



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

January 26, 2016

Darrin Radeke, Administrator
Mini-Cassia Care Center
PO Box 1224
Burley, ID 83318

Provider #: 135081

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

Dear Mr. Radeke:

On **January 20, 2016**, a Facility Fire Safety and Construction survey was conducted at **Mini-Cassia Care 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 Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator

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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 **February 8, 2016**. Failure to submit an acceptable PoC by **February 8, 2016**, may result in the imposition of civil monetary penalties by **February 28, 2016**.

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 **February 24, 2016**, (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 **February 24, 2016**. A change in the seriousness of the deficiencies on **February 24, 2016**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **February 24, 2016**, includes the following:

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Denial of payment for new admissions effective **April 20, 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 **July 20, 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 **January 20, 2016**, 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 **February 8, 2016**. If your request for informal dispute resolution is received after **February 8, 2016**, 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, appearing to read 'M. Grimes', followed by a horizontal line extending to the right.

Mark P. Grimes, Supervisor
Facility Fire Safety and Construction

MPG/lj
Enclosures

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

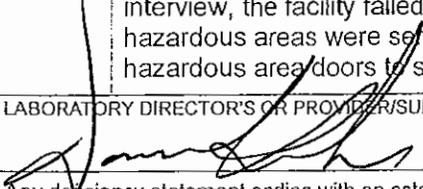
Printed: 01/26/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135081	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE BLDG B. WING _____ RECEIVED FEB - 8 2016	(X3) DATE SURVEY COMPLETED 01/20/2016
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NAME OF PROVIDER OR SUPPLIER MINI-CASSIA CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 1224 BURLEY, ID 83318
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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	<p>INITIAL COMMENTS</p> <p>The facility is a single story type V (000) building built in 1974, and is currently licensed for 68 SNF/NF beds. The building is covered by fire alarm/smoke detection and is fully sprinklered. There is a basement that houses the laundry, maintenance shop, break room central supply, and miscellaneous offices. The facility completed a cosmetic upgrades of floors and walls in 2001.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on January 20, 2016. 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>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	K 000	<p>This plan of correction is submitted as required under Federal and State regulations and statutes applicable to long term care providers. This plan of correction does not constitute an admission of liability on the part of the facility and, such liability is hereby specifically denied. The submission of the plan does not constitute agreement by the facility that the surveyor's findings and/or conclusions are accurate, that the findings constitute a deficiency or that the scope and severity regarding any of the deficiencies cited are correctly applied.</p>	
K 029 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>One hour fire rated construction (with 0 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 doors to hazardous areas were self-closing. Failure of hazardous area doors to self-close would allow</p>	K 029	<p>F029</p> <p>The facility will ensure that one hour fire rated construction or an approved automatic fire extinguishing system in accordance with 8.4.2 and or 19.3.5.4 protects hazardous areas.</p> <p>1) The citation will be corrected for the laundry door closures by providing education to laundry and other staff. The floor will be marked to show the area that needs to be free from obstruction, and a daily checklist for laundry will be implemented to ensure that doors are not obstructed.</p>	2/24/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE ADMINISTRATOR	(X6) DATE 2/4/16
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 029	<p>Continued From page 1</p> <p>smoke and dangerous gases to pass into corridors during a fire event, hindering resident egress. This deficient practice affected 38 residents, staff and visitors on the date of the survey. The facility is licensed for 68 SNF/NF beds and had a census of 54 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on January 20, 2016 from approximately 10:30 AM to 3:45 PM, observation and operational testing of facility doors revealed the following:</p> <p>1) Testing of both doors entering the Laundry from the corridor revealed both doors were equipped with self-closing devices, however 1 of 2 doors tested was blocked by a dust mop and would not self-close when activated. The Maintenance Supervisor stated the staff was aware this door was required to self-close and not to store items in front of it.</p> <p>2) 2 of 2 doors tested leading from the Kitchen to the corridor revealed both doors were equipped with self-closing mechanisms but were blocked by dietary carts. Interview of the Maintenance Supervisor revealed he was aware these doors were require to self-close.</p> <p>3) Observation of the Activity storage area in the North wing of the facility revealed the room measured approximately six feet by ten feet (60 sf) and four feet by five feet (20 sf); contained an assortment of stacked, combustible storage such as cardboard puzzles, party supplies and boxed games. Activation of the door to this room revealed the door would not self-close.</p>	K 029	<p>2) Citation will be corrected for dietary door closures by providing education to dietary staff on 1/21/16 and again to all staff on 2/10/16. The doors to kitchen will be changed to swing outward allowing carts to be brought in and the doors to close behind them. An automatic closure system will be installed and a daily monitoring form will be implemented to ensure doors are without obstruction.</p> <p>3) On 1/21/16 a self closure was connected to the activity closet door. All other hazardous areas will be checked to ensure they are self closing or automatic closing and are unobstructed.</p> <p>These corrections will be monitored weekly X 4, then q 2 weeks X 2, then monthly X 3 on the Maintenance Rounding Form. Rounding forms will be brought to the quality assurance team for review.</p> <p>The Maintenance Manager will be responsible to ensure that the plan of correction is followed properly.</p>

