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

February 26, 2016

Scott Burpee, Administrator
Bell Mountain Village & Care Center
620 N 6th St
Bellevue, ID 83313-5174

Provider #: 135069

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

Dear Mr. Burpee:

On **February 18, 2016**, a Facility Fire Safety and Construction survey was conducted at **Bell Mountain Village & 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

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 **March 10, 2016**. Failure to submit an acceptable PoC by **March 10, 2016**, may result in the imposition of civil monetary penalties by **March 30, 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 **March 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 **March 24, 2016**. A change in the seriousness of the deficiencies on **March 24, 2016**, may result in a change in the remedy.

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

Denial of payment for new admissions effective **May 18, 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 **August 18, 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 **February 18, 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

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 **March 10, 2016**. If your request for informal dispute resolution is received after **March 10, 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,

Mark P. Grimes, Supervisor
Facility Fire Safety and Construction

MPG/lj
Enclosures

Printed: 02/25/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - ENTIRE STRUCTURE B. WING	(X3) DATE SURVEY COMPLETED
	135069		02/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL MOUNTAIN VILLAGE & CARE CENTER	620 NORTH SIXTH STREET BELLEVUE, ID 83313

(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 comprised of two (2) SNF/NF small house model buildings, identical in design. The buildings are defined as buildings A and C which house residential sleeping rooms. Building B houses the physical therapy occupancy with administrative offices and an assisted living facility separated by two-hour construction. All buildings are type II (000) construction equipped with automatic sprinkler protection, corridor smoke detection. Type 2 Emergency Electrical Systems with automatic transfer switching is provided for building A and C. Building B EES provides emergency power for the Assisted Living, Physical Therapy and Administrative offices. Both buildings A and C have commercial kitchens which are separated by one-hour construction. The facility was built in 2015 and is licensed for 32 SNF/NF beds The following deficiencies were cited during the annual Fire/Life Safety survey conducted on February 18, 2016. The facility was surveyed under the LIFE SAFETY CODE 2000 Edition, New Health Care Occupancy in accordance with CFR 483.70. The survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	K 000		
K 039 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Width of aisles or corridors (clear and unobstructed) serving as exit access in hospitals and nursing homes shall be at least 8 feet. In limited care facility and psychiatric hospitals, width of aisles or corridors shall be at least 6 feet.	K 039		

MAR 1 2016
FACILITY STATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Robert W Loach, AIt for Scott Burger	C.N.H.A.	3/10/16

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.

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

Printed: 02/25/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - ENTIRE STRUCTURE B. WING	(X3) DATE SURVEY COMPLETED
	135069		02/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL MOUNTAIN VILLAGE & CARE CENTER	620 NORTH SIXTH STREET BELLEVUE, ID 83313

(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 039	Continued From page 1 18.2.3.3, 18.2.3.4 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to maintain corridor exit access in accordance with NFPA 101. Failure to maintain exit access could hinder the safe evacuation of residents during a fire or other emergency. This deficient practice affected 16 residents, staff and visitors in 2 of 3 buildings on the date of the survey. The facility is licensed for 32 SNF/NF beds and had a census of 26 on the day of the survey. Findings include: During the facility tour conducted on February 18, 2016 from approximately 11:30 AM to 3:45 PM, observation of Building A and Building C revealed the following obstructions in the exit access corridors: 1) Building A was storing a dietary cart and the wheelchair accessible weight scale on the northwest side of the smoke compartment doors reducing the corridor width from eight (8) feet to approximately 54 inches. Further observation revealed the storage of a linen cart outside of the Laundry which reduced the corridor width from eight feet to approximately 79 inches. 2) Building C was storing a dietary cart and the wheelchair accessible weight scale on the southwest side of the smoke compartment doors reducing the corridor width from eight (8) feet to approximately 54 inches. Further observation revealed the storage of a linen cart and dietary cart outside of the Laundry, reducing the corridor width from eight feet to approximately 79 inches.	K 039	Tag K039 This deficiency has the potential to affect all residents in the buildings. The deficient practice or failure will be corrected by March 14, 2016. All staff have been inserviced as to the proper location of the equipment and all charge nurses have been instructed to monitor this throughout their shifts. New employees will be oriented on the National Fire Protection Agency standard to keep corridors clear of equipment and carts in order to maintain the 8 foot rule whereby hallways and corridors will be clear and unobstructed	03/14/2016

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

Printed: 02/25/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - ENTIRE STRUCTURE B. WING	(X3) DATE SURVEY COMPLETED
	135069		02/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL MOUNTAIN VILLAGE & CARE CENTER	620 NORTH SIXTH STREET BELLEVUE, ID 83313

