



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

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

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

July 16, 2015

James Hayes, Administrator  
River Ridge Center  
640 Filer Avenue West  
Twin Falls, ID 83301-4533

Provider #: 135106

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

Dear Mr. Hayes:

On **July 7, 2015**, a Facility Fire Safety and Construction survey was conducted at **River Ridge Center** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. Please provide **ONLY ONE** completion date for each federal and state tag in column (X5) Completion Date to signify when 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 the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office. If a State Form with deficiencies was issued, it should be signed, dated and returned along with the CMS-2567 Form.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **July 29, 2015**. Failure to submit an acceptable PoC by **July 29, 2015**, may result in the imposition of civil monetary penalties by **August 18, 2015**.

Your PoC must contain the following:

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

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **August 11, 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 **August 11, 2015**. A change in the seriousness of the deficiencies on **August 11, 2015**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **August 11, 2015**, includes the following:

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Denial of payment for new admissions effective **October 7, 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 **January 7, 2016**, if substantial compliance is not achieved by that time.

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

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

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **July 7, 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 29, 2015**. If your request for informal dispute resolution is received after **July 29, 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,

A handwritten signature in black ink that reads "Scott for M. G.". The signature is written in a cursive style with a large, looped "S" at the beginning.

Mark P. Grimes, Supervisor  
Facility Fire Safety and Construction

MPG/lj  
Enclosures

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

Printed: 07/15/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135106</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/07/2015</b>
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NAME OF PROVIDER OR SUPPLIER <b>RIVER RIDGE CARE &amp; REHABILITATION CEN*</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>640 FILER AVENUE WEST TWIN FALLS, ID 83301</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) fully sprinklered structure that was built in 1960. A renovation was completed in 1998. It has a basement area accessible by staff only. Currently the facility is licensed for 119 SNF/NF beds.

The following deficiencies were cited during the annual fire/life safety survey conducted on July 7, 2015. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.

The Survey was conducted by:

Sam Burbank  
Health Facility Surveyor  
Facility Fire Safety and Construction

**K 025 NFPA 101 LIFE SAFETY CODE STANDARD SS=F**

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 upon observation, the facility failed to ensure smoke resistive properties are maintained to prevent the transfer of smoke and dangerous

**K 000** "This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, River Ridge Care and Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."

**K025**

**08/14/15**

**Affected:**

The penetrations in the 100 hallway fire wall were sealed on 07/09/15

**Potential:**

On or before 08/14/15, attic fire walls will be assessed by the Maintenance Director for unsealed openings.  
On or before 08/14/15, any unsealed openings discovered will be sealed

**Systemic:**

Effective 07/15/15, for any work completed near fire walls, the Maintenance Director and contractor will inspect the work area together and seal any penetrations discovered.

**QA Audit:**

Work completed near fire walls will be reported in the QAPI meeting.

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

TITLE

(X6) DATE

*Sam Burbank*

*Administrator*

*07-29-15*

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>gases between smoke compartments. Failure to seal penetrations could allow products of combustion to migrate through the facility. This deficient practice affected 32 residents, staff and visitors on the date of the survey. The facility is licensed for 119 beds and had a census of 32 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on July 7, 2015 from 11:15 AM to 4:00 PM, the following penetrations were revealed:</p> <p>An approximately 1-inch diameter unsealed pipe passed through the wall separating the dining room and the 100 wing, directly above the smoke compartment doors.</p> <p>An above the ceiling inspection at room 111 revealed an unsealed opening used for wiring installation, approximately six inches wide by two inches high, cut through the cinder block wall.</p> <p>Actual NFPA standard:</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.</p> <p>Exception: A smoke 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 provides resistance to the passage of smoke</p>	K 025	

