



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
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CERTIFIED MAIL: 7012 3050 0001 2128 2620

June 18, 2014

Joe Rudd, Jr., Administrator
Marquis Care at Shaw Mountain
909 Reserve Street
Boise, Idaho 83712

Provider #: 135090

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Mr. Rudd, Jr.:

On **June 3, 2014**, a Facility Fire Safety and Construction survey was conducted at **Marquis Care at Shaw Mountain** 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 and a similar State Form 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

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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 both Statement of Deficiencies and Plan of Correction, Form CMS-2567 and State Form, in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **July 1, 2014**. Failure to submit an acceptable PoC by **July 1, 2014**, may result in the imposition of civil monetary penalties by **July 21, 2014**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.
- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567 and the state licensure survey report, State Form.

All references to federal regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **July 8, 2014**, (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 **July 8, 2014**. A change in the seriousness of the deficiencies on **July 8, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **July 8, 2014**, includes the following:

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Denial of payment for new admissions effective **September 3, 2014**.
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 **December 3, 2014**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Mark P. Grimes, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **June 3, 2014**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

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Go to the middle of the page to Information Letters section and click on State and select the following:

BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process
2001-10 IDR Request Form

This request must be received by **July 1, 2014**. If your request for informal dispute resolution is received after **July 1, 2014**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Grimes', with a long horizontal flourish extending to the right.

Mark P. Grimes, Supervisor
Facility Fire Safety and Construction

MPG/lj
Enclosures

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

Printed: 06/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135090	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/03/2014
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NAME OF PROVIDER OR SUPPLIER MARQUIS CARE AT SHAW MT	STREET ADDRESS, CITY, STATE, ZIP CODE 909 RESERVE STREET BOISE, ID 83712
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	<p>INITIAL COMMENTS</p> <p>The facility is a Type V(111) single story building. The original building was built in 1963 with an addition in 1971. The east portion of the building was significantly re-modeled in 2007 and a special care unit set-up in the wing. The facility is fully sprinklered. There is a complete fire alarm/smoke detection system installed to include coverage in sleeping rooms. The facility is currently licensed for 98 SNF beds.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on June 3, 2014. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.</p> <p>The Survey was conducted by:</p> <p>Dan Holbrook Health Facility Surveyor</p>	K 000	<p>This plan of correction constitutes the facility's written allegation of compliance for the deficiencies cited in the CMS 2567. However, the submission of this plan is not an admission that a deficiency exists. The Plan of Correction is prepared and executed solely because it is required by federal and state law. This response and Plan of Correction does not constitute an admission or agreement by the provider of the facts alleged or set forth in the statement of deficiencies.</p> <p>Survey Definitions:</p> <p>ESS - Environmental Services Supervisor</p> <p style="text-align: center;">RECEIVED JUL 01 2014 DIV. OF MEDICAID FACILITY STANDARDS</p>	
K 018 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p>	K 018	<p>Corrective Action: Door identified in 2567 as room #211 has been adjusted to close and latch completely.</p> <p>Identification: All residents are identified as possibly being affected by this deficiency.</p> <p>Systemic Changes: ESS will continue to conduct monthly inspections of all interior doors to ensure compliance.</p> <p>Monitor:</p> <ol style="list-style-type: none"> ESS to conduct weekly inspection of all interior doors for one month, and monthly thereafter Administrator to review ESS weekly and monthly inspections of self-closing doors for three months and quarterly thereafter. 	7/8/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 7/1/2014
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 018	<p>Continued From page 1</p> <p>This Standard is not met as evidenced by: Based on observation, interview, and operational testing the facility failed to maintain corridor doors. This deficiency may result in products of combustion passing from the room to the corridor. This condition affects one of 11 smoke compartments, 17 residents, staff, and visitors. The facility has a license for 98 SNF beds and had a census of 62 the day of survey.</p> <p>Findings include:</p> <p>Observation and operational testing on June 3, 2014 at 2:08 pm revealed the corridor door to patient room number 211 swung approximately 80 degrees before becoming bound and stopping. This finding was acknowledged by the Environmental Services Supervisor who stated he was not aware of this condition and stated he believes building settling is the cause.</p> <p>Actual NFPA reference</p> <p>101 Life Safety Code 19.3.6.3 Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors</p>	K 018		

