



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

FILE COPY

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
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PHONE 208-334-6626
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March 19, 2015

Trevor Cardon, Administrator
Madison Carriage Cove Short Stay Rehabilitation
410 West 1st North
Rexburg, ID 83440-1406

Dear Mr. Cardon:

On **February 26, 2015**, an initial state licensure survey was conducted at Madison Carriage Cove Short Stay Rehabilitation by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with State Licensure.

Enclosed is a Statement of Deficiencies and Plan of Correction, State Form, listing licensure health and fire life safety 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 state tag in column X5 (Completion Date)**, to signify when you allege that each tag will be back in compliance.

After each deficiency has been answered and dated, the administrator should sign both State Forms, Statement of Deficiencies and Plan of Correction in the space provided, and return the originals to this office.

Your Plan of Correction (POC) for the deficiencies must be submitted by **April 1, 2015**.

- 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

Trevor Cardon, Administrator
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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,
- Provide dates when corrected action will be completed.

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 5.

Sincerely,



DEBRA RANSOM, R.N., R.H.I.T.
Bureau Chief

DR/dmj
Enclosures

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

PRINTED: 05/07/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001445	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/26/2015
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NAME OF PROVIDER OR SUPPLIER MADISON CARRIAGE COVE SHORT STAY REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST 1ST NORTH REXBURG, ID 83440
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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
F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the initial Federal Certification survey of your facility.</p> <p>The surveyors conducting the survey were: Debby Ransom, RN, RHIT Nina Sanderson, LSW David Scott, RN</p> <p>The team entered the facility on Wednesday February 25, 2015 and exited the facility on Thursday February 26, 2015</p>	F 000		
F 156 SS=C	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and</p>	F 156		4/23/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
		04/06/2015

efficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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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F 156	<p>Continued From page 1</p> <p>inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the</p>	F 156			

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F 156	<p>Continued From page 2 facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, policy review, and staff interview, it was determined the facility's admission agreement failed to fully inform residents of their rights at the time of admission. The facility also failed to ensure postings for resident advocacy groups were accessible to residents. The deficient practice had the potential to affect any resident admitted to the facility, or any resident wishing to contact an advocacy group. Findings included: 1. On 2/25/15, review of the facility's admission agreement revealed: Residents were not informed the facility was required to immediately notify the resident, the resident's physician, and potentially the resident's legal representative if the resident experienced an accident involving injury, a significant change in their health status, had to be transferred or discharged from the facility, or had a change in their roommate situation.</p>	F 156		

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F 156	<p>Continued From page 3</p> <p>Residents were not informed they could not be billed for dietary services, the activities program, routine maintenance, or medically related social services as part of a Medicare covered stay. Residents were not informed whether personal comfort items, such as cosmetic and grooming services, personal comfort items, or personal clothing, may result in additional charges. The admission agreement specified all resident complaints had to be filed in writing, with no allowance for a verbal complaint to be made. The agreement did not inform the residents they had a right to prompt resolution to any grievance once it had been expressed to the facility, The agreement stated the resident had a right to perform services for the facility, if the work was part of the resident's care plan and the resident was compensated. The agreement did not, however, inform the resident they had the right to refuse to perform services for the facility. The agreement informed residents they had a right to share a room with their spouse. However, the facility consisted entirely of private rooms. On 2/25/15 at 2:30 PM, the Administrator was informed of the concerns with the facility's admission agreement. The Administrator stated many of those items were either oversights, or the result of a word inadvertently omitted from the final draft of the document. The Administrator indicated each of the identified items would be fixed for residents admitted in the future. The facility provided no further information.</p> <p>2. On 2/25/15 at 8:15 AM, the surveyor was unable to locate postings for resident advocacy groups within the facility. At 8:30 AM, unable to find those postings, the surveyor asked for staff assistance. LN #1 led the surveyor to the breezeway between the skilled nursing facility and the assisted living portion of the facility to show</p>	F 156		

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F 156	Continued From page 4 where the postings were located. The posting for the state survey agency was at eye level for the 5 foot 10 inch surveyor, with the posting for the ombudsman placed above. The posting contained a paragraph in regular sized print, encouraging residents to make the facility aware of any concerns, and notifying the residents either the state agency or ombudsman's office could also be contacted. The telephone number for each posting was in large bold print, but it was difficult to determine the number provided corresponded with one of the advocacy agencies. Following the phone number, the posting contained a paragraph in regular-size print directing the reader to inquire about massage or music therapy services. In order to access this area of the facility, a resident would need to leave their living area, travel down the hallway past the therapy gym, around a corner past the reception desk, continue down another hallway, open one of the fire doors to exit the resident living space, and enter the breezeway. On 2/26/15 at 11:00 AM, the Administrator and DNS were informed of these findings. The Administrator stated the postings could be moved to the resident living area. The facility offered no further information.	F 156		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and	F 325		4/23/15

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F 325	<p>Continued From page 5</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interview, and observation, it was determined the facility failed to identify a rapid weight loss of 12.8 pounds in 16 days for 1 of 2 sampled residents (#2). The facility 's system failed to identify the severe weight loss and implement interventions to prevent the potential for harm. The findings include:</p> <p>Resident #2 was admitted to the facility on 2/8/15, for rehabilitation following a left total knee replacement. The resident had additional diagnoses of hypothyroidism and pleural effusion.</p> <p>On 2/25/15 at 8:30 am, Resident #2 stated the food was " very good " and more than she could eat. She requested small portions and now she desired " extra small " portions. She further indicated that she had no appetite. She acknowledged that she was losing weight because she wanted to.</p> <p>On 2/25/15 at 9:05 am, the resident was observed eating breakfast in her room. She ate approximately half of a plate-sized pancake with syrup and butter, a slice of bacon, and an orange slice, and drank the hot chocolate.</p> <p>Observation on 2/26/15: 8:25 am - the resident ' s breakfast was delivered.</p>	F 325		

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F 325	<p>Continued From page 6</p> <ul style="list-style-type: none"> 8:32 am - the resident was cheerful and indicated that the breakfast (scrambled eggs, 2 slices of bacon, 1 slice of toast, an orange cut into 6 wedges, and hot chocolate) was "good" and the bacon is was "wonderful." 8:50 am - Physical Therapy is was in the room palpating the resident 's knee, which caused some pain, and the resident is was complaining of stomach upset. The resident asked for the tray to be removed after eating one-quarter of her toast, half her eggs, and a bite of bacon. The resident kept her orange and did accept an offer of oatmeal, which arrived at 9:05 am <p>The resident 's Weight and Vital Summary record for 2/8/15-2/25/15 had a documented "severe" weight loss of 8% in 16 days. The summary documented the following: 2/8/15 at 3:17 pm: 167.6 (all weights in pounds)* 2/9/15 at 3:47 pm: 159.6 2/10/15 at 11:10 am, 11:47 am, & 3:16 pm: 160 2/11/15 at 10:42 am: 156.8 2/13/15 at 11:59 am: 160.8* 2/13/15 at 3:50 pm: 160.4* 2/16/15 at 3:54 pm: 106.4* 2/14/15 at noon: 150.2 2/20/14 at 3:18 pm: 149.4 2/23/15 at 11:52 am: 146 2/25/15 at 1:32: 147.4</p> <p>NOTE: Weights with * were crossed through with a note that read, "incorrect documentation." Interview with the DON on the afternoon of 2/25/15 reveled that when weights were "way off" staff crossed through the entry and noted "incorrect" and re-weighed the resident the next day.</p>	F 325		

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F 325	<p>Continued From page 7</p> <p>The Guest Care Conference notes from 2/9/15 indicated that the focus of Dietary was maintaining health and health with nutrition. The resident asked for half portions, however the plan was for Dietary to provide a full portion of meat, and half portion of carbs and vegetables. Resident preferences were noted as chocolate chip cookies and peanut clusters. The Dietary Manager, when asked on 2/26/15 what type of diet the resident was to receive, provided the admission order of " Regular. "</p> <p>The nutrition report for 2/8/15-2/24/15 (17 days) documented 49 meals with the following percentage of the meal eaten: 6 meals at 0-25% 9 meals at 26-50% 14 meals at 51-75% 20 meals at 76-100%</p> <p>An e-mail from the RD to the DON, dated 2/12/15 at 7:35 pm, documented the RD asked for information to complete the assessment. The RD noted that the resident ' s weight was decreasing and she asked about possible reasons such as:</p> <ul style="list-style-type: none"> · Decrease in surgical fluids? · Decrease in edema? · Increase in mobility? <p>The RD went on to ask whether the resident ' s appetite was improving. The RD asked whether the taste of the food was acceptable, as one of the residents ordered medications, Coumadin, could alter the taste of food. Additionally, the RD asked whether half portion had increased the resident ' s intake and whether the admission weight of 167.6 pounds was correct, or whether it should have been crossed out in the record.</p>	F 325		

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F 325	<p>Continued From page 8</p> <p>The complete nutrition assessment, completed on 2/13/15 by the RD, indicated:</p> <ul style="list-style-type: none"> · The resident ' s current body weight was 152.8, her usual body weight was 145. · The resident had a significant weight loss. · The resident requested half portions but staff would continue to provide full portions. · There was 2+ non-pitting edema in the left lower leg. · The resident ' s average meal intake for breakfast, lunch and dinner was 51-75%. · The resident refused snakes a majority of the time, but had her own in the room. · The resident often refused Ensure supplement. · Estimated calorie intake needed was 1750, with 70 grams of protein. · The percentage of intake to meet estimated nutritional needs was 88%. · The resident was seen sending uneaten food home with a friend, question food insecurity. · The residents ' weight was trending back to her usual body weight. The weight loss may have been related to a decrease in surgical and pleural fluids, resolution of edema, increased activity, and the use of levothyroxine (thyroid hormone replacement). · No labs available. <p>The Medication Administration record for February 2015 documented the resident ' s response to staff offering Ensure. However, the record did not document the amount the resident consumed. The DON confirmed that the record did not contain the amount consumed during interview on the afternoon of 2/25/15.</p> <p>An unsigned and undated nutritional note</p>	F 325		

