



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER -- Governor
RICHARD M. ARMSTRONG -- Director

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

December 16, 2014

Kelly Spiers, Administrator
Teton Post Acute Care & Rehabilitation
3111 Channing Way
Idaho Falls, ID 83404-7534

Provider #: 135138

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

Dear Mr. Spiers:

On **December 9, 2014**, a Facility Fire Safety and Construction survey was conducted at **Teton Post Acute Care & 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 and a similar State Form 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 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

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page 2). After each deficiency has been answered and dated, the administrator should sign both Statement of Deficiencies and Plan of Correction, Form CMS-2567 and State Form, in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **December 29, 2014**. Failure to submit an acceptable PoC by **December 29, 2014**, may result in the imposition of civil monetary penalties by **January 18, 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 **February 10, 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 **February 10, 2015**. A change in the seriousness of the deficiencies on **February 10, 2015**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **February 10, 2015**, includes the following:

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Denial of payment for new admissions effective **March 9, 2015**.
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 **June 9, 2015**, 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 **December 9, 2014**, 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>

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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 **December 29, 2014**. If your request for informal dispute resolution is received after **December 29, 2014**, 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

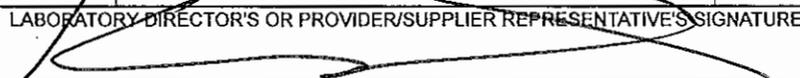
MPG/lj
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135138	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - TETON POST ACUTE CARE & REHABILITATION B. WING _____	(X3) DATE SURVEY COMPLETED 12/09/2014
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NAME OF PROVIDER OR SUPPLIER TETON POST ACUTE CARE & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 3111 CHANNING WAY IDAHO FALLS, ID 83404
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	<p>INITIAL COMMENTS</p> <p>The Facility is a single story Type V (III) building with pitched roof and composite shingles. The building is approximately 43,000 square feet, and is composed of a service wing, a center core, and four resident wings. The building was originally built in 1988, but was unoccupied and re-licensed in May of 2013 for 88 skilled nursing beds. The facility is fully sprinklered with a dry system covering the attic and a wet system with quick response heads covering the resident care areas. The building has a manual fire alarm system with corridor smoke detection interconnected with the sprinkler flow switches, the system is off site monitored. The building is served by a natural gas powered generator, automatic transfer switches and two branch circuits. There are multiple exits to grade equipped with delayed egress devices.</p> <p>The following deficiencies were cited during the annual life safety code survey conducted on December 9, 2014 in accordance with 42 CFR 483.70, Chapter 18 of the 2000 Edition of NFPA 101, the Life Safety Code.</p> <p>The Surveyor conducting the survey was: Nathan Elkins Health Facility Surveyor</p>	K 000	<p style="text-align: center;">RECEIVED 26 DEC 24 2014</p> <p style="text-align: center;">FACILITY STANDARDS</p> <p>K029</p> <ul style="list-style-type: none"> How corrective action accomplished for the identified residents? On 12/9/2014 the door leading into the dry storage room was repaired so it would properly latch. How you will identify other residents with the potential of being affected by the same practice? Other hazardous areas have had the doors observed to validate they are self-closing and latch correctly on or before 12/16/14. 	
K 029 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1</p> <p>This Standard is not met as evidenced by:</p>	K 029	<ul style="list-style-type: none"> Address what measures will be put in place to ensure deficient practice will not recur. Maintenance staff and kitchen staff will be re-educated by the Administrator on ensuring hazardous areas are protected by a securely latching self-closing fire door. 	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 12-24-14
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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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135138	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - TETON POST ACUTE CARE & REHABILITATION B. WING _____	(X3) DATE SURVEY COMPLETED 12/09/2014
NAME OF PROVIDER OR SUPPLIER TETON POST ACUTE CARE & REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 3111 CHANNING WAY IDAHO FALLS, ID 83404		
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K 029	Continued From page 1 Based on observation it was determined that the facility did not ensure that there is no impediment to the closing of the doors protecting hazardous areas. Failure to provide effective self closing doors can allow smoke and fire gases to spread beyond the hazardous areas in the event of a fire. This condition affects approximately 10 staff members. Findings Include: During the facility tour on December 9, 2014 at approximately 11:30 am observation and operational testing revealed that the door leading to the dry storage room inside the kitchen area was impeded by the door frame and would not close and latch properly. The room is over 100 sq feet with combustible materials stored inside. Actual NFPA reference: 7.2.1.8.1* A door normally required to be kept closed shall not be secured in the open position at any time and shall be self-closing or automatic-closing in accordance with 7.2.1.8.2. 18.3.2.1* Hazardous Areas. Any hazardous area shall be protected in accordance with Section 8.4. The areas described in Table 18.3.2.1 shall be protected as indicated.	K 029	<ul style="list-style-type: none"> <i>How will the plan be monitored to ensure the solutions are sustained?</i> The Administrator or designee will audit hazardous areas to validate the door is securely latching. These audits will be completed: 2 days a week X4 weeks, and 1 day a week for 1 month. Findings will be brought to CQI monthly for further review and educational opportunities. <i>The ED is responsible for compliance</i> <i>Compliance date is 12/16/14</i> 	
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This Standard is not met as evidenced by:	K 147	<ul style="list-style-type: none"> <i>How corrective action accomplished for the identified residents?</i> On 12/9/2014 the electrical room adjacent to the dining room area had the boxes moved from in front of the electrical panel. 	

