



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

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

DEBRA RANSOM, R.N., R.H.I.T., Chief  
BUREAU OF FACILITY STANDARDS  
3232 Ekler Street  
P.O. Box 83720  
Boise, ID 83720-0009  
PHONE 208-334-6626  
FAX 208-364-1888

July 6, 2015

David Green, Administrator  
Karcher Estates  
1127 Caldwell Boulevard  
Nampa, ID 83651-1701

Provider #: 135110

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

Dear Mr. Green:

On **June 23, 2015**, a Facility Fire Safety and Construction survey was conducted at **Karcher Estates** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. Please provide **ONLY ONE** completion date for each federal and state tag in column (X5) Completion Date to signify when you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **July 20, 2015**. Failure to submit an acceptable PoC by **July 20, 2015**, may result in the imposition of civil monetary penalties by **August 8, 2015**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.
- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567 and the state licensure survey report, State Form.

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **July 21, 2015**, (Opportunity to Correct). Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **July 21, 2015**. A change in the seriousness of the deficiencies on **July 21, 2015**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **July 21, 2015**, includes the following:

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Denial of payment for new admissions effective **September 23, 2015**.  
42 CFR §488.417(a)

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **December 23, 2015**, if substantial compliance is not achieved by that time.

**Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.**

If you believe these deficiencies have been corrected, you may contact Mark P. Grimes, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **June 23, 2015**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

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

BFS Letters (06/30/11)

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

This request must be received by **July 20, 2015**. If your request for informal dispute resolution is received after **July 20, 2015**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



Mark P. Grimes, Supervisor  
Facility Fire Safety and Construction

MPG/lj  
Enclosures

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

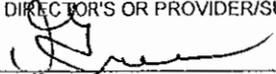
Printed: 07/01/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135110</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/23/2015</b>
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NAME OF PROVIDER OR SUPPLIER <b>KARCHER ESTATES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1127 CALDWELL BOULEVARD NAMPA, ID 83651</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	INITIAL COMMENTS  The facility is a single story type V(111) structure with a two hour wall between the common area shared with the adjacent independent living facility. The building was originally constructed in 1989 and is fully protected by an automatic fire alarm and sprinkler system. Currently the facility is licensed for 66 SNF/NF beds.  The following deficiencies were found during the annual Fire/Life Safety survey conducted on June 23, 2015. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Chapter 19, Existing Health Care Occupancies, in accordance with 42 CFR 483.470.  The Survey was conducted by Sam Burbank Health Care Surveyor Facility Fire, Safety and Construction	K 000	Preparation or execution of the Plan of Correction does not constitute admission or agreement by the provider of the truth or facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and /or executed solely because it is required by law.	
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4  This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that smoke barriers were	K 025  FACILITY STANDARDS JUL 20 2015 RECEIVED	All residents have the potential to be affected by the lack of smoke barriers. All areas that require such barriers will be corrected/repaired.  The four missing ceiling tiles in the Physical Therapy bath and shower room were removed for plumbing repairs. Tiles were replaced and holes patched on July 2, 2015. Ceiling tiles on each side of the new fire door operation were under construction at the time of survey and have since been replaced and work completed.	07/02/15  07/02/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>Administrator</b>	(X6) DATE <b>7-20-15</b>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 025	<p>Continued From page 1</p> <p>maintained to resist the passage of smoke. Failure to maintain smoke barriers would allow smoke and dangerous gases to pass freely and hinder performance of systems such as sprinklers and smoke detection. This deficient practice affected 23 residents, staff and visitors in the Skilled Nursing section (Station D); residents, staff and visitors utilizing the Physical Therapy suite on the date of the survey. The facility is licensed for 66 SNF/NF beds and had a census of 49 on the day of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on June 23, 2015 from 12:30 PM to 2:00 PM, observation of the common bath and shower room in the Physical Therapy suite found four (4) missing ceiling tiles in the grid ceiling and five (5) unsealed penetrations ranging in size from 1/2 inch to 1 inch diameter, extending through walls separating the P/T suite to the corridor. When asked, the Maintenance Supervisor stated this area had been opened for a leak repair but was not aware the penetrations hadn't been sealed, or the ceiling tiles were still removed.</p> <p>2) During the facility tour conducted on June 23, 2015 from 2:00 PM to 2:30 PM, observation of the new fire door separation installation found three (3) ceiling tiles on each side of the new wall had been removed from the grid ceiling. Further observation above the ceiling outside room 555 found an approximately one foot by one foot hole broken through the 1 hour separation above the grid ceiling, exposing the attic area above this wing. When asked, the Maintenance Supervisor stated he did not know the smoke barrier had been broken into the attic or the exposed risk of leaving the ceiling tiles out at the new wall</p>	K 025	<p>The 1' x 1' hole above room 555 has been repaired. In the future, ceiling tiles and holes will be repaired and replaced immediately upon completion of work.</p> <p>Fire barriers, ceiling tiles, smoke barriers and such related items will be checked on monthly inspection rounds by the Maintenance Director or his designee.</p> <p>Maintenance Director will report monthly for 1 year to QA regarding compliance.</p>	<p>07/02/15</p> <p>07/08/15</p> <p>07/08/15</p>
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K 025	<p>Continued From page 2 installation.</p> <p>Actual NFPA standard:</p> <p>19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour. 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. Exception No. 2*: Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.3 has been provided for smoke compartments adjacent to the smoke barrier.</p> <p>8.3 SMOKE BARRIERS 8.3.1* General. Where required by Chapters 12 through 42, smoke barriers shall be provided to subdivide building spaces for the purpose of restricting the movement of smoke.</p> <p>8.3.2* Continuity. Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces. Exception: A smoke barrier required for an occupied space below an interstitial space shall</p>	K 025			



