Dear Mr. Davidson:

On July 24, 2017, a Facility Fire Safety and Construction survey was conducted at Good Samaritan Society - Boise Village 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 **August 14, 2017.** Failure to submit an acceptable PoC by **August 14, 2017,** may result in the imposition of civil monetary penalties by **September 3, 2017.**

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 **August 28, 2017,** (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 **August 28, 2017.** A change in the seriousness of the deficiencies on **August 28, 2017,** may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by
August 28, 2017, includes the following:

Denial of payment for new admissions effective October 24, 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 January 24, 2018, 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 July 24, 2017, 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 **August 14, 2017**. If your request for informal dispute resolution is received after **August 14, 2017**, 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) construction with multiple additions and renovations. The most recent addition was completed in 2002 on the West side. A new complete fire alarm/smoke detection system was installed in 2001. The facility was originally built in 1957 and is fully sprinklered. Currently it is licensed for 127 SNF/NF beds.

The following deficiencies were cited during the annual fire/life safety survey conducted on July 24, 2017. 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
Fire Life Safety & Construction

Means of Egress - General
Asiles, 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.

This Standard is not met as evidenced by:
Based on record review, observation and interview, the facility failed to ensure that rated assemblies were inspected in accordance with NFPA 80 and/or NFPA 105, as applicable. Failure to inspect and test rated assemblies has the potential to hinder system performance as designed. This deficient practice affected 85 residents.

K 211 - Means of Egress

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<tr>
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| The facility is a single story, type V(111) construction with multiple additions and renovations. The most recent addition was completed in 2002 on the West side. A new complete fire alarm/smoke detection system was installed in 2001. The facility was originally built in 1957 and is fully sprinklered. Currently it is licensed for 127 SNF/NF beds. The following deficiencies were cited during the annual fire/life safety survey conducted on July 24, 2017. 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:

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Based on record review, observation and interview, the facility failed to ensure that rated assemblies were inspected in accordance with NFPA 80 and/or NFPA 105, as applicable. Failure to inspect and test rated assemblies has the potential to hinder system performance as designed. This deficient practice affected 85 residents. |
**K 211 Continued From page 1**

Residents, staff and visitors on the date of the survey. The facility is licensed for 127 SNF/NF beds and had a census of 85 on the day of the survey.

Findings include:

1) During review of provided facility annual inspection records conducted on July 24, 2017 from approximately 9:00 AM to 10:00 AM, records provided did not indicate rated assemblies were being inspected and tested under NFPA 80 or NFPA 105, only a checkbox of pass/fail. Further examination of these records revealed only fifteen (15) doors were identified as being inspected or tested, with no information documented as to the rating of the door or the rating and purpose of the barrier. When asked about this lack of documentation, the Environmental Services Director stated these were the only doors he had identified and was not aware of specific testing requirements under NFPA standards.

2) During the facility tour conducted on July 24, 2017 from approximately 10:00 AM to 3:30 PM, observation of installed doors revealed the following rated doors were not documented as having been inspected or tested annually. Additionally, those deficiencies observed were not indicated on provided records as having been addressed:

   a) The chapel door was observed to be tagged with a 20 minute fire label and inspection of this door revealed it was missing approximately 16 inches of installed smoke gasket. This door was not shown on provided documentation as having been inspected or tested.

   b) Observation of the doors to Physical Therapy rated assemblies could hinder system performance as designed and potentially affect all residents, staff and visitors.

**Facility System**

1.) All required door assemblies will be inspected and tested to include documentation of door rating and rating/purpose of the barrier.

2.)

   a.) The chapel door has a complete smoke gasket and inspection/testing of the door has been documented.

   b.) Inspection and testing of the Physical Therapy doors has been completed and documented to include rating/purpose.

   c.) Inspection and testing of the boiler room door has been completed and documented to include rating/purpose.

   d.) The gasket material deficiency has been corrected for the west side kitchen door. Inspection, testing, rating, purpose, and repair of this door have been documented.

   e.) The smoke gasket deficiency
K 211 Continued From page 2 revealed the doors were tagged as 20 minute and indicated as part of a smoke assembly. These doors were not listed on provided documentation.

c) Observation of the door to the boiler room revealed the door to be part of a two-hour rated assembly, but documentation of this assembly and testing of this door, was not provided.

d) Observation of the west side Kitchen door entering from the dining hall revealed the door was tagged with a 90 minute label. Further observation revealed approximately 48 inches of the installed gasket material, had damages from what appeared to be the movement of carts in and out of the Kitchen. Documentation provided did not indicate any noted deficiencies for this door, or the rating and purpose of the assembly.

e) Inspection of doors entering the dining hall from the east revealed these doors were rated as part of a two-hour assembly. Further inspection revealed approximately 6 inches of installed smoke gasketing was missing from the right hand leaf. Provided documentation did not indicate the rating of the doors, or purpose of this assembly. No noted deficiencies or repairs were indicated on the documentation provided.

