30/20



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September 3, 2020

Jason Jensen, Administrator
Bingham Memorial Skilled Nursing & Rehabilitation
98 Poplar Street
Blackfoot, ID 83221-1758

Provider #: 135007

RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER

Dear Mr. Jensen:

On **August 27, 2020**, an Emergency Preparedness survey was conducted at **Bingham Memorial Skilled Nursing & 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" (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.

Jason Jensen, Administrator
September 3, 2020
Page 2 of 4

Your Plan of Correction (PoC) for the deficiencies must be submitted by **September 16, 2020**. Failure to submit an acceptable PoC by **September 16, 2020**, may result in the imposition of civil monetary penalties by **October 8, 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 **October 1, 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 **October 18, 2020**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **October 1, 2020**, includes the following:

Denial of payment for new admissions effective **November 27, 2020**.
42 CFR §488.417(a)

Jason Jensen, Administrator
September 3, 2020
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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 27, 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 **August 27, 2020**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

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

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BFS Letters (06/30/11)

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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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E 000	Initial Comments The facility is a single-story, type V (III) structure with a partial basement utilized for mechanical/electrical rooms, storage, offices and classrooms. A two-hour fire wall separates the Accredited Hospital and the Accredited Geriatric Psychiatric Hospital from the Skilled Nursing Facility. The facility was originally built in 1963 with a renovation and addition in 1999. The building is fully sprinklered and is protected by a complete fire alarm system with smoke detection in corridors and open spaces. The Essential Electrical System is supplied by a diesel powered, on-site automatic generator. The facility is currently licensed for 53 SNF/NF beds and had a census of 42 on the date of the survey. The following deficiencies were cited during the emergency preparedness survey conducted on August 27, 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 and Construction	E 000	This plan of correction is submitted by the facility in accordance with the pertinent terms of provisions of 42CFR Section 488 and/or related State regulations, and is intended to serve as credible allegations of our intent to correct the practices identified as deficient. The Plan of Correction should not be construed or interpreted as an admission that the deficiencies alleged did, in fact, exist; rather, the facility is filing this document in order to comply with its obligations as a provider participating in the Medicare/Medicaid program(s). RECEIVED SEP 15 2020 FACILITY STANDARDS	
E 004 SS=F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.	E 004	E 004 All patients and staff have the potential to be affected.	9/30/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 9/14/20
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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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NAME OF PROVIDER OR SUPPLIER BINGHAM MEMORIAL SKILLED NURSING & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 90 POPLAR STREET BLACKFOOT, ID 83221
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E 004	<p>Continued From page 1</p> <p>The emergency preparedness program must include, but not be limited to, the following elements:</p> <p>(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following:</p> <p>* [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.</p> <p>* [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed and updated at least annually.</p> <p>* [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to demonstrate the Emergency Plan (EP) had been reviewed and updated annually. Failure to update the EP annually has the potential to provide information not relevant to the facility procedures and hinder staff emergency response and training during a disaster. This deficient practice affected</p>	E 004	<p>E 004 con't</p> <p>Root cause analysis revealed that the annual review meeting was not schedule due to restrictions on meetings due to Covid-19 and was not rescheduled later or via electronic methods.</p> <p>We believe education/training is the best prevention. Staff involved in the annual review will be educated on the need for annual reviews/updates to the Emergency Plan. A member of the review committee will be assigned to schedule the next annual review.</p> <p>We will maintain this through scheduled calendar review a week after the annual review meeting is held to make sure it is on all committee member calendars.</p> <p>Audit of this the week after annual meeting to review Emergency Plan by administrator or designee.</p> <p>Areas of concern will be addressed immediately and discussed at QA (Quality Assurance) meeting, quarterly and PRN.</p>	9/30/20
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E 004	Continued From page 2 42 residents and staff on the date of the survey. Findings include: During review of the provided Emergency Preparedness Plan conducted on August 27, 2020, from approximately 11:00 AM to 1:45 PM, documentation showed the last annual review had been conducted on March 25, 2019.	E 004	Date of completion: 9/30/20	9/30/20
E 006 SS=F	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. *[For LTC facilities at §483.73(a)(1):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment.	E 006	E 006 All patients and staff have the potential to be affected. Root-cause analysis revealed lack of continuity in the risk assessment to include the identified hazards in the Hazard Vulnerability Assessment (HVA). Some items need to be separated out and others may need to be combined. Each of the 3 identified facilities need separate HVA's. We believe education/training is the best prevention. Members of the Emergency Planning Committee were educated and trained on comprehensive facility-based and	9/30/20

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E 006	Continued From page 3 *[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, 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 conduct a comprehensive facility-based and community-based risk assessment to include strategies for addressing emergency events identified by the risk assessment. Failure to conduct a facility and community-based risk assessment with strategies for response hinders the facility's ability to respond to localized disasters and emergencies. This deficient	E 006	community-based risk assessments and for properly addressing emergency events identified through the HVA all have strategies for response for each facility that may be affected. We will maintain this through annual review of the HVA, facility-based and community based risk assessments to make sure all identified hazards are in the Emergency Program (EP) and the HVA. Similar issues with similar processes will be condensed, others may be separated out or added. Audit of this the week will be conducted the week after annual meeting to review Emergency Plan by administrator or designee. Areas of concern will be addressed immediately and discussed at QA (Quality Assurance) meeting, quarterly and PRN. Date of completion: 9/30/20	9/30/20	