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K 018	Continued From page 2 are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted.	K 018		
K 029 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This Standard is not met as evidenced by: Based on observation the facility failed to protect hazardous areas with self closing doors and smoke resistive partitions. Failure to protect hazardous areas may expose the facility to products of combustion in event of fire. This deficiency affected four of 11 smoke compartments, 38 residents, staff, and visitors. The facility is licensed for 98 SNF beds and had a census of 62 the day of survey.</p> <p>Findings include:</p> <p>1. Observation on June 3, 2014 at 2:39 pm revealed no self closing device on the corridor door of the activities storage room. This room measured greater than 50 square feet and contained combustible resident activities items. The Environmental Services Supervisor acknowledged this deficiency and stated this</p>	K 029	<p>Corrective Action:</p> <ol style="list-style-type: none"> 1. Self-closing hinges installed on door identified in 2567 as Activities Storage. 2. Door for room identified in 2567 as Medical Records Storage could not be adjusted to close properly due to warpage. This door will be replaced with a new door. (see Extension Waiver request) 3. Penetrations in ceiling noted in room identified in 2567 as Southeast Mechanical Room have been sealed with Fire Block material. 4. Penetrations in ceiling noted in room identified in 2567 as Riser Room have been sealed with Fire Block material. <p>Identification: All residents are identified as possibly being affected by this deficiency.</p> <p>Systemic Changes:</p> <ol style="list-style-type: none"> 1. ESS will continue to conduct monthly inspections of all interior doors. 2. ESS will continue to conduct monthly inspections of facility walls and ceilings to ensure compliance. <p>Monitor:</p> <ol style="list-style-type: none"> 1. ESS to conduct inspections of interior doors as noted in POC for K018 2. ESS to conduct inspections of facility walls and ceilings on a monthly basis. 3. Administrator to review ESS monthly inspections of interior doors on a monthly basis for three months and quarterly thereafter 	7/8/2014

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K 029	<p>Continued From page 3</p> <p>room is a former resident room and indicated he was not aware of this requirement.</p> <p>2. Observation on June 3, 2014 at 3:04 pm revealed the medical records storage room was not equipped with a self closing corridor door. This room measured greater then 50 square feet and contained combustible cardboard boxed medical records. The Environmental Services Supervisor acknowledged this deficiency and stated this room is a former resident room and indicated he was not aware of this requirement.</p> <p>3. Observation on June 3, 2014 at 3:12 pm revealed the southeast mechanical room had multiple unsealed penetrations in the ceiling. This finding was acknowledged by the Environmental Services Supervisor who stated he was not aware of this condition.</p> <p>4. Observation on June 3, 2014 at 4:55 pm revealed the furnace/sprinkler riser room had multiple unsealed penetrations in the ceiling and wall common to room 405. This finding was acknowledged by the Environmental Services Supervisor who stated he was not aware of this condition.</p> <p>Actual NFPA reference:</p> <p>101.19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be</p>	K 029		

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K 029	<p>Continued From page 4</p> <p>self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:</p> <ol style="list-style-type: none"> (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door. <p>NFPA 101, 8.3.6.1</p> <ol style="list-style-type: none"> (1) Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: <ol style="list-style-type: none"> (1) The space between the penetrating item and the smoke barrier shall meet one of the following conditions: <ol style="list-style-type: none"> a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (2) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be 	K 029		

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K 029	Continued From page 5 solidly set in the smoke barrier, and the space between the item and the sleeve shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (3) Where designs take transmission of vibration into consideration, any vibration isolation shall meet one of the following conditions: a. It shall be made on either side of the smoke barrier. b. It shall be made by an approved device that is designed for the specific purpose.	K 029		
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to provide clear unobstructed access to the public way from a designated emergency exit. Failure to maintain clear unobstructed access may hinder evacuation of the building. This condition affects four of 11 smoke compartments 33 residents, staff, and visitors. The facility is licensed for 98 SNF beds and had a census of 62 the day of survey. Findings include: 1. Observation on June 3, 2014 at 3:45 pm revealed designated emergency exit nearest the	K 038	<p>Corrective Action:</p> <ol style="list-style-type: none"> 1. Concrete installed from emergency exit, identified in 2567 as exit "nearest the Laundry Room", to public way. 2. Concrete installed from emergency exit, identified in 2567 as exit from Dining Room, to public way. 3. Carpet repaired in hallway 100 and 300 to eliminate uneven walking surface. <p>Identification: All residents are identified as possibly being affected by this deficiency.</p> <p>Systemic Changes:</p> <ol style="list-style-type: none"> 1. ESS to continue to conduct monthly inspections of emergency exit path to ensure compliance. 2. ESS to conduct inservice of staff related to the emergency exits out of the facility. 3. ESS to continue to conduct weekly inspections of the facility carpet to ensure compliance. <p>Monitor:</p> <ol style="list-style-type: none"> 1. ESS to conduct monthly inspections of emergency exits. 2. ESS to conduct weekly inspections of facility carpet. 3. Administrator to review inspections of Emergency exits and facility carpet on a monthly basis for three months and quarterly thereafter. 	7/8/2014

