November 16, 2016

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 November 7, 2016, 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 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 **November 29, 2016**. Failure to submit an acceptable PoC by **November 29, 2016**, may result in the imposition of civil monetary penalties by **December 19, 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. If a State Form was issued as well, it should also be signed, dated and returned.

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 **December 12, 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 **December 12, 2016**. A change in the seriousness of the deficiencies on **December 12, 2016**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **December 12, 2016**, includes the following:
Denial of payment for new admissions effective **February 7, 2017.**

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 **May 7, 2017,** 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 Nate Elkins, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, option 3; 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 **November 7, 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:

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 November 29, 2016. If your request for informal dispute resolution is received after November 29, 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, option 3.

Sincerely,

Nate Elkins, Supervisor
Facility Fire Safety and Construction

Enclosures
The facility is a single story, Type V(111) structure constructed in August of 1971. It is fully sprinklered with a complete fire alarm/smoke detection system in hallways and open spaces. Currently the facility is licensed for 80 SNF/NF beds.

The following deficiencies were cited during the annual fire/life safety survey conducted on November 7, 2016. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.

The survey was conducted by:

Sam Burbank
Health Facility Surveyor
Facility Fire Safety and Construction

K 324 NFPA 101 Cooking Facilities
SS=D

1) The hood cleaning documentation that was at 8 months instead of 6 months was self-identified by the maintenance manager. At that time the administrator and the maintenance manager determined going forward to have the vendor come at 5 months instead of 6 to take into account vendor load and vendor delay possibilities and also possible changes in vendor. The next cleaning is due 03/28/17 and the vendor will be asked to accomplish the cleaning by 02/26/17.

2) The maintenance manager is tracking the cleaning due date and is asking the vendor to come a month earlier to accomplish the task on time.

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.
Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2

This STANDARD is not met as evidenced by:
Based on record review and interview, the facility failed to ensure a semi-annual inspection of the Kitchen hood was conducted in accordance with NFPA 96. Failure to conduct semi-annual inspections of cooking ventilation systems could increase the risk of fires due to excessive build-up of grease laden vapors. This deficient practice affected staff and vendors of the main Kitchen on the date of the survey. The facility is licensed for 80 SNF/NF beds and had a census of 28 on the day of the survey.

Findings include:
During review of provided hood inspection records conducted on November 7, 2016 from approximately 9:00 AM to 10:00 AM, inspection records provided for the Kitchen cooking ventilation system revealed an eight month gap between inspections. Interview of the Maintenance Supervisor revealed the time lapse between inspections was due to a change in vendors. Further evaluation revealed the facility's system served moderate volume cooking operations requiring semi-annual inspections of the hood exhaust system.

Actual NFPA standard:

<table>
<thead>
<tr>
<th>K 324</th>
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<tbody>
<tr>
<td>Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2</td>
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</table>

3) Weekly documentation verifying the date of contacting the vendor will be completed by the maintenance manager for 4 weeks.

4) The maintenance manager has been educated to the importance of making sure that the vendor comes before the due date; this was completed by 12/09/16.

5) The 4 weekly audits results performed by the maintenance manager will be reviewed by the Quality Committee in the December and January QAPI meetings. The QAPI meetings will be held on 12/13/16 and 01/10/17. Further action by the QAPI team will be taken if necessary at that time.
**Summary Statement of Deficiencies**

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<thead>
<tr>
<th>K 324</th>
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<tr>
<td><strong>NFPA 96</strong></td>
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11.4* Inspection for Grease Buildup

The entire exhaust system shall be inspected for grease buildup by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction and in accordance with Table 11.4.

11.6 Clearing of Exhaust Systems

11.6.1 Upon inspection, if the exhaust system is found to be contaminated with deposits from grease-laden vapors, the contaminated portions of the exhaust system shall be cleaned by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction.

**K 345 NFPA 101 Fire Alarm System - Testing and Maintenance**

Fire Alarm System - Testing and Maintenance

A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.

9.7.5, 9.7.7, 9.7.8, and NFPA 25

This STANDARD is not met as evidenced by:

<table>
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<tr>
<th>K 324</th>
<th>K 345</th>
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<tbody>
<tr>
<td><strong>1) The 5 year sensitivity test was completed on 11/14/16 by Crane alarm service. There were no issues found wrong with the 5 year Fire Alarm test.</strong></td>
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<td><strong>2) The maintenance manager has noted in his binder when the next test is due, so that it isn't missed the next time it comes due; this was completed on 11/28/16.</strong></td>
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<td><strong>3) Weekly documentation of the next due test will be noted for 4 weeks.</strong></td>
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</table>
K 345 Continued From page 3

Based on record review and interview, the facility failed to ensure fire alarm systems were maintained in accordance with NFPA 72. Failure to conduct sensitivity testing on non-addressable fire alarm systems could hinder system response during a fire event. This deficient practice affected 28 residents, staff and visitors on the date of the survey. The facility is licensed for 80 SNF/NF beds and had a census of 28 on the day of the survey.

