



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.O. Box 83720  
Boise, ID 83720-0009  
PHONE 208-334-6626  
FAX 208-364-1888

October 15, 2015

Richard Ord, Administrator  
Bennett Hills Center  
1220 Montana Street  
Gooding, ID 83330-1856

Provider #: 135134

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

Dear Mr. Ord:

On **October 6, 2015**, a Facility Fire Safety and Construction survey was conducted at **Bennett Hills 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

Richard Ord, Administrator  
October 15, 2015  
Page 2 of 4

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 28, 2015**. Failure to submit an acceptable PoC by **October 28, 2015**, may result in the imposition of civil monetary penalties by **November 17, 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 **November 10, 2015**, (Opportunity to Correct). Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **November 10, 2015**. A change in the seriousness of the deficiencies on **November 10, 2015**, may result in a change in the remedy.

Richard Ord, Administrator  
October 15, 2015  
Page 3 of 4

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

Denial of payment for new admissions effective **January 6, 2016**.  
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 **April 6, 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 **October 6, 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:

Richard Ord, Administrator  
October 15, 2015  
Page 4 of 4

<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 28, 2015**. If your request for informal dispute resolution is received after **October 28, 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/j  
Enclosures

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

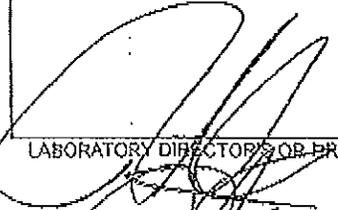
Printed: 10/15/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135134	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - HELPING HANDS OF GOODING B. WING _____	(X3) DATE SURVEY COMPLETED  10/06/2015
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NAME OF PROVIDER OR SUPPLIER <b>BENNETT HILLS CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1220 MONTANA STREET GOODING, ID 83330</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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<p><b>K 000 INITIAL COMMENTS</b></p> <p>The building is a single story structure Type V(111) construction completed in August of 1971. It is fully sprinklered and has a complete fire alarm system to include smoke detection in hallways and open spaces. Currently it is licensed for 80 SNF/NF beds.</p> <p>The following deficiencies were cited during the Life Safety Code Survey conducted on October 6, 2015. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.</p> <p>The Survey was conducted by:</p> <p>Nate Elkins Health Facility Surveyor Facility Fire Safety &amp; Construction</p> <p><b>K 018 NFPA 101 LIFE SAFETY CODE STANDARD SS=E</b></p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 1/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p>	<p><b>F000</b></p> <p>The Bennett Hills Center provides this plan of correction without admitting or denying the validity or existence of the alleged deficiencies. The Plan of Correction is prepared and executed solely because it is required by federal and state law.</p> <p><b>K 018 - E</b></p> <ol style="list-style-type: none"> <li>1) The door to the employee break room now has a pass through latch and a sign that tells staff that the door must remain closed for fire barrier reasons and that the door can't be propped open at any time, this was completed as of 10/28/15. Resident room door number 9 door latch has been fixed and the door latches on 10/7/15.</li> <li>2) A review of the whole facility was completed by the maintenance manager with no other doors found being propped on fire barrier areas. There were no other resident room doors found to be not latching properly in the building as of 10/28/15.</li> <li>3) Weekly documentation for propped fire doors and resident room doors not latching properly will be completed by the maintenance manager for 4 weeks.</li> <li>4) The maintenance manager has received education from the administrator regarding the importance of not propping fire barrier doors and the importance of making sure that all resident doors latch properly, this was completed by 10/28/15.</li> <li>5) The 4 weekly audits results performed by the maintenance manager will be reviewed by the quality committee in the November and December QAPI meetings. The QAPI meetings will be held on 11/12/15 and 12/10/15. Further action by the QAPI team will be taken if necessary at that time.</li> </ol>	<p>11/09/15</p>
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>Administrator</b>	(X6) DATE <b>10/22/15</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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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER <b>BENNETT HILLS CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1220 MONTANA STREET GOODING, ID 83330</b>		
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K 018	<p>Continued From page 1</p> <p>This Standard is not met as evidenced by: Based on observation, operational testing, and interview the facility failed to maintain doors that protect corridor openings. Failure to maintain corridor doors could allow smoke and dangerous gases to pass freely between smoke compartments. This deficient practice affected 11 residents, staff, and visitors on the day of survey. The facility is licensed for 80 SNF/NF beds with a census of 28 on the date of survey.</p> <p>Findings include:</p> <p>1.) During the facility tour on October 6, 2015 at approximately 11:30 PM, observation revealed the self closing door leading to the employee break room area which included the Maintenance office, and the Laundry Supervisor's office was blocked open by a 1 gallon clear plastic bucket of beads. When asked, the Maintenance Supervisor stated the door was blocked open for convenience.</p> <p>2.) During the facility tour on October 6, 2015 at approximately 3:30 PM, observation and operational testing of room 9 revealed the door would not latch when closed. When asked, the Maintenance Supervisor stated the facility was unaware the door would not latch.</p> <p>Actual NFPA standard:</p> <p>19.3.6.3 Corridor Doors. 19.3.6.3.1* Doors protecting corridor openings in other than</p>	K 018		