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K 038	<p>Continued From page 6</p> <p>laundry room empties into a courtyard with a concrete discharge area and an extensive grassy area. The exit to the public way was impeded by changes in elevation of an uneven grassy surface which had intermittent paver stones. The Environmental Services Supervisor indicated he was not aware of this requirement.</p> <p>2. Observation on June 3, 2014 at 3:57 pm revealed a designated emergency exit in the dining/sun room discharges into a courtyard with concrete discharge area surrounded by an uneven grassy surface which was being watered at the time. The exit to the public way was impeded by changes in elevation of an uneven grassy surface and a drain pipe which created an approximately 3 inch curb that had to be crossed. It also had an approximate 2 inch rise to meet a concrete ramp to the public way. The Environmental Services Supervisor acknowledged this deficiency during the survey.</p> <p>3. Observation on June 3, 2014 between the hours of 1:50 pm and 4:55 pm revealed carpeting in hallway 100 and hallway 300 was loose creating an uneven walking surface. The Environmental Services Supervisor acknowledged this deficiency during the survey.</p> <p>Actual NFPA reference: 101 Life Safety Code, 7 Means of Egress</p> <p>7.1.6 Walking Surfaces in the Means of Egress. 7.1.6.1 General. Walking surfaces in the means of egress shall comply with 7.1.6.2 through 7.1.6.4. Exception: Existing walking surfaces shall be permitted where approved by the authority having jurisdiction.</p>	K 038		

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K 038	Continued From page 7 7.1.6.2 Changes in Elevation. Abrupt changes in elevation of walking surfaces shall not exceed 1/4 in. (0.6 cm). Changes in elevation exceeding 1/4 in. (0.6 cm), but not exceeding 1/2 in. (1.3 cm), shall be beveled 1 to 2. Changes in elevation exceeding 1/2 in. (1.3 cm) shall be considered a change in level and shall be subject to the requirements of 7.1.7. 7.1.6.3 Level. Walking surfaces shall be nominally level. The slope of a walking surface in the direction of travel shall not exceed 1 in 20 unless the ramp requirements of 7.2.5 are met. The slope perpendicular to the direction of travel shall not exceed 1 in 48. 7.1.6.4* Slip Resistance. Walking surfaces shall be slip resistant under foreseeable conditions. The walking surface of each element in the means of egress shall be uniformly slip resistant along the natural path of travel. 7.7.1* Exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way. Exception No. 1: This requirement shall not apply to interior exit discharge as otherwise provided in 7.7.2. Exception No. 2: This requirement shall not apply to rooftop exit discharge as otherwise provided in 7.7.6. Exception No. 3: Means of egress shall be permitted to terminate in an exterior area of refuge as provided in Chapters 22 and 23.	K 038		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance	K 052	Please see p. 9	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135090	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/03/2014
NAME OF PROVIDER OR SUPPLIER MARQUIS CARE AT SHAW MT		STREET ADDRESS, CITY, STATE, ZIP CODE 909 RESERVE STREET BOISE, ID 83712		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 052	<p>Continued From page 8 with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>This Standard is not met as evidenced by: Based on record review and interview the facility failed to maintain and test smoke detectors as required. Failure to maintain smoke detectors may cause them to fail to notify building occupants in case of fire. This deficiency affected all residents, staff, and visitors. The facility has a license for 98 SNF beds and had a census of 62 the day of survey.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Record review on June 3, 2014 between the hours of 12:00 noon and 1:50 pm revealed no evidence of smoke detector sensitivity testing within the last 5 years. The Environmental Services Supervisor stated he was unaware of the requirement and was told by the out-going Environmental Services Supervisor no need existed for records to be kept beyond two years. The Environmental Services Supervisor made arrangements to conduct the test during record review. Observation of the communication/server room at 3:02 pm on June 3, 2014 revealed the fire alarm relay panel batteries were not dated and 	K 052	<p>Corrective Action:</p> <ol style="list-style-type: none"> Smoke Detector Sensitivity testing completed on June 16, 2014. Batteries in Fire Alarm Relay Panel, in room identified in 2567 as Communications /Server Room, have been changed out, dated, and terminals cleaned on July 10, 2014. (See Extension Waiver request) <p>Identification: All residents are identified as possibly being affected by this deficiency.</p> <p>Systemic Changes:</p> <ol style="list-style-type: none"> ESS to include Smoke Detector Sensitivity testing every five years to current physical plant audit and service processes. ESS to inservice alarm system vendor as to location of alarm relay panel in Communication / Server Room and to add this location to their annual inspection and service process <p>Monitor: Administrator review ESS records annually to ensure compliance.</p>	7/8/2014