Findings include:

During review of facility fire alarm inspection records conducted on November 7, 2016 from approximately 9:00 AM to 10:00 AM, no record was provided indicating a sensitivity testing was conducted within the last five years. Interview of the Maintenance Supervisor revealed he was not aware a sensitivity test was required for non-addressable fire alarm systems.

Actual NFPA standard:

NFPA 72
Chapter 14 Inspection, Testing, and Maintenance

14.4.5.3.1 Sensitivity shall be checked within 1 year after installation.

14.4.5.3.2 Sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with 14.4.5.3.3.

14.4.5.3.3 After the second required calibration test, if sensitivity
## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

### PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:

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<tr>
<th>ID</th>
<th>PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER</th>
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<td>135134</td>
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### STATEMENT OF DEFICIENCIES

#### PROVIDER/SUPPLIER/CUA

**BENNETT HILLS CENTER**

#### PLAN OF CORRECTION

**A. BUILDING 01 - HELPING HANDS OF GOODING**

#### STREET ADDRESS, CITY, STATE, ZIP CODE

1220 MONTANA STREET

GOODING, ID 83330

#### DATE SURVEY COMPLETED

11/07/2016

### SUMMARY STATEMENT OF DEFICIENCIES

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<tr>
<th>K 345</th>
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Tests indicate that the device has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years.

### K 353

1. **NFPA 101 Sprinkler System - Maintenance and Testing**

   Sprinkler System - Maintenance and Testing

   Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.

   - a) Date sprinkler system last checked
   - b) Who provided system test
   - c) Water system supply source

   Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by:

   Based on observation and interview, the facility failed to ensure fire suppression system pendants were maintained free of obstructions such as paint or corrosion. Failure to maintain fire sprinkler pendants free of obstructions could hinder system performance during a fire event.

   - 1) The 12 sprinklers that were found to have corrosion or paint on them, along with 140 other sprinklers identified totaling 152 sprinklers have been scheduled to be replaced with quick response sprinklers; the capital PO has been approved as of 11/29/16 and the vendor Viking Sprinkler is ordering and organizing to complete the sprinkler change out by 01/30/17.

   - 2) Maintenance reviewed the whole building and found 61 other sprinklers in need of replaced. The total of 152 sprinklers was due to the location of corroded or painted sprinklers along with maintenance findings and also, if 1 sprinkler in a room needed replaced than all that same room needed a new quick response sprinkler. This review was completed on 11/18/16. (Also an additional 12 new sprinklers will be placed in the spare sprinkler storage box as of 01/30/17.)

   - 3) Weekly documentation for checking all rooms for corroded or painted sprinklers by the maintenance manager for 4 weeks to assure that there is none in the building.

   - 4) The maintenance manager has received education from the administrator regarding the importance of identifying and having replaced corroded or painted sprinklers in the building was completed by 12/09/16.

   - 5) The 4 weekly audits results performed by the maintenance manager will be reviewed by the Quality Committee in the December and January QAPI meetings. The QAPI meetings will be held on 12/13/16 and 01/10/17. Further action by the QAPI team will be taken if necessary at that time.
This deficient practice affected 28 residents, staff and visitors on the date of the survey. The facility is licensed for 80 SNF/NF beds and had a census of 28 on the day of the survey.

Findings include:

During the facility tour conducted on November 7, 2016 from approximately 10:00 AM to 3:30 PM, observation of the installed fire sprinkler pendants revealed the following:

Housekeeping storage by room 3: corroded pendant
Resident weigh/scale space: painted pendant
Dietary services office: painted pendant
Medical Records office: corroded pendant, painted pendant
Physical Therapy office: two (2) painted pendants
Housekeeping storage across from Medical records: corroded pendant
Lobby: three (3) painted pendants

Interview of the Maintenance Supervisor revealed he was not aware of these deficiencies prior to the date of the survey.

Actual NFPA standard:

NFPA 25

5.2.1 Sprinklers.

5.2.1.1* Sprinklers shall be inspected from the floor level annually.

5.2.1.1.1* Sprinklers shall not show signs of leakage; shall be
**Summary Statement of Deficiencies**

Each deficiency must be preceded by full regulatory or LSC identifying information.