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K 018	<p>Continued From page 2</p> <p>required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors.</p> <p>Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.</p> <p>Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke.</p> <p>19.3.6.3.2*</p> <p>Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.2.</p> <p>Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.</p> <p>Exception No. 2: Existing roller latches demonstrated to keep the door closed against a force of 5 lbf (22 N) shall be permitted to be kept</p>	K 018	

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K 018	Continued From page 3 in service.	K 018		
K 022	NFPA 101 LIFE SAFETY CODE STANDARD SS=F:	K 022 - F		11/09/15
	<p>Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that exits were clearly identified by appropriate means. Failure to ensure exits are identified clearly would hinder the safe evacuation of occupants during an emergency. This deficient practice has the potential to affect all residents, staff and visitors on the date of the survey. The facility is licensed for 80 SNF/NF beds with a census of 28 on the day of the survey.</p> <p>Findings include:</p> <p>1.) During the facility tour on October 6, 2015 at approximately 9:30 AM observation of the exit signs entering the south hallway found the exit sign directional to the right indicated by an arrow or chevron and would lead occupants into the corridor wall. Upon further observation it was revealed the exit sign leaving the south hallway was also directional to the right which would lead occupants into the Director of Nursing office.</p>	<ol style="list-style-type: none"> <li>1) The directional arrow signs at the top of the south hallway and the top of the north hallway have been slid back to the non-arrow status. This was completed on 10/7/15. The root cause was when the bulbs were changed the panels slid to the 1/2 arrow status.</li> <li>2) A review of the whole facility was completed by the maintenance manager with no other exit sign arrows slid to the wrong position as of 10/28/15.</li> <li>3) Weekly documentation for exit sign arrow observations of arrows in the wrong position will be completed by the maintenance manager for 4 weeks.</li> <li>4) The maintenance manager has received education from the administrator regarding the importance of the exit sign arrow being in the appropriate position; this was completed by 10/28/15.</li> <li>5) The 4 weekly audits results performed by the maintenance manager will be reviewed by the quality committee in the November and December QAPI meetings. The QAPI meetings will be held on 11/12/15 and 12/10/15. Further action by the QAPI team will be taken if necessary at that time.</li> </ol>		

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K 022	<p>Continued From page 4</p> <p>2.) During the facility tour on October 6, 2015 at approximately 2:00 PM, observation of the exit signs entering the north hallway revealed was directional to the right which would lead occupants into room 13.</p> <p>When asked, the Maintenance Supervisor stated the facility was unaware of the arrows or chevrons were wrong on the exit signs.</p> <p>Actual NFPA standard:</p> <p>7.10.1.4* Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. Sign placement shall be such that no point in an exit access corridor is in excess of 100 ft (30 m) from the nearest externally illuminated sign and is not in excess of the marked rating for internally illuminated signs. Exception: Signs in exit access corridors in existing buildings shall not be required to meet the placement distance requirements.</p> <p>7.10.2* Directional Signs. A sign complying with 7.10.3 with a directional indicator showing the direction of travel shall be placed in every location where the direction of travel to reach the nearest exit is not apparent.</p>	K 022	
K 027 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 7.2.2.6. Swinging doors are</p>	K 027	