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K 052	<p>Continued From page 9</p> <p>the electrical connection terminals were corroded. Environmental Services Supervisor acknowledged this finding and stated he believed the alarm maintenance company was unaware of the location.</p> <p>Actual NFPA reference:</p> <p>1. 7-3.2.1*</p> <p>Detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector 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. If the frequency is extended, records of detector-caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed.</p> <p>To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods:</p> <p>(1) Calibrated test method (2) Manufacturer ' s calibrated sensitivity test instrument (3) Listed control equipment arranged for the purpose (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range (5) Other calibrated sensitivity test methods approved by the authority having jurisdiction</p> <p>Detectors found to have a sensitivity outside the</p>	K 052		

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K 052	Continued From page 10 listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. Exception No. 1: Detectors listed as field adjustable shall be permitted to be either adjusted within the listed and marked sensitivity range and cleaned and recalibrated, or they shall be replaced. Exception No. 2: This requirement shall not apply to single station detectors referenced in 7-3.3 and Table 7-2.2. The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of smoke or other aerosol into the detector. 2. FPA 72, National Fire Alarm Code 7-4 Maintenance. 7-4.1 Fire alarm system equipment shall be maintained in accordance with the manufacturer ' s instructions. The frequency of maintenance shall depend on the type of equipment and the local ambient conditions.	K 052		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to maintain the fire sprinkler system. Failure to maintain the fire sprinkler system may allow fire to grow unabated. This condition affects all residents, staff, and visitors. The facility is	K 062	Corrective Action: 1. Escutcheons installed on the two sprinklers in room identified in 2567 as Resident Relations. 2. Hangers installed on four sprinkler heads in room identified in 2567 as Maintenance Room. 3. Escutcheon installed on the one sprinkler in space identified in 2567 as Nurse Station #2. 4. 200 degree sprinkler head installed in room identified in 2567 as Boiler Room. 5. Quarterly sprinkler inspections set up with fire sprinkler maintenance vendor. To begin on 7/8/2014 Continued on p. 12	

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K 062	<p>Continued From page 11 licensed for 98 SNF beds and had a census of 62 on the day of survey.</p> <p>Findings include:</p> <p>1. During record review on June 3, 2014 between the hours of 12:00 noon and 1:50 pm revealed the fire sprinkler maintenance company report dated 10/27/2013 contained the following deficiencies: A. 2 escutcheons are missing in resident relations room 401. B. 4 sprinkler heads need hangers in maintenance room. (Also noted in fire sprinkler maintenance company 2012 report). C. 1 escutcheon missing from nurses station #2. D. Boiler room should be a 200 degree sprinkler head. (Also noted in fire sprinkler maintenance company 2012 report). No evidence of corrective action for A., B., C., and D. was provided to the surveyor.</p> <p>2. Record review on June 3, 2014 between the hours of 12:00 noon and 1:50 pm revealed no documentation of quarterly sprinkler inspections in 2014. The last documented quarterly inspection was dated June 6, 2013. Environmental Services Supervisor stated he was unaware of the requirement.</p> <p>Actual NFPA reference:</p> <p>NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems 1-11 Maintenance. 1-11.1 Maintenance shall be performed to keep the system equipment operable or to make repairs.</p>	K 062	<p>Identification: All residents are identified as possibly being affected by this deficiency.</p> <p>Systemic Changes: 1. Quarterly fire sprinkler inspections by vendor added to fire equipment maintenance processes by ESS. 2. ESS and Administrator to review fire Sprinkler maintenance company reports to ensure areas noted as needing attention are corrected.</p> <p>Monitor: Administrator to review quarterly and annual reports and inspection to ensure all work done as prescribed.</p>	7/8/2014
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K 062	Continued From page 12 As-built system installation drawings, original acceptance test records, and device manufacturer ' s maintenance bulletins shall be retained to assist in the proper care of the system and its components. 2-3.3* Alarm Devices. Waterflow alarm devices including, but not limited to, mechanical water motor gongs, vane-type waterflow devices, and pressure switches that provide audible or visual signals shall be tested quarterly. 101 Life Safety Code Chapter 13 Standard for the Installation of Sprinkler Systems 13.3.3-2.7.2* Escutcheon plates used with a recessed or flush-type sprinkler shall be part of a listed sprinkler assembly.	K 062		
K 069	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This Standard is not met as evidenced by: Based on record review, observation, and interview, the facility failed to maintain the kitchen dry chemical fire system. Failure to maintain the dry chemical fire system may allow a kitchen fire to grow unabated. This condition affects all residents, staff, and visitors. The facility is licensed for 98 SNF beds and had a census of 62 on the day of survey. Findings include:	K 069	No corrective action required due to the following information: Dry Chemical Extinguisher System in Kitchen was installed some time after August 2002 as therefore is compliant with regard to hydrostatic testing at least every 12 years. However, Hydrostatic testing scheduled to be performed by July 8, 2014 to be compliant. Label will be affixed to unit as to testing date and when next testing is recommended.	