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F 325	<p>Continued From page 9</p> <p>documented that the weight loss appeared to be tapering off. The resident has had a decrease in appetite in the last previous few days, which may be have been related to new medications (Percocet for pain, Ambien for sleep and Coumadin, an anticoagulant), the resident ' s increase in activity related to therapy, use of levothyroxine, and/or edema 1+ non-pitting in left lower leg. Staff was directed to continue monitoring for significant changes to skin, oral intake, labs and weight.</p> <p>The plan of care implemented on 2/11/15 for nutrition was related to Vitamin D deficiency, decreased intake, desire to lose weight, and pleural effusion. The goals were to achieve adequate nutritional intake of greater than 75% per meal, and stabilize weights related to pleural effusion. The interventions, dated 2/15/15, were to encourage intake of 75%, but to respect her desire for weight loss; provide half portions with full protein; offer Ensure or alternate meal for intake less than 50%; and report to the RD and MD any significant weight loss. A related intervention was to reduce the risk of gastrointestinal distress to provide small frequent meals rather than three large ones. The following interventions were not implemented as planned: Half portions with full protein, notification of the MD of significant weight loss, and the provision of small frequent meals rather than three large meals.</p> <p>The resident had a chest x-ray completed 2/9/15 for a persistent cough. The X-ray documented a small left pleural effusion. A note from the Physician Assistant noted that the facility should watch for weight gain and signs of peripheral edema, and to schedule a follow up for weight</p>	F 325		

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F 325	<p>Continued From page 10 gain.</p> <p>The 5 day MDS completed on 2/15/15 noted that the resident had a poor appetite one time at the most over the assessment period and snacks were not very important to the resident. This same MDS noted that the resident had not experienced a weight loss of 5% or more in the previous month. The Weight and Vital Summary record, however, documented the resident lost 6.6% (159.6 -149.0 = 10.6 pounds) in the 7-day assessment period.</p> <p>Interview with the RD and DON on the morning of 2/26/15 revealed:</p> <ol style="list-style-type: none"> 1) The electronic medical record system only allowed documentation of the percentage of intake in increments of 25-points. Greater accuracy of food consumed would allow for more informed decision about intake and weight loss. The DON stated she would modify this field to smaller increments. 2) The facility did not monitor intake and output of post-surgical rehab residents to help determine if the weight loss was due to fluid loss. 3) The MD was not notified of the resident ' s significant weight loss. 4) The facility did not talk with the resident about the amount of weight she was losing and the potential outcome to her healing and recovery. 5) The RD did not consider implementation of a calorie count for this resident and stated they would not do a calorie count unless ordered by the MD. 6) There is was a planned menu for each meal, however residents could order from the varied (restaurant type) menu in their room. The RD stated the system did not allow staff to determine the number of calories that a resident consumed 	F 325		

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F 325	Continued From page 11 in a day when given the ability to choose a variety of food.	F 325		
F 329 SS=D	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 329		4/23/15

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F 329	<p>Continued From page 12</p> <p>Based on record review and staff interview, it was determined the facility failed to ensure 1 of 2 (#2) sampled residents were free from unnecessary medications. The facility failed to implement non-pharmacological interventions before giving a medication for difficulty going to sleep. This created the potential for harm for residents to receive unnecessary medications. The findings include:</p> <p>Resident #2 was admitted to the facility on 2/8/15 for rehabilitation following a left total knee replacement. The resident had additional diagnoses of hypothyroidism and pleural effusion.</p> <p>A note to the resident 's attending physician, dated 2/17/15, asked for an as-needed order for Unisom as the resident used the sleep aid at home. In an undated response from the attending physician 's office, a provider ordered Unisom as needed at night, not to be used with hydroxyzine or lorazepam. In another note to the resident 's attending physician, dated 2/18/15, the facility noted that Resident #2 was seen by the orthopedic surgeon on 2/18/15 and returned to the facility with orders for Ambin 5 mg as needed at night. The physician also ordered and a change in her pain medication. The note asked the attending physician if there were changes he/she would like to make to the current orders for sleep. The note stated the resident had occasional difficulty falling asleep, but once asleep the resident remained asleep until she needed to toilet. The resident did not have a problem returning to sleep after toileting. A provider note, dated 2/19/15, stated the orthopedic doctor orders supersede the orders for Unisom and Norco.</p>	F 329		

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F 329	Continued From page 13 The medication administration record for 2/18/-2/24/15 indicated Unisom was not given, however, the Ambien 5mg was given each night between 8:22 pm and 11:30 pm. The 5 day MDS, completed on 2/15/15, noted the resident had trouble falling or staying asleep at least 2-6 of the days during the assessment period. Use of an antidepressant medication, given at night as the medication helped her sleep, was initiated on 2/11/15. Another focus area, initiated on 2/18/15, was for difficulty falling asleep and risk for insomnia. The care plan interventions were to evaluate factors potentially causing insomnia ...and to attempt to modify and control the external factors before initiating hypnotic (Ambien) therapy and to precede or accompany hypnotic use by other intervention to try to improve sleep. Interview with the DON on 2/25/15 and 2/26/15 revealed some documentation in the daily skilled notes of poor sleep, and the MDS completed on 2/15/15 identified concerns with sleep. The plan of care and interventions were not implemented until the Ambien and Unisom were ordered.	F 329		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441		4/23/15

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F 441	<p>Continued From page 14</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it -</p> <ol style="list-style-type: none"> (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. <p>(b) Preventing Spread of Infection</p> <ol style="list-style-type: none"> (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, policy and procedure review, and staff interview, it was determined the facility failed to implement systems to recognize, analyze, and track infection trends in the facility. The deficient practice had the potential to cause harm to all residents if appropriate measures</p>	F 441		

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F 441	<p>Continued From page 15</p> <p>were not taken to protect residents from the spread of infection.</p> <p>The State Operations Manual, under the guidance at F 441, documented, "infection preventionist (IP) " (a.k.a. infection control professional) refers to a person whose primary training is in either nursing, medical technology, microbiology, or epidemiology and who has acquired additional training in infection control ...an effective infection prevention and control program incorporates ...an infection preventionist ..."</p> <p>The facility's Infection Control policy and procedure documented the facility developed policies and procedures consistent with the requirements under F 441, including policies for surveillance, investigation, prevention, control, and reporting of infections, and the requirement for an Infection Preventionist, or Infection Control nurse.</p> <p>On 2/5/15 at 4:00 PM, the facility's DON, who was also the Infection Control (IC) nurse, stated her primary experience with infection control was from experience working in the hospital as a floor nurse, rather than from an administrative perspective, and she had not received any additional training. The IC nurse stated she was only aware of how to manage an individual resident with infection, and was not familiar with oversight of the Infection Control program as a whole. Specifically, the IC nurse stated:</p> <p>*The facility's information gathering process for resident infections included only the antibiotic ordered, and the start and end date. It did not include information on the specific organism being treated, or resident room number.</p> <p>*The facility did not have a process for analyzing data to identify trends and prevent the spread of</p>	F 441		

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F 441	Continued From page 16 infection, such as mapping of infections or other tracking tools . *The facility's IC nurse could not state when isolation precautions would be implemented (i.e. onset of symptoms, culture results, etc.). *The facility would identify an antibiotic as appropriate and effective only after three days of treatment, based on symptom relief. The facility's process did not involve the use of laboratory results as a factor in determining the appropriateness of starting or continuing an antibiotic. *The facility did not have a centralized system to document completion of staff training on infection control, monitoring of staff competency at infection control practices, or changes in infection control policies and procedures.	F 441		
F 514 SS=C	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it	F 514		4/23/15

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F 514	Continued From page 17 was determined that the facility failed to ensure that all documents were signed and dated at the time of entry. This affected 2 of 2 sampled residents (#1 & 2). The findings include: Interview with the administrator on the morning of 2/25/15 identified that resident records were maintained in an electronic health information system, Point Click Care. Review of the assessments records such as the device assessments and nutritional assessments for Residents #1 and 2 did not contain dates the document was created nor the identity/electronic signature of the author.	F 514			

The following Plan of Correction is submitted by the facility in accordance with the pertinent terms and provisions of 42 CFR Section 488 and/or related state regulations, and is intended to serve as a credible allegation 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).

F156

What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice?

Specific residents were not identified as being affected by the deficient practice.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?

All current and future residents have the potential to be affected by the deficient practice.

The Admission Agreement has been reviewed and revised to reflect the expectations outlined in F156, which includes the right to file a grievance verbally or in writing and to receive a prompt response. Current residents were informed of the Grievance Policy in person (by LSW or designee and there is a notice posted in the facility with grievance forms available). We added an addendum page for resident to sign acknowledging the single occupancy room policy.

Current residents will be asked to review and sign a copy of the revised admission agreement.

The revised admission agreement will be signed by all new admissions.

All postings are now located in common areas accessible for viewing, which is at the Nurses Station and within the SNF Resident Hall. The postings are at a level visible both by residents in a wheelchair or standing and with larger print.

What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?

The policy related to the Admission Agreement was reviewed and revised to reflect review and revision strategy to include a comparison with any new regulatory expectations as well as changes in company policy.

Resident rights have been updated to exclude the right to share a room with a spouse and to include the right to refuse to work for the facility.

The policy related to resident related postings was reviewed and revised to reflect location and font size.

How will the corrective action(s) be monitored to ensure the deficient practice will not recur?

The Quality Improvement Committee will review our admission agreement on an annual basis making revisions, as needed.

The Administrator will ensure the postings are added to our quarterly environmental audits to ensure postings per requirement.

When will the corrective actions be completed?

4/23/15

F325

What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice?

Resident 2 – The resident has discharged. A comprehensive weight loss assessment had been completed; Physician notified and care plan updated per resident preferences.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?