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K 027	<p>Continued From page 5 not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>This Standard is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure smoke barrier doors would close when activated. Failure to ensure that smoke barrier doors closed completely would allow the passage of smoke and dangerous gases to travel freely and negate the opportunity to defend in place. This deficient practice affected 11 residents, staff and visitors on the date of the survey. The facility is licensed for 80 SNF/NF beds with a census of 28 on the day of the survey.</p> <p>Findings include:</p> <p>1.) During the facility tour on October 6, 2015 at approximately 9:30 AM, observation and operational testing of the cross corridor doors in the south hallway revealed the doors would not close properly when activated from the magnetic hold open device leaving an approximate 1-2 inch gap between the leading edge of the doors.</p> <p>2.) During the facility tour on October 6, 2015 at approximately 2:00 PM, observation and operational testing of the cross corridor doors in the north hallway revealed the doors would not close properly when activated from the magnetic hold open device leaving an approximate 1-2 inch gap between the leading edge of the doors.</p> <p>When asked, the Maintenance Supervisor stated the facility was unaware the doors would not close and seal properly.</p>	K 027 - E	<ol style="list-style-type: none"> <li>1) The south fire barrier doors and the north fire barrier doors were repaired by the maintenance director. The door closes appropriately without gaps now. This was completed on 10/14/15.</li> <li>2) A review of the whole facility was completed by the maintenance manager with no gaps found on any of the fire barrier doors as of 10/28/15.</li> <li>3) Weekly documentation for observations for gaps on any of the fire barrier doors will be completed by the maintenance manager for 4 weeks.</li> <li>4) The maintenance manager has received education from the administrator regarding the importance of there being no gaps at the fire barrier doors; this was completed by 10/28/15.</li> <li>5) The 4 weekly audits results performed by the maintenance manager will be reviewed by the quality committee in the November and December QAPI meetings. The QAPI meetings will be held on 11/12/15 and 12/10/15. Further action by the QAPI team will be taken if necessary at that time.</li> </ol>
			11/09/15

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K 027 Continued From page 6

K 027

Actual NFPA standards:

NFPA 101  
19.3.7.6\*

Doors in smoke barriers shall comply with 8.3.4 and shall be self-closing or automatic-closing in accordance with 19.2.2.2.6. Such doors in smoke barriers shall not be required to swing with egress travel. Positive latching hardware shall not be required.

8.3.4.1\*

Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles.

K 029 NFPA 101 LIFE SAFETY CODE STANDARD  
SS=D

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

This Standard is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure that hazardous areas were protected with self-closing doors. Failure to provide self-closing doors for hazardous areas would allow smoke and

K 029 - D

- 1) The 2 doors on the south hall that require self-closure mechanisms have been purchased and installed. This was completed on 10/28/15.
- 2) A review of the whole facility was completed by the maintenance manager with no other rooms being used for storage were found needing self-closure mechanisms as of 10/28/15.
- 3) Weekly documentation for working self-closure doors on storage rooms will be completed by the maintenance manager for 4 weeks.
- 4) The maintenance manager has received education from the administrator regarding the importance of self-closure mechanisms on storage rooms for fire safety; this was completed by 10/28/15.
- 5) The 4 weekly audits results performed by the maintenance manager will be reviewed by the quality committee in the November and December QAPI meetings. The QAPI meetings will be held on 11/12/15 and 12/10/15. Further action by the QAPI team will be taken if necessary at that time.

11/09/15

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K 029	<p>Continued From page 7</p> <p>dangerous gases to pass freely into corridors and hinder egress of occupants during a fire event. This deficient practice affected staff and visitors on the date of the survey. The facility is licensed for 80 SNF/NF beds with a census of 28 on the day of the survey.</p> <p>Findings include:</p> <p>1.) During the facility tour on October 6, 2015 at approximately 9:30 AM, observation and operational testing revealed the door to room 43 in the south hallway was not on a self closure. The room was converted to a storage room and was storing combustible supplies and equipment and was greater than 50 square feet. When asked, Maintenance Director stated the facility was unaware the door was required to be on a self closure.</p> <p>2.) During the facility tour on October 6, 2015 at approximately 10:00 AM, observation and operational testing revealed the door to the Maintenance room in the south hallway was not on a self closure. The room was storing combustible supplies and equipment and was greater than 50 square feet. When asked, the Maintenance Supervisor stated the facility was unaware the door needed to be on a self closure.</p> <p>Actual NFPA standard:</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</p>	K 029	