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<tr>
<th>ID</th>
<th>Prefix</th>
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<th>Summary Statement of Deficiencies</th>
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<td>K 353</td>
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<td>free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., upright, pendant, or sidewall):</td>
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<td>5.2.1.1.2 Any sprinkler that shows signs of any of the following shall be replaced:</td>
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<td>(1) Leakage</td>
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<td>(2) Corrosion</td>
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<td>(3) Physical damage</td>
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<td>(4) Loss of fluid in the glass bulb heat responsive element</td>
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<td>(5)*Loading</td>
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<td>(6) Painting unless painted by the sprinkler manufacturer</td>
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<tr>
<td>K 355</td>
<td>NFPA 101 Portable Fire Extinguishers</td>
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<td></td>
<td>Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers 18.3.5.12, 19.3.5.12, NFPA 10</td>
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<td>This STANDARD is not met as evidenced by:</td>
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<td>Based on observation the facility failed to ensure fire extinguishers were installed in accordance with NFPA 10. Failure to install fire extinguishers at the correct height could hinder staff access during a fire. This deficient practice affected 28 residents, staff and visitors on the date of the survey. The facility is licensed for 80 SNF/NF beds and had a census of 28 on the day of the survey.</td>
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<td>Findings include:</td>
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<thead>
<tr>
<th>Deficiency</th>
<th>Correction Plan</th>
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<tbody>
<tr>
<td>K 353</td>
<td>1) The 4 fire extinguishers that were found to be at the wrong height have been placed at the correct height by the maintenance manager; this was completed as of 11/8/16.</td>
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<td>2) A review of the whole facility was completed by the maintenance manager with no other fire extinguishers found to be at the wrong height; this was completed as of 11/8/16.</td>
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<td>3) Weekly documentation for checking all extinguisher heights will be completed by the maintenance manager for 4 weeks to assure that the extinguishers remain at the correct height.</td>
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<td>4) The maintenance manager has received education from the administrator regarding the importance of the extinguishers remaining at the correct height.</td>
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<td>5) The 4 weekly audits results performed by the maintenance manager will be reviewed by the Quality Committee in the December and January QAPI meetings. The QAPI meetings will be held on 12/13/16 and 01/10/17. Further action by the QAPI team will be taken if necessary at that time.</td>
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K 355  Continued From page 7

During the facility tour conducted on November 7, 2016 from approximately 10:00 AM to 3:30 PM, observation of installed portable fire extinguishers revealed the following extinguishers were installed over 60" to the top of the extinguisher when measured from the floor:

Outside room #39: the extinguisher top was 63 inches from the floor
Outside room #5: the extinguisher top was 51-1/2 inches from the floor
Outside room #22: the extinguisher top was 62 inches from the floor
Kitchen dishroom: the extinguisher top was 61 inches from the floor

Actual NFPA standard:
NFPA 10

6.1.3.8 Installation Height. Fire extinguishers having a gross weight not exceeding 40 lb (18.14 kg) shall be installed so that the top of the fire extinguisher is not more than 5 ft (1.53 m) above the floor.

K 511 12/09/16

1) The extension cords that ran through the wall in the laundry room to the power soap dispensers have been removed and an electrician has wired an appropriate box in the wall; this was completed as of 11/14/16.

2) A review of the whole facility was completed by the maintenance manager with no other extension cords found going through walls; this was completed as of 11/14/16.

3) Weekly documentation for checking all rooms for extension cord use will be completed by the maintenance manager for 4 weeks to assure that there is no extension cord use in the building.

4) The maintenance manager has received education from the administrator regarding the importance of extension cords not being used in the building; this was completed by 12/09/16.

5) The 4 weekly audits performed by the maintenance manager will be reviewed by the Quality Committee in the December and January QAPI meetings. The QAPI meetings will be held on 12/13/16 and 01/10/17. Further action by the QAPI team will be taken if necessary at that time.
Based on observation, the facility failed to ensure safe electrical installations in accordance with NFPA 70. Installing flexible electrical cords through walls could damage cords, resulting in fires by arcing or electrocution. This deficient practice affected staff and visitors in the main Laundry on the date of the survey. The facility is licensed for 80 SNF/NF beds and had a census of 28 on the day of the survey.

Findings include:

During the facility tour conducted on November 7, 2016 from approximately 10:00 AM to 3:30 PM, observation of the Laundry room revealed two (2) extension cords which supplied power to the soap dispensers, were run through the wall into the abutting electrical room.

Actual NFPA standard:

NFPA 70

Chapter 4
Equipment for General Use
ARTICLE 400
Flexible Cords and Cables

400.8 Uses Not Permitted.
Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following:

(1) As a substitute for the fixed wiring of a structure
(2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors
(3) Where run through doorways, windows, or
### K 511

Continued From page 9

- Similar openings
  - (4) Where attached to building surfaces
    - Exception to (4): Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of 368.56(6)
  - (5) Where concealed by walls, floors, or ceilings or located above suspended or dropped ceilings
  - (6) Where installed in raceways, except as otherwise permitted in this Code
  - (7) Where subject to physical damage