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K 025	<p>Continued From page 2 equal to that provided by the smoke barrier.</p> <p><b>19.3.7.3</b> 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><b>K 029 NFPA 101 LIFE SAFETY CODE STANDARD SS=F</b> One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This Standard is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure that hazardous areas would be protected with</p>	K 025  <b>K029</b>	<p><b>08/15/15</b></p> <p><b>Affected:</b> On or before 08/30/15, doors in rooms 113, the clean linen room, and the Nurse Station storage room will be equipped with self-closing devices.</p> <p><b>Potential:</b> On or before 08/15/15, the Maintenance Director will inspect the facility for any other rooms identified in NFPA Standard 19.3.2.1 for the presence of self-closing doors. Those rooms not having self-closing devices will be identified. On or before 08/30/15, the identified rooms will be equipped by the Maintenance Director with door-closer devices.</p> <p><b>Systemic:</b> Effective 08/15/15, proposed changes in room functions will be reviewed and approved by the IDT committee subject to State regulations..</p> <p><b>QA Audit:</b> Room function changes approved by the IDT will be reviewed in the monthly QAPI meeting.</p>

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K 029	<p>Continued From page 3</p> <p>self-closing doors. Failure to provide self-closing doors to hazardous areas would allow smoke and dangerous gases to pass into corridors affecting egress. This deficient practice affected 32 residents, staff and visitors on the date of the survey. The facility is licensed for 119 SNF/NF beds and had a census of 32 on the day of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on July 7, 2015 from 11:15 AM to 4:00 PM, observation of room 113 found it had been converted to storage, measured approximately twelve feet by twelve feet (144 square feet) and was not equipped with a self-closing device. When interviewed, the Maintenance Supervisor stated he was aware of this door being required to self-close and that he had closure devices on order.</p> <p>2) During the facility tour conducted on July 7, 2015 from 11:15 AM to 4:00 PM, observation and operational testing of the door from the corridor into the clean linen side of the main laundry found it would not self-close when activated.</p> <p>3) During the facility tour conducted on July 7, 2015 from 11:15 AM to 4:00 PM, observation of a storage room across from the Medicare desk found it housed adult diapers and assorted paper products, measuring approximately eight feet by eight feet (64 square feet). When activated, the south door from the corridor into this area would not self-close.</p> <p>Actual NFPA standard:</p> <p>3.3.13.2 Area, Hazardous. An area of a structure or building that poses a</p>	K 029	

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K 029	<p>Continued From page 4</p> <p>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>19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:</p> <ol style="list-style-type: none"> <li>(1) Boiler and fuel-fired heater rooms</li> <li>(2) Central/bulk laundries larger than 100 ft<sup>2</sup> (9.3 m<sup>2</sup>)</li> <li>(3) Paint shops</li> <li>(4) Repair shops</li> <li>(5) Soiled linen rooms</li> <li>(6) Trash collection rooms</li> <li>(7) Rooms or spaces larger than 50 ft<sup>2</sup> (4.6 m<sup>2</sup>), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction</li> <li>(8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard.</li> </ol> <p>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.</p>	K 029	
(X5) COMPLETION DATE			

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K 062 K 062 SS=F	Continued From page 5 NFPA 101 LIFE SAFETY CODE STANDARD 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  This Standard is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure that sprinkler system installations were maintained in accordance with NFPA 25. Failure to maintain sprinkler systems could result in a lack of system performance as designed. This deficient practice affected 32 residents, staff and visitors on the date of the survey. The facility is licensed for 119 SNF/NF beds and had a census of 32 on the day of the survey.  Findings include:  1) During review of the facility's suppression system inspection records conducted on July 7, 2015 from 8:15 AM to 11:15 AM, it was found that the annual inspection report provided did not indicate the system was equipped with an anti-freeze loop, nor tested for type and concentration. Interview of the Maintenance Supervisor and further review of previous years' inspections found the facility is equipped with 2 (two) anti-freeze loops and that he was unaware the concentration of the anti-freeze solution was not documented.  2) During the facility tour conducted on July 7, 2015 from 11:15 AM to 4:00 PM, observation of sprinkler risers located in the south basement	K 062 K 062 <b>K062</b>	<b>08/30/15</b>  <b>Affected:</b> On or before 08/30/15, the fire systems Contractor will resolve the anti-freeze charge % in accordance with NFPA regulations. The maintenance Director will insure the loops are labeled correctly, to include the presence and type and percentage of anti-freeze solution. On 07/13/15, the Maintenance Director replaced the hose and tank with UL approved devices. On 07/17/15, the affected sprinkler pipes were repaired and replaced by the fire systems contractor.  <b>Potential:</b> On 07/07/15, the Maintenance Director and Fire Safety Contractor verified there were no other sprinkler loops charged with anti-freeze solution. On 07/18/15, the other compressor was monitored for indications of significant air leaks in the sprinkler pipes. None were found.  <b>Systemic:</b> Effective 08/01/15, the Maintenance Director will inspect the compressors monthly and report any possible leaks in the stand-up meeting. Repairs will be scheduled as needed.  <b>QA Audit:</b> Effective 08/01/15, the Maintenance Director will report compressor inspection results in the monthly QAPI meeting.