All residents have the potential to be at risk. Comprehensive assessments and care plan updates have been completed. Current residents have been reweighed. Weight changes, diets, preferences have been verified and communicated to team members. Provider notification has been completed, if necessary.

What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?

The Policy and Procedure related to Nutrition has been reviewed and revised. Weights for residents at risk will continue weekly; weekly weights (with comparison from previous weights) will be made available to RD and DON weekly to determine assessments / interventions and referrals needed to the Physician; the Care Area Assessments will be used as a guide in conducting and documenting assessments; a review of interventions will be conducted to ensure all interventions as planned per residents' preferences; we will document amounts of supplements taken on the Medication Administration Record.

Education has been provided for the nursing and dietary staff related to the Weight Procedures-calibrating scale, calculating weight of equipment, obtaining weights and reweights, documenting related edema and lab values; weight verification by nursing; communication between nursing and dietary as well as notification of providers. The importance of ensuring all documents are dated and signed was reviewed with staff as well. Education has been provided to all staff (Therapy, Housekeeping, Laundry, C.N.A.'s, Licensed Nurses, Activities, Social Services, Maintenance, and Administration) to not disrupt residents during meal services.

Education related to passing snacks, nourishments and documentation of percentage consumed as well as education related to documenting percentage consumed for meal service was provided.

Our menus have been revised to offer only full nutritional value meals, which nutritional value was determined by RD using IDAPA guidelines.

Nutrition at Risk committee meets weekly to discuss residents with nutrition concerns. Intake (meals, liquids, supplements), Skin, Weight, Labs, Diet, Medications, Diagnosis, I/O's as needed, Mood State, and Pharmacy review are addressed with recommendations and changes in interventions identified.

How will the corrective action(s) be monitored to ensure the deficient practice will not recur?

Nurses will review weights prior to the C.N.A. entering weights into the Electronic Medical Record. If weight is plus or minus 3 pounds, reweigh immediately. Weekly weights (with comparison from previous weights) will be made available to RD and DON weekly and a RD report of recommendations will be provided to the DON for implementation and/or notify the MD for review. Nutrition at Risk committee will address residents with weight concerns on a weekly basis to ensure interventions are appropriate.

During the initial care conference after admission, we will discuss with the resident if the resident feels they are being interrupted during their meal times.

Concerns identified with the internal facility systems will be referred to the Administrator and Quality Improvement Committee.

We have established a quality assurance and performance improvement (QAPI) measure / goal for weight changes that will be reviewed as part of our QAPI plan quarterly. A full evaluation of all the systems and processes relating to nutrition will occur should we fail to meet our goal. All resident records identified with significant gains/losses will be reviewed to ensure our processes have been followed. The DON and QAPI committee is responsible.

When will the corrective actions be completed?

4/23/15

F329

What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice?

Resident 2 has been discharged. A comprehensive assessment relating to insomnia had been completed. Non-pharmacological interventions had been discussed with the resident and care planned per resident preferences. Physician had been notified.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?

All residents with pharmacological sleep aides will be considered at risk. Current residents with sleep aids have had a comprehensive assessment related to insomnia completed. The Pharmacist has reviewed the records for all current residents and has communicated concerns to the Director of Nursing. Providers have been notified of identified concerns. Non-pharmacological interventions and preferences have been identified and added to resident care plans.

What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?

The policy and procedure for Psychotropic medications and Care Planning has been reviewed and revised to reflect identification of insomnia and a Comprehensive Assessment of Insomnia has been created which indicates the non-pharmacological interventions and preferences for each resident.

Education has been provided for nursing and caregiver staff related to sleep related interventions and the importance of providing non-pharmacological interventions prior to giving a sleep aid. Informed and discussed the Psychotropic SNF regulations with Medical Director.

How will the corrective action(s) be monitored to ensure the deficient practice will not recur?

Implemented new documentation record in PCC for non-pharmacological interventions, outcomes, sleep barriers prior to administration of PRN hypnotic medication.

Our QAPI goal is to prevent use of psychoactive medications absent of attempting all other non-pharmacological alternatives. The use of psychoactive medications is reviewed by the Quality Improvement Committee on a quarterly basis.

When will the corrective actions be completed?

4/23/15

F441

What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice?

Specific residents were not identified as being affected by the deficient practice.

The Infection Control nurse is the Director of Nursing. She has completed training on March 13th 2015 at the Idaho Healthcare Association related to Infection Control. Also, the Director of Nursing and the Administrator received training from the Madison

Memorial Hospital Infection Prevention Specialist on March 18th, 2015. These trainings included: oversight of an infection control program; identification of organisms/trending/tracking; isolation; use of lab results to ensure appropriate treatment is ordered; and staff training.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?

All residents have the potential to be affected by the deficient practice. A review of the Infection Control program has been completed. Procedures will be implemented as outlined in the IC program.

What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?

We have implemented an infection control program that includes the following:

1. Documentation that includes recognition, analysis, tracking and trending all infections
2. Monthly analysis includes cross referencing organisms through lab reports, identifying suites of infection through mapping, and cross referencing employee data as needed.
3. Performing process audits with employees as needed to identify cause(s) when our infection rates in a particular area or suites of infections in a particular area are identified.
4. Determination of isolation criteria as recommended by the CDC.
5. Determination of vaccination status with each employee hire and resident admission.
6. Ensuring infection control is part of employee orientation and ongoing education.
7. Quarterly reports to the QAPI committee and facility Medical Director.
8. Quarterly Infection Control Committee meetings to include all required departments
9. DON or designee is responsible as the Infection Control Nurse.

Education has been provided for the staff related to the infection control program.

How will the corrective action(s) be monitored to ensure the deficient practice will not recur?

Infection Control surveillance is expected as part of the daily routine for nurses and any concerns will be report to the Resident Care team. The Resident Care Team will add new infections/antibiotic orders to a facility map with resident identifiers daily so that the team can identify trends as they begin to emerge. The infection control tracking/trending report will be reviewed daily by the Resident Care Team with interventions being implemented per policy.

A sub-committee for the Infection Control Committee will meet at least monthly to identify concerns, trends and recommend changes on current infection control procedures and policies to the Infection Control Committee. The members involved in the sub-committee infection control meeting may include: ED, DON, Infection Control Nurse, Housekeeping / Laundry Supervisor, Dietary Services Supervisor and Maintenance services representative.

A specialized trained Infection Control Preventionist will consult on a monthly basis for six months (ending October), then quarterly for the next 6 months. Then during the next Infection Control Committee Meeting, the committee will decide the frequency of the consultation but not less than semi-annually and/or on a PRN basis. This Preventionist will review data collected, quality of data and analysis of data.

Quarterly Infection Control committee meetings will be conducted with Quarterly reports of findings being reviewed at the Quality Improvement meetings. The Medical Director, Administrator, Pharmacist, Dietary Services Supervisor, Director of Nursing Services, Housekeeping services representative, and Maintenance services representative will receive copies of the reports and be a part of the Infection Control and QUPI committees.

When will the corrective actions be completed?

4/23/15

F514

What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice?

Residents #1 and #2 were identified as being affected. Resident #2 has been discharged. Resident #1's records have been reviewed to identify documents lacking dates/signatures on the electronic record system. Late entry documentation has been added to reflect the dates/signatures.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?

All current and future residents have the potential to be affected.

All current residents' records have been reviewed to identify documents lacking dates/signatures on the electronic record system. Late entry documentation has been added to reflect the dates/signatures.

What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?

A work order has been placed with PCC (Point Click Care) to identify system concerns and corrective actions. The issue has been resolved. Assessments now show the date, time and person who created the document.

It is our policy to ensure all entries are authenticated and dated per standards. We have educated staff on this policy and standards.

How will the corrective action(s) be monitored to ensure the deficient practice will not recur?

Medical records staff will include this audit as part of medical record review on admission, quarterly and at discharge to ensure authentication and dates of entries.

Data collection from the Medical Record audits will be reported the Quality Improvement Committee on a quarterly basis.

When will the corrective actions be completed?

4/23/15

C268

What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice?

Facility and consultant RD will continue to monitor Dietary Supervisor progress and successful completion in the Idaho CDM coursework as well as successfully passing the final exam and maintain the credit hours required of him by the DMA. The RD will continue to complete all nutritional assessments and reviews until the kitchen manager achieves his CDM Certificate. RD will make weekly on-site visits with each visit lasting enough time to complete his/her reviews. Once Dietary Supervisor as received his CDM certificate, the frequency of the RD on-site visits will be re-evaluated. The RD will also be available by phone seven days a week. The RD will also maintain remote computer access into PCC so she/he can make nutritional reviews, assessments and recommendations. Once Dietary Supervisor has received his certificate as a CDM, the RD will continue training to review the

CDM's charting, accuracy, timeliness, and suggested recommendations. Once the RD and CDM both are comfortable with the quality of work, the RD will audit three charts per month for the first six months. After this time, if warranted the RD will sign off on the CDM's assessments. Facility will provide a copy of Dietary Supervisor certificate once received and will continue having the consultant RD work as Dietary Supervisor preceptor and mentor.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?

Specific residents were not identified however any future Food Service Supervisor would be affected. The training and qualifications of potential FSS applicants will be verified prior to hire and all necessary training will be in place or scheduled to meet State and Federal requirements.

What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?

The job application for FSS has been modified to include certification and training requirements. The Administrator and Human Resource staff has been educated about the specific requirements of this position.

How will the corrective action(s) be monitored to ensure the deficient practice will not recur?

An annual review of employee files is conducted by the Human Resource staff to ensure appropriate licensure and training certificates are current. A report of findings is directed to the Administrator and the Quality Improvement Committee.

When will the corrective actions be completed?

4/23/15

C654

What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice?

Specific residents were not identified as being affected. Maintenance, Housekeeping and Pharmacy were affected. They have been notified of the need to attend the quarterly infection control meetings.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?

Specific Departments identified in the IDAPA rules for infection control could be affected. The IC Nurse notify all specific departments of their role on the IC committee and the expectations for attendance at scheduled meetings.