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K 069	<p>Continued From page 13</p> <p>Record review between the hours of 12:00 noon and 1:50 pm on June 3, 2014 revealed no documentation of a hydrostatic test date of the extinguishment systems. Observation revealed no evidence affixed to the kitchen dry chemical system indicating a hydrostatic test date. Environmental Services Supervisor stated he was advised by the out-going Environmental Services Supervisor there was no need for any records to be maintained beyond two years and was not aware of the previous hydrostatic test date.</p> <p>Actual NFPA reference</p> <p>101 Life Safety Code 2000</p> <p>NFPA 17, Standard for Dry Chemical Extinguishing Systems 9-3 Maintenance. 9-3.1*</p> <p>At least semiannually, maintenance shall be conducted in accordance with the manufacturer ' s listed installation and maintenance manual. As a minimum, such maintenance shall include the following:</p> <p>(a) A check to see that the hazard has not changed</p> <p>(b) An examination of all detectors, expellant gas container(s), agent container(s), releasing devices, piping, hose assemblies, nozzles, signals, and all auxiliary equipment</p> <p>(c) * Verification that the agent distribution piping is not obstructed</p> <p>(d) Examination of the dry chemical (If there is evidence of caking, the dry chemical shall be discarded and the system shall be recharged in accordance with the manufacturer ' s instructions.)</p> <p>Exception: Dry chemical in stored pressure systems shall not require semiannual</p>	K 069		

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K 069	<p>Continued From page 14</p> <p>examination but shall be examined at least every 6 years.</p> <p>(e) Where semiannual maintenance of any dry chemical containers or system components reveals conditions such as, but not limited to, corrosion or pitting in excess of the manufacturer ' s limits, structural damage or fire damage, or repairs by soldering, welding, or brazing, the affected part(s) shall be replaced or hydrostatically tested in accordance with the recommendations of the manufacturer or the listing agency. The hydrostatic testing of dry chemical containers shall follow the applicable procedures outlined in Section 9-5.</p> <p>(f) All dry chemical systems shall be tested, which shall include the operation of the detection system, signals, and releasing devices, including manual stations and other associated equipment. A discharge of the dry chemical normally is not part of this test.</p> <p>(g) Where the maintenance of the system(s) reveals defective parts that could cause an impairment or failure of proper operation of the system(s), the affected parts shall be replaced or repaired in accordance with the manufacturer ' s recommendations.</p> <p>(h) The maintenance report, including any recommendations, shall be filed with the owner or with the designated party responsible for the system.</p> <p>(i) * Each dry chemical system shall have a tag or label indicating the month and year the maintenance is performed and identifying the person performing the service. Only the current tag or label shall remain in place.</p> <p>9-5* Hydrostatic Testing. Hydrostatic testing shall be performed by persons trained in pressure-testing procedures and safeguards and having available suitable testing</p>	K 069		