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K 062	<p>Continued From page 6</p> <p>and the maintenance shop in the basement of the 100 wing, found them to be anti-freeze loop installations and neither location was labeled with what type or the percentage of anti-freeze solution installed.</p> <p>3) During the facility tour conducted on July 7, 2015 from 11:15 AM to 4:00 PM, observation of the dry system "B" riser in the closet of the Serving Room, found the compressor cycling approximately every 15-20 minutes and equipped with a non UL listed hose and storage tank. When interviewed, the Maintenance Supervisor stated the system had been leaking in the past, but he thought the system had been repaired. He further stated he had added the tank to the system to add capacity.</p> <p>Actual NFPA standard:</p> <p>Findings 1 &amp; 2 NFPA 25 2-3.4* Antifreeze Systems. The freezing point of solutions in antifreeze shall be tested annually by measuring the specific gravity with a hydrometer or refractometer and adjusting the solutions if necessary. Solutions shall be in accordance with Tables 2-3.4(a) and (b). The use of antifreeze solutions shall be in accordance with any state or local health regulations. [See Table 2-3.4(b).]</p> <p>Finding 3 NFPA 25 4-2.6.6 Automatic Air Compressor. Where a dry pipe system is supplied by an automatic air compressor or plant air system, any device or apparatus used for automatic maintenance of air pressure shall be of a type</p>	K 062	

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K 062	Continued From page 7 specifically listed for such service and capable of maintaining the required air pressure on the dry pipe system. Automatic air supply to more than one dry pipe system shall be connected to enable individual maintenance of air pressure in each system. A check valve or other positive backflow prevention device shall be installed in the air supply to each system to prevent airflow or waterflow from one system to another.	K 062	<b>K064</b> <b>Affected:</b> On 07/22/15, the Maintenance Director purchased new 5 lb. fire extinguishers for the identified units and repositioned them to the proper height.  <b>Potential:</b> On 07/22/15, the Maintenance Director assessed all other fire extinguisher locations identifying those in need of repositioning. Identified units were repositioned on 07/22/15.  <b>Systemic:</b> Effective 07/22/15, positioning of the fire extinguishers will be included on the monthly extinguisher inspection.  <b>QA Audit:</b> Effective 08/01/15, fire extinguisher inspections will be reviewed in the Monthly QAPI meeting.	<b>08/01/15</b>
K 064 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6. NFPA 10  This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that fire extinguisher installations were in accordance with NFPA 10. Failure to mount fire extinguishers at the proper height could prevent the ability to use them in the event of a fire. This deficient practice affected 32 residents, staff and visitors on the date of the survey. The facility is licensed for 119 SNF/NF beds and had a census of 32 on the day of the survey.  Findings include:  During the facility tour conducted on July 7, 2015 from 11:15 AM to 4:00 PM, observation of 20 fire extinguishers installed in the facility found the top of each fire extinguisher measured between 62 to 62-1/2 inches from the floor. Interview of the Maintenance Supervisor found that recently the facility replaced fire extinguishers and had not	K 064		