(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 039	Continued From page 2 When asked about the storage in the corridor, the Maintenance Manager stated this was the area where these items were normally stored. When interviewed about the location of the linen carts, the Housekeeping staff stated linen carts were stored in the corridors outside Laundry area of both Building A and C so staff could access linens. Actual NFPA Standard: 18.2.3.3* Aisles, corridors, and ramps required for exit access in a hospital or nursing home shall be not less than 8 ft (2.4 m) in clear and unobstructed width. Where ramps are used as exits, see 18.2.2.6.	K 039	Tag K048 This deficiency has the potential to affect all residents in the buildings. The deficient practice or failure will be corrected by March 14, 2016. All staff have been inserviced as to the proper procedure to follow during the evacuation of the buildings.	03/14/2016
K 048 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 18.7.1.1, 19.7.1.1 This Standard is not met as evidenced by: Based on record review and interview, the facility failed to ensure that staff was trained in the evacuation procedures of the facility during a fire or other emergency. Failure to train staff on the evacuation procedures could hinder the safe evacuation of residents during a fire or other emergency. This deficient practice affected 26 residents, staff and visitors in 2 of 3 buildings on the date of the survey. The facility is licensed for 32 SNF/NF beds and had a census of 26 on the day of the survey. Findings include: During review of facility records conducted on	K 048	An in-service of staff was held on February 23 where the proper evacuation protocols were presented and discussed. Additionally, the proper procedure for evacuating the building in case of an emergency or fire was also instructed. Staff were then issued mini cards they can affix to the back of their ID badges that briefly describe the steps to follow for using a fire extinguisher, the fire safety policy at Bell Mountain, and intruder or other emergency public announcement codes. This fire safety in-service was tape-recorded and maintained in the therapy room for employees to view at their leisure. Additionally proof of	

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

Printed: 02/25/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - ENTIRE STRUCTURE B. WING	(X3) DATE SURVEY COMPLETED
	135069		02/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL MOUNTAIN VILLAGE & CARE CENTER	620 NORTH SIXTH STREET BELLEVUE, ID 83313

(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 048	Continued From page 3 February 18, 2016 from 8:45 AM to 11:30 AM, the facility failed to provide any staff inservice or training documentation for emergency evacuation procedures of the facility. Interview of the DON and Maintenance Manager revealed no documentation of training was available. When asked about the proper procedure for safely evacuating the building, the RN and CNA's on shift in both Building A and C, stated they did not know the procedure of where or how they would evacuate in the event of a fire or emergency. Actual NFPA standard: 18.7* OPERATING FEATURES 18.7.1 Evacuation and Relocation Plan and Fire Drills. 18.7.1.1 The administration of every health care occupancy shall have, in effect and available to all supervisory personnel, written copies of a plan for the protection of all persons in the event of fire, for their evacuation to areas of refuge, and for their evacuation from the building when necessary. All employees shall be periodically instructed and kept informed with respect to their duties under the plan. A copy of the plan shall be readily available at all times in the telephone operator ' s position or at the security center. The provisions of 18.7.1.2 through 18.7.2.3 shall apply.	K 048	employees attending this in-service is located in the "in-service" file.	
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an	K 052		

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

Printed: 02/25/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - ENTIRE STRUCTURE B. WING	(X3) DATE SURVEY COMPLETED
	135069		02/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL MOUNTAIN VILLAGE & CARE CENTER	620 NORTH SIXTH STREET BELLEVUE, ID 83313

(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 052	Continued From page 4 approved maintenance and testing program complying with applicable requirement of NFPA70 and 72. 9.6.1.4, 9.6.1.7, This Standard is not met as evidenced by: Based on record review and interview, the facility failed to conduct an annual inspection of the fire alarm system. Failure to conduct annual inspections for the fire alarm could result in lack of system performance in the event of a fire. This deficient practice affected 26 residents, staff and visitors in 3 of 3 buildings on the date of the survey. The facility is licensed for 32 SNF/NF beds and had a census of 26 on the day of the survey. Findings include: During review of the facility inspection records conducted on February 18, 2016 from approximately 8:45 AM to 11:30 AM, no record was provided for an annual fire alarm inspection. Further review revealed the Certificate of Occupancy for the facility was issued January 20, 2015. Interview of the Maintenance Manager revealed he was not aware of why the annual test had not been performed. Actual NFPA standard: 9.6.1.4 A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm Code, unless an existing installation, which shall be permitted to be continued in use, subject to the approval of the authority having jurisdiction. 7-3 Inspection and Testing Frequency.	K 052	Tag K052 This deficiency has the potential to affect all residents in the building. However, the facility would have been in compliance if the official Certificate of Occupancy dated 02/26/2015 had been used instead of the temporary Certificate of Occupancy from a month earlier. [redacted] was the vendor that performed the test. The test was performed in each building on February 2, 2016 by [redacted] technicians. Documentation to this effect was sent to Bell Mountain care center on February 11 by the vendor. That documentation has since been added to the survey ready book and is available for inspection.	03/14/2016