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

Printed: 10/15/2015  
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K 029	Continued From page 8 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:  (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.	K 029		
K 046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.  This Standard is not met as evidenced by: Based on record review and interview the facility failed to provide monthly and annual emergency lighting system test documentation. Failure to test the emergency lighting system could inhibit egress of residents during an emergency. This deficient practice affected all residents, staff and visitors on the day of survey. The facility is licensed for 80 SNF/NF beds with a census of 28 on the date of survey.  Findings include:	K 046 - F	1) The emergency lighting tests documentation for monthly and yearly tests were done as stated by the maintenance director, but was not documented. All emergency lights were tested during the survey and worked appropriately. The maintenance manager will keep a paper trail of documentation of monthly and yearly tests as he is required to do, starting October 2015. This was completed on 10/28/15.  2) All emergency lighting in the building was tested and was working appropriately as of 10/28/15.  3) Additional weekly documentation for the emergency lighting tests will be completed by the maintenance manager for 4 weeks.  4) The maintenance manager has received education from the administrator regarding the importance of documenting emergency lighting test monthly and yearly; this was completed by 10/28/15.  5) The 4 weekly audits results performed by the maintenance manager will be reviewed by the quality committee in the November and December QAPI meetings. The QAPI meetings will be held on 11/12/15 and 12/10/15. Further action by the QAPI team will be taken if necessary at that time.	11/09/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135134	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - HELPING HANDS OF GOODING B. WING _____	(X3) DATE SURVEY COMPLETED  10/06/2015
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K 046 Continued From page 9

K 046

During record review on October 6, 2015 at approximately 9:00 AM, it was observed the facility was unable to provide monthly and annual emergency lighting system test documentation. According to the documented records, the last monthly test of the emergency lighting systems was dated June 2015 and the last annual test was conducted in February 2014. When asked, the Maintenance Supervisor stated the facility was conducting the tests but was not correctly documenting.

Actual NFPA standard:

NFPA 101  
19.2.9.1

Emergency lighting shall be provided in accordance with Section 7.9.

7.9.3

A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 11/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction.

K 062 NFPA 101 LIFE SAFETY CODE STANDARD  
SS=F

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

K 062 - F

- 1) The maintenance manager had the vendor come and test the percentage of antifreeze solution in the sprinkler system on 10/20/15. The extra-high temperature sprinkler head utilized for the kitchen hood suppression system was changed on 10/28/15.
- 2) The documentation for both findings is being kept in a binder in the maintenance manager's office and is now up to date as of 10/28/15.
- 3) Weekly documentation to assure that the 2 findings remain in compliance will be completed by the maintenance manager for 4 weeks.
- 4) The maintenance manager has received education from the administrator regarding the importance documentation of the required 2 tests; this was completed by 10/28/15.
- 5) The 4 weekly audits results performed by the maintenance manager will be reviewed by the quality committee in the November and December QAPI meetings. The QAPI meetings will be held on 11/12/15 and 12/10/15. Further action by the QAPI team will be taken if necessary at that time.

11/09/15

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K 062	<p>Continued From page 10</p> <p>This Standard is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that fire suppression systems were tested and maintained in accordance with NFPA 25. Failure to provide proper testing and inspection of the sprinkler system could result in the system not performing as designed during a fire event. This deficient practice affected all residents, staff and visitors on the date of the survey. The facility is licensed for 80 SNF/NF beds with a census of 28 on the day of the survey.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1.) During record review on October 6, 2015 at approximately 9:00 AM, the facility was unable to provide documentation of the percentage of antifreeze solution in the sprinkler system. Upon further observation of the sprinkler riser room revealed no tags or paperwork that documented percentage of antifreeze solution. When asked, the Maintenance Supervisor stated the facility was unaware of the antifreeze percentage testing requirements.</li> <li>2.) During the facility tour on October 6, 2015 at approximately 12:00 PM, observation revealed one (1) extra-high temperature solder-type sprinkler head being utilized for the kitchen hood suppression system with no documentation of the required 5 year interval testing of the extra-high temperature sprinkler head. When asked, the Maintenance Supervisor stated the facility was unaware of the 5 year interval testing requirement.</li> </ol> <p>Actual NFPA standards:</p> <p>Item #1</p>	K 062	
(X5) COMPLETION DATE			

