November 23, 2016

Jeff Lines, Administrator
McCall Rehabilitation & Care Center
418 Floyde Street
McCall, ID 83638-4508

Provider #: 135082

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Mr. Lines:

On November 21, 2016, a Facility Fire Safety and Construction survey was conducted at McCall Rehabilitation & 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 **December 6, 2016.** Failure to submit an acceptable PoC by **December 6, 2016,** may result in the imposition of civil monetary penalties by **December 26, 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 26, 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 26, 2016.** A change in the seriousness of the deficiencies on **December 26, 2016,** may result in a change in the remedy.
The remedy, which will be recommended if substantial compliance has not been achieved by December 26, 2016, includes the following:

Denial of payment for new admissions effective February 21, 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 21, 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 21, 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 December 6, 2016. If your request for informal dispute resolution is received after December 6, 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

NE/lj
Enclosures
The facility is a single story, type V (111) wood frame building that was built in 1965. The original building was flat roof construction which has been built over with a peaked roof system. The facility is fully sprinklered to include the attic space. The facility is equipped with an automatic fire alarm system which protects corridors and open spaces and was upgraded in 2015. The facility is currently licensed for 65 SNF/NF beds.

The following deficiencies were cited during the annual fire/life safety survey conducted on November 21, 2016. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.

Plan of correction does not constitute an admission that the deficiencies alleged did in fact exist. This plan of correction is filed as evidence of McCall Rehab & Care Center desire to comply with requirements of participation and to continue to provide high quality resident care.

The facility does ensure that all fire rated doors are properly inspected and tested.:

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tbody>
<tr>
<td>(X4)</td>
<td>(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
<td>(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
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<td>The Survey was conducted by:</td>
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<td>Sam Burbank</td>
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<td></td>
<td>Health Facility Surveyor</td>
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<td>Facility Fire Safety &amp; Construction</td>
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<tr>
<td>K 200</td>
<td>NFPA 101 Means of Egress Requirements - Other</td>
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<td>SS=F Other</td>
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<td>Means of Egress Requirements - Other</td>
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<td>List in the REMARKS section any LSC Section</td>
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<td>18.2 and 19.2 Means of Egress requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.</td>
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<td>18.2, 19.2</td>
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<td>This Standard is not met as evidenced by:</td>
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<td>Based on record review, observation and</td>
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12/26/16

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.
K 200  Continued From page 1

During the facility tour conducted on November 21, 2016 from approximately 12:30 PM to 3:30 PM, observation of installed doors revealed doors in the following locations were tagged with fire labels:

Resident rooms with one-hour labels
Smoke barrier doors with one-hour labels

Actual NFPA standard:

NFPA 101

19.2 Means of Egress Requirements
   19.2.2.2 Doors.
   19.2.2.2.1 Doors complying with 7.2.1 shall be permitted.
K 200 Continued From page 2
7.2.1 Door Openings.
7.2.1.15 Inspection of Door Openings.
7.2.1.15.1* Where required by Chapters 11 through 43, the following door assemblies shall be inspected and tested not less than annually in accordance with 7.2.1.15.2 through 7.2.1.15.8:
(1) Door leaves equipped with panic hardware or fire exit hardware in accordance with 7.2.1.7
(2) Door assemblies in exit enclosures
(3) Electrically controlled egress doors
(4) Door assemblies with special locking arrangements subject to 7.2.1.6

7.2.1.15.2 Fire-rated door assemblies shall be inspected and tested in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Smoke door assemblies shall be inspected and tested in accordance with NFPA 105, Standard for Smoke Door Assemblies and Other Opening Protectives.

NFPA 80
5.2* Inspections.
5.2.1* Fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ.

K 211 NFPA 101 Means of Egress - General

Means of Egress - General
Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11, 18.2.1, 19.2.1, 7.1.10.1
This Standard is not met as evidenced by:
Based on observation and operational testing, the facility failed to ensure that means of egress were

The facility does ensure that all means of egress are maintained free of obstructions by providing locking arrangements that are in accordance to NFPA 101.