Printed: 02/25/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - ENTIRE STRUCTURE B. WING	(X3) DATE SURVEY COMPLETED
	135069		02/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL MOUNTAIN VILLAGE & CARE CENTER	620 NORTH SIXTH STREET BELLEVUE, ID 83313

(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 052	Continued From page 5 7-3.1* Visual Inspection. Visual inspection shall be performed in accordance with the schedules in Section 7-3 or more often if required by the authority having jurisdiction. The visual inspection shall be made to ensure that there are no changes that affect equipment performance. Exception No. 1: Devices or equipment that is inaccessible for safety considerations (for example, continuous process operations, energized electrical equipment, radiation, and excessive height) shall be inspected during scheduled shutdowns if approved by the authority having jurisdiction. Extended intervals shall not exceed 18 months. Exception No. 2: If automatic inspection is performed at a frequency of not less than weekly by a remotely monitored fire alarm control unit specifically listed for such application, the visual inspection frequency shall be permitted to be annual. The requirements of Table 7-3.1 shall apply.	K 052		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 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 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 result in a lack of system performance during a fire event. This deficient practice affected 26 residents, staff and visitors in 3 of 3 buildings on the date of the survey. The facility is licensed for 26 SNF/NF buildings and had a census of 26 on the day of the survey.	K 062		

Printed: 02/25/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - ENTIRE STRUCTURE B. WING	(X3) DATE SURVEY COMPLETED
	135069		02/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL MOUNTAIN VILLAGE & CARE CENTER	620 NORTH SIXTH STREET BELLEVUE, ID 83313

(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 062	Continued From page 6 Findings include: During review of facility records conducted on February 18, 2016 from 8:45 AM to 11:30 AM, no record was provided for annual or quarterly inspections for the fire suppression system. Further investigation found the Certificate of Occupancy was issued on January 20, 2016. When asked about the missing records, the Maintenance Manager stated he was not sure why the inspections had not been performed. Actual NFPA standard: NFPA 25 2-2 Inspection. 2-2.1 Sprinklers. 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 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. 2-3 Testing. 2-3.1 Sprinklers. 2-3.3* Alarm Devices. Waterflow alarm devices including, but not limited to, mechanical water motor gongs, vane-type	K 062	Tag K062 This deficiency has the potential to affect all residents in the building. However, the facility would have been in compliance if the official Certificate of Occupancy dated 02/26/2015 had been used instead of the temporary Certificate of Occupancy from a month earlier. [redacted], the vendor that performs the tests for Bell Mountain Care Center, visited the facility on February 2, 2016 and conducted those tests. The automatic sprinkler systems were visually tested and inspected. As a result, documentation is available in the Survey Ready binder for review.	03/14/2016

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

Printed: 02/25/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - ENTIRE STRUCTURE B. WING	(X3) DATE SURVEY COMPLETED
	135069		02/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL MOUNTAIN VILLAGE & CARE CENTER	620 NORTH SIXTH STREET BELLEVUE, ID 83313

(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 067	Continued From page 8 Actual NFPA standard: 18.5.2 Heating, Ventilating, and Air Conditioning. 18.5.2.1 Heating, ventilating, and air conditioning shall comply with the provisions of Section 9.2 and shall be installed in accordance with the manufacturer's specifications. Exception: As modified in 18.5.2.2.	K 067		
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 operational testing, observation and interview, the facility failed to ensure that means of egress were free from impediments to their instant use in an emergency. Failure for delayed egress doors to operate as designed could hinder the safe evacuation of residents during a fire or other emergency. This deficient practice affected 13 residents in 1 of 3 buildings on the date of the survey. The facility is licensed for 32 SNF/NF beds and had a census of 26 on the day of the survey. Findings include: During the facility tour conducted on February 18, 2016 from approximately 11:30 AM to 3:45 PM, observation and operational testing of the front door to Building C revealed the door was equipped with elopement security which activated a magnetic lock. Further observation and testing revealed the delayed egress	K 072	Tag K072 This deficiency has the potential to affect all residents. The deficient practice or failure will be corrected by March 14, 2016. All staff have been inserviced as to the proper location of the equipment and all charge nurses have been instructed to monitor this throughout their shifts. The vendor that installed the system was contacted on February 18, 2016. [redacted], LLC, the vendor that installed the system, reported to the Maintenance Manager they will send a technician to Bell Mountain Care Center to reprogram the doors	