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K 029	<p>Continued From page 4</p> <p>Medical Records - Room #580 Central Supply Office/Storage - Room #581 Staff Development and Medical Records storage - Room #593 Oxygen Storage and Transfill Room</p> <p>Further observation found these areas range in size from approximately 12' by 10' to 12' by 16' (120 sf to 192 sf). The Medical Records and Staff Development/Medical Records housed records storage in both file cabinets and boxed/loose records storage. Central Supply Office/Storage consisted of haphazard chemical supply storage; office product storage and adult diapers.</p> <p>Actual NFPA standard:</p> <p>3.3.13.2 Area, Hazardous. An area of a structure or building that poses a degree of hazard greater than that normal to the general occupancy of the building or structure, such as areas used for the storage or use of combustibles or flammables; toxic, noxious, or corrosive materials; or heat-producing appliances.</p> <p>19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to,</p>	K 029		

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K 029	Continued From page 5 the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		
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. 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. 19.7.1.2  This Standard is not met as evidenced by: Based on record review and interview, the facility failed to perform one fire drill per shift per quarter. Failure to ensure fire drills are performed as	K 050	Lack of regular fire drills for staff and residents have the potential to affect all residents. Regular regional fir drills will be conducted quarterly for each shift.  The lack of regular fire drills has the potential to affect all residents.  Fire drills will be conducted during each shift quarterly.  The Maintenance Director will report to QA quarterly for fire drill compliance.	07/31/15

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K 050	Continued From page 6 required would hinder response by staff during a fire or other emergency. This deficient practice affected 49 residents, staff and visitors on the date of the survey. The facility is licensed for 66 SNF/NF beds and had a census of 49 on the day of the survey.  Findings include:  During review of the facility's fire drill documentation conducted on June 23, 2015 from 9:00 AM to 12:00 PM, the facility was unable to demonstrate performing a fire drill for the NOC (late evening) shift during the fourth quarter of 2014 and the first quarter of 2015. When asked about the missing fire drills, the Maintenance Supervisor stated that some drills had been missed during transition of Maintenance personnel.  Actual NFPA standard:  19.7.1.2* 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.	K 050		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD	K 062		