### K 711

NFPA 101 Evacuation and Relocation Plan

- SS=F
- Evacuation and Relocation Plan
- There is a written plan for the protection of all patients and for their evacuation in the event of an emergency.
- Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2.1.
- 18.7.1.1 through 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.2.1.2, 19.7.2.2, 19.7.2.3
- This STANDARD is not met as evidenced by:
  - Based on record review and interview, the facility failed to ensure the nine (9) elements of fire safety plan were in accordance with NFPA 101.
  - Failure to ensure the notification of the local fire authority during a fire event, in addition to the general alarm notification, could result in diminished response time for first responders.
- This deficient practice affected 28 residents, staff and visitors on the date of the survey. The facility

<table>
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<th>ID TAG</th>
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#### 1) The Fire Safety Policy in the Emergency Disaster binder at the nurse station was updated by the administrator to include #3. Emergency phone call to fire department; this was completed as of 12/09/16.

#### 2) The Fire Safety Policy in the Emergency Disaster binder at the nurse station was also reviewed to make sure and include all 9 components per NFPA 101 Chapter 19 requirement. 1. Use of alarms 2. Transmission of alarms to fire department 3. Emergency phone call to fire department 4. Response to alarms 5. Isolation of fire 6. Evacuation of immediate area 7. Evacuation of smoke compartment 8. Preparation of building for evacuation 9. Extinguishment of fire; this was completed as of 12/09/16.

#### 3) Weekly documentation verifying that the steps remain in place in the emergency disaster binder will be completed by the maintenance manager for 4 weeks.

#### 4) The staff has received education from the administrator or designee regarding the importance of the emergency phone call to the fire department; this was completed by 12/09/16.

#### 5) The 4 weekly audits results performed by the maintenance manager will be reviewed by the Quality Committee in the December and January QAPI meetings. The QAPI meetings will be held on 12/13/16 and 01/10/17. Further action by the QAPI team will be taken if necessary at that time.
K 711 Continued From page 10

is licensed for 80 SNF/NF beds and had a census of 28 on the day of the survey.

Findings include:

During review of the facility emergency plan conducted on November 7, 2016 from approximately 9:00 AM to 10:00 AM, review of the fire safety plan did not reveal the plan included separate notification of the local fire authority during a fire event.

When asked, the Maintenance Supervisor and the Administrator indicated they were unaware the plan did not contain notifying the fire department.

Actual NFPA standard:

NFPA 101
Chapter 19

19.7.2.2 Fire Safety Plan. A written health care occupancy fire safety plan shall provide for all of the following:
(1) Use of alarms
(2) Transmission of alarms to fire department
(3) Emergency phone call to fire department
(4) Response to alarms
(5) Isolation of fire
(6) Evacuation of immediate area
(7) Evacuation of smoke compartment
(8) Preparation of floors and building for evacuation
(9) Extinguishment of fire

K 712 NFPA 101 Fire Drills

SS=F

Fire Drills
K 712 Continued From page 11

Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.

18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7
This STANDARD is not met as evidenced by:

Based on record review and interview the facility failed to ensure fire drills were conducted with audible notification in accordance with NFPA 101. Conducting silent or "static" fire drills outside of allowable times could hinder staff response during a fire event. This deficient practice affected 28 residents, staff and visitors on the date of the survey. The facility is licensed for 80 SNF beds and had a census of 28 on the day of the survey.

Findings include:

During review of the fire drill records provided, conducted on November 7, 2016 from approximately 9:00 AM to 10:00 AM, records revealed the drill conducted on February 25, 2016 at 6:45 PM was a "static" drill that did not activate the fire alarm. When asked about this drill and the description as "static", the Maintenance Supervisor stated it was company policy to conduct all drills after 6:00 PM as silent and to not activate the fire alarm.

1) The maintenance manager did a 6:45pm "static" silent drill in February 2016. The NFPA standard is 9pm to 6am. All other drills were held appropriately other than that 1 time.

2) The maintenance manager has noted in his binder in bold print that a silent fire alarm test can only be performed between the hours of 9pm and 6am.

3) Weekly documentation that silent alarm fire drills can only be performed from 9pm to 6am will be noted for 4 weeks.

4) The maintenance manager has received education from the administrator that silent alarm fire drills can only be done between 9pm and 6am; this was completed by 12/09/16.

5) The 4 weekly audits results performed by the maintenance manager will be reviewed by the Quality Committee in the December and January QAPI meetings. The QAPI meetings will be held on 12/13/16 and 01/10/17. Further action by the QAPI team will be taken if necessary at that time.
<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
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Actual NFPA standard:

19.7* Operating Features.

19.7.1 Evacuation and Relocation Plan and Fire Drills.

19.7.1.4*

Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions.

19.7.1.5 Infirn or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building.

19.7.1.6 Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions.

19.7.1.7 When drills are conducted between 9:00 p.m. and 6:00 a.m. (2100 hours and 0600 hours), a coded announcement shall be permitted to be used instead of audible alarms.