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K 064	Continued From page 8 confirmed the height.  Actual NFPA standard:  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 extinguishers having a gross weight greater than 40 lb (18.14 kg) (except wheeled types) shall be so installed that the top of the fire extinguisher is not more than 31/2 ft (1.07 m) above the floor. In no case shall the clearance between the bottom of the fire extinguisher and the floor be less than 4 in. (10.2 cm).	K 064	<b>K066</b> <b>08/01/15</b>  <b>Affected:</b> On 07/15/15, the Maintenance removed the chairs from the area identified by the Surveyor. A sign was posted in the area warning of the proximity of the oxygen storage cage, and reiterating the facility smoking policy.  <b>Potential:</b> On 07/15/15, The Maintenance Director inspected the facility campus finding no other areas being used for unauthorized smoking.  <b>Systemic:</b> Effective 08/01/15, the Housekeeping Supervisor will include observation of possible unauthorized smoking occurring on facility premises during his regular monthly inspection of the outside areas.  <b>QA Audit:</b> Effective 08/01/15, adverse results from the Housekeeping external inspection will be reported in the monthly QAPI meeting.
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:  (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.  (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.  (3) Ashtrays of noncombustible material and safe 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	K 066	

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K 066	Continued From page 9 permitted. 19.7.4  This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that smoking was limited to designated smoking areas and outside of exposure to oxygen. Failure to limit smoking in designated areas and away from oxygen could expose residents to elevated risks of fires. This deficient practice affected staff and visitors of the 400 wing on the date of the survey. The facility is licensed for 119 SNF/NF beds and had a census of 32 on the day of the survey.  Findings include:  During the facility tour conducted on July 7, 2015 from 11:15 AM to 4:00 PM, observation of the exterior of the Employee Lounge located in the 400 wing found a smoking area had been established by staff across from the oxygen transfill/storage cage. Interview of the Maintenance Supervisor found he was not aware of this area being used for smoking activities and knew the risk of smoking in close proximity to oxygen.  Actual NFPA standard:  NFPA 101 19.7.4* Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored	K 066	

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K 066	Continued From page 10 and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. Exception: In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (2) Smoking by patients classified as not responsible shall be prohibited. Exception: The requirement of 19.7.4(2) shall not apply where the patient is under direct supervision. (3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.	K 066	<b>K072</b> <b>08/30/15</b>  <b>Affected:</b> On or before 08/30/15, the door knobs on rooms 102, 103, 107, 109, 110, 111, 113, 115, 117, and 119 will be replaced with knobs in compliance with NFPA Standard 7.1.10. The deadbolt locks on rooms 107,110,117, and 119 will be removed.  <b>Potential:</b> On or Before 08/20/15 the Maintenance Director will inspect all rooms equipped with knobs to determine compliance with NFPA Standard 7.1.10. Those found to be not in compliance will be replaced on or before 08/30/15.  <b>Systemic:</b> Effective 08/01/15 any re-purposing of rooms will require a review of the door knob and locking mechanism to ensure compliance with NFPA regulation.
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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 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	K 072	<b>QA Audit:</b> Effective 08/01/15, any re-purposing of rooms will be reviewed in QAPI Committee.

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K 072	<p>Continued From page 11</p> <p>a fire or other emergency. This deficient practice affected staff and visitors on the date of the survey. The facility is licensed for 119 SNF/NF beds and had a census of 32 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on July 7, 2015 from 11:15 AM to 4:00 PM, observation and operational testing of facility doors revealed the following:</p> <p>Rooms 102, 103, 107, 109, 110, 111, 113 and 115 all were equipped with door knobs and dual-keyed deadbolt locks requiring a key to operate the lock from the egress side. Rooms 107, 110, 117, 119 and Admissions all were equipped with keyed locking mechanisms requiring more than one single operation to operate the lock from the egress side.</p> <p>Interview of the Maintenance Supervisor found he was not aware of the requirement for single operational locking mechanisms from the egress side.</p> <p>Due to the amount and extent of locations found, the condition was deemed widespread and further documentation was not required.</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>	K 072	

