



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK -- ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.D. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

September 23, 2015

Rebecca Butler, Administrator
Prestige Care & Rehabilitation-- The Orchards
1014 Burrell Avenue
Lewiston, ID 83501-5589

Provider #: 135103

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

Dear Ms. Butler:

On **September 15, 2015**, a Facility Fire Safety and Construction survey was conducted at **Prestige Care & Rehabilitation-- The Orchards** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

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

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you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office. If a State Form with deficiencies was issued, it should be signed, dated and returned along with the CMS-2567 Form.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **October 6, 2015**. Failure to submit an acceptable PoC by **October 6, 2015**, may result in the imposition of civil monetary penalties by **October 26, 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 **October 20, 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 **October 20, 2015**. A change in the seriousness of the deficiencies on **October 20, 2015**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **October 20, 2015**, includes the following:

Denial of payment for new admissions effective **December 15, 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 **March 15, 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 **September 15, 2015**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

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

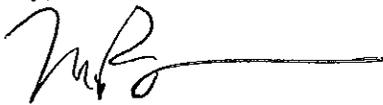
BFS Letters (06/30/11)

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

This request must be received by **October 6, 2015**. If your request for informal dispute resolution is received after **October 6, 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: 09/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135103	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 09/15/2015
NAME OF PROVIDER OR SUPPLIER PRESTIGE CARE & REHABILITATION - THE OI		STREET ADDRESS, CITY, STATE, ZIP CODE 1014 BURRELL AVENUE LEWISTON, ID 83501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The facility is a single story type V (111) structure completed in 1958, with an addition of comparable construction. The facility is sprinklered with a new fire alarm and smoke detection system installed in 2013. The building has a partial basement which is used for storage and maintenance. The building is currently licensed for 127 beds. The following deficiencies were cited during the annual fire/life safety survey conducted on September 15, 2015. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70. The Survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	K 000	This plan of correction is being submitted in compliance with specific regulatory requirements and preparation and/or execution of this plan does not constitute admission or agreement by the provider of the facts alleged or conclusions set forth on the statement of deficiencies.	
K 017 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5	K 017	1. No residents were affected 2. No residents were identified at risk 3. Systemic Changes include: a. All penetrations through identified wall have been sealed. b. To ensure all in house or contracted work causing any penetrations will be sealed as soon as work is completed 4. Monitoring: a. Weekly maintenance director will during facility walk throughs will ensure that there are no new penetrations present b. QAPI committee will review monthly x 3 months and annually thereafter	9/16/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rebecca Butley TITLE: LWHA (X6) DATE: 10/8/15

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 017	Continued From page 1 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that smoke and fire resistive properties of corridor walls were maintained. Failure to maintain the smoke and fire resistive properties of a corridor wall would allow fire, smoke and dangerous gases to communicate between compartments during a fire event. This deficient practice affected residents, staff and visitors utilizing the physical therapy wing on the date of the survey. The facility is licensed for 127 SNF/NF beds and had a census of 57 on the day of the survey. Findings include: During the facility tour conducted on September 15, 2015 from 10:30 AM to 4:00 PM, observation of the Bookkeeping storage closet located in the Physical Therapy wing revealed three (3) holes in the interior of the closet, exposing the interior wall cavity on two sides. Further inspection of these unsealed penetrations did not reveal any fire stopping or smoke resistive barriers. Observation revealed these penetrations ranged in size from approximately one inch by six inches to three inches by six inches. When asked about the unsealed penetrations, the Maintenance Supervisor stated he did not know of the presence of these holes, but thought they were cut into the walls to access hardware of a pocket door formally installed in this area. Actual NFPA standard:	K 017	This page intentionally left blank.	