- The facility maintenance director on 11/28/2016 changed all non-single operational locks from the side of egress in the facility to single operational door knobs.
- The maintenance director inspected each door in the facility thereafter to ensure continued compliance with NFPA 101.
K 211 Continued From page 3

Maintained free of obstructions to full instant use by providing approved locking arrangements in accordance with NFPA 101. Failure to maintain locks on doors which do not require the use of a key, tool, special knowledge or effort could hinder escape during an emergency. This deficient practice affected residents, staff and visitors utilizing Physical Therapy office, Gym and the Kitchen on the date of the survey. The facility is licensed for 65 SNF/NF beds and had a census of 27 on the day of the survey.

Findings include:

During the facility tour conducted on November 21, 2016 from approximately 12:30 PM to 3:30 PM, observation and operational testing of the following locks revealed they were non-single operational from the egress side:

Physical Therapy office - equipped with a keyed entry locking requiring two actions to unlock from the egress side.

Physical Therapy Gym - equipped with a keyed entry locking requiring two actions to unlock from the egress side.

Main Kitchen door which entered the service corridor - equipped with a keyed entry locking requiring two actions to unlock from the egress side.

Actual NFPA standard:

NFPA 101
3.2 NFPA Official Definitions.
3.2.1 Approved. Acceptable to the authority having jurisdiction.

19.2 Means of Egress Requirements.
19.2.1 General. Every aisle, passageway,

"ORM CMS-2567(02-99) Previous Versions Obsolete"
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  

(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:  135082  

(02) MULTIPLE CONSTRUCTION  

A. BUILDING 01 - ENTIRE BUILDING  

B. WING  

(X5) DATE SURVEY COMPLETED  11/21/2016  

NAME OF PROVIDER OR SUPPLIER  

MCCALL REHABILITATION & CARE CENTER  

STREET ADDRESS, CITY, STATE, ZIP CODE  418 FLOYDE STREET  

MC CALL, ID  83638  

(X4) ID PREFIX TAG  

SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  

ID PREFIX TAG  

K 211: Continued From page 4  

corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7, unless otherwise modified by 19.2.2 through 19.2.11.  

7.2.1.5.3 Locks, if provided, shall not require the use of a key, a tool, or special knowledge or effort for operation from the egress side. 

K 511  

NFPA 101 Utilities - Gas and Electric  

Utilities - Gas and Electric  

equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life.  

18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2  

This Standard is not met as evidenced by:  
Based on observation, the facility failed to ensure approved, safe electrical installations in accordance with NFPA 70. Substitution of the fixed wiring of the facility with flexible cords such as a relocatable power tap (RPT) could result in arc fires or electrocution. This deficient practice affected staff and visitors in the Maintenance/Housekeeping office and staff breakroom on the date of the survey. The facility is licensed for 65 SNF/NF beds and had a census of 27 on the day of the survey.  

Findings include:  
During the facility tour conducted on November 21, 2016 from approximately 12:30 PM to 3:30 PM, observation of the facility electrical installations revealed the following:  

The facility does ensure safe electrical installations are in accordance with NFPA standards.  
- The facility maintenance director on 11/28/2016 removed all RPT's plugged into another RPT.  
- The facility maintenance director on 11/28/2016 removed the 3-1 extension cord used to power a transformer.  
- By 12/19/2016 the facility maintenance director will inservice staff about using RPT's and the proper use of them.  
- Starting on 12/09/2016 the facility maintenance director will audit each resident area and staff area to ensure that RPT's are being used properly. The maintenance director will report findings to the quarterly CQI meeting.  
Continuation or discontinuation of monitoring will be discussed in the quarterly meeting.
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<tr>
<td>K 511</td>
<td>Two (2) RPT's in the Maintenance/Housekeeping office were plugged into multiple-plug adapters which were plugged into the main wall outlet. A 3-1 extension cord was used to supply power to a transformer. Further observation revealed the cord of the transformer was ran through the wall. Microwave oven plugged into a RPT in the staff breakroom. 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 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(B) (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</td>
<td>K 511</td>
<td>11/21/2016</td>
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### Statement of Deficiencies and Plan of Correction

