



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

November 5, 2019

Shon Shuldberg, Administrator
Ashton Memorial Living Center
PO Box 838
Ashton, ID 83420-0838

Provider #: 135097

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

Dear Mr. Shuldberg:

On **October 23, 2019**, a Facility Fire Safety and Construction survey was conducted at **Ashton Memorial Living 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 **November 18, 2019**. Failure to submit an acceptable PoC by **November 18, 2019**, may result in the imposition of civil monetary penalties by **December 10, 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 **November 27, 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 **January 21, 2020**. A change in the seriousness of the deficiencies on **December 7, 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 **November 27, 2019**, includes the following:

Denial of payment for new admissions effective **January 23, 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 **April 23, 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 **October 23, 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:

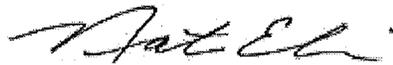
BFS Letters (06/30/11)

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

This request must be received by **November 18, 2019**. If your request for informal dispute resolution is received after **November 18, 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: 11/05/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135097	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/23/2019
NAME OF PROVIDER OR SUPPLIER ASHTON MEMORIAL LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 700 NORTH SECOND STREET ASHTON, ID 83420	
(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)	(X6) COMPLETION DATE
K 000	INITIAL COMMENTS The facility is a single story, Type V (111) construction. The building was completed in 2002 and is fully sprinklered with quick response heads. There is smoke detection coverage throughout, including sleeping rooms corridors and open spaces to corridors. The facility incorporates a propane fueled, spark ignited Emergency Power Supply System (EPSS) generator. Currently the facility is licensed for 38 SNF/NF beds, with a census of 29 on the date of the survey. The following deficiencies were cited during the annual fire/life safety survey conducted on October 23, 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	Preparation and/or execution of the plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the deficiencies.	11/27/2019
K 363 SS=F	Corridor - Doors CFR(s): NFPA 101 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	K 363	<p>RECEIVED NOV 18 2019 FACILITY STANDARDS</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE Administrator DATE 11/13/19

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 363	<p>Continued From page 1</p> <p>materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxillary 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.</p> <p>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485</p> <p>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>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 6 residents and staff on the date of the survey.</p> <p>Findings include:</p>	K 363		

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K 363	Continued From page 2 During the facility tour on October 23, 2019, from approximately 2:45 PM to 4:00 PM, observation and operational testing of the resident room doors revealed resident rooms #3, #7, #9, #11, #55 and #57 had an approximately 5/8" gap, or more, between the face of the door and the frame of the door when fully closed. When asked, the Maintenance Supervisor stated the facility thought they could use smoke seal to close the gap. Actual NFPA Standard: 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 minutes	K 363	K363 Specific Residents - Rm #3, #7, #9, #11, #55, #57 were elvaluated by Architectural Building Supply & Ashton Living Center Maintenance it was determined 4 of the wood doors have a warp in them and will need replaced. Those 4 doors have been ordered from the manufacture it could take up to 8 weeks for them to come in but they will be replaced at that time with door that meets all NFPA 101 19.3.6.3 and the gap will be corrected. The other 2 doors will be adjusted to to not allow smoke and dangerous gases to pass freely. Other Residents - All other residents have the ability to be affected. Each door in the building was evaluated for compliance with NFPA19.3.6.3. Found to be in compliance. Systemic changes - Each door will be individually evaluated by Enviromental supervisor and Maintenance and any repairs needed will be completed in a timely fashion. Monitor - Enviromental Supervisor will reprot quarterly to QAPI committtee evaluation of doors and any concerns and repairs needed will be reported to and followed up on by that committee.	12-27-19 K
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2	K 511		