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K 029	<p>Continued From page 2</p> <p>Actual NFPA standard:</p> <p>3.3.13.2 Area, Hazardous. An area of a structure or building that poses a degree of hazard greater than that normal to the general occupancy of the building or structure, such as areas used for the storage or use of combustibles or flammables; toxic, noxious, or corrosive materials; or heat-producing appliances.</p> <p>19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:</p> <ol style="list-style-type: none"> (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		

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K 029	Continued From page 3 Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		
K 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 record review, observation and interview, the facility failed to ensure that fire suppression systems were maintained in accordance with NFPA 25. Failure to maintain fire suppression systems could hinder system response during a fire event. This deficient practice affected 54 residents, staff and visitors on the date of the survey. The facility is licensed for 68 SNF/NF beds and had a census of 54 on the day of the survey. Findings include: 1) During review of facility fire suppression system inspection records conducted on January 20, 2016 from approximately 8:30 AM to 10:00 AM, no documentation was provided indicating a quarterly inspection had been conducted since March of 2015. When asked about the missing documentation, the Maintenance Supervisor stated he was not aware of the requirement for quarterly sprinkler inspections. 2) During the facility tour conducted on January 20, 2016 from approximately 10:00 AM to 3:45 PM, observation of installed fire suppression system sprinkler pendants revealed the following:	K 062	K 062 The facility will ensure that the required automatic sprinkler system is continuously maintained in reliable operating condition and is inspected and tested periodically. 1)2) The citations will be corrected for the quarterly inspection by having Delta Fire Systems train the Maintenance Manager on proper quarterly inspections on 2/2/16. There will also be a new form that will be completed quarterly by the new Maintenance Manager. The new form will address the flow test and condition and upkeep on the sprinkler pendants throughout the building. On 1/27/16 Delta Fire Systems replaced the corroded sprinkler head in Laundry and the Kitchen and the painted sprinkler head in the Business Office. These corrections will be monitored monthly X 3, quarterly thereafter on the Maintenance Rounding Form. Rounding forms will be brought to the quality assurance team for review. The Maintenance Manager will be responsible to ensure that the plan of correction is followed properly.	2/24/16

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K 062	<p>Continued From page 4</p> <p>a. One (1) corroded sprinkler in the Main Laundry</p> <p>b. One (1) corroded sprinkler in the Kitchen dishwashing area</p> <p>c. One (1) painted sprinkler in the Business office under construction.</p> <p>When asked about these pendants condition, the Maintenance Supervisor stated he was not aware of these conditions prior to the survey.</p> <p>Actual NFPA standard:</p> <p>Finding 1</p> <p>NFPA 25 2-3 Testing. 2-3.1 Sprinklers.</p> <p>2-3.3* Alarm Devices. Waterflow alarm devices including, but not limited to, mechanical water motor gongs, vane-type waterflow devices, and pressure switches that provide audible or visual signals shall be tested quarterly.</p> <p>Finding 2</p> <p>NFPA 25 2-2 Inspection. 2-2.1 Sprinklers.</p> <p>2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall</p>	K 062	

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K 062	Continued From page 5 be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. Exception No. 1*: Sprinklers installed in concealed spaces such as above suspended ceilings shall not require inspection. Exception No. 2: Sprinklers installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown.	K 062	
K 072 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD 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. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10, 18.2.1, 19.2.1 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 to their instant use. Failure to keep means of egress free of impediments could hinder safe evacuation of residents during a fire or other emergency. This deficient practice affected 54 residents, staff and visitors in 3 of 3 smoke compartments. The facility is licensed for 68 SNF/NF beds and had a census of 54 on the day of the survey. Findings include: During the facility tour conducted on January 20, 2016 from approximately 10:00 AM to 3:45 PM, observation and operational testing of the following doors revealed the doors were equipped with locks which required more than one releasing operation when activated from the egress side:	K 072	K072 The facility will ensure that means of egress will be maintained free of impediments. The citation will be corrected for the facility by replacing locking door mechanisms with locks which only require single action releasing operation when activated from the egress side for the listed survey identified doors and 18 facility identified doors. These will be monitored weekly X 4, then q 2 weeks X 2, then monthly X 3 on the Maintenance Rounding Form. Rounding forms will be brought to the quality assurance team for review. The Maintenance Manager will be responsible to ensure that the plan of correction is followed properly. 2/24/16