What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?

The Infection Control nurse is the Director of Nursing. She has completed training on March 13th 2015 at the Idaho Healthcare Association related to Infection Control. Also, the Director of Nursing and the Administrator received training from the Madison Memorial Hospital Infection Prevention Specialist on March 18th, 2015. These trainings included: oversight of an infection control program; identification of organisms/trending/tracking; isolation; use of lab results to ensure appropriate treatment is ordered; and staff training.

The IC Nurse will review the IDAPA rules as well as the Federal rules for skilled nursing facilities and ensure that the facility policies/procedures/committee expectations are outlined accordingly.

How will the corrective action(s) be monitored to ensure the deficient practice will not recur?

Quarterly Infection Control committee meetings will be conducted with Quarterly reports of findings being reviewed at the Quality Improvement meetings. The Medical Director, Administrator, Pharmacist, Dietary Services Supervisor, Director of Nursing Services, Housekeeping services representative, and Maintenance services representative will receive copies of the reports and be a part of the Infection Control and QUPI committees. An attendance record will be kept for the Infection Control Committee quarterly meeting. If a pattern of absence (2 consecutive meetings) is shown the DON will notify the Administrator at which point the Administrator will address the pattern of absence.

When will the corrective actions be completed?

4/23/15

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001445	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/26/2015
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NAME OF PROVIDER OR SUPPLIER MADISON CARRIAGE COVE SHORT STAY REH	STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST 1ST NORTH REXBURG, ID 83440
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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) COMPLETE DATE
C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The initial state licensure survey was conducted on February 26, 2015 by:</p> <p>Debby Ransom, RN, RHIT Nina Sanderson, LSW David Scott, RN</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>	C 000		
C 268	<p>02.107,01 Dietary Service</p> <p>107. DIETARY SERVICE.</p> <p>01. Dietary Supervision. A qualified food service supervisor shall be designated by the administrator to be in charge of the dietary department. This person shall:</p> <p>This Rule is not met as evidenced by: Based on staff interview, it was determined the facility did not ensure the food service supervisor was qualified for the position. This had the potential to affect 2 of 2 (#1 & 2) sampled residents. Findings included:</p> <p>Based on interview with the licensed facility administrator on the morning of 2/25/15, the food service manager would not complete food service training requirement until July of 2015.</p>	C 268		4/23/15
C 654	<p>02.150,01,d Quarterly Infection Surveillance Reports</p>	C 654		4/23/15

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE 04/06/15
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Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER
MADISON CARRIAGE COVE SHORT STAY REF

STREET ADDRESS, CITY, STATE, ZIP CODE
410 WEST 1ST NORTH
REXBURG, ID 83440

(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) COMPLETE DATE
C 654	<p>Continued From page 1</p> <p>d. Specifics for monitoring the course of infections which shall include at a minimum a prepared written quarterly report by the designated surveillance person describing the status of each infection. The report shall include: This Rule is not met as evidenced by: Based on staff interview, review of Infection Control Committee (ICC) meeting minutes and attendance logs, and policy review, it was determined the facility failed to ensure a pharmacist, a representative from housekeeping, and a representative from maintenance attended ICC meetings every quarter. This failure created the potential for a negative effect for all residents including 2 of 2 sample residents (#s 1-2), staff, and visitors to the facility. Findings included:</p> <p>The Infection Control Protocol was reviewed on the afternoon of 2/25/15 with the Director of Nursing who was also the Infection Control Manager. The Infection Control Manager provided the sign in sheet for the quarterly Infection Control Committee Meetings. Upon review of the sign-in sheets, it was determined the following ICC members did not attend/participate in the ICC meetings at least quarterly: *Pharmacy - did not attend/participate for the 1st Quarter; *Pharmacy and Housekeeping did not attend/participate for the 2nd Quarter; and, *Housekeeping and Maintenance - did not attend/participate for the 3rd Quarter.</p> <p>On 2/26/15 at 9:00 AM, the Administrator and IC nurse were asked about the required attendees at the IC meetings. The Administrator and IC nurse stated they were unaware of the state</p>	C 654		

Bureau of Facility Standards

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C 654	Continued From page 2 requirements for attendees at that meeting, and the required group had not yet participated in a meeting together. The Administrator stated now that he was aware of the requirement, the facility would implement a system to ensure all required parties participated together at least quarterly.	C 654		

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

Printed: 03/04/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: mds001445	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/26/2015
NAME OF PROVIDER OR SUPPLIER MADISON CARRIAGE COVE SHORT STAY REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST 1ST NORTH REXBURG, ID 83440		
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K 000	INITIAL COMMENTS Madison Carriage Cove Short Stay Rehabilitation is a single story with mechanical loft Type V (111) constructed, skilled nursing facility, that is approximately 35,874 square feet in size. Plans were approved in May of 2013 and construction completed in July of 2014. The facility was licensed for 20 beds in August 2014 with an initial Medicare Certification survey being conducted on February 25 & 26, 2015. The facility is co-located with a 20 bed Assisted Living facility without occupancy separation. The facility is fully sprinklered, with complete smoke detection and fire alarm system, type 2 Essential Electrical Service, piped medical gas, and is subdivided into three smoke compartments, with ten exits to grade. The following deficiencies were cited during the initial medicare certification survey conducted on February 25 & 26, 2015. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, New Health Care Occupancy in accordance with 42 CFR 483.70.a The surveyor conducting the survey was: Mark P. Grimes, Supervisor Facility Fire Safety & Construction Program	K 000		
K 012 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following: 18.1.6.2, 18.1.6.3, 18.2.5.1 This Standard is not met as evidenced by:	K 012		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Signature & date is on Page 1 of the attachment dmj

A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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 012	<p>Continued From page 1</p> <p>Based upon observation and interview the facility failed to ensure smoke and fire barrier protection between the main floor smoke compartments, mechanical lofts and attic spaces. This deficient practice would allow smoke and heat in one area or space to move into and through smoke and fire compartments on all levels and spaces. This deficient practice affected all residents, staff, visitors and vendors in the assisted living (AL) and skilled nursing facility. The AL census was 15 and the skilled census was two, with a combined license capacity of 40.</p> <p>Findings Include:</p> <p>During the tour of the facility on February 25, 2015 between 1:30 PM and 5:00 PM observation revealed unsealed conduits located in the communications room on the mechanical mezzanine which communicated between floors and smoke compartments throughout the building. A strong and obvious movement of air was felt at each of the exposed conduit openings. These openings would allow smoke and heat to forcefully migrate. When asked about the unsealed penetrations, the Facility Administrator, advised he had been told that the conduits had been sealed.</p> <p>Actual NFPA Standard:</p> <p>18.1.6.2 Health care occupancies shall be limited to the types of building construction shown in Table 18.1.6.2. (See 8.2.1.)</p> <p>18.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1 hour.</p>	K 012		

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K 012	<p>Continued From page 2</p> <p>Exception No. 1: Where an atrium is used, smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with Exception No. 2 to 8.2.5.6(1). Not less than two separate smoke compartments shall be provided on each floor.</p> <p>Exception No. 2*: Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems.</p> <p>8.2.1* Construction.</p> <p>Buildings or structures occupied or used in accordance with the individual occupancy chapters (Chapters 12 through 42) shall meet the minimum construction requirements of those chapters. NFPA 220, Standard on Types of Building Construction, shall be used to determine the requirements for the construction classification. Where the building or facility includes additions or connected structures of different construction types, the rating and classification of the structure shall be based on either of the following:</p> <p>(1) Separate buildings if a 2-hour or greater vertically-aligned fire barrier wall in accordance with NFPA 221, Standard for Fire Walls and Fire Barrier Walls, exists between the portions of the building</p> <p>Exception: The requirement of 8.2.1(1) shall not apply to previously approved separations between buildings.</p> <p>(2) The least fire-resistive type of construction of the connected portions, if no such separation is provided</p> <p>8.2.2 Compartmentation.</p> <p>8.2.2.1</p> <p>Where required by Chapters 12 through 42, every building shall be divided into compartments to limit the spread of fire and restrict the movement of smoke.</p>	K 012		

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K 012	<p>Continued From page 3</p> <p>8.2.2.2*</p> <p>Fire compartments shall be formed with fire barriers that are continuous from outside wall to outside wall, from one fire barrier to another, or a combination thereof, including continuity through all concealed spaces, such as those found above a ceiling, including interstitial spaces. Walls used as fire barriers shall comply with Chapter 3 of NFPA 221, Standard for Fire Walls and Fire Barrier Walls. The NFPA 221 limitation on percentage width of openings shall not apply. Exception: A fire barrier required for an occupied space below an interstitial space shall not be required to extend through the interstitial space, provided that the construction assembly forming the bottom of the interstitial space has a fire resistance rating not less than that of the fire barrier.</p> <p>8.3.6.1</p> <p>Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows:</p> <p>(1) The space between the penetrating item and the smoke barrier shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(2) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier.</p>	K 012		

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K 012	Continued From page 4 b. It shall be protected by an approved device that is designed for the specific purpose. (3) Where designs take transmission of vibration into consideration, any vibration isolation shall meet one of the following conditions: a. -It shall be made on either side of the smoke barrier. b. It shall be made by an approved device that is designed for the specific purpose.	K 012		
K 022 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4 This Standard is not met as evidenced by: Based upon observation and operational testing the facility failed to ensure exit signage was visible at each smoke barrier and convenience door leading to an exit. This deficient practice affected all staff and residents. Failure to provide exit access signage prohibits rapid exiting and movement to areas of refuge. The facility is licensed for 20 beds, and had a census of two on the date of the survey. Findings include: Observation and operational testing of smoke barrier and convenience doors revealed exit signage on one side only of three required smoke barriers and two convenience doors. These doors were identified and mapped during the exit	K 022		