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K 511	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure safe electrical installations in accordance with their listed assemblies and those requirements under NFPA 70. Use of extension cords and relocatable power taps (RPTs) outside of those defined in the referenced standard, UL 1363, has the potential to expose residents to risks of electrocution and arc fires. This deficient practice affected 1 resident and staff on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on October 23, 2019, from approximately 2:45 PM to 4:00 PM, observation of installed electrical systems revealed the following:</p> <ol style="list-style-type: none"> 1.) The Med. Room behind the nurse's station had three (3) refrigerators plugged in to a Relocatable Power Tap (RPT). 2.) Room number 22 was using an extension cord. 3.) Physical Therapy room was using an extension cord. <p>Actual NFPA standards: NFPA 70 110.2 Approval. The conductors and equipment required or permitted by this Code shall be acceptable only if approved. Informational Note: See 90.7, Examination of Equipment for Safety, and 110.3, Examination, Identification, Installation, and Use of Equipment. See definitions of Approved, Identified, Labeled, and Listed.</p>	K 511	<p>K511</p> <p>Specific Residents: Med Room RPT Removed and all refrigerators were plugged into wall outlets. Room #22 Resident and Family were collaborated and consulted with and alternative solutions were made and the extension cord was removed and safety concerns were explained to family about extension cords. Physical Therapy room extension cord was removed. Equipment plugged directly into wall outlet.</p> <p>Other Residents:</p> <p>All Residents have the ability to be affected.</p> <p>Systemic Changes : Ashton Living Center policies were reviewed and retaught to staff. Explaining that extension cords are not allowed in the building due to fire hazard.</p> <p>Monitor:</p> <p>Enviromental Supervisor and House Keeping and Maintenance will check for extension cords and remove any that get brought in. QAPI committee will ask quarterly if any extension cords have been found and will identify issues from that reporting.</p>	11-27-19 <i>W</i>

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K 511	Continued From page 4 110.3 Examination, Identification, Installation, and Use of Equipment. (A) Examination. In judging equipment, considerations such as the following shall be evaluated: (1) Suitability for installation and use in conformity with the provisions of this Code Informational Note: Suitability of equipment use may be identified by a description marked on or provided with a product to identify the suitability of the product for a specific purpose, environment, or application. Special conditions of use or other limitations and other pertinent information may be marked on the equipment, included in the product instructions, or included in the appropriate listing and labeling information. Suitability of equipment may be evidenced by listing or labeling. (2) Mechanical strength and durability, including, for parts designed to enclose and protect other equipment, the adequacy of the protection thus provided (3) Wire-bending and connection space (4) Electrical insulation (5) Heating effects under normal conditions of use and also under abnormal conditions likely to arise in service (6) Arcing effects (7) Classification by type, size, voltage, current capacity, and specific use (8) Other factors that contribute to the practical safeguarding of persons using or likely to come in contact with the equipment. (B) Installation and Use. Listed or labeled equipment shall be installed and used in accordance with any instructions included in the listing or labeling.	K 511		

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K 511	Continued From page 5 400.8 Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces Exception to (4): Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of 368.56(B) (5) Where concealed by walls, floors, or ceilings or located above suspended or dropped ceilings (6) Where installed in raceways, except as otherwise permitted in this Code (7) Where subject to physical damage	K 511		
K 741 SS=D	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited.	K 741		

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K 741	<p>Continued From page 6</p> <p>(4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision.</p> <p>(5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.</p> <p>(6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.</p> <p>18.7.4, 19.7.4</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that smoking was conducted in areas equipped with proper receptacles. Conducting smoking in areas not equipped with proper disposal receptacles could expose residents and staff to increased risk of fire associated with the practice of smoking. This deficient practice potentially affects those residents that smoke and staff on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour on October 23, 2019, from approximately 2:45 PM to 4:00 PM, observation of the designated smoking area revealed a metal container with self-closing lid was not provided. When asked, at approximately 3:00 PM, the Maintenance Supervisor stated the facility was unaware a metal container with self-closing lid was required.</p> <p>Actual NFPA standard:</p> <p>NFPA 101 19.7.4* Smoking. Smoking regulations shall be</p>	K 741	<p>K741</p> <p>No specific residents identified there were no residents that smoked in our care at the time of survey.</p> <p>All Residents could be affected</p> <p>Systemic Changes - Plastic Snorkels were replaced with metal containers with self-closing cover devices into which ashtrays can be readily available to all areas where smoking is permitted.</p> <p>Monitor - Enviromental Supervisor will check monthly metal containers to make sure they are in good working order and report to QAPI committee quarterly.</p>	11/27/19 K