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K 072	Continued From page 12 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 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.	K 072	<b>K147</b> <b>08/30/15</b> <b>Affected:</b> On 07/15/15, the Air conditioning units were plugged into regular electrical outlets. On 07/15/15, the television in the unused staff lounge was disconnected and the penetration sealed. On or before 08/30/15, an alternate chart storage unit will be utilized, which will allow access to the breaker box without moving the chart rack. On 07/08/15, the 3 to one multiple adaptor was removed and the television was plugged into the regular outlet. On 07/08/15, the microwave oven was unplugged from the relocatable power tap and connected to a regular outlet.  <b>Potential:</b> On 07/14/15 all rooms were inspected by the Maintenance Director for the presence of, and proper use of, relocatable power taps. Violations were corrected immediately. On or before 08/20/15 all breaker boxes will be assessed by the Maintenance Director to insure they are not obstructed. Any obstructions will be removed.
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 safe and in compliance with NFPA 70. Failure to	K 147	<b>Systemic:</b> Effective 08/01/15, the Maintenance Director will inspect breaker boxes monthly for the presence of obstructions, and correct any issues found.  <b>QA Audit:</b> Effective 08/01/15, results of the monthly inspections will be reported in the monthly QAPI committee meeting

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K 147	<p>Continued From page 13</p> <p>ensure electrical systems are properly installed could result in fire by arcing or electrocution. This deficient practice affected 32 residents, staff and visitors on the date of the survey. The facility is licensed for 119 SNF/NF beds and had a census of 32 on the day of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on July 7, 2015 from 11:15 AM to 4:00 PM, observation of the following areas found window mounted air conditioning units using relocatable power taps as extension cords:</p> <p>Administrators office Physical Therapy office Central Supply office (abutting Admissions) Staff Lounge by the Kitchen.</p> <p>2) During the facility tour conducted on July 7, 2015 from 11:15 AM to 4:00 PM, room #208 had a television plugged into a 3 to 1 multiple plug adapter. Interview of the Maintenance Supervisor found he was not aware of this installation.</p> <p>3) During the facility tour conducted on July 7, 2015 from 11:15 AM to 4:00 PM, observation of the Medicare Desk in the 300 wing found the electrical breaker box #1 blocked by a binder storage cart. Interview of the Maintenance Supervisor indicated he was aware this panel could not be obstructed.</p> <p>4) During the facility tour conducted on July 7, 2015 from 11:15 AM to 4:00 PM, observation of the Staff Lounge in the 400 wing found a television power cord ran through the wall into the relocatable power tap on the other side.</p>	K 147	

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K 147	<p>Continued From page 14</p> <p>5) During the facility tour conducted on July 7, 2015 from 11:15 AM to 4:00 PM, observation of the Housekeeping office abutting the main Laundry found a microwave plugged into a relocatable power tap.</p> <p>Findings 1, 4, and 5 NFPA 70 400.8 Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following:</p> <ol style="list-style-type: none"> <li>(1) As a substitute for the fixed wiring of a structure</li> <li>(2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors</li> <li>(3) Where run through doorways, windows, or similar openings</li> <li>(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.</li> <li>(5) Where concealed by walls, floors, or ceilings or located above suspended or dropped ceilings</li> <li>(6) Where installed in raceways, except as otherwise permitted in this Code</li> </ol> <p>Finding 3 110.26 Spaces About Electrical Equipment. Sufficient access and working space shall be provided and maintained about all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons. (A) Working Space. Working space for equipment operating at 600 volts, nominal, or less to ground and likely to require examination,</p>	K 147	

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K 147	Continued From page 15  adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A)(1), (2), and (3) or as required or permitted elsewhere in this Code. (1) Depth of Working Space. The depth of the working space in the direction of live parts shall not be less than that specified in Table 110.26(A)(1) unless the requirements of 110.26(A)(1)(a), (b), or (c) are met. Distances shall be measured from the exposed live parts or from the enclosure or opening if the live parts are enclosed.  Finding 2 IDAPA 16.03.02.120 10 Electrical and Lighting. All electrical and lighting installation shall be in accordance with the National Electrical Code (1984 ed.) and as follows: c. Plug adaptors and multiple outlets are prohibited.	K 147		