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<tr>
<th>(X1) ID</th>
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<tr>
<td>511</td>
<td>Continued From page 6</td>
<td>741</td>
<td>The facility does ensure that smoking areas are maintained away from oxygen storage areas.</td>
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<td>741</td>
<td>(7) Where subject to physical damage</td>
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<td>- By 12/09/2016 Staff and residents will be inserviced with regards to new no smoking policy.</td>
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<td>(K) NFPA 101 Smoking Regulations</td>
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<td>- By 12/09/2016 facility maintenance director will remove signs dedicated as smoking areas to reflect new no smoking policy.</td>
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<td>Smoking Regulations</td>
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<td>- By 12/09/2016 the no smoking policy will be added to employee handbook as well as admission packet informing any new residents and staff of new no smoking policy.</td>
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<td>Smoking regulations shall be adopted and shall include not less than the following provisions:</td>
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<td>- By 12/09/2016 signs posted around the facility will alert visitors to the no smoking policy.</td>
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<td>(1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking.</td>
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<td>(2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required.</td>
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<td>(3) Smoking by patients classified as not responsible shall be prohibited.</td>
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<td>(4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision.</td>
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<td>(5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.</td>
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<td>(6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.</td>
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<td>18.7.4, 19.7.4</td>
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This Standard is not met as evidenced by:

Based on record review and observation, the facility failed to maintain smoking areas safely away from oxygen storage areas. Oxygen storage areas not maintained away from designated smoking areas could expose oxygen rich environments to an ignition source (cigarettes) resulting in fires or explosions. This deficient practice affected staff and visitors on the date of the survey. The facility is licensed for 65 SNF/NF
### Summary Statement of Deficiencies

**K 741** Continued From page 7

**Findings include:**

1) **During review of the provided facility smoking policy, policy indicated smoking was prohibited "in any area where oxygen, flammable liquids, and/or combustible gases are being used or stored, in any area that bears a no-smoking sign, or in any area that would create a hazardous or unsafe condition."** Further evaluation of the location of the employee designated smoking area revealed it was approximately four feet from the door into the oxygen storage and transfill space on the northwest side of the building.

2) **During the facility tour conducted on November 21, 2016 from approximately 12:30 PM to 3:30 PM, observation of the designated smoking area for employees revealed it was outside the back door of the facility off the service corridor.** Further inspection of this area revealed the door entering the area from the facility had a "No Smoking" sign and on the outside of the door was another sign labeled "Designated Smoking Area".

**Actual NFPA standard:**

19.7.4* **Smoking.** Smoking regulations shall be adopted and shall include not less than the following provisions:

1. **Smoking shall be prohibited in any room, ward, or individual enclosed space where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted**
<table>
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<td>K 741</td>
<td>Continued From page 8 with the international symbol for no smoking.</td>
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<tr>
<td>K 918 SS=F</td>
<td>NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing</td>
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<td></td>
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<td>The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in</td>
<td>12/26/16</td>
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<td>The facility does ensure that proper documentation of load testing and maintenance are kept for backup generator.</td>
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<td>-The facility maintenance director on 11/30 2016 corrected documentation error and updated said documentation to reflect new load.</td>
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<td>-On 11/30/2016 facility maintenance director was inserviced and educated on proper documentation and calculation of load for the backup generator.</td>
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<td>-The facility maintenance director will continue monthly testing on backup generator</td>
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K 918  Continued From page 9  

accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.

6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)  

This Standard is not met as evidenced by:

Based on record review and interview, the facility failed to ensure Emergency Power Supply Systems (EPSS) were maintained in accordance to NFPA 110. Failure to inspect and test generators under load monthly could hinder early detection of system problems and the performance of the equipment during an emergency. This deficient practice affected 27 residents, staff and visitors on the date of the survey. The facility is licensed for 65 SNF/NF beds and had a census of 27 on the day of the survey.

Findings include:

During review of the EPSS inspection and monthly load testing documentation provided on November 21, 2016 from approximately 10:00 AM to 12:00 PM, records indicated no documentation of the amp load achieved, or manufacturer's specifications of water and oil stability during monthly testing of the generator during 2016, but instead listed voltage obtained during those tests.

When asked about the documented information,
The Maintenance Director stated he had not been aware he was not documenting the load obtained during the monthly tests as required.

Actual NFPA standard:

NFPA 110

8.4 Operational Inspection and Testing.
8.4.1* EPSSs, including all appurtenant components, shall be inspected weekly and exercised under load at least monthly.

8.4.2.4 Spark-ignited generator sets shall be exercised at least once a month with the available EPSS load for 30 minutes or until the water temperature and the oil pressure have stabilized.