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K 741	Continued From page 7 adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or individual enclosed space where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited, and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 19.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.	K 741		
K 928 SS=F	Gas Equipment - Labeling Equipment and Cylind CFR(s): NFPA 101 Gas Equipment - Labeling Equipment and Cylinders Equipment listed for use in oxygen-enriched atmospheres are so labeled. Oxygen metering equipment and pressure reducing regulators are labeled "OXYGEN-USE NO OIL." Flowmeters, pressure reducing regulators, and oxygen-dispensing apparatus are clearly and permanently labeled designating the gases for which they are intended. Oxygen-metering	K 928		

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K 928	<p>Continued From page 8</p> <p>equipment, pressure reducing regulators, humidifiers, and nebulizers are labeled with name of manufacturer or supplier. Cylinders and containers are labeled in accordance with CGA C-7. Color coding is not utilized as the primary method of determining cylinder or container contents. All labeling is durable and withstands cleaning or disinfecting.</p> <p>11.5.3.1 (NFPA 99)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, the facility failed to provide conspicuously displayed precautionary signs readable from a distance of 1.5 m (5 ft) wherever supplemental oxygen is in use. Failure to alert supplemental oxygen is in use, could lead to ignition of an oxygen rich environment affecting 13 residents and staff on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour on October 23, 2019, from approximately 2:45 PM to 4:00 PM, observation of corridors and resident room doors revealed residents using supplemental oxygen did not have the required signage on or near their room door. This determination was based on a list of residents currently using supplemental oxygen supplied by the Director of Nursing.</p> <p>Actual NFPA standard: NFPA 99 11.5.3.2* Signs. 11.5.3.2.1 In health care facilities where smoking is not prohibited, precautionary signs readable from a distance of 1.5 m (5 ft) shall be conspicuously displayed wherever supplemental oxygen is in use and in aisles and walkways</p>	K 928	<p>K928</p> <p>Specific Residents - All 13 residents rooms with 13 residents using oxygen have a precautionary signs readable from a distance of 1,5m (5FT). 11/27/19 JC</p> <p>All Other Residents have the potential to be affected. All residents new to building or new on oxygen there rooms will be provided a precautionary sign indicating oxygen is in use.</p> <p>Systemic changes - All residents will have a precautionary sign on entry of their room to indicate oxygen is in use.</p> <p>Monitor - Environmental Supervisor will identify residents on oxygen and make sure the appropriate signs are in place. In the QAPI committee a list of patients will be made of current Residents on oxygen to verify Oxygen signs are in place quarterly.</p>

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

PRINTED: 11/05/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135097	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED 10/23/2019
NAME OF PROVIDER OR SUPPLIER ASHTON MEMORIAL LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 700 NORTH SECOND STREET ASHTON, ID 83420		
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K 928	Continued From page 9 leading to such an area. 11.5.3.2.2 The signs shall be attached to adjacent doorways or to building walls or be supported by other appropriate means.	K 928			



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

November 5, 2019

Shon Shuldberg, Administrator
Ashton Memorial Living Center
PO Box 838
Ashton, ID 83420-0838

Provider #: 135097

RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER

Dear Mr. Shuldberg:

On **October 23, 2019**, an Emergency Preparedness survey was conducted at Ashton Memorial Living Center by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. Your facility was found to be in substantial compliance with Federal regulations during this survey.

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

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

Sincerely,

Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosure

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

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E 000	<p>Initial Comments</p> <p>The facility is a single story, Type V (111) construction. The building was completed in 2002 and is fully sprinklered with quick response heads. There is smoke detection coverage throughout, including sleeping rooms corridors and open spaces to corridors. The facility incorporates a propane fueled, spark ignited Emergency Power Supply System (EPSS) generator. Currently the facility is licensed for 38 SNF/NF beds, with a census of 29 on the date of the survey.</p> <p>The facility was found to be in substantial compliance during the annual Emergency Preparedness Survey conducted on October 23, 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>Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction</p>	E 000			

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

TITLE

(X6) DATE

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