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K 022	Continued From page 5 conference. Actual NFPA standard: 18.2.10.1 Means of egress shall have signs in accordance with Section 7.10. 7.10.1.4* Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. Sign placement shall be such that no point in an exit access corridor is in excess of 100 ft (30 m) from the nearest externally illuminated sign and is not in excess of the marked rating for internally illuminated signs. Exception: Signs in exit access corridors in existing buildings shall not be required to meet the placement distance requirements.	K 022		
K 027 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Swinging doors are arranged so that each door swings in an opposite direction. Doors are self-closing and rabbets, bevells or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.5, 18.3.7.6, 18.3.7.8	K 027		

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K 027	Continued From page 6 This Standard is not met as evidenced by: Based upon observation, operational testing and interview the facility failed to ensure smoke barrier doors resist the passage of smoke. This deficient practice would allow smoke to move across the barrier endangering residents on both sides. This affected all residents, staff, visitors and vendors in the assisted living (AL) and skilled nursing. The AL census was 15 and the skilled census was two, with a combined license capacity of 40. Findings include: During the facility tour on February 25, 2015 observation revealed smoke barrier doors at the AL dining to Skilled Nursing wing had improperly installed astragals not capable of resisting the passage of smoke. The vision panel in one leaf was not properly seated and of questionable integrity Actual NFPA Standard: 18.3.7.7* Vision panels consisting of fire-rated glazing or wire glass panels in approved frames shall be provided in each cross-corridor swinging door and at each cross-corridor horizontal sliding door in a smoke barrier. 18.3.7.8 Rabbets, bevels, or astragals shall be required at the meeting edges, and stops shall be required at	K 027		

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K 027	Continued From page 7 the head and sides of door frames in smoke barriers. Positive latching hardware shall not be required. Center mullions shall be prohibited.	K 027		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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 This Standard is not met as evidenced by: Based upon observation and operational testing the facility failed to ensure hazardous areas doors were maintained self closing. This deficient practice could allow smoke and gases to enter the service exit access corridor affecting staff egress. The facility is licensed for 20 and had a census of two on the day of the survey. Findings include: 1. During the facility tour on February 25, 2015 observation revealed the door between the exit access corridor and the mechanical -boiler room was not equipped with a self-closing or automatic closing device. 2. During the facility tour on February 25, 2015 observation revealed the door between the exit access corridor and the clean side of laundry was not equipped with a self or automatic closing device. These findings were acknowledged by the Administrator during the exit interview.	K 029		

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K 029	Continued From page 8 Actual NFPA standard: 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. 8.4.1.1* Protection from any area having a degree of hazard greater than that normal to the general occupancy of the building or structure shall be provided by one of the following means: (1) Enclose the area with a fire barrier without windows that has a 1-hour fire resistance rating in accordance with Section 8.2. (2) Protect the area with automatic extinguishing systems in accordance with Section 9.7. (3) Apply both 8.4.1.1(1) and (2) where the hazard is severe or where otherwise specified by Chapters 12 through 42. 8.4.1.3 Doors in barriers required to have a fire resistance rating shall have a 3/4-hour fire protection rating and shall be self-closing or automatic-closing in accordance with 7.2.1.8.	K 029		
K 033 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit components (such as stairways) in buildings four stories or more are enclosed with construction having fire resistance rating of at least two hours, are arranged to provide a continuous path of escape, and provide protection against fire and smoke from other parts of the building. In all buildings less than four stories, the enclosure is at least one hour. 8.2.5.4, 18.3.1.1	K 033		

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K 033	<p>Continued From page 9</p> <p>This Standard is not met as evidenced by: Based upon observation and operational testing the facility failed to ensure stair enclosure openings are protected properly and maintained in a closed and latched position. This deficient practice can allow products of combustion to migrate between floors, and also allows a hiding place for wandering behaviors. The facility is licensed for 20 beds and had a census of two on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour on February 25, 2015 the stairwell door on the main level would not latch and secure the door in a closed position. This deficiency was acknowledged by the Administrator during the exit conference.</p> <p>Actual NFPA Standard:</p> <p>18.3.1.2 A door in a stair enclosure shall be self-closing and shall normally be kept in the closed position. Exception: Doors in stair enclosures held open under the conditions specified by 18.2.2.2.6 and 18.2.2.2.7.</p> <p>18.3.6.3.2 Doors shall be provided with positive latching hardware. Roller latches shall be prohibited. Exception: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.</p>	K 033		

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K 038 K 038 SS=F	<p>Continued From page 10</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1</p> <p>This Standard is not met as evidenced by: Based upon observation and operational testing the facility failed to ensure immediate access to exits at all times. Failure to provide an immediate means of egress could allow occupannts to become trapped or jammed and trampled. This deficient practice affected all staff, visitors, vendors and residents. of both the AL and skilled nursing. The SNF is licensed for 20 beds and had a census of two on the day of the survey, the AL is licensed for 20 and had a census of 15.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. During the facility tour on February 25, 2015 between 10:00 AM and 2:00 PM, observation and operational testing of exit doors revealed the exit access door between the service corridor and the Skilled Nursing wing was locked in one direction of travel. The exit access corridor was marked by an overhead exit sign and shown on the diagram as an exit corridor. A key or electronic key card was needed to exit back into the building. 2. Three exit access doors from the kitchen to the private and main dining rooms, were equipped with a thumbblatch deadbolt, in addition to the door latch. 3. A pair of exit doors from the main dining area 	K 038 K 038		

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K 038	<p>Continued From page 11 to the exterior is equipped with a thumbclatch deadbolt (left leaf) and two throw bolts,(upper and lower) on the right hand leaf.</p> <p>4. A pair of doors leading to an enclosed courtyard from physical therapy is equipped with a thumbclatch deadbolt potentially locking people in the courtyard.</p> <p>5. A pair of doors leading to an enclosed courtyard from AL dining is equipped with a thumbclatch deadbolt potentially locking people in the courtyard.</p> <p>6. The double egress doors from the AL dining room to the exterior was difficult to open exceeding the 15 lbf force required to begin operation, also an alarm device hampered the opening of the door.</p> <p>7. Room 221 doorknob is install backwards potentially delaying egress.</p> <p>Actual NFPA Standards:</p> <p>All Findings - 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.</p> <p>Finding #1 - 18.2.5.9 Every corridor shall provide access to not less than two approved exits in accordance with Sections 7.4 and 7.5 without passing through any intervening rooms or spaces other than corridors or lobbies.</p>	K 038		

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K 038	<p>Continued From page 12.</p> <p>Finding #2, 3, 4 & 5 - 18.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1: Door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. (See 18.1.1.1.5 and 18.2.2.2.5.) Exception No. 2*: Delayed-egress locks complying with 7.2.1.6.1 shall be permitted, provided that not more than one such device is located in any egress path. Exception No. 3: Access-controlled egress doors complying with 7.2.1.6.2 shall be permitted. 7.2.1.5.4* A latch or other fastening device on a door shall be provided with a releasing device having an obvious method of operation and that is readily operated under all lighting conditions. The releasing mechanism for any latch shall be located not less than 34 in. (86 cm), and not more than 48 in. (122 cm), above the finished floor. Doors shall be operable with not more than one releasing operation. Exception No. 1*: Egress doors from individual living units and guest rooms of residential occupancies shall be permitted to be provided with devices that require not more than one additional releasing operation, provided that such device is operable from the inside without the use of a key or tool and is mounted at a height not exceeding 48 in. (122 cm) above the finished floor. Existing security devices shall be permitted to have two additional releasing operations. Existing security devices other than automatic</p>	K 038		
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K 038	Continued From page 13 latching devices shall not be located more than 60 in. (152 cm) above the finished floor. Automatic latching devices shall not be located more than 48 in. (122 cm) above the finished floor. Exception No. 2: The minimum mounting height for the releasing mechanism shall not be applicable to existing installations. Finding #6 - 7.2.1.4.5 The forces required to fully open any door manually in a means of egress shall not exceed 15 lbf (67 N) to release the latch, 30 lbf (133 N) to set the door in motion, and 15 lbf (67 N) to open the door to the minimum required width. Opening forces for interior side-hinged or pivoted-swinging doors without closers shall not exceed 5 lbf (22 N). These forces shall be applied at the latch stile. Exception No. 1: The opening force for existing doors in existing buildings shall not exceed 50 lbf (222 N) applied to the latch stile. Exception No. 2: The opening forces for horizontal sliding doors shall be as provided in Chapters 22 and 23. Exception No. 3: The opening forces for power-operated doors shall be as provided in 7.2.1.9. Finding #7 - 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K 038		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine.	K 050		

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K 050	<p>Continued From page 14</p> <p>Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2</p> <p>This Standard is not met as evidenced by: Based upon record review the facility failed to record and evaluate fire drills one per shift per quarter. The facility failed to record the scenario, location and evaluation of drills, since licensure. Failure to evaluate drills leads to little or no improvement and does not allow the capture of successes; failures or issues needing improvement. This deficient practice affected all staff, visitors and residents. of both the AL and skilled nursing. The facility is licensed for 20 beds and had a census of two on the day of the survey, the AL is licensed for 20 and had a census of 15.</p> <p>Findings include:</p> <p>During record review conducted on February 25, 2015, records revealed the facility was licensed effective 8/1/14 but did not conduct any drills during the third quarter, conducted two drills during the fourth quarter and had conducted one drill so far during the first quarter. Fire drill records included date, time and signatures of participants but no description of the required actions and conditions or evaluation of performance.</p> <p>Actual NFPA standard: NFPA 101- 2000</p>	K 050		

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K 050	<p>Continued From page 15</p> <p>18.7.1.2* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building.</p> <p>18.7.1.3 Employees of health care occupancies shall be instructed in life safety procedures and devices.</p> <p>18.7.2 Procedure in Case of Fire.</p> <p>18.7.2.1* For health care occupancies, the proper protection of patients shall require the prompt and effective response of health care personnel. The basic response required of staff shall include the removal of all occupants directly involved with the fire emergency, transmission of an appropriate fire alarm signal to warn other building occupants and summon staff, confinement of the effects of the fire by closing doors to isolate the fire area, and the relocation of patients as detailed in the health care occupancy's fire safety plan.</p> <p>18.7.2.2 A written health care occupancy fire safety plan shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area</p>	K 050			