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E 006	Continued From page 4 practice affected 42 residents and staff on the date of the survey. Findings include: On August 27, 2020, from approximately 11:00 AM to 1:45 PM, review of the provided emergency preparedness plan, including the facility Hazard Vulnerability Assessment (HVA) revealed some hazards identified on the HVA did not have strategies for response. Additionally, the facility failed to include "Emerging Infectious Diseases" to the HVA. When asked, the Administrator and Director of Engineering stated the facility was not aware of the discrepancies.	E 006			
E 042 SS=F	Reference: 42 CFR 483.73 (a) (1) - (2) Integrated EP Program CFR(s): 483.73(f) (e) [or (f)]integrated healthcare systems. If a [facility] is part of a healthcare system consisting of multiple separately certified healthcare facilities that elects to have a unified and integrated emergency preparedness program, the [facility] may choose to participate in the healthcare system's coordinated emergency preparedness program. If elected, the unified and integrated emergency preparedness program must- [do all of the following:] (1) Demonstrate that each separately certified facility within the system actively participated in the development of the unified and integrated emergency preparedness program.	E 042	E 042 All patients and staff have the potential to be affected. Root-cause analysis revealed lack of continuity in the risk assessment to include the identified hazards in the Hazard Vulnerability Assessment (HVA). Some items need to be separated out and others may need to be combined. Each of the 3 identified facilities need separate HVA's.	9/30/20	

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E 042	<p>Continued From page 5</p> <p>(2) Be developed and maintained in a manner that takes into account each separately certified facility's unique circumstances, patient populations, and services offered.</p> <p>(3) Demonstrate that each separately certified facility is capable of actively using the unified and integrated emergency preparedness program and is in compliance [with the program].</p> <p>(4) Include a unified and integrated emergency plan that meets the requirements of paragraphs (a)(2), (3), and (4) of this section. The unified and integrated emergency plan must also be based on and include the following:</p> <p>(i) A documented community-based risk assessment, utilizing an all-hazards approach.</p> <p>(ii) A documented individual facility-based risk assessment for each separately certified facility within the health system, utilizing an all-hazards approach.</p> <p>(5) Include integrated policies and procedures that meet the requirements set forth in paragraph (b) of this section, a coordinated communication plan, and training and testing programs that meet the requirements of paragraphs (c) and (d) of this section, respectively.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to demonstrate compliance with the requirements to participate in a unified and integrated health systems' emergency preparedness program. Failure to meet all the requirements for participation, has the potential to impede communication, incumber coordination of</p>	E 042	<p>We believe education/training is the best prevention. Members of the Emergency Planning Committee were educated and trained on comprehensive facility-based and community-based risk assessments and for properly addressing emergency events identified through the HVA all have strategies for response for each facility that may be affected.</p> <p>We will maintain this through annual review of the HVA, facility-based and community based risk assessments to make sure all identified hazards are in the Emergency Program (EP) and the HVA. Similar issues with similar processes will be condensed, others may be separated out or added.</p> <p>Audit of this the week will be conducted the week after annual meeting to review Emergency Plan by administrator or designee.</p> <p>Areas of concern will be addressed immediately and discussed at QA (Quality Assurance) meeting, quarterly and PRN.</p> <p>Date of completion: 9/30/20</p>	9/30/20	

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E 042	<p>Continued From page 6</p> <p>training and hinder staff response during a disaster. This deficient practice affected 42 residents and staff on the date of the survey.</p> <p>Findings include:</p> <p>On August 27, 2020, from approximately 11:00 AM to 1:45 PM, review of the provided emergency preparedness plan, policies and procedures revealed the facility was one (1) of three (3) facilities on campus, each separately certified as a Medicare-participating provider in a unified and integrated healthcare system. The facilities were identified as:</p> <ol style="list-style-type: none"> 1.) Bingham Memorial Hospital 2.) Bingham Memorial Skilled Nursing and Rehabilitation Center 3.) Bingham Memorial New Leaf Geriatric Psychiatric Unit <p>These facilities had developed a unified and integrated emergency preparedness program that included all the facilities within the healthcare system. However, documentation could not be provided to demonstrate each separately certified facility actively participated in the development and subsequent review and updates of the program. Nor did it address unique circumstances, patient populations and services offered at each facility. Additionally, a facility-based risk assessment had not been developed for each separate entity, taking into consideration facility specific hazards unique to each facility as required.</p> <p>The unified and integrated emergency preparedness program did not include a coordinated communication plan or training and</p>	E 042		9/30/20	

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E 042	Continued From page 7 testing program designed to meet all the specific requirements for each facility type. Interview of the Administrator and the Director of Engineering revealed the facility was actively participating in a unified and integrated emergency preparedness program but did not have the documentation required to support their efforts. Reference: 42 CFR 441.184(e)	E 042		9/30/20