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K 072	<p>Continued From page 6</p> <p>a. Both doors from the Maintenance shop to the corridor were equipped with keyed deadbolts and passage locks</p> <p>The following doors were all equipped with keyed entrance locks which required more than one releasing operation or special knowledge from the egress side:</p> <p>b. Basement door locks numbering 12, 35, 33 c. Electrical room abutting the Maintenance shop d. Medical Records e. Activity Office f. T.V. Room g. Physical Therapy h. Business Office i. Showers located in both wings</p> <p>Interview of the Maintenance Supervisor revealed he had recently replaced facility locks due to security concerns. He further confirmed that this condition was widespread and systemic and that he was not aware of locks requiring a single operation without the use of a key or special knowledge from the egress side. Due to the extent and number of findings, no further documentation was deemed necessary.</p> <p>Actual NFPA standard:</p> <p>NFPA 101 Chapter 19</p> <p>19.2 MEANS OF EGRESS REQUIREMENTS 19.2.1 General. Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7. Exception: As modified by 19.2.2 through 19.2.11.</p>	K 072	

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K 072	<p>Continued From page 7</p> <p>19.2.2.2.4</p> <p>Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side.</p> <p>Exception No. 1: Door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. (See 19.1.1.1.5 and 19.2.2.2.5.)</p> <p>Exception No. 2*: Delayed-egress locks complying with 7.2.1.6.1 shall be permitted, provided that not more than one such device is located in any egress path.</p> <p>Exception No. 3: Access-controlled egress doors complying with 7.2.1.6.2 shall be permitted.</p> <p>Chapter 7</p> <p>7.2.1.5 Locks, Latches, and Alarm Devices.</p> <p>7.2.1.5.1</p> <p>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.</p> <p>Exception No. 1: This requirement shall not apply where otherwise provided in Chapters 18 through 23.</p> <p>Exception No. 2: Exterior doors shall be permitted to have key-operated locks from the egress side, provided that the following criteria are met:</p> <p>(a) Permission to use this exception is provided in Chapters 12 through 42 for the specific occupancy.</p>	K 072		
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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135081	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE BLDG B. WING _____	(X3) DATE SURVEY COMPLETED 01/20/2016
NAME OF PROVIDER OR SUPPLIER MINI-CASSIA CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 1224 BURLEY, ID 83318	
(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 072	Continued From page 8 (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 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This Standard is not met as evidenced by: Based on record review and interview, the facility failed to ensure that emergency power supply systems (EPSS) were tested in accordance with NFPA 110. Failure to test EPSS under load could hinder the ability of the system to supply emergency power during extended periods of power loss. This deficient practice affected 54 residents, staff and visitors on the date of the survey. The facility is licensed for 68 SNF/NF beds and had a census of 54 on the day of the survey. Findings include: During the review of the facility EPSS records	K 144	K144 The facility will ensure that the required emergency generator is inspected weekly and tested 30 minutes under load monthly. The citation will be corrected for the load testing by having an electrician certify that the load test switch used to exercise the generator each month achieves the 30 percent or more load for the generator. These will be monitored monthly X 3, quarterly thereafter on the Maintenance Rounding Form. Rounding forms will be brought to the quality assurance team for review. The Maintenance Manager will be responsible to ensure that the plan of correction is followed properly. 2/24/16