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K 050	Continued From page 16 (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire 18.7.2.3 All health care occupancy personnel shall be instructed in the use of and response to fire alarms. In addition, they shall be instructed in the use of the code phrase to ensure transmission of an alarm under the following conditions: (1) When the individual who discovers a fire must immediately go to the aid of an endangered person (2) During a malfunction of the building fire alarm system Personnel hearing the code announced shall first activate the building fire alarm using the nearest manual fire alarm box and then shall execute immediately their duties as outlined in the fire safety plan.	K 050		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This Standard is not met as evidenced by: Based upon observation the facility failed to ensure the automatic sprinkler system was maintained in proper operating condition, failure to maintain sprinkler systems can result in the system not operating at optimum design. This deficient practice affected two residents and staff, the facility is licensed for 20 beds and had a census of two on the date of the survey.	K 062		

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K 062	<p>Continued From page 17</p> <p>Findings include:</p> <p>During the facility tour on February 25, 2015 observation revealed a sprinkler escutcheon cover missing in the bathroom of room #219.</p> <p>Actual NFPA standard:</p> <p>NFPA 25 - 1998 1-4.4</p> <p>The owner or occupant promptly shall correct or repair deficiencies, damaged parts, or impairments found while performing the inspection, test, and maintenance requirements of this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor.</p> <p>Exception: Where an occupant, management firm, or managing individual has received the authority for inspection, testing, and maintenance in accordance with the Exception to 1-4.2, the occupant, management firm, or managing individual shall comply with 1-4.4.</p>	K 062		
K 066 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is 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 is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe</p>	K 066		

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K 066	Continued From page 18 design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 18.7.4 This Standard is not met as evidenced by: Based upon observation and record review the facility failed to ensure smoking policies are adopted and proper signage provided to safeguard residents. Failure to establish a policy and provide signage could result is visitors/vendors smoking in unauthorized areas creating a fire hazard. The facility is licensed for 20 beds and had a census of two on the date of the survey. Findings include: During record review no comprehensive smoking policy could be produced, a staff no smoking policy and a no smoking statement in the admissions agreement was all that could be produced. Observation on February 25, 2015 revealed the only No smoking sign on the premises was located on the Medical Gas Manifold room door located in the service corridor. No signage prohibiting smoking was present at any entrance to the facility.	K 066		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144		

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K 144	Continued From page 19 This Standard is not met as evidenced by: Based upon observation and record review the facility failed to ensure the emergency generator was being tested under load on a monthly basis and that the generator was installed properly, failure to ensure loaded testing could result in the generator not performing properly in an emergency. The facility is licensed for 20 beds and had a census of two on the date of the survey. Findings include: 1. Record review on February 25, 2015 of the generator testing documents revealed the facility was not recording any amperage/voltage draw, nor exhaust stack temperature, demonstrating testing under load. 2. Observation revealed a generator emergency off switch located in the electrical switch room, but no indication/signage at the generator of the switch location and only minimal labeling on the switch for its purpose. Actual NFPA Standards: NFPA 110 -1999 6-4.1* Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly. Exception: If the generator set is used for	K 144		

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K 144	<p>Continued From page 20</p> <p>standby power or for peak load shaving, such use shall be recorded and shall be permitted to be substituted for scheduled operations and testing of the generator set, provided the appropriate data are recorded.</p> <p>6-4.2*</p> <p>Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>(a) Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating</p> <p>(b) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations.</p> <p>Finding #2</p> <p>3-5.5.2</p> <p>An automatic control and safety panel shall be a part of the EPS and shall contain the following equipment or possess the following characteristics, or both:</p> <p>(a) Cranking control equipment to provide the complete cranking cycle described in 3-5.4.2 and Table 3-5.4.2.</p> <p>(b) A panel-mounted control switch(es) marked "run-off-automatic" to perform the following functions:</p> <ol style="list-style-type: none"> 1. Run: Manually initiate, start, and run prime mover 2. Off: Stop prime mover or reset safeties, or both 3. Automatic: Allow prime mover to start by closing a remote contact and stop by opening the remote contact <p>(c) Controls to shut down and lock out the prime</p>	K 144		

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K 144	Continued From page 21 mover under the following conditions: failing to start after specified cranking time, overspeed, low lubricating-oil pressure, high engine temperature, or operation of remote manual stop station. An automatic engine shutdown device for high lubricating-oil temperature shall not be required. (See 3-5.5.6.) (d) Battery-powered individual alarm indication to annunciate visually at the control panel the occurrence of any of the conditions in Table 3-5.5.2(d); additional contacts or circuits for a common audible alarm that signals locally and remotely when any of the itemized conditions occurs. A lamp test switch(es) shall be provided to test the operation of all alarm lamps listed in Table 3-5.5.2(d). (e) Controls to shut down the prime mover upon removal of the initiating signal or manual emergency shutdown. (f) The ac instruments listed in 3-5.9.7. Where the control panel is mounted on the energy converter, it shall be mounted by means of antivibration shock mounts, if required, to maximize reliability.	K 144		
K 147 SS=D	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: Based upon observation the facility failed to ensure electrical installations and equipment were maintained in a safe manner in accordance with NFPA 70 National Electrical Code. Failure to protect electrical connections from tampering could result in loss of power or electrocution. This deficient practice affected no staff, vendors or visitors.	K 147		

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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
K 147	<p>Continued From page 22</p> <p>Findings include:</p> <p>During the exterior facility tour on February 25, 2015, observation revealed the main disconnect equipment housing between the electrical service provider and the facility had the door propped closed by a steel bar wedged into the door. The steel bar was keeping the doors closed, when removed, both doors swung open, revealing immediate access to switchboards of high voltage equipment. the hinge of the left leaf appeared damaged preventing closure.</p> <p>Actual NFPA standard:</p> <p>NFPA 70 Article 110 110.26 Spaces About Electrical Equipment.</p> <p>...</p> <p>(F) Dedicated Equipment Space. All switchboards, panelboards, distribution boards, and motor control centers shall be located in dedicated spaces and protected from damage. Exception: Control equipment that by its very nature or because of other rules of the Code must be adjacent to or within sight of its operating machinery shall be permitted in those locations.</p> <p>(1) Indoor. Indoor installations shall comply with 110.26(F)(1)(a) through (d).</p> <p>(a) Dedicated Electrical Space. The space equal to the width and depth of the equipment and extending from the floor to a height of 1.8 m (6 ft) above the equipment or to the structural ceiling, whichever is lower, shall be dedicated to the electrical installation. No piping, ducts, leak protection apparatus, or other equipment foreign to the electrical installation shall be located in this zone.</p> <p>Exception: Suspended ceilings with removable panels shall be permitted within the 1.8-m (6-ft)</p>	K 147		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: mds001445	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/26/2015
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K 147	Continued From page 23 zone. (b) Foreign Systems. The area above the dedicated space required by 110.26(F)(1)(a) shall be permitted to contain foreign systems, provided protection is installed to avoid damage to the electrical equipment from condensation, leaks, or breaks in such foreign systems. (c) Sprinkler Protection. Sprinkler protection shall be permitted for the dedicated space where the piping complies with this section. (d) Suspended Ceilings. A dropped, suspended, or similar ceiling that does not add strength to the building structure shall not be considered a structural ceiling. (2) Outdoor. Outdoor electrical equipment shall be installed in suitable enclosures and shall be protected from accidental contact by unauthorized personnel, or by vehicular traffic, or by accidental spillage or leakage from piping systems. The working clearance space shall include the zone described in 110.26(A). No architectural appurtenance or other equipment shall be located in this zone.	K 147		
K 211 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers shall have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 18.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623	K 211		

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K 211	Continued From page 24 This Standard is not met as evidenced by: Based upon observation and operational testing the facility failed to ensure alcohol based hand rub (ABHR) dispensers were not located above or adjacent to an ignition source. Failure to separate the location of flammable liquids and ignition sources could create a fire. This deficient practice affected no residents, visitors or staff. the facility is licensed for 20 beds and had a census of two on the date of the survey. Findings include: During the facility tour on February 25, 2015 observation revealed an ABHR dispenser installed directly over an electrical convenience receptacle in the clean laundry. Operational testing demonstrated no ABHR would dispense when activated. Actual NFPA Standard: NFPA 101, TIA 00-1 1. Add new text to Chapter 18 for new health care occupancies as follows: 18.3.2.7* Alcohol-based Hand-rub Solutions. Alcohol-based hand-rub dispensers shall be protected in accordance with 8.4.3 unless all of the following conditions are met: (1) Where dispensers are installed in a corridor, the corridor shall have a minimum width of 6 ft (1.8 m). (2) The maximum individual dispenser fluid capacity shall be: (a) 0.3 gallons (1.2 liters) for dispensers in rooms, corridors, and areas open to corridors	K 211		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: mds001445	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/26/2015
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K 211	Continued From page 25 (b) 0.5 gallons (2.0 liters) for dispensers in suites of rooms (3) The dispensers shall have a minimum horizontal spacing of 4 ft (1.2 m) from each other. (4) Not more than an aggregate 10 gallons (37.8 liters) of alcohol-based hand rub solution shall be in use in a single smoke compartment outside of a storage cabinet. (5) Storage of quantities greater than 5 gallons (18.9 liters) in a single smoke compartment shall meet the requirements of NFPA 30, Flammable and Combustible Liquids Code. (6) The dispensers shall not be installed over or directly adjacent to an ignition source. (7) In locations with carpeted floor coverings, dispensers installed directly over carpeted surfaces shall be permitted only in sprinklered smoke compartments.	K 211		

The following Plan of Correction is submitted by the facility in accordance with the pertinent terms and provisions of 42 CFR Section 488 and/or related state regulations, and is intended to serve as a credible allegation 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).