Actual NFPA standard:

NFPA 101
19.2 Means of Egress Requirements
19.2.2.2 Doors.
19.2.2.1 Doors complying with 7.2.1 shall be permitted.

7.2.1 Door Openings.
7.2.1.15 Inspection of Door Openings.

K 211 was corrected for the doors entering the east dining hall. Documentation now shows rating of the doors, purpose of the assembly, and repairs made.

Weekly inspections x4, bi-weekly inspections x2, and monthly inspections x4 will be completed by the Director of Environmental Services to ensure door assemblies are being inspected, tested, properly rated, and documented (to include any deficiencies or repairs).

Quality Assurance and Monitoring

The Director of Environmental Services will report any findings to the Quality Assurance and Performance Improvement (QAPI) meeting for further monitoring and plan modification if compliance is not met.

Date of compliance

August 28, 2017
### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLIA Identification Number:**
135085

**Multiple Construction**
- **A. Building 02 - Entire Bldg**
- **B. Wing**

**Date Survey Completed:**
07/24/2017

**Name of Provider or Supplier:**
Good Samaritan Society - Boise Villag

**Street Address, City, State, Zip Code:**
3115 Sycamore Drive
Boise, ID 83703

<table>
<thead>
<tr>
<th>ID Prefix Tag</th>
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<th>Provider's Plan of Correction (Each corrective action should be cross-referenced to the appropriate deficiency)</th>
<th>COMPLETION DATE</th>
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</table>
| K 211         | Continued From page 3  
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.  
NFPA 105  
5.2 Specific Requirements.  
5.2.1* Inspections.  
5.2.1.1 Smoke door assemblies shall be inspected annually.  
5.2.1.2 Doors shall be operated to confirm full closure.  
5.2.1.3 Hardware and gaskets shall be inspected annually, and any parts found to be damaged or inoperative shall be replaced. | K 211 | | |

**K 324**
**SS=D**
**NFPA 101 Cooking Facilities**
**K 324 - Cooking Facilities**
**Resident Specific**
K 324 Continued From page 4
with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:
* residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2
* cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or
* cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.
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 observation and interview, the facility failed to ensure cooking exhaust hood filtration and suppression systems were maintained in accordance with NFPA 96 and NFPA 17A. Failure to ensure cooking vapors pass over grease filters and suppression system protective caps are in place, has the potential to allow grease laden vapors to bypass filtration and coat system components, hindering system performance and increasing fire exposure. This deficient practice affected staff and vendors of the main kitchen on the date of survey. The facility is licensed for 127 SNF/NF beds and had a census of 85 on the day of the survey.

Other Residents
The failure to ensure cooking exhaust hood filtration and suppression systems were maintained had the potential to affect staff and vendors of the main kitchen on the date of survey.

Facility System
The missing grease filters were re-installed under the exhaust hood.

The vendor was contacted to ensure grease filters are re-installed after inspection, cleaning, or repair.

The Dietary Director will routinely check to ensure the grease filters are properly installed and have environmental services correct any deficiencies found.

The identified fire suppression pendant over the deep fat fryer now has a protective cap.
**Summary Statement of Deficiencies**

**Findings:**

During the facility tour conducted on July 24, 2017 from approximately 1:00 PM to 2:00 PM, observation of the cooking exhaust hood revealed three of the grease filters were missing and were subsequently located stored on a metal rack adjacent to the cooking area. Gaps created by the lack of these filters measured approximately six inches to twelve inches between filters. When asked about the missing filters, the dietary manager on duty stated the vendor who performed the inspection in June had not replaced the filters, but had left them on the rack.

Further inspection of the hood suppression system revealed 1 of 3 fire suppression system pendants installed over the deep fat fryer was missing its protective cap.

**Actual NFPA Standard:**

- NFPA 96
- Chapter 6 Grease Removal Devices in Hoods
- 6.2.3 Grease Filters
- 6.2.3.3 Grease filters shall be arranged so that all exhaust air passes through the grease filters.