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K 017	Continued From page 2 19.3.6.2 Construction of Corridor Walls. 19.3.6.2.1* Corridor walls shall be continuous from the floor to the underside of the floor or roof deck above, through any concealed spaces, such as those above suspended ceilings, and through interstitial structural and mechanical spaces, and they shall have a fire resistance rating of not less than 1/2 hour. Exception No. 1*: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, a corridor shall be permitted to be separated from all other areas by non-fire-rated partitions and shall be permitted to terminate at the ceiling where the ceiling is constructed to limit the transfer of smoke. Exception No. 2: Existing corridor partitions shall be permitted to terminate at ceilings that are not an integral part of a floor construction if 5 ft (1.5 m) or more of space exists between the top of the ceiling subsystem and the bottom of the floor or roof above, provided that the following criteria are met: (a) The ceiling shall be part of a fire-rated assembly tested to have a fire resistance rating of not less than 1 hour in compliance with the provisions of 8.2.3.1. (b) The corridor partitions form smoketight joints with the ceilings (joint filler, if used, shall be noncombustible). (c) Each compartment of interstitial space that constitutes a separate smoke area is vented, in a smoke emergency, to the outside by mechanical means having sufficient capacity to provide not less than two air changes per hour but, in no case, a capacity less than 5000 ft ³ /min (2.36 m ³ /s). (d) The interstitial space shall not be used for	K 017	This page intentionally left blank.	

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K 017	Continued From page 3 storage. (e) The space shall not be used as a plenum for supply, exhaust, or return air, except as noted in 19.3.6.2.1(3). Exception No. 3*: Existing corridor partitions shall be permitted to terminate at monolithic ceilings that resist the passage of smoke where there is a smoketight joint between the top of the partition and the bottom of the ceiling. 19.3.6.2.2* Corridor walls shall form a barrier to limit the transfer of smoke.	K 017		
K 062 SS=F	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 observation, the facility failed to ensure that sprinkler systems were maintained free of obstructions. Failure to keep sprinklers free from obstructions would limit the capabilities of the system design and allow fires to grow beyond incipient stages. This deficient practice affected 31 residents, staff and visitors on the date of the survey. The facility is licensed for 127 SNF/NF beds and had a census of 57 on the day of the survey. Findings include: During the facility tour conducted on September 15, 2015 from 10:30 AM to 4:00 PM, observation of sprinklers installed in the facility revealed two	K 062	1. No residents were affected 2. No residents were identified at risk 3. Systemic Changes include: a. Vendor, Simplex Grinnell, to lower sprinkler heads within regulation, so the required distance from the light fixtures is maintained. b. Maintenance will ensure during weekly facility walkthrough that all sprinkler heads are compliant with regulations 4. Monitoring: a. Facility maintenance director will review monthly with QAPI committee x 3 months and annually thereafter	10/20/15

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K 062	Continued From page 4 (2) sprinkler pendants in the 300 wing directly outside rooms 302 and 307, were blocked by the installation of fluorescent light fixtures. Further inspection revealed these pendants were less than four (4) inches from the fixtures and the fixtures projected below the bottom of the deflector by approximately one inch. Actual NFPA standard: NFPA 13 5-6.5 Obstructions to Sprinkler Discharge (Standard Pendent and Upright Spray Sprinklers). 5-6.5.1 Performance Objective. 5-6.5.1.1 Sprinklers shall be located so as to minimize obstructions to discharge as defined in 5-6.5.2 and 5-6.5.3, or additional sprinklers shall be provided to ensure adequate coverage of the hazard.	K 062		
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 extinguishers properly could hinder their use during a fire event. This deficient practice affected 31 residents, staff and visitors at the 300 wing, staff and visitors of the Kitchen and south basement service area on the date of the survey.	K 064	1. No residents were affected 2. No residents were identified at risk 3. Systemic Changes include: a. The 4 fire extinguishers were lowered to comply with regulation height. b. Facility walk through to ensure all fire extinguishers were within regulation. c. All additional fire extinguishers identified as not being within regulation were lowered to meet standards. d. Maintenance Director will monthly during fire extinguisher pressure checks will also ensure heights are maintained 4. Monitoring: a. QAPI will monthly x3 months and annually thereafter review maintenance monthly checks to ensure compliance	9/16/15