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K 062	<p>Continued From page 7</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This Standard is not met as evidenced by: Based on record review and interview, the facility failed to ensure the automatic fire suppression system was inspected on a semi-annual basis for the Kitchen Ansul system per NFPA 96 and a quarterly basis for the main sprinkler system as required under NFPA 25. Failure to inspect fire suppression systems could result in a lack of system performance during a fire. This deficient practice affected 49 residents, staff and visitors on the date of the survey. The facility is licensed for 66 SNF/NF beds and had a census of 49 on the day of the survey.</p> <p>Findings include:</p> <p>During the review of the facility sprinkler records conducted on June 23, 2015 from 9:00 AM to 12:00 PM, review of the sprinkler inspection reports for both the wet system and the Kitchen Ansul system the facility failed to produce reports for the third quarter sprinkler inspection on the wet system and the Kitchen fire suppression system conducted on a semi-annual basis. When asked about the missing reports/inspections, the Maintenance Supervisor stated that some inspections had been missed during the transition of Maintenance staffing.</p> <p>Actual NFPA standard:</p> <p>NFPA 13</p>	K 062	<p>Failure to have quarterly sprinkler system inspections and kitchen ansul system inspections have the potential to affect all residents of the facility.</p> <p>The facility does have the cited semi-annual inspection report for the kitchen ansul system for the period in question.</p> <p>Karcher Estates now has agreements for both the kitchen ansul semi-annual inspection and the quarterly main sprinkler system.</p> <p>The Maintenance Director will maintain logs and reports of inspection reports. Report will be made to the QA committee and quarterly for 1 year.</p>	06/28/15

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K 062	<p>Continued From page 8</p> <p>12-1* General. A sprinkler system installed in accordance with this standard shall be properly inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, to provide at least the same level of performance and protection as designed.</p> <p>4.6.12 Maintenance and Testing. 4.6.12.1 Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be continuously maintained in accordance with applicable NFPA requirements or as directed by the authority having jurisdiction.</p> <p>NFPA 25 2-3.3* Alarm Devices. Waterflow alarm devices including, but not limited to, mechanical water motor gongs, vane-type waterflow devices, and pressure switches that provide audible or visual signals shall be tested quarterly.</p> <p>NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations 2001 Edition</p> <p>11.2 Inspection of Fire-Extinguishing Systems. 11.2.1* An inspection and servicing of the fire-extinguishing system and listed exhaust hoods containing a constant or fire-actuated water system shall be made at least every 6 months by properly trained and qualified persons.</p>	K 062		

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K 064 K 064 SS=D	<p>Continued From page 9</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that fire extinguishers were mounted in accordance with NFPA 10. Failure to install fire extinguishers at the correct height could increase the risk of damages or injury to staff in the event of a fire. This deficient practice affected all staff and visitors on the date of the survey. The facility is licensed for 66 SNF/NF beds and had a census of 49 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on June 23, 2015 from 1:50 PM to 3:00 PM, observation of the fire extinguisher mounted in the Laundry found it to be mounted approximately 64" above the floor. When asked, the Maintenance Supervisor stated he was not aware of the height requirement for fire extinguishers.</p> <p>Actual NFPA standard:</p> <p>NFPA 10 1-6.10 Fire extinguishers having a gross weight not exceeding 40 lb (18.14 kg) shall be installed so that the top of the fire extinguisher is not more than 5 ft (1.53 m) above the floor. Fire</p>	K 064 K 064	<p>Improper height of fire extinguisher could potentially cause harm and injury to any staff responding to an emergency. All fire extinguishers will be evaluated for proper height.</p> <p>The fire extinguisher in the laundry room has been lowered to meet height requirements, below 60" from the floor.</p> <p>The Maintenance Director or designee has checked all fire extinguishers to ensure compliance with requirements. Report will be made to QA quarterly for 1 year.</p>	07/02/15