**Quality Assurance and Monitoring**

The Director of Environmental Services will report any findings to the Quality Assurance and Performance Improvement (QAPI) meeting for further monitoring and plan modification if compliance is not met.

**Date of Compliance**

August 28, 2017
### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CUA Identification Number:** 135085

**Multiple Construction**

- **A. Building 02 - Entire Bldg**
- **B. Wing**

**Date Survey Completed:** 07/24/2017

**Name of Provider or Supplier:** Good Samaritan Society - Boise Village

**Street Address, City, State, Zip Code:**

3115 Sycamore Drive
Boise, ID 83703

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### Summary Statement of Deficiencies

<table>
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<tbody>
<tr>
<td>K324</td>
<td>Continued From page 6</td>
</tr>
<tr>
<td>K325</td>
<td>Alcohol Based Hand Rub Dispenser (ABHR)</td>
</tr>
</tbody>
</table>

**ID Number:** K324

- **NFPA 17A**
  - 4.3.1.5 All discharge nozzles shall be provided with caps or other suitable devices to prevent the entrance of grease vapors, moisture, or other foreign materials into the piping.

**ID Number:** K325

- **NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR)**
- ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met:
  - * Corridor is at least 6 feet wide
  - * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols
  - * Dispensers shall have a minimum of 4-foot horizontal spacing
  - * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room
  - * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30
  - * Dispensers are not installed within 1 inch of an ignition source
  - * Dispensers over carpeted floors are in sprinklered smoke compartments
  - * ABHR does not exceed 95 percent alcohol
  - * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11)
  - * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485

*This Standard is not met as evidenced by:*
- Based on record review, observation and interview, the facility failed to ensure Alcohol Based Hand Rub dispensers (ABHR) were maintained in accordance with NFPA 101. Failure

**ID Number:** K325

- **Alcohol-Based Hand Rub Dispensers (ABHR)**

**Resident Specific**

The failure to ensure Alcohol-Based Hand Rub dispensers were inspected and tested for proper operation, condition and then documented had the potential to affect 85 residents, staff and visitors on the date of survey.

**Other Residents**

The failure to ensure Alcohol-Based Hand Rub dispensers were inspected and tested for proper operation, condition and then documented has the potential to affect all residents, staff and visitors.

**Facility System**

1. Records are now available indicating inspection and testing of ABHR dispensers after each refill.
<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>K 325</td>
<td>Continued From page 7 to test and document the operation and condition of ABHR dispensers has the potential to inadvertently spill flammable liquids, increasing the risk of fires. This deficient practice affected 85 residents, staff and visitors on the date of the survey. The facility is licensed for 127 SNF/NF residents and had a census of 85 on the day of the survey. Findings include: 1) During review of facility inspection records conducted on July 24, 2017 from approximately 9:00 AM to 10:00 AM, no records were available indicating inspection and testing of ABHR dispensers was performed when refilling dispensers. 2) During the facility tour conducted on July 24, 2017 from approximately 10:00 AM to 3:30 PM, observation of installed ABHR dispensers revealed manually activated ABHR dispensers were installed in nine of nine smoke compartments. When asked if the facility tested dispenser operation at the time a refill was installed, the Environmental Services Director stated he was not aware of the requirement for dispenser testing. Actual NFPA standard: NFPA 101 19.3.2.6* Alcohol-Based Hand-Rub Dispensers. Alcohol-based hand-rub dispensers shall be protected in accordance with 8.7.3.1, unless all of the following conditions are met: (1) Where dispensers are installed in a corridor,</td>
<td>K 325</td>
<td>2.) The Environmental Services Director has been made aware of the requirement for ABHR dispenser inspection and testing and will ensure compliance. Weekly inspections x4, bi-weekly inspections x2, and monthly inspections x4 will be completed by the Director of Environmental Services to ensure ABHR dispensers are being inspected and tested after each refill. Quality Assurance and Monitoring The Director of Environmental Services will report any findings to the Quality Assurance and Performance Improvement (QAPI) meeting for further monitoring and plan modification if compliance is not met. Date of compliance August 28, 2017</td>
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</table>
| K 325        | Continued From page 8 the corridor shall have a minimum width of 6 ft (1830 mm).
|              | (2) The maximum individual dispenser fluid capacity shall be as follows:                                         |
|              | (a) 0.32 gal (1.2 L) for dispensers in rooms, corridors, and areas open to corridors                             |
|              | (b) 0.53 gal (2.0 L) for dispensers in suites of rooms                                                         |
|              | (3) Where aerosol containers are used, the maximum capacity of the aerosol dispenser shall be 18 oz (0.51 kg) and |
|              | shall be limited to Level 1 aerosols as defined in NFPA30B, Code for the Manufacture and Storage of Aerosol |
|              | Products.                                                        |
|              | (4) Dispensers shall be separated from each other by horizontal spacing of not less than 48 in. (1220 mm).     |
|              | (5) Not more than an aggregate 10 gal (37.8 L) of alcohol-based hand-rub solution or 1135 oz (32.2 kg) of Level  |
|              | 1 aerosols not to exceed, in total, the equivalent of 10 gal (37.8 L) or 1135 oz (32.2 kg), shall be in use     |
|              | outside of a storage cabinet in a single smoke compartment, except as otherwise provided in 19.3.2.6(6).       |
|              | (6) One dispenser complying with 19.3.2.6 (2) or (3) per room and located in that room shall not be included in |
|              | the aggregated quantity addressed in 19.3.2.6(5).                                                            |
|              | (7) Storage of quantities greater than 5 gal (18.9 L) in a single smoke compartment shall meet the requirements of |
|              | NFPA 30, Flammable and Combustible Liquids Code.                                                               |
|              | (8) Dispensers shall not be installed in the following locations:                                               |
|              | (a) Above an ignition source within a 1 in. (25 mm) horizontal distance from each side of the ignition source |
K 325 Continued From page 9