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K 064	Continued From page 5 The facility is licensed for 127 SNF/NF beds and had a census of 57 on the day of the survey. Findings include: During the facility tour conducted on September 15, 2015 from 10:30 AM to 4:00 PM, observation of installed fire extinguishers in the facility revealed the following extinguishers measured over sixty (60) inches from the floor to the top of the extinguisher: a) The "K" style fire extinguisher in the Kitchen measured 72 inches to the top of the extinguisher. b) Two extinguishers in the south basement service area measured 64 inches and 68 inches to the top of the extinguisher. c) Extinguisher at the southwest exit of the 300 wing measured 62 inches to the top of the extinguisher. 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	This page intentionally left blank.	
K 072 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained	K 072		

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K 072	<p>Continued From page 6</p> <p>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</p> <p>This Standard is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure means of egress were readily available. Failure to maintain means of egress free of obstructions or impediments would limit safe evacuation of residents during an emergency. This deficient practice affected 31 residents, staff and visitors on the date of the survey. The facility is licensed for 127 SNF/NF beds and had a census of 57 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on September 15, 2015 from 10:30 AM to 4:00 PM, observation and operational testing of the southwest gate at the path to the public way from the 300 wing, found the gate was equipped with a combination padlock. When interviewed, 4 of 5 staff members were not aware of the combination to this lock.</p> <p>Operational testing further demonstrated special knowledge was required due to the unique nature of the padlock dial. Interview of the Maintenance Supervisor revealed that to unlock the mechanism, the numbers were required to be aligned off-center and in a non-conventional manner. When asked about this special operational feature, only 1 of 5 staff interviewed knew of this requirement.</p>	K 072	<ol style="list-style-type: none"> 1. No residents were affected 2. No residents were identified at risk 3. Systemic Changes include: <ol style="list-style-type: none"> a. Combination was removed b. Keyed pad lock was installed c. Keys placed on nursing keychains, housekeeping keys and handed out to Administrator, Maintenance Director, Maintenance Assistant, and Director of Nursing d. Key hung at gate in an inconspicuous location for resident safety, and for quick access to egress e. On 9/30/15 at three all staff meetings, staff were informed of changes to securing smoke courtyard egress gate f. In-Service page added to facility in-service book for staff to review and sign-off that they have read in-service. g. New hires during orientation will be made aware of lock and location of keys. h. Maintenance director will weekly ensure egress is not blocked by ensuring key is present. 4. Monitoring: <ol style="list-style-type: none"> a. Maintenance Director will monthly x3 months review courtyard egress b. QAPI will review monthly x 3 months to ensure compliance with clear egress 	09/30/15

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K 072	Continued From page 7 Actual NFPA standard: 19.2.2.2.5 Doors located in the means of egress that are permitted to be locked under other provisions of this chapter shall have adequate provisions made for the rapid removal of occupants by means such as remote control of locks, keying of all locks to keys carried by staff at all times, or other such reliable means available to the staff at all times. Only one such locking device shall be permitted on each door. Exception No. 1: Locks in accordance with Exception Nos. 2 and 3 to 19.2.2.2.4. Exception No. 2: More than one lock shall be permitted on each door subject to approval of the authority having jurisdiction. 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. 7.2.1.5 Locks, Latches, and Alarm Devices. 7.2.1.5.1 Doors shall be arranged to be opened readily from the egress side whenever the building is occupied. Locks, if provided, shall not require the use of a key, a tool, or special knowledge or effort for operation from the egress side. Exception No. 1: This requirement shall not apply where otherwise provided in Chapters 18 through 23. Exception No. 2: Exterior doors shall be permitted to have key-operated locks from the egress side, provided that the following criteria are met:	K 072	This page intentionally left blank.	