K012

What corrective action(s) will be accomplished for those residents, staff, visitors or vendors found to be affected by the deficient practice?

Specific residents, staff, visitors, or vendors were not identified as being affected by the deficient practice.

How will you identify other residents, staff, visitors or vendors having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?

All current and future residents, staff, visitors, and vendors have the potential to be affected by the deficient practice.

All unsealed conduits located in the communications room have been sealed with a material that is capable of maintaining the smoke resistance of the smoke barrier in that room. Maintenance Director has been in-serviced on this regulation. Staff has been in-serviced on this regulation and to record maintenance issues in the maintenance service log for repairs.

What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?

The Maintenance Director or designee will perform a visual check at least quarterly to ensure the unsealed conduits located in the communication room remained sealed. Any unsealed conduit found during these inspections will be resealed as soon as possible.

How will the corrective action(s) be monitored to ensure the deficient practice will not recur?

The Quality Improvement Committee will review the reports from the Maintenance Director or designee at least quarterly.

When will the corrective actions be completed?

March 31st, 2015

K022

What corrective action(s) will be accomplished for those residents, staff, visitors or vendors found to be affected by the deficient practice?

Specific residents, staff, visitors, or vendors were not identified as being affected by the deficient practice.

How will you identify other residents, staff, visitors or vendors having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?

All current and future residents, staff, visitors, and vendors have the potential to be affected by the deficient practice.

The additional Exit Signs have been installed per the map provided at the time of exit and are working properly.

What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?

The Maintenance Director or designee will perform a check at least monthly of the Exit Signs to ensure these additional Exit Signs as well as all other installed Exit Signs are working properly. Properly working includes each Exit Sign is currently on, a 30 second check on battery power will be performed monthly and a 90 second check on battery power will be performed annually.

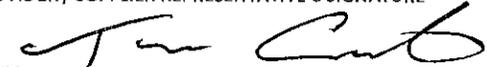
How will the corrective action(s) be monitored to ensure the deficient practice will not recur?

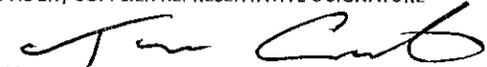
The Quality Improvement Committee will review the reports from the Maintenance Director or designee at least quarterly.

When will the corrective actions be completed?

March 31st, 2015

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

Trevor Cardon  E.I.D. 3/31/15

Print Name	Signature	Title	Date
Trevor Cardon		E.I.D.	3/31/15

K027

What corrective action(s) will be accomplished for those residents, staff, visitors or vendors found to be affected by the deficient practice?

Specific residents, staff, visitors, or vendors were not identified as being affected by the deficient practice.

How will you identify other residents, staff, visitors or vendors having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?

All current and future residents, staff, visitors, and vendors have the potential to be affected by the deficient practice.

Astragals capable of resisting the passage of smoke have been installed on the smoke barrier doors at the AL dining to Skilled Nursing wing. The vision panel in the one leaf is properly seated and integrity resolved. Maintenance Director has been in-serviced on this regulation. Staff has been in-serviced on this regulation and to record maintenance issues in the maintenance service log for repairs.

What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?

The Maintenance Director or designee will perform a check at least quarterly of the AL dining to Skilled Nursing wing fire door to ensure the Astragals are still properly installed and the vision panels for each door in that location remain properly seated and there integrity maintained.

How will the corrective action(s) be monitored to ensure the deficient practice will not recur?

The Quality Improvement Committee will review the reports from the Maintenance Director or designee at least quarterly.

When will the corrective actions be completed?

March 31st, 2015

K029

What corrective action(s) will be accomplished for those residents, staff, visitors or vendors found to be affected by the deficient practice?

Specific residents, staff, visitors, or vendors were not identified as being affected by the deficient practice.

How will you identify other residents, staff, visitors or vendors having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?

All current and future residents, staff, visitors, and vendors have the potential to be affected by the deficient practice.

A self-closing device has been installed on the door between the exit access corridor and the mechanical-boiler room as well as the door between the exit access corridor and the clean side of the laundry. Both doors with the self-closer are working properly. Maintenance Director has been in-serviced on this regulation. Staff has been in-serviced on this regulation and to record maintenance issues in the maintenance service log for repairs.

What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?

The Maintenance Director or designee will perform a check at least quarterly on these two doors to ensure the door between the exit access corridor and the mechanical-boiler room as well as the door between the exit access corridor and the clean side of the laundry continue to function properly with the self-closer installed.

How will the corrective action(s) be monitored to ensure the deficient practice will not recur?

The Quality Improvement Committee will review the reports from the Maintenance Director or designee at least quarterly.

When will the corrective actions be completed?

March 31st, 2015

K033

What corrective action(s) will be accomplished for those residents, staff, visitors or vendors found to be affected by the deficient practice?

Specific residents, staff, visitors, or vendors were not identified as being affected by the deficient practice.

How will you identify other residents, staff, visitors or vendors having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?

All current and future residents, staff, visitors, and vendors have the potential to be affected by the deficient practice.

The stairwell door on the main level will now latch and is secure in the closed position. Maintenance Director has been in-serviced on this regulation. Staff has been in-serviced on this regulation and to record maintenance issues in the maintenance service log for repairs.

What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?

The Maintenance Director or designee will perform a check at least quarterly to ensure the stairwell door on the main level will continue to latch and be secure in the closed position.

How will the corrective action(s) be monitored to ensure the deficient practice will not recur?

The Quality Improvement Committee will review the reports from the Maintenance Director or designee at least quarterly.

When will the corrective actions be completed?

March 31st, 2015

K038

What corrective action(s) will be accomplished for those residents, staff, visitors or vendors found to be affected by the deficient practice?

Specific residents, staff, visitors, or vendors were not identified as being affected by the deficient practice.

How will you identify other residents, staff, visitors or vendors having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?

All current and future residents, staff, visitors, and vendors have the potential to be affected by the deficient practice.

The following action as be taken;

1. The exit back into the building from the service corridor into the Skilled Nursing wing is now permanently unlocked, no electronic key or regular key is need to open the door.
2. The thumb latch deadbolts have been removed on three exit doors from the kitchen to the private and main dining rooms.
3. The thumb latch has been removed from the pair of exit doors form the main dining to the exterior. Both doors are now equipped with crash bars.
4. The thumb latch has been removed from the pair of doors leading to the enclosed courtyard from physical therapy. Both doors are now equipped with crash bars to exit from the physical therapy and the doors are unlocked with single action access from the courtyard into the physical therapy area.
5. The thumb latch has been removed from the pair of doors leading to the enclosed courtyard from AL dining. Both doors are now equipped with crash bars to exit from the AL dining and the doors are unlocked with single action access from the courtyard into the AL dining area.
6. The double egress doors from the AL dining room to the exterior have been repaired to allow easy egress. The alarm device has been rearranged so it doesn't hamper the opening of the door.
7. Room 221 doorknob is now installed correctly.

Maintenance Director has been in-serviced on this regulation. Staff has been in-serviced on this regulation and to record maintenance issues in the maintenance service log for repairs.

What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?

The Maintenance Director or designee will perform a check at least quarterly to ensure all doors mentioned above are working properly for a single action egress.

How will the corrective action(s) be monitored to ensure the deficient practice will not recur?

The Quality Improvement Committee will review the reports from the Maintenance Director or designee at least quarterly.

When will the corrective actions be completed?

March 31st, 2015

K050

What corrective action(s) will be accomplished for those residents, staff, visitors or vendors found to be affected by the deficient practice?

Specific residents, staff, visitors, or vendors were not identified as being affected by the deficient practice.

How will you identify other residents, staff, visitors or vendors having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?

All current and future residents, staff, visitors, and vendors have the potential to be affected by the deficient practice.

The remaining fire drills were performed during the 1st quarter to ensure that quarterly each shift participated in a fire drill. Also, a new form was created and used for the fire drills that included the following information: scenario, date, time, shift, day of week, conditions, problems encountered during the drill, source of the fire, Success with the drill, participating staff signature, and recommendations for improvement. The Maintenance Director was in-serviced regarding the regulations on frequency and information needed during the fire drill.

What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?

The Administrator or designee will perform a check of the fire drill log at least quarterly to ensure quarterly each shift participates in a fire drill.

How will the corrective action(s) be monitored to ensure the deficient practice will not recur?

The Quality Improvement Committee will review the reports from the Maintenance Director or designee at least quarterly.

When will the corrective actions be completed?

March 31st, 2015

K062

What corrective action(s) will be accomplished for those residents, staff, visitors or vendors found to be affected by the deficient practice?

Specific residents, staff, visitors, or vendors were not identified as being affected by the deficient practice.

How will you identify other residents, staff, visitors or vendors having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?

All current and future residents, staff, visitors, and vendors have the potential to be affected by the deficient practice.

The sprinkler escutcheon cover was installed in room 219. Maintenance Director has been in-serviced on this regulation. Staff has been in-serviced on this regulation and to record maintenance issues in the maintenance service log for repairs.

What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?

The Maintenance Director or designee will perform a check at least quarterly to ensure the escutcheon in room 219 and all other escutcheons in the building on installed.

How will the corrective action(s) be monitored to ensure the deficient practice will not recur?

The Quality Improvement Committee will review the reports from the Maintenance Director or designee at least quarterly.

When will the corrective actions be completed?

March 31st, 2015

K066

What corrective action(s) will be accomplished for those residents, staff, visitors or vendors found to be affected by the deficient practice?

Specific residents, staff, visitors, or vendors were not identified as being affected by the deficient practice.

How will you identify other residents, staff, visitors or vendors having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?

All current and future residents, staff, visitors, and vendors have the potential to be affected by the deficient practice.

Signage prohibiting smoking on the facility grounds has been placed at all entrances of the facility. Also, a form has been added to the admission agreement ensuring the resident and/or the responsible party is aware of the non-smoking campus policy. Staff has been in-serviced on this policy as well.