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K 064	Continued From page 10 extinguishers having a gross weight greater than 40 lb (18.14 kg) (except wheeled types) shall be so installed that the top of the fire extinguisher is not more than 3 1/2 ft (1.07 m) above the floor. In no case shall the clearance between the bottom of the fire extinguisher and the floor be less than 4 in. (10.2 cm).	K 064		
K 072 SS=D	<b>NFPA 101 LIFE SAFETY CODE STANDARD</b> Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10  This Standard is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure that means of egress were maintained free of all impediments and available for use in a fire or other emergency. Failure to provide instant use of doors from the egress side would hinder safe evacuation during a fire or other emergency. This deficient practice affected staff and visitors on the date of the survey. The facility is licensed for 66 SNF/NF beds and had a census of 49 on the day of the survey.  Findings include:  During the facility tour conducted on June 23, 2015 from 12:30 PM to 1:50 PM, observation and operational testing of the door to Central Supply found it was equipped with a non-single operational doorknob and a keyed deadbolt. Futher observation found the door was locked	K 072	<b>Improper means of egress in case of an emergency could potentially affect all staff and residents. All doors and means of egress will be provided with proper devices and maintained free of all impediments.</b>  The Central Supply door knob has been replaced with a single-action operational door knob. All doors have been checked for single-action door knob compliance by the Maintenance Director. Report will be made by the Maintenance Director to QA quarterly for 1 year.	07/02/15

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K 072	<p>Continued From page 11</p> <p>with an occupant inside eating lunch. When asked, both the Maintenance Supervisor and Administrator stated they did not have a key for this door. Additional interview of the Maintenance Supervisor found that the door was kept locked to limit access to supplies stored inside to.</p> <p>Actual NFPA standard:</p> <p>7.1.10 Means of Egress Reliability. 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>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 latching devices shall not be located more than 60 in. (152 cm) above the finished floor. Automatic latching devices shall not be located</p>	K 072		



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K 144	<p>Continued From page 13</p> <p>Generator logs from May 5, 2014 to June 23, 2015 showed no indication of transfer time or load testing being performed. No generator inspection or load testing logs for 3 of 4 weeks in January 2015. No generator inspection or load testing log for February 2015. No generator inspection or load testing log for week of March 2, 2015. The facility was not found to be performing any annual load bank testing from an outside vendor.</p> <p>When asked about the method of testing performed and the missing documentation for the generator set, the Maintenance Supervisor stated his staff only documented information obtained from the generator during its normal automatic start-up. He further stated he was not aware of the missing logs and not aware of the requirement for documenting load and transfer time.</p> <p>Actual NFPA standard:</p> <p>NFPA 99 3-4.4.1 Maintenance and Testing of Essential Electrical System. 3-4.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches. (a) Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-4.3.1. Maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6.</p>	K 144		

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K 144	<p>Continued From page 14</p> <p>(b) Inspection and Testing.</p> <p>1. * Test Criteria. Generator sets shall be tested twelve (12) times a year with testing intervals between not less than 20 days or exceeding 40 days. Generator sets serving emergency and equipment systems shall be in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6.</p> <p>2. Test Conditions. The scheduled test under load conditions shall include a complete simulated cold start and appropriate automatic and manual transfer of all essential electrical system loads.</p> <p>3. Test Personnel. The scheduled tests shall be conducted by competent personnel. The tests are needed to keep the machines ready to function and, in addition, serve to detect causes of malfunction and to train personnel in operating procedures.</p> <p>3-4.3.1 Source. The branches of the emergency system shall be installed and connected to the alternate power source specified in 3-4.1.1.2 and 3-4.1.1.3 so that all functions specified herein for the emergency system shall be automatically restored to operation within 10 seconds after interruption of the normal source.</p> <p>NFPA 110 Chapter 6 Routine Maintenance and Operational Testing</p> <p>6-4 Operational Inspection and Testing. 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</p>	K 144		

