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
FAX 208-364-1888

CERTIFIED MAIL: 7012 3050 0001 2128 3481

August 1, 2014

Richard Ord, Administrator
Meridian Center Genesis Healthcare
1351 West Pine Avenue
Meridian, ID 83642-5031

Provider #: 135125

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

Dear Mr. Ord:

On **July 25, 2014**, a Facility Fire Safety and Construction survey was conducted at **Meridian Center Genesis Healthcare** 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

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 **August 14, 2014**. Failure to submit an acceptable PoC by **August 14, 2014**, may result in the imposition of civil monetary penalties by **September 3, 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 **August 29, 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 **August 29, 2014**. A change in the seriousness of the deficiencies on **August 29, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **August 29, 2014**, includes the following:

Denial of payment for new admissions effective **October 25, 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 **January 25, 2015**, 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 **July 25, 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

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, 2014**. If your request for informal dispute resolution is received after **August 14, 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,

Mark P. Grimes, Supervisor
Facility Fire Safety and Construction

MPG/lj
Enclosures

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

Printed: 07/31/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	135125		07/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN CENTER GENESIS HEALTHCARE	1351 WEST PINE AVENUE MERIDIAN, ID 83642

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FACILITY STANDARDS RECEIVED AUG 15 2014	K 000		
	The facility is a single story building except for the upper level used for classroom, medical records, marketing and board room. The building is a Type V (III) construction, fully sprinklered and was completed in March 1997. The building is covered by a complete fire alarm system with smoke detectors throughout. The facility is currently licensed