



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – 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

October 29, 2015

Trent Alder, Administrator
Franklin County Transitional Care
44 North First East
Preston, ID 83263-1326

Provider #: 135059

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

Dear Mr. Alder:

On **October 21, 2015**, a Facility Fire Safety and Construction survey was conducted at **Franklin County Transitional Care** 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 11, 2015**. Failure to submit an acceptable PoC by **November 11, 2015**, may result in the imposition of civil monetary penalties by **December 1, 2015**.

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 and the state licensure survey report, State Form.

All references to federal regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **November 25, 2015**, (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, 2015**. A change in the seriousness of the deficiencies on **November 25, 2015**, 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 25, 2015**, includes the following:

Denial of payment for new admissions effective **January 21, 2016**.
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 21, 2016**, 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 Mark P. Grimes, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, 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 21, 2015**, 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 11, 2015**. If your request for informal dispute resolution is received after **November 11, 2015**, 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.

Sincerely,

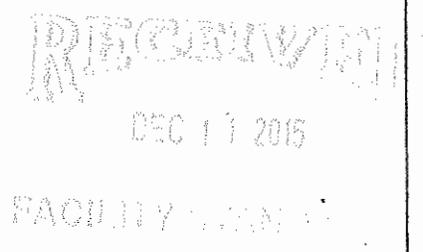


Mark P. Grimes, Supervisor
Facility Fire Safety and Construction

MPG/lj
Enclosures

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

PRINTED: 12/09/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135059	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE NF BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/21/2015
NAME OF PROVIDER OR SUPPLIER FRANKLIN COUNTY TRANSITIONAL CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 44 NORTH FIRST EAST PRESTON, ID 83263	
(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 II (111) building with a complete sprinkler system that was installed in July 2012. The plans for the building were approved in 1970 and construction completed in 1971. There have been subsequent remodels. Currently the facility is licensed for 35 SNF/NF beds. The following deficiencies were cited during the annual fire/life safety survey conducted on October 21, 2015. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70. The Survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	K 000		
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1	K 029		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *W. T. Allen* TITLE *NHA* (X6) DATE *12/10/15* 11/11/2015

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 029	Continued From page 2 Actual NFPA standard: NFPA 101 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft ² (9.3 m ²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft ² (4.6 m ²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029	the safety committee deems that it doesn't need to be reported any longer. 5-The corrective action was completed by 12/10/2015. Please see attached photo of the corrective action.	

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K 062	Continued From page 4 3) Soiled Linen storage abutting room A-11 had approximately ten (10) inches clearance from the storage of foam pads to the deflector. Actual NFPA standard: NFPA 13 5-5.6* Clearance to Storage The clearance between the deflector and the top of storage shall be 18 in. (457 mm) or greater. Exception No. 1: Where other standards specify greater minimums, they shall be followed. Exception No. 2: A minimum clearance of 36 in. (0.91 m) shall be permitted for special sprinklers. Exception No. 3: A minimum clearance of less than 18 in. (457 mm) between the top of storage and ceiling sprinkler deflectors shall be permitted where proven by successful large-scale fire tests for the particular hazard. Exception No. 4:* The clearance from the top of storage to sprinkler deflectors shall be not less than 3 ft (0.9 m) where rubber tires are stored.	K 062	committee, quarterly, for the next year or until the safety committee deems that it doesn't need to be reported any longer. 5-The corrective action was completed by 12/10/2015. Please see attached photo of the corrective action.		
K 064 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that portable fire extinguishers were installed in accordance with NFPA 10.	K 064	<u>K064-Portable Fire Extinguishers:</u> 1-The corrective action for Tag K064 was to remove all existing fire extinguishers and replace them with a 5 lb. extinguisher that will be placed in the existing storage wall container on the extinguishers side, to ensure that NFPA 10 standards are met and maintained.		

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K 064	Continued From page 6 than 5 ft (1.53 m) above the floor. Fire extinguishers having a gross weight greater than 40 lb (18.14 kg) (except wheeled types) shall be so installed that the top of the fire extinguisher is not more than 31/2 ft (1.07 m) above the floor. In no case shall the clearance between the bottom of the fire extinguisher and the floor be less than 4 in. (10.2 cm).	K 064		
K 070 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8 This STANDARD is not met as evidenced by: Based on record review, operational testing and interview, the facility failed to ensure that portable space heating appliances were used in accordance with the allowable standard. Historical evidence has shown portable space heating devices pose a significant risk to fires in Nursing Homes. This deficient practice affected residents, staff and visitors utilizing the north entrance and the abutting nurse's station on the date of the survey. The facility is licensed for 35 SNF/NF beds and had a census of 26 on the day of the survey. Findings include: 1) During review of the facility maintenance records conducted on October 21, 2015 from 8:45 AM to 10:00 AM, no documentation was	K 070	<u>K 070- Portable Space Heating Devices:</u> 1-The corrective action for Tag K 070 was to hard wire the heating device to a wall box and securely attach the heating device to the existing wall. 2-The Maintenance staff have performed a sweep of the entire facility to identify any other portable heating devices that do not meet the NFPA 70 standards. 3-As part of their monthly fire inspection, the maintenance staff will inspect the entire facility for portable heating devices that do not meet the NFPA 70 standards. 4-Each month the Maintenance Supervisor will monitor the inspection process to make sure it is performed. The Maintenance Supervisor will report his findings to the safety	

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K 147	<p>Continued From page 8</p> <p>affected 15 residents, staff and visitors on the date of the survey. The facility is licensed for 35 SNF/NF beds and had a census of 26 on the day of the survey. .</p> <p>Findings include:</p> <p>1) During the facility tour conducted on October 21, 2015 from 10:00 AM to 4:00 PM, observation of the sprinkler riser room in the "B" wing revealed an open electrical junction box, approximately 4 inches square with exposed wiring located behind the suppression system.</p> <p>2) During the facility tour conducted on October 21, 2015 from 10:00 AM to 4:00 PM, observation of the nurse's station revealed a microwave using a relocatable power tap as an extension cord.</p> <p>Actual NFPA standard:</p> <p>NFPA 70 400.8 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: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of 368.8. (5) Where concealed by walls, floors, or ceilings or located above suspended or dropped ceilings</p>	K 147	<p><u>K147-Uncovered Electrical Boxes and Relocatable Power Tap:</u></p> <p>1-The corrective action for Tag K147 was to cover the exposed and/or unsealed electrical box in the sprinkler riser room. Also, the microwave was unplugged from the relocatable power tap and plugged into a wall outlet with a sign adjacent to the outlet stating that this outlet was only to have the fridge and/or microwave plugged directly into it.</p> <p>2-The maintenance staff will identify all areas having the potential for the deficient practice by inspecting the</p>	

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K 147	Continued From page 10 which conductors enter shall be adequately closed.....	K 147			