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K 144	Continued From page 15 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.  6-4.2* 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: (a) Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating (b) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer The date and time of day for required testing shall be decided by the owner, based on facility operations.	K 144		
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2  This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that electrical installations were in accordance with NFPA 70. Failure to ensure electrical systems are installed properly could result in fire by arcing or electrocution. This deficient practice affected 23 residents, staff and visitors on the date of the survey. The facility is licensed for 66 SNF/NF beds and had a census of 49 on the day of the survey.  Findings include:	K 147	Improper electrical installation/connections could have the potential to affect all staff, residents and visitors resulting in fire or electrocution. All equipment and installations will be evaluated for proper connection and installation.  The open electrical junction in the MDS office now has a cover plate installed.  The microwave that had been plugged into an extension cord has been removed. The microwave is now plugged into a proper outlet. I was done on day of inspection.	07/08/15  06/23/15

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K 147	<p>Continued From page 16</p> <p>1). During the facility tour conducted on June 23, 2015 from 12:30 PM to 3:00 PM, observation of the MDS office found an open electrical junction box approximately 3-1/2" diameter in size with exposed wiring . When asked, the Maintenance Supervisor stated he was not aware this electrical box had not been covered.</p> <p>2) During the facility tour conducted on June 23, 2015 from 12:30 PM to 3:00 PM, observation of the private dining area in the southwest section of the 500 wing found a microwave plugged into a relocatable power tap. Both the Administrator and the Maintenance Supervisor stated they were unaware of this condition.</p> <p>Actual NFPA standard:</p> <p>NFPA 70</p> <p>400.8 Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following:</p> <p>(1) As a substitute for the fixed wiring of a structure</p> <p>(2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors</p> <p>(3) Where run through doorways, windows, or similar openings</p> <p>(4) Where attached to building surfaces Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of 368.8.</p> <p>(5) Where concealed by walls, floors, or ceilings or located above suspended or dropped ceilings</p> <p>(6) Where installed in raceways, except as otherwise permitted in this Code</p>	K 147	<p>The Maintenance Director will check for compliance of all electrical appliances and extension cords during compliance rounds each month. Report will be made to QA quarterly for 1 year.</p>	

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K 147	<p>Continued From page 17</p> <p><b>110.12 Mechanical Execution of Work.</b> Electrical equipment shall be installed in a neat and workmanlike manner.</p> <p>(A) Unused Openings. Unused cable or raceway openings in boxes, raceways, auxiliary gutters, cabinets, cutout boxes, meter socket enclosures, equipment cases, or housings shall be effectively closed to afford protection substantially equivalent to the wall of the equipment. Where metallic plugs or plates are used with nonmetallic enclosures, they shall be recessed at least 6 mm (¼ in.) from the outer surface of the enclosure.</p> <p>(B) Subsurface Enclosures. Conductors shall be racked to provide ready and safe access in underground and subsurface enclosures into which persons enter for installation and maintenance.</p> <p>(C) Integrity of Electrical Equipment and Connections. Internal parts of electrical equipment, including busbars, wiring terminals, insulators, and other surfaces, shall not be damaged or contaminated by foreign materials such as paint, plaster, cleaners, abrasives, or corrosive residues. There shall be no damaged parts that may adversely affect safe operation or mechanical strength of the equipment such as parts that are broken; bent; cut; or deteriorated by corrosion, chemical action, or overheating.</p> <p><b>314.17 Conductors Entering Boxes, Conduit Bodies, or Fittings.</b> Conductors entering boxes, conduit bodies, or fittings shall be protected from abrasion and shall comply with 314.17(A) through (D).</p> <p>(A) Openings to Be Closed. Openings through which conductors enter shall be adequately closed.....</p>	K 147		