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K 069	Continued From page 15 equipment, facilities, and an appropriate service manual(s). The following parts of dry chemical extinguishing systems shall be subjected to a hydrostatic pressure test at intervals not exceeding 12 years: (a) Dry chemical containers (b) Auxiliary pressure containers (c) Hose assemblies Exception No. 1: Dry chemical containers that are part of extinguishing systems having an agent capacity exceeding 150 lb (68 kg). Exception No. 2: Auxiliary pressure containers not exceeding 2 in. (0.05 m) outside diameter and less than 2 ft (0.6 m) in length. Exception No. 3: * Auxiliary pressure containers bearing the DOT " 3E " marking.	K 069		
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This Standard is not met as evidenced by: Based on observation, investigation, and interview, the facility failed to maintain wiring according to NFPA 70 National Electrical Code. Failure to provide for electrical safety may result in electric shock or fire. This condition affects all residents, staff, and visitors. The facility has a license for 98 SNF beds and had a census of 62 on the day of survey. Findings include: 1. Observation on June 3, 2014 at 3:12 pm in the southeast mechanical room revealed electrical wires protruding out of an uncovered junction box on the hot water recirculating pump. Environmental Services Supervisor stated he was	K 147	Corrective Action: 1. Wiring at junction box in room identified in 2567 as Southeast Mechanical Room has been placed inside the box and the proper cover has been installed. 2. Wiring at junction box in room identified in 2567 as Riser Room has been placed inside the box and the proper cover has been installed. 3. Hair Dryer has been replaced with a different model that has a longer power cord. The extension cord has been removed. Identification: All residents are identified as possibly being affected by this deficiency. Systemic Changes: ESS to continue to conduct monthly inspections of facility rooms to ensure compliance with regard to electrical compliance. Monitor: Administrator to review monthly inspections by ESS monthly for three months and quarterly thereafter.	7/8/2014

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K 147	<p>Continued From page 16 unaware of this condition.</p> <p>2. Observation on June 3, 2014 at 4:55 pm in the furnace/sprinkler riser room revealed electrical wires protruding from an uncovered electrical service junction box. Maintenance Engineer acknowledge this finding and stated he was unaware of this condition.</p> <p>3. At 3:30 pm on June 3, 2014 observation of the beauty shop revealed an extension cord powering a 1900 watt hair dryer. Outlets were positioned so as to not allow the beautician to reach her customers with the hair dryer without the use of an extension cord. Environmental Services Supervisor stated he was not aware of the extension cord.</p> <p>NFPA 70 National Electrical Code</p> <p>1. and 2.: ARTICLE 314 Outlet, Device, Pull, and Junction Boxes; Conduit Bodies; Fittings; and Manholes II. Installation (C) Covers. All pull boxes, junction boxes, and conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use. Where metal covers are used, they shall comply with the grounding requirements of 250.110. An extension from the cover of an exposed box shall comply with 314.22, Exception.</p> <p>2. NFPA 70, 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:</p>	K 147		

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K 147	Continued From page 17 (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: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of 368.8. (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	K 147			

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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2.</p> <p>The facility is a Type V(111) single story building. The original building was built in 1963 with an addition in 1971. The east portion of the building was significantly re-modeled in 2007 and a special care unit set-up in the wing. The facility is fully sprinklered. There is a complete fire alarm/smoke detection system installed to include coverage in sleeping rooms. The facility is currently licensed for 98 SNF beds.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on June 3, 2014. The facility was surveyed under IDAPA 16.03.02, Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities.</p> <p>The surveyor conducting the survey was:</p> <p>Dan Holbrook Health Facility Surveyor Division of Building Safety</p>	C 000	<p>This plan of correction constitutes the facility's written allegation of compliance for the deficiencies cited in the CMS 2567. However, the submission of this plan is not an admission that a deficiency exists. The Plan of Correction is prepared and executed solely because it is required by federal and state law. This response and Plan of Correction does not constitute an admission or agreement by the provider of the facts alleged or set forth in the statement of deficiencies.</p> <p>Survey Definitions:</p> <p>ESS – Environmental Services Supervisor</p> <p style="text-align: right;">RECEIVED JUL 01 2014 DIV. OF MEDICAID</p> <p style="text-align: right;">RECEIVED JUL -1 2014 FACILITY STANDARDS</p>	
C 226	<p>02.106 FIRE AND LIFE SAFETY</p> <p>106. FIRE AND LIFE SAFETY. Buildings on the premises used as facilities shall meet all the requirements of local, state and national codes concerning fire and life safety standards that are applicable to health care facilities. This RULE: is not met as evidenced by: Refer to form 2567:</p> <p>K18 Door Maintenance K25 Penetrations</p>	C 226	<p>C226</p> <p>See POC for the following: K018 K025 K029 K038 K052 K062 K147</p>	7/8/2014

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Jeff. Rodden

TITLE

Administrator

(X6) DATE

7/11/2014

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C 226	Continued From Page 1 K29 Self Closing Doors K38 Egress K52 Smoke Detectors K62 Sprinkler Maintenance K147 Electrical	C 226		

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.