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

Printed: 02/25/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - ENTIRE STRUCTURE B. WING	(X3) DATE SURVEY COMPLETED
	135069		02/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL MOUNTAIN VILLAGE & CARE CENTER	620 NORTH SIXTH STREET BELLEVUE, ID 83313

(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 9 component would not release the door with excessive pressure applied for over 15 seconds, or signed for the operation of the delayed egress override. When asked about the problems with the door lock, the Maintenance Manager stated he was not aware the door was not releasing under delayed egress, or that the missing signage was required. Actual NFPA standard: 18.2 MEANS OF EGRESS REQUIREMENTS 18.2.1 General. Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7. Exception: As modified by 18.2.2 through 18.2.11. 7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed-egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met. (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6. (b) The doors shall unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock	K 072	by April 1, 2016. However, the locking mechanism was fixed on February 18. Currently the egress functionality has not been reprogrammed and is currently under warranty by the vendor. They have assured us this will be remedied by April 1, 2016 Weekly periodic checks will be added to focus rounds to maintain adequate assurance of compliance with this regulation. The "focused round" employee will test the locking capability, the egressed functionality, and the magnetic lock at least weekly. Non-functionality as well as functionality will be entered into the employee's round notes and reviewed each Monday morning with the department head staff during stand up. This practice will begin on March 14, 2016.	04/01/2016

Printed: 02/25/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - ENTIRE STRUCTURE B. WING	(X3) DATE SURVEY COMPLETED
	135069		02/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL MOUNTAIN VILLAGE & CARE CENTER	620 NORTH SIXTH STREET BELLEVUE, ID 83313

(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 10 within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) * On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS	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 the generator of the Emergency Power Supply System (EPSS) was inspected weekly and tested monthly in accordance with NFPA 110. Failure to inspect and test EPSS generators could result in a lack of system reliability during a power loss. This deficient practice affected 26 residents, staff and visitors in 2 of 3 buildings on the date of the survey. The facility is licensed for 32 SNF/NF residents and had a census of 26 on the day of the survey. Findings include:	K 144	Tag K144 This deficiency has the potential to affect all residents. The deficient practice or failure will be corrected by March 14, 2016. Maintenance staff have been inserviced as to the proper procedure of calculating the generator load requirements for the tests. The facility will move to reviewing the logs each month to ensure completion.	03/14/2016

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

Printed: 02/25/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - ENTIRE STRUCTURE B. WING	(X3) DATE SURVEY COMPLETED
	135069		02/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL MOUNTAIN VILLAGE & CARE CENTER	620 NORTH SIXTH STREET BELLEVUE, ID 83313

(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 062	Continued From page 7 waterflow devices, and pressure switches that provide audible or visual signals shall be tested quarterly.	K 062	Tag K067	03/14/2016
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2, NFPA 90A, 18.5.2.2, 19.5.2.2 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure electric wall heaters were kept clear of obstructions. Improper clearance to combustibles from electric wall heaters are historically linked to facility fires. This deficient practice affected 22 residents, staff and visitors in 2 of 3 buildings on the date of the survey. The facility is licensed for 32 SNF/NF beds and had a census of 26 on the day of the survey. Findings include: During the facility tour conducted on February 18, 2016 from approximately 11:30 AM to 3:45 PM, observation of the Therapy room and the Office/Personal Care rooms in both Building A and C revealed all four locations had combustible items such as cardboard boxes of files, furnishings and foam pads stored directly against the wall mounted electric heaters in these locations in both Building A and C. When asked about the storage of these materials against the heating devices, the Maintenance Manager stated he was not sure why the materials were stored against the heaters, but was aware of the risk to fires associated.	K 067	This deficiency has the potential to affect all residents. The deficient practice or failure will be corrected by March 14, 2016. All staff have been inserviced as to the policy of not blocking heaters with supplies or other materials. All charge nurses have been instructed to monitor this throughout their shifts. This item will be added to focused rounds on March 14 and will be reviewed weekly. If the department performing the round encounters this practice, they will instruct the appropriate employees to move or remove those items obstructing the heaters. Additionally all new employees will be trained during orientation regarding the policy to not block these heaters with miscellaneous supplies. Employees were also in-serviced on the current policy of Bell Mountain Care Center not to put supplies in front of these heaters during a February 23 in-service. This in-service was recorded for the benefit of employees who were not able to attend the original in-service.	