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K 144	<p>Continued From page 9</p> <p>conducted on January 20, 2016 from approximately 10:00 AM to 3:45 PM, documentation provided did not demonstrate the generator had been tested on a monthly basis for thirty minutes at thirty percent of the rated nameplate capacity. When asked about the provided documentation and the method of testing, the Maintenance Supervisor stated he ran the generator for thirty minutes monthly and documented that timeframe, but not any type of documentation indicating the load achieved. He also stated was not aware what the requirement was for documenting the load test.</p> <p>Actual NFPA standard:</p> <p>NFPA 99</p> <p>3-4.4.1 Maintenance and Testing of Essential Electrical System.</p> <p>3-4.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches.</p> <p>(a) Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-4.3.1. Maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6.</p> <p>(b) Inspection and Testing.</p> <p>1. * Test Criteria. Generator sets shall be tested twelve (12) times a year with testing intervals between not less than 20 days or exceeding 40 days. Generator sets serving emergency and equipment systems shall be in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6.</p>	K 144		
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K 144	<p>Continued From page 10</p> <p>2. Test Conditions. The scheduled test under load conditions shall include a complete simulated cold start and appropriate automatic and manual transfer of all essential electrical system loads.</p> <p>3. Test Personnel. The scheduled tests shall be conducted by competent personnel. The tests are needed to keep the machines ready to function and, in addition, serve to detect causes of malfunction and to train personnel in operating procedures.</p> <p>3-3.4.3 Recordkeeping. 3-3.4.3.1* General. A record shall be maintained of the tests required by this chapter and associated repairs or modification. At a minimum, this record shall contain the date, the rooms or areas tested, and an indication of which items have met or have failed to meet the performance requirements of this chapter.</p> <p>NFPA 110 Chapter 6</p> <p>6-4 Operational Inspection and Testing. 6-4.1* Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly. Exception: If the generator set is used for standby power or for peak load shaving, such use shall be recorded and shall be permitted to be substituted for scheduled operations and testing of the generator set, provided the appropriate data are recorded.</p> <p>6-4.2* 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</p>	K 144		
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K 144	Continued From page 11 following methods: (a) Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating (b) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer The date and time of day for required testing shall be decided by the owner, based on facility operations.	K 144		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to maintain safe electrical installations in accordance with NFPA 70. Exposure of open electrical connections, wiring, or improper use of flexible cords and cables, could result in fires by arcing or electrocution. This deficient practice affected 16 residents, staff and visitors on the date of the survey. The facility is licensed for 68 SNF/NF beds and had a census of 54 on the day of the survey. Findings include: During the facility tour conducted on January 20, 2015 from approximately 10:00 AM to 3:45 PM, observation of installed electrical systems revealed the following: 1) In the medical records storage abutting the Laundry, a fluorescent light fixture was installed using the power supply from an abandoned bath fan and exposing the wiring of the installation through an opening approximately three inches by ten inches.	K 147	K147 The facility will ensure that electrical wiring shall be in accordance with National Electrical Code. 1) The citation will be corrected for the opening in medical records by proper repair of the opening completed on 1/22/16. 2) The citation will be corrected for the missing cover on the thermostat controller in the social service office by replacing the thermostat. 3) The citation will be corrected for the power tap fed through the wall by having a licensed electrician adding a plug in the Central Supply Storage area. These will be monitored weekly X 4, then q 2 weeks X 2, then monthly X 3 on the Maintenance Rounding Form. Rounding forms will be brought to the quality assurance team for review. The Maintenance Manager will be responsible to ensure that the plan of correction is followed properly.	2/24/16

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K 147	<p>Continued From page 12</p> <p>2) In the Social Services office, the two-phase thermostat controller for the radiant heating system was missing the protective cover, exposing the wiring and the electrical contacts.</p> <p>3) In the North Nurse's station and Central supply storage, observation of the wall separating the two spaces revealed the power supply cord for a relocatable power tap was fed through the wall.</p> <p>Interview of the Maintenance Supervisor revealed he was aware the above findings were not approved electrical installations.</p> <p>Actual NFPA standard:</p> <p>NFPA 70</p> <p>Finding 1 & 2</p> <p>110.27 Guarding of Live Parts. (A) Live Parts Guarded Against Accidental Contact. Except as elsewhere required or permitted by this Code, live parts of electrical equipment operating at 50 volts or more shall be guarded against accidental contact by approved enclosures or by any of the following means: (1) By location in a room, vault, or similar enclosure that is accessible only to qualified persons. (2) By suitable permanent, substantial partitions or screens arranged so that only qualified persons have access to the space within reach of the live parts. Any openings in such partitions or screens shall be sized and located so that persons are not likely to come into accidental contact with the live parts or to bring conducting objects into contact with them.</p>	K 147		
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K 147	<p>Continued From page 13</p> <p>(3) By location on a suitable balcony, gallery, or platform elevated and arranged so as to exclude unqualified persons.</p> <p>(4) By elevation of 2.5 m (8 ft) or more above the floor or other working surface.</p> <p>Finding 3</p> <p>400.8 Uses Not Permitted.</p> <p>Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following:</p> <p>(1) As a substitute for the fixed wiring of a structure</p> <p>(2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors</p> <p>(3) Where run through doorways, windows, or similar openings</p> <p>(4) Where attached to building surfaces</p> <p>Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of 368.8.</p> <p>(5) Where concealed by walls, floors, or ceilings or located above suspended or dropped ceilings</p> <p>(6) Where installed in raceways, except as otherwise permitted in this Code</p>	K 147	