What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?

The Maintenance Director or designee will perform a check at least quarterly to ensure the "Smoke Free Campus" signs are still installed at the entrances of the building. Medical Records or designee will ensure the Smoke Free Campus signed acknowledgement form in the admission packet is signed and completed.

How will the corrective action(s) be monitored to ensure the deficient practice will not recur?

The Quality Improvement Committee will review the reports from the Maintenance Director or designee and Medical Records or designee at least quarterly.

When will the corrective actions be completed?

March 31st, 2015

K144

What corrective action(s) will be accomplished for those residents, staff, visitors or vendors found to be affected by the deficient practice?

Specific residents, staff, visitors, or vendors were not identified as being affected by the deficient practice.

How will you identify other residents, staff, visitors or vendors having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?

All current and future residents, staff, visitors, and vendors have the potential to be affected by the deficient practice.

1. The Maintenance Director has been in-serviced regarding the requirement to record the amperage / voltage draw when the monthly generator test is performed. A monthly tracking form / log has been created to record the amperage / voltage draws for each monthly test performed.
2. Signage was placed at the generator indicating the location of the generator emergency switch as well as a sign labeling the purpose of the generator emergency switch at the emergency generator switch.

What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?

The Administrator or Designee will perform an audit of monthly generator test log to ensure amperage / voltage draws are being recorded monthly. The Maintenance Director or designee will perform visual check at least quarterly to ensure the signs (the sign next to the generator and the sign next to the emergency shut off switch) are still installed.

How will the corrective action(s) be monitored to ensure the deficient practice will not recur?

The Quality Improvement Committee will review the reports from the Maintenance Director or designee at least quarterly.

When will the corrective actions be completed?

March 31st, 2015

K147

What corrective action(s) will be accomplished for those residents, staff, visitors or vendors found to be affected by the deficient practice?

Specific residents, staff, visitors, or vendors were not identified as being affected by the deficient practice.

How will you identify other residents, staff, visitors or vendors having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?

All current and future residents, staff, visitors, and vendors have the potential to be affected by the deficient practice.

The doors to the container that houses the main disconnect equipment between the electrical service provider and the facility have been repaired. The doors now are securely closed without as designed. Maintenance Director has been in-serviced on this regulation. Staff has been in-serviced on this regulation and to record maintenance issues in the maintenance service log for repairs.

What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?

The Maintenance Director or Designee will perform a visual check at least quarterly to ensure the doors continue to be securely closed as designed.

How will the corrective action(s) be monitored to ensure the deficient practice will not recur?

The Quality Improvement Committee will review the reports from the Maintenance Director or designee at least quarterly.

When will the corrective actions be completed?

March 31st, 2015

K211

What corrective action(s) will be accomplished for those residents, staff, visitors or vendors found to be affected by the deficient practice?

Specific residents, staff, visitors, or vendors were not identified as being affected by the deficient practice.

How will you identify other residents, staff, visitors or vendors having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?

All current and future residents, staff, visitors, and vendors have the potential to be affected by the deficient practice.

The ABHR dispenser installed directly over the electrical convenience receptacle in the clean laundry has been removed and placed in the Clean Laundry room on the wall not directly over the electrical convenience receptacle or any other ignition source. Maintenance Director has been in-serviced on this regulation. Staff has been in-serviced on this regulation and to record maintenance issues in the maintenance service log for repairs.

Maintenance Director has been in-serviced on this regulation. Staff has been in-serviced on this regulation and to record maintenance issues in the maintenance service log for repairs.

What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?

The Maintenance Director or Designee will perform a visual check at least quarterly this regulation is met in the facility.

How will the corrective action(s) be monitored to ensure the deficient practice will not recur?

The Quality Improvement Committee will review the reports from the Maintenance Director or designee at least quarterly.

When will the corrective actions be completed?

March 31st, 2015

POC
missing for
C 224

See Attachment
Pages 1-3 -
or POC -
is adequate.
MPB

C252

What corrective action(s) will be accomplished for those residents, staff, visitors or vendors found to be affected by the deficient practice?

Specific residents, staff, visitors, or vendors were not identified as being affected by the deficient practice.

How will you identify other residents, staff, visitors or vendors having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?

All current and future residents, staff, visitors, and vendors have the potential to be affected by the deficient practice.

The eye wash stations for a weekly flush have been added to the weekly maintenance checks. An eye wash station flush was performed on all eye wash stations in the facility. All are working properly.

What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?

The Maintenance Director or Designee will perform a weekly eye wash station flush for all eye stations in the facility as well as an annual flow test for each eye wash station.

How will the corrective action(s) be monitored to ensure the deficient practice will not recur?

The Quality Improvement Committee will review the reports from the Maintenance Director or designee at least quarterly.

When will the corrective actions be completed?

March 31st, 2015

C615

What corrective action(s) will be accomplished for those residents, staff, visitors or vendors found to be affected by the deficient practice?

Specific residents, staff, visitors, or vendors were not identified as being affected by the deficient practice.

How will you identify other residents, staff, visitors or vendors having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?

All current and future residents, staff, visitors, and vendors have the potential to be affected by the deficient practice.

The hot and cold water supply to the hand wash sinks in the Physical Therapy and the ante room of #222 have been reversed so they are installed properly. Maintenance Director has been in-serviced on this regulation. Staff has been in-serviced on this regulation and to record maintenance issues in the maintenance service log for repairs.

What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?

The Maintenance Director or Designee will perform at least a monthly inspection on water temperatures in the facility to ensure water temperatures meet regulations.

How will the corrective action(s) be monitored to ensure the deficient practice will not recur?

The Quality Improvement Committee will review the reports from the Maintenance Director or designee at least quarterly.

When will the corrective actions be completed?

March 31st, 2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: mds001445	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/26/2015
NAME OF PROVIDER OR SUPPLIER MADISON CARRIAGE COVE SHORT STAY REHABI		STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST 1ST NORTH REXBURG, ID 83440		
(X4) ID PREFIX TAG C 000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG C 000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	<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>Madison Carriage Cove Short Stay Rehabilitation is a single story with mechanical loft Type V (111) constructed, skilled nursing facility, that is approximately 35,874 square feet in size. Plans were approved in May of 2013 and construction completed in July of 2014. The facility was licensed for 20 beds in August 2014 with an initial Medicare Certification survey being conducted on February 25 & 26, 2015. The facility is co-located with a 20 bed Assisted Living facility without occupancy separation.</p> <p>The facility is fully sprinklered, with complete smoke detection and fire alarm system, type 2 Essential Electrical Service, piped medical gas, and is subdivided into three smoke compartments with ten exits to grade.</p> <p>The following deficiencies were cited during the initial medicare certification survey conducted on February 25 & 26, 2015. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, New Health Care Occupancy in accordance with 42 CFR 483.70.a. and IDAPA 16.03.02 Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities in Idaho</p> <p>The surveyor conducting the survey was:</p> <p>Mark P. Grimes, Supervisor Facility Fire Safety & Construction Program</p>			

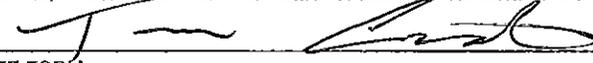
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APR - 1 2015
FACILITY STANDARDS

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

(X6) DATE



ED.

3/31/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: mcs001445	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/26/2015
NAME OF PROVIDER OR SUPPLIER MADISON CARRIAGE COVE SHORT STAY REHABI		STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST 1ST NORTH REXBURG, ID 83440		
(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) COMPLETE DATE
C 226	Continued From Page 1	C 226		
C 226	02.106 FIRE AND LIFE SAFETY 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 life safety standards that are applicable to health care facilities. This RULE: is not met as evidenced by: Refer to deficiencies listed on the federal form 2567: K012 Penetrations by Conduit K022 Smoke Barrier Doors K029 Hazardous Area Separation K033 Stairwell Door Latch K038 Locking Devices Immediate Access K050 Fire Drills K062 Sprinkler Escutcheon K066 No Smoking Signage K144 Generator testing K147 Electrical Safety K211 Alcohol Based Hand Rub Dispenser	C 226	C226 See Attachment pages 1 through 7	
C 252	02.106,07 MAINTENANCE OF EQUIPMENT 07. Maintenance of Equipment. The facility shall establish routine test, check and maintenance procedures for all equipment. This RULE: is not met as evidenced by: Based upon observation the facility failed to ensure emergency eyewash stations are included in a regular maintenance schedule. Failure to inspect and test emergency equipment can result in equipment failure when needed. The facility is licensed for 20 beds and had a census of two on the date of the survey, this deficient practice affected no residents, only staff.	C 252	C252 See Attachment page 7	

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: mds001445	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/26/2015
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C 252	Continued From Page 2 Findings include: Eyewash stations are not included in any regular scheduled maintenance or testing program as required by ANSI Z358.1-2014 (weekly flushing and annual flow testing requirements). Actual Standard: See: OSHA 1910.15.151.C(c)	C 252		
C 615	02.121,16,f,iv iv. Water distribution systems shall be arranged to provide hot water at each hot water outlet at all times. Hot water at shower, bathing and handwashing facilities shall not exceed one hundred twenty degrees (120) Fahrenheit. This RULE: is not met as evidenced by: Based upon operational testing the facility failed to ensure hot water taps were plumbed correctly. Failure to provide hot water at handwash stations can discourage hand sanitizing. Findings include: Operational testing of the handwash sinks at the Physical Therapy hand wash sink and in the ante room of #222 revealed the hot and cold water supply is reversed. Actual Standard: IDAPA 16.03.02. 121.16.f.iv Water distribution systems shall be arranged to provide hot water at each hot water outlet at all times. Hot water at	C 615	C615 See Attachment page 7	

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: mds001445	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/26/2015
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C 615	Continued From Page 3 shower, bathing and handwashing facilities shall not exceed one hundred twenty degrees (120) Fahrenheit.	C 615		

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