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K 062	<p>Continued From page 11</p> <p>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>Item #2 NFPA 25 2-3.1.1* Where sprinklers have been in service for 50 years, they shall be replaced or representative samples from one or more sample areas shall be submitted to a recognized testing laboratory acceptable to the authority having jurisdiction for field service testing. Test procedures shall be repeated at 10-year intervals. Exception No. 1: Sprinklers manufactured prior to 1920 shall be replaced. Exception No. 2: Sprinklers manufactured using fast response elements that have been in service for 20 years shall be tested. They shall be retested at 10-year intervals. Exception No. 3*: Representative samples of solder-type sprinklers with a temperature classification of extra high [325°F (163°C)] or greater that are exposed to semicontinuous to continuous maximum allowable ambient temperature conditions shall be tested at 5-year intervals. Exception No. 4: Where sprinklers have been in service for 75 years, they shall be replaced or representative samples from one or more sample areas shall be submitted to a recognized testing laboratory acceptable to the authority having</p>	K 062	

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K 062	Continued From page 12 jurisdiction for field service testing. Test procedures shall be repeated at 5-year intervals. *See Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance.	K 062		
K 144 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>This Standard is not met as evidenced by: Based on record review and interview, the facility failed to exercise the generator under load to meet the requirements of NFPA 110. Failure to operate the generator under load could lead to the system not operating correctly when required. This deficient practice affected all residents, staff and visitors on the date of survey. The facility is licensed for 80 SNF/NF beds with a census of 28 on the day of survey.</p> <p>Findings include:</p> <p>During review of the generator inspection records on October 6, 2015 at approximately 9:00 AM, it was revealed the facility failed to exercise the generator under load for 30 minutes per month to 30 percent of the EPS nameplate rating of the generator. The facility also failed to conduct an annual load bank test with supplemental loads to meet requirements when the monthly requirements could not be obtained. When</p>	K 144 - F	<ol style="list-style-type: none"> <li>1) The maintenance manager had the generator tested under load for 30 minutes to 30 percent of the EPS nameplate rating on 11/09/15. The 2 hour annual load bank test was also completed on 11/09/15.</li> <li>2) The documentation for both findings is being kept in a binder in the maintenance manager's office and is now up to date as of 11/09/15.</li> <li>3) Weekly documentation to assure that the 2 findings remain in compliance will be completed by the maintenance manager for 4 weeks.</li> <li>4) The maintenance manager has received education from the administrator regarding the importance documentation of the required tests; this was completed by 10/28/15.</li> <li>5) The 4 weekly audits results performed by the maintenance manager will be reviewed by the quality committee in the November and December QAPI meetings. The QAPI meetings will be held on 11/12/15 and 12/10/15. Further action by the QAPI team will be taken if necessary at that time.</li> </ol>	11/09/15

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K 144	<p>Continued From page 13</p> <p>asked, Maintenance Supervisor stated the facility was load testing monthly for 30 minutes monthly but could not get a 30 percent load and was delinquent on the annual load bank test.</p> <p>Actual NFPA standard:</p> <p>NFPA 110 1999 6-4.2*</p> <p>Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>(a) Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating</p> <p>(b) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations.</p> <p>6-4.2.1 Equivalent loads used for testing shall be automatically replaced with the emergency loads in case of failure of the primary source.</p> <p>6-4.2.2 Diesel-powered EPS installations that do not meet the requirements of 6-4.2 shall be exercised monthly with the available EPSS load and exercised annually with supplemental loads at 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30 minutes, followed by 75 percent of nameplate rating for 60 minutes, for a total of 2 continuous hours.</p>	K 144	
(X5) COMPLETION DATE			