(b) To the side of an ignition source within a 1 in. (25mm) horizontal distance from the ignition source.

(c) Beneath an ignition source within a 1 in. (25 mm) vertical distance from the ignition source.

(9) Dispensers installed directly over carpeted floors shall be permitted only in sprinklered smoke compartments.

(10) The alcohol-based hand-rub solution shall not exceed 95 percent alcohol content by volume.

(11) Operation of the dispenser shall comply with the following criteria:

(a) The dispenser shall not release its contents except when the dispenser is activated, either manually or automatically by touch-free activation.

(b) Any activation of the dispenser shall occur only when an object is placed within 4 in. (100 mm) of the sensing device.

(c) An object placed within the activation zone and left in place shall not cause more than one activation.

(d) The dispenser shall not dispense more solution than the amount required for hand hygiene consistent with label instructions.

(e) The dispenser shall be designed, constructed, and operated in a manner that ensures that accidental or malicious activation of the dispensing device is minimized.

(f) The dispenser shall be tested in accordance with the manufacturer's care and use instructions each time a new refill is installed.

K 353 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.

K 353 - Sprinkler System Maintenance & Testing

Resident Specific

The failure to test and replace dry barrel pendants as required had
K 353 Continued From page 10

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 record review and interview, the facility failed to ensure fire suppression systems were maintained in accordance with NFPA 25. Failure to test or replace dry barrel pendants as required has the potential to hinder system performance during a fire event. This deficient practice affected staff and vendors of the main Kitchen on the date of survey. The facility is currently licensed for 127 SNF/NF beds and had a census of 85 on the day of the survey.

Findings include:

1) During review of provided fire suppression system inspection records conducted on July 24, 2017 from approximately 9:00 AM to 10:00 AM, no records were provided for replacement or testing of dry barrel pendants within the last ten years. Interview of the Environmental Services Director revealed that he was not aware of any replacement or testing of the dry barrel pendants having been conducted.

2) During the facility tour conducted on July 24, 2017 from approximately 1:00 PM to 2:00 PM, the potential to affect staff and vendors of the main Kitchen on the date of survey.

Other Residents

The failure to test and replace dry barrel pendants as required has the potential to affect all residents, staff and visitors.

Facility System

1.) The Environmental Services Director (ESD) is now aware of replacing dry barrel pendants at 10-year intervals.

Records are being maintained by the ESD for replacement of dry barrel pendants at 10-year intervals.

2.) Both barrel pendants in the walk-in cooler were replaced, the work was recorded, and will be replaced at 10-year intervals.

Weekly inspections x4, bi-weekly inspections x2, and monthly inspections x4 will be completed by the Director of Environmental Services to ensure barrel pendants are being replaced at 10-year intervals.

Quality Assurance and Monitoring
### Statement of Deficiencies and Plan of Correction

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</table>
| K 741 | SS=D | | | **Date of compliance**
August 28, 2017 |

**K 353** - Smoking Regulations

**Resident Specific**

The failure to provide and adhere to facility smoking policies had the potential to affect residents, staff and visitors on the date of survey.