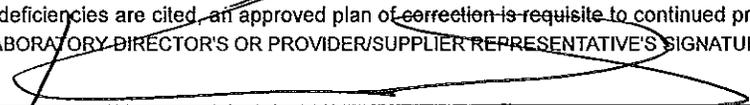
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K 147	Continued From page 3 fittings shall be suitable for the conditions of use and location. 110-3. Examination, Identification, Installation, and Use of Equipment (a) Examination. In judging equipment, considerations such as the following shall be evaluated: 1. Suitability for installation and use in conformity with the provisions of this Code FPN: 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. 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. See UL listings: XBYS Guide information XBZN2 Guide information	K 147	<ul style="list-style-type: none"> <i>How will the plan be monitored to ensure the solutions are sustained?</i> The Administrator or designee will audit electrical rooms to validate that boxes are not left in front of the electrical panels. These audits will be completed: 2 days a week X4 weeks, and 1 day a week for 1 month. The Administrator or designee will audit administration offices to validate that electrical cords are not being used. These audits will be completed: 2 days a week X4 weeks, and 1 day a week for 1 month. Findings will be brought to CQI monthly for further review and educational opportunities. <i>The ED is responsible for compliance</i> <p><i>Compliance date is 12/16/14</i></p>	

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K 147	<p>Continued From page 2</p> <p>Based on observation, the facility failed to provide a safe electrical installation and use. The deficient practice affected all residents, staff, and visitors present on the day of the survey. The facility is licensed for 88 beds with a census of 35 on day of survey.</p> <p>Findings include:</p> <p>#1. During the facility tour on December 9, 2014 at approximately 11:00 AM, it was observed that the electrical panel located in the electrical room adjacent to the dining room area had boxes within 36 inches of the electrical panel. Interview with the maintenance supervisor revealed the facility was unaware of the blocked electrical panel.</p> <p>#2. During the facility tour on December 9, 2014 at approximately 11:40 AM, it was observed that the use of extension cord was powering a relocatable power tap located in the Activities Director's office. Interview with maintenance supervisor and the Administrator revealed the facility was unaware of the usage.</p> <p>Actual NFPA Reference:</p> <p>NFPA 70 110.26-(A) Spaces About Electrical Equipment. Sufficient access and working space shall be provided and maintained about all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons.</p> <p>NFPA 70 National Electrical Code 1999 Edition 400-3. Suitability Flexible cords and cables and their associated</p>	K 147	<p>On 12/9/2014 the extension cord was removed from the Activities Directors office.</p> <ul style="list-style-type: none"> <i>How you will identify other residents with the potential of being affected by the same practice?</i> All of the electrical rooms have been inspected to validate that boxes are not in the near the electrical panels on or before 12/16/2014. All of the administrative offices have been inspected to validate that extension cords have been removed. <i>Address what measures will be put in place to ensure deficient practice will not recur.</i> The Central Supply Coordinator and Maintenance Director will be re-educated by the Administrator to validate that boxes are not left front of electrical panels in the electrical room. Administrative staff have been re-educated by the Administrator to validate extension cords are not in use in offices. 	

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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2.</p> <p>The Facility is a single story Type V (III) building with pitched roof and composite shingles. The building is approximately 43,000 square feet, and is composed of a service wing, a center core, and four resident wings. The building was originally built in 1988, but was unoccupied and re-licensed in May of 2013 for 88 skilled nursing beds. The facility is fully sprinklered with a dry system covering the attic and a wet system with quick response heads covering the resident care areas. The building has a manual fire alarm system with corridor smoke detection interconnected with the sprinkler flow switches, the system is off site monitored. The building is served by a natural gas powered generator, automatic transfer switches and two branch circuits. There are multiple exits to grade equipped with delayed egress devices.</p> <p>The following deficiencies were cited during the annual life safety code survey conducted on December 9, 2014 in accordance with 42 CFR 483.70, Chapter 18 of the 2000 Edition of NFPA 101, the Life Safety Code and IDAPA 16.03.02 Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities.</p> <p>The Surveyor conducting the survey was: Nathan Elkins Health Facility Surveyor</p>	C 000	<p style="text-align: center;">RECEIVED DEC 26 2014 FACILITY STANDARDS</p> <p>C226</p> <p>Refer to the plan of correction for K029 on the 2567.</p> <p>Refer to the plan of correction for K147 on the 2567.</p>	
C 226	<p>02.106 FIRE AND LIFE SAFETY</p> <p>106. FIRE AND LIFE SAFETY. Buildings on the premises used as facilities shall meet all the requirements of local, state and national codes concerning fire and</p>	C 226		

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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



TITLE

Administrator

(X6) DATE

1224-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135138	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - TETON POST ACUTE CARE & REHABILITATION B. WING _____	(X3) DATE SURVEY COMPLETED 12/09/2014
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C 226	Continued From Page 1 life safety standards that are applicable to health care facilities. This RULE: is not met as evidenced by: Refer to the following Federal "K" tags on the CMS-2567 K-29 Hazardous Areas K-147 Electrical	C 226		

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.