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K 072	Continued From page 8 (a) Permission to use this exception is provided in Chapters 12 through 42 for the specific occupancy. (b) On or adjacent to the door, there is a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high on a contrasting background that reads as follows: THIS DOOR TO REMAIN UNLOCKED WHEN THE BUILDING IS OCCUPIED (c) The locking device is of a type that is readily distinguishable as locked. (d) A key is immediately available to any occupant inside the building when it is locked. Exception No. 2 shall be permitted to be revoked by the authority having jurisdiction for cause. Exception No. 3: Where permitted in Chapters 12 through 42, key operation shall be permitted, provided that the key cannot be removed when the door is locked from the side from which egress is to be made.	K 072		
K 130 SS=F	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This Standard is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure that renovation projects affecting the life safety of residents were isolated and sufficient interim life safety measures were in place. Failure to isolate substantial, ongoing renovation projects from residents and provide interim life safety measures, could affect egress during an emergency and expose residents to increased hazards associated with facility renovations. This deficient practice affected 31 residents, staff and visitors on the date of the survey. The facility is	K 130	1. No residents were affected 2. No residents were identified at risk 3. Systemic Changes include: a. Vendor, Simplex Grinnell, contacted and confirmed that a representative will be at the facility on 10/1/15 to assist in determining the most effective way in ensuring the annunciator panel no longer shows "trouble" and detectors continue to operate effectively. b. Updates will continue to be provided to Bureau of Facility Standards as required by code to ensure proper fire protection to entire facility. c. The exit signs signifying exit through repaired hallway area have been covered d. Signs signifying, " emergency exit is behind you thru the diningroom" have been placed next to covered exit signs. e. Sign reading, "Do Not Enter! Danger Construction Zone!" was placed on plastic covering door.	10/20/15

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K 130	<p>Continued From page 9 licensed for 127 SNF/NF beds and had a census of 57 on the day of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on September 15, 2015 from 10:30 AM to 4:00 PM, observation of the fire alarm annunciator panel located at the main entrance revealed the alarm was currently indicating "trouble". When asked about this condition, the Maintenance Supervisor stated several smoke detection devices in the "Bridge" wing had been removed and the relays disabled by the vendor, due to an on-going construction project in that wing. When asked to demonstrate the location of the trouble through the addressable fire alarm system, operational testing by the Maintenance Assistant at the annunciator panel could not reveal the source location.</p> <p>2) During the facility tour conducted on September 15, 2015 from 10:30 AM to 4:00 PM, observation of the entrance into the "Bridge" wing from the Annex dining room, revealed a black plastic membrane over the double doors which enter the wing. Further observation exhibited three (3) exit signs indicated the path of egress from the dining hall was through this plastic membrane and no signs indicating this area was closed to access.</p> <p>3) Interview conducted with the Maintenance Supervisor on September 15, 2015 from 8:30 AM to 9:00 AM revealed the fire alarm system "trouble" code was due to repairs of ceiling leaks in the "Bridge" wing. Further inquiry indicated these repairs resulted in removal of smoke detection devices in the corridor and deactivation of interconnected relays.</p>	K 130	<p>Continued from page 9</p> <p>f. Interim Life Safety Measures Assessment completed</p> <p>g. Smoke barrier placed to inside of fire doors on affected hallway</p> <p>4. Monitoring:</p> <p>a. Maintenance Director will weekly with preventative maintenance ensure that fire panel is continuing to read no trouble and will notify vendor if system doesn't read clear.</p> <p>b. Interim Life Safety Measures Assessment will be completed at the start of each new construction project</p> <p>c. QAPI will review monthly x3 months, and monthly thereafter during any construction project to ensure compliance</p>	

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K 130	Continued From page 10 4) Interview conducted with the Administrator on September 15, 2015 from 2:30 PM to 3:00 PM revealed the repair project being conducted in the "Bridge" wing was deemed necessary due to extensive leaking discovered in the corridor ceiling in August, 2014. Further inquiry found delays were encountered due to conditions not in the original scope of work. When asked about timeline for completion of the project, the Administrator was not sure of a completion date. 5) During the exit conference conducted on September 15, 2015 from 4:00 PM to 5:00 PM, the Administrator and the Maintenance Supervisor stated they were not aware of the requirements of Interim Life Safety measures during extensive construction or renovation projects. Actual NFPA standard: NFPA 101 19.1.1.4.6 Construction, Repair, and Improvement Operations. (See 4.6.10.) 4.6.10 Construction, Repair, and Improvement Operations. 4.6.10.1* Buildings or portions of buildings shall be permitted to be occupied during construction, repair, alterations, or additions only where required means of egress and required fire protection features are in place and continuously maintained for the portion occupied or where alternative life safety measures acceptable to the authority having jurisdiction are in place.	K 130	This page intentionally left blank.	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 147		