**Other Residents**

The failure to provide and adhere to facility smoking policies has the potential to affect all residents, staff and visitors.

**Facility System**

1.) The facility has three designated areas (behind the Laundry, outside Syringa II, and the Gazebo when not occupied) for staff smoking and two designated areas (Courtyard

**Observation of the walk-in cooler and walk-in freezer confirmed dry barrel pendants were installed.** Inspection revealed 1 of 2 dry barrel pendants had a manufacture date of 1998.

Actual NFPA standard:

NFPA 25

5.3.1.1.6* Dry sprinklers that have been in service for 10 years shall be replaced or representative samples shall be tested and then retested at 10-year intervals.

**K 741** - Smoking Regulations

Smoking Regulations

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

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.

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.

3. Smoking by patients classified as not responsible shall be prohibited.

4. The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision.

5. Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.

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.

**Date of compliance**

August 28, 2017

**8/28/17**
### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CUA Identification Number:** 135085  
**Multiple Construction:** A. Building 02 - Entire Bldg  
**Date Survey Completed:** 07/24/2017

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix Tag</th>
<th>Summary Statement of Deficiencies</th>
<th>Provider's Plan of Correction</th>
</tr>
</thead>
</table>
| K741 | Continued From page 12  
18.7.4, 19.7.4 | This Standard is not met as evidenced by:  
Based on record review, observation and interview, the facility failed to ensure that smoking regulations were provided in accordance with NFPA 101. Failure to provide and adhere to facility smoking policies has the potential to expose residents to the hazards associated with smoking and fires from improper disposal of smoking materials. This deficient practice affected staff and visitors on the date of the survey. The facility is licensed for 127 SNF/NF beds and had a census of 85 on the day of the survey.  

Findings include:  
1) During review of the provided facility smoking policy conducted on July 24, 2017 from approximately 9:00 AM to 10:00 AM, the policy included a provision which allowed smoking in designated smoking areas. Interview of the Environmental Services Director revealed the facility provided two areas, one for staff and one for residents.  
2) During the facility tour conducted on July 24, 2017 from approximately 10:00 AM to 3:30 PM, observation of the designated resident smoking area outside Hoeger House Lounge, revealed the smoking area trash can was not a metal receptacle with self-closing lid for emptying ash trays. Further observation of this area revealed the provided receptacle was a plastic trash can whose self-closing lid was broken on one side and was also being used as a support for a box fan.  

Interview of the Environmental Services Director outside of the Activities Room and Hoeger House patio) for resident smoking.  
2.) A metal receptacle with a self-closing lid was present, but pushed to the corner out of reach. The can is now in reach and being used. The plastic trash can with a broken lid was discarded and replaced with a new trash can. A new fan was purchased and being supported on its own pedestal.  
3.) The ice-melt bucket was removed outside Syringa II's exit door. A notice has been posted at the time clock reminding all staff of the designated staff smoking areas.  

Weekly inspections x4, bi-weekly inspections x2, and monthly inspections x4 will be completed by the Director of Environmental Services to ensure the designated smoking areas have the proper receptacles and that staff and residents are smoking in only the designated smoking areas.  

**Quality Assurance and Monitoring**  
The Director of Environmental Services will report any findings to the Quality Assurance and Performance Improvement (QAPI)
K 741 Continued From page 13

revealed this receptacle was not intended for ashtray disposal and he was not sure why it had been placed there.

3) During the facility tour conducted on July 24, 2017 from approximately 10:00 AM to 3:30 PM, observation of the staff smoking area outside Syringa II, revealed the door exiting the facility and leading to the designated smoking area, had an ice-melt bucket directly outside the door which was being used as an ashtray. Asked about this observation, the Environmental Services Director stated it was likely a result of noc shift staff who did not feel comfortable smoking in the designated area after hours.

Actual NFPA standard:

19.7.4 Sm 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 with the international symbol for no smoking.

(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.

(3) Smoking by patients classified as not responsible shall be prohibited.

(4) The requirement of 19.7.4(3) shall not apply where the patient is under direct supervision.

(5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.

meeting for further monitoring and plan modification if compliance is not met.

**Date of compliance**

August 28, 2017
Continued From page 14

(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.

K 741 - Gas Equipment Storage

Resident Specific

The failure to segregate empty oxygen cylinders from full oxygen cylinders had the potential to affect residents in need of supplemental oxygen, staff and visitors on the date of survey.

Other Residents

The failure to segregate empty oxygen cylinders from full oxygen cylinders has the potential to affect all residents in need of supplemental oxygen, staff and visitors.

Facility System

The Environmental Services Director has setup a system to segregate empty oxygen cylinders from full oxygen cylinders. The staff will mark the empty cylinders by placing a tag over the top stating, "Cylinder Empty. Do Not Use" and then keep these cylinders separately stored.
**ID** | **PREFIX** | **TAG** | **SUMMARY STATEMENT OF DEFICIENCIES** | **ID** | **PREFIX** | **TAG** | **PROVIDER'S PLAN OF CORRECTION**
---|---|---|---|---|---|---|---
K 923 | Continued From page 15 | are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure medical gases were stored in accordance with NFPA 99. Failure to segregate empty oxygen cylinders from full oxygen cylinders, potentially results in staff using incorrect cylinders during an emergency. This deficient practice had the potential to affect residents in need of supplemental oxygen, staff and visitors on the date of the survey. The facility is licensed for 127 SNF/NF beds and had a census of 85 on the day of the survey.

Findings include:

During the facility tour conducted on July 24, 2017 from approximately 10:00 AM to 3:30 PM, observation of the oxygen storage room in the Harbor Care wing, revealed two (2) "E" cylinders stored in wheeled racks for emergency use. Further observation revealed one of the two cylinders was equipped with a plastic protective cap on the top, while the second was not. When asked how the distinction was made between full cylinders versus empty cylinders, the direct care staff present stated the full cylinders have a plastic cap attached and empty cylinders do not.

Further observation of the storage room revealed two stationary racks with intermixed cylinders identified by the direct care staff as "full" and "empty", based on the above distinction. When the direct care staff was asked if they had full cylinders stored with empty cylinders, she stated "I guess so".

Actual NFPA standard:

<table>
<thead>
<tr>
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<th>(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A memo has been placed at each oxygen storage area to remind staff of the new system to segregate empty and full oxygen cylinders. Nursing staff have been in-serviced on this new process. Weekly inspections x4, bi-weekly inspections x2, and monthly inspections x4 will be completed by the Director of Environmental Services to ensure the empty oxygen cylinders are marked and kept separate from the full oxygen cylinders.</td>
<td></td>
</tr>
</tbody>
</table>

**Quality Assurance and Monitoring**

The Director of Environmental Services will report any findings to the Quality Assurance and Performance Improvement (QAPI) meeting for further monitoring and plan modification if compliance is not met.

**Date of compliance**

August 28, 2017
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<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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| K 923 | Continued From page 16 | K 923 | 11.6.2.3 Cylinders shall be protected from damage by means of the following specific procedures:  
(1) Oxygen cylinders shall be protected from abnormal mechanical shock, which is liable to damage the cylinder, valve, or safety device.  
(2) Oxygen cylinders shall not be stored near elevators or gangways or in locations where heavy moving objects will strike them or fall on them.  
(3) Cylinders shall be protected from tampering by unauthorized individuals.  
(4) Cylinders or cylinder valves shall not be repaired, painted, or altered.  
(5) Safety relief devices in valves or cylinders shall not be tampered with.  
(6) Valve outlets clogged with ice shall be thawed with warm - not boiling - water.  
(7) A torch flame shall not be permitted, under any circumstances, to come in contact with a cylinder, cylinder valve, or safety device.  
(8) Sparks and flame shall be kept away from cylinders.  
(9) Even if they are considered to be empty, cylinders shall not be used as rollers, supports, or for any purpose other than that for which the supplier intended them.  
(10) Large cylinders (exceeding size E) and containers larger than 45 kg (100 lb) weight shall be transported on a proper hand truck or cart complying with 11.4.3.1.  
(11) Freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart.  
(12) Cylinders shall not be supported by radiators, steam pipes, or heat ducts. |
### Statement of Deficiencies and Plan of Correction

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</table>
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11.6.5 Special Precautions - Storage of Cylinders and Containers.  
11.6.5.1 Storage shall be planned so that cylinders can be used in the order in which they are received from the supplier.  
11.6.5.2 If empty and full cylinders are stored within the same enclosure, empty cylinders shall be segregated from full cylinders.  
11.6.5.3 Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed in a rapid manner. | K 923         |                                                                                                             |