Printed: 02/25/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - ENTIRE STRUCTURE B. WING	(X3) DATE SURVEY COMPLETED
	135069		02/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL MOUNTAIN VILLAGE & CARE CENTER	620 NORTH SIXTH STREET BELLEVUE, ID 83313

(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 144	Continued From page 11 1) During review of the the facility generator inspection and testing records conducted on February 18, 2016 from 8:45 AM to 11:30 AM, records indicated a missed weekly inspection for the following week: November 30, 2015 to December 4, 2015 Interview of the Maintenance Manager revealed he was not aware he had missed that week's inspection of the emergency generator. 2) During review of the the facility generator inspection and testing records conducted on February 18, 2016 from 8:45 AM to 11:30 AM, records showed the generator was not being exercised for thirty (30) percent of the rated capacity. When asked about the lack of documentation for the required thirty (30) percent load test of the rated capacity, the Maintenance Supervisor stated he documented readings from manual transfers such as time duration, date and time of transfer, but had not been aware of testing to meet the standard of thirty (30) percent of the name plate rating. Actual NFPA standard: NFPA 99 3-4.4.1 Maintenance and Testing of Essential Electrical System. 3-4.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches. (a) Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time	K 144		

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

Printed: 02/25/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - ENTIRE STRUCTURE B. WING	(X3) DATE SURVEY COMPLETED
	135069		02/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL MOUNTAIN VILLAGE & CARE CENTER	620 NORTH SIXTH STREET BELLEVUE, ID 83313

(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 144	Continued From page 12 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. (b) Inspection and Testing. 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. 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. 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. 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. NFPA 110 Chapter 6 6-4 Operational Inspection and Testing. 6-4.1* Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected	K 144		

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

Printed: 02/25/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - ENTIRE STRUCTURE B. WING	(X3) DATE SURVEY COMPLETED
	135069		02/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL MOUNTAIN VILLAGE & CARE CENTER	620 NORTH SIXTH STREET BELLEVUE, ID 83313

(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 144	Continued From page 13 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. 6-4.2* Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (a) Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating (b) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer The date and time of day for required testing shall be decided by the owner, based on facility operations.	K 144		
K 147 SS=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 ensure that electrical panels were kept clear and accessible. Failure to maintain clearance in front of electrical panels could hinder access during a power outage or other emergency. This deficient practice affected staff and visitors in Building B, Physical Therapy on the date of the survey. The facility is licensed for 32 SNF/NF beds and had a census of 26 on the day of the survey. Findings include:	K 147	Tag K147 This deficiency has the potential to affect all the residents in the building and the deficiency has been corrected. Maintenance Manager found and removed objects blocking the electrical panel doors on February 18, 2016 during the review. An in-service for all staff will be conducted on March 16 and recorded for future reference for employees not present regarding the	03/16/2016

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

Printed: 02/25/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - ENTIRE STRUCTURE B. WING	(X3) DATE SURVEY COMPLETED
	135069		02/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL MOUNTAIN VILLAGE & CARE CENTER	620 NORTH SIXTH STREET BELLEVUE, ID 83313

(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 147	Continued From page 14 During the facility tour conducted on February 18, 2016 from 11:30 AM to 3:45 PM, observation of the main electrical panel adjacent to the Therapy Pool in Building B revealed the panel blocked by storage of pool equipment, mats and a privacy screen. When asked, the Maintenance Manager acknowledged he knew the panel was to be kept clear of obstructions. Actual NFPA standard: 110.26 Spaces About Electrical Equipment. Sufficient access and working space shall be provided and maintained about all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons. (A) Working Space. Working space for equipment operating at 600 volts, nominal, or less to ground and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A)(1), (2), and (3) or as required or permitted elsewhere in this Code. (1) Depth of Working Space. The depth of the working space in the direction of live parts shall not be less than that specified in Table 110.26(A)(1) unless the requirements of 110.26(A)(1)(a), (b), or (c) are met. Distances shall be measured from the exposed live parts or from the enclosure or opening if the live parts are enclosed.	K 147	instruction of the facility practice of maintaining unobstructed electrical panels. This this will also be included in the focused rounds documentation. If while doing the focused rounds, the department head notices equipment, supplies, or debris, or other materials blocking the access panels, they will catalog that instance on their focused round documentation. If the department head performing the focused round notices a deficiency with this policy, that manager will immediately bring the infraction to the attention of housekeeping and/or aide staff. The documentation will be discussed and evaluated at Department Head Meeting on Monday mornings. There will also be an in-service performed on 16 February for all housekeeping staff and CNA staff to make sure the control plans are not blocked in the future.	