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K 147	<p>Continued From page 11</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This Standard is not met as evidenced by: Based on observation, the facility failed to ensure electrical installations were maintained in accordance with NFPA 70. Failure to maintain electrical installations could result in electrocution or fires by arcing. This deficient practice affected 6 residents in the 200 wing, staff and visitors to the south basement service area. The facility is licensed for 127 SNF/NF beds and had a census of 57 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on September 15, 2015 from 10:30 AM to 4:00 PM, observation of electrical installations revealed the following:</p> <p>1) Inspection of a sub-panel located in the 200 wing outside the Kitchen, revealed it was missing two (2) sections of the breaker bar cover, approximately 18 to 20 inches in length. The area was covered with strips of blue masking tape.</p> <p>2) Inspection of the interior of the elevator shaft revealed two (2) electrical conduit boxes approximately four inches by four inches, missing covers and with exposed wiring.</p> <p>3) Inspection of the crawl space access located in the south basement service area revealed five (5) electrical conduit boxes approximately four inches by four inches, missing covers and with exposed wiring. Further inspection of this crawl space revealed a portable worklight with a cord which had been spliced into an extension cord.</p>	K 147	<ol style="list-style-type: none"> 1. No residents were affected 2. No residents were identified at risk 3. Systemic Changes include: <ol style="list-style-type: none"> a. Electrician was contacted while surveyor was in facility. Electrician immediately came to facility. b. Blue tape was removed c. All spaces in sub-panel were properly covered d. Elevator company was previously scheduled to come to facility on 9/29/15. Will at the time of their visit have their assistance with 2 electrical conduit boxes. e. Electrical wiring in crawl space was covered. f. Work light removed from crawl space g. Extension cord removed from riser room and spliced wires removed. Conduit installed to ensure proper installation h. Cover placed on electrical boxes in furnace room 4. Monitoring: <ol style="list-style-type: none"> a. Maintenance will ensure that all spaces continue to be properly covered whenever work is being performed on subpanel. b. Maintenance Director will ensure when electrical contracted work is performed that all panel and electrical boxes are secured prior to contractors exiting c. Maintenance director will during weekly walkthroughs ensure that proper work lights will be used and removed at completion of project and no extension cords will be left in use d. QAPI to review monthly x 3 months for compliance 	9/30/15

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K 147	Continued From page 12 4) Inspection of the riser room in the south basement service area revealed the overhead fluorescent lighting wiring had been cut and spliced into an extension cord plugged into an outlet. Further inspection found this extension cord was also wired into an overhead incandescent light. 5) Inspection of the furnace room revealed two (2) electrical conduit boxes approximately four inches by four inches and an electrical timer missing covers with exposed wiring. Actual NFPA standard: Findings 1,2,3 & 5 NFPA 70 110.12 Mechanical Execution of Work. Electrical equipment shall be installed in a neat and workmanlike manner. (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. (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. (C) Integrity of Electrical Equipment and Connections. Internal parts of electrical equipment, including busbars, wiring terminals, insulators, and other surfaces, shall not be	K 147	This page intentional left blank.	

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K 147	<p>Continued From page 13</p> <p>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>314.17 Conductors Entering Boxes, Conduit Bodies, or Fittings. Conductors entering boxes, conduit bodies, or fittings shall be protected from abrasion and shall comply with 314.17(A) through (D). (A) Openings to Be Closed. Openings through which conductors enter shall be adequately closed.....</p> <p>Findings 3, 4</p> <p>NFPA 70 400.8 Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of 368.8. (5) Where concealed by walls, floors, or ceilings or located above suspended or dropped ceilings (6) Where installed in raceways, except as otherwise permitted in this Code</p>	K 147	This page intentional left blank.	

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K 147	Continued From page 14 400.9 Splices. Flexible cord shall be used only in continuous lengths without splice or tap where initially installed in applications permitted by 400.7(A). The repair of hard-service cord and junior hard-service cord (see Trade Name column in Table 400.4) 14 AWG and larger shall be permitted if conductors are spliced in accordance with 110.14(B) and the completed splice retains the insulation, outer sheath properties, and usage characteristics of the cord being spliced.	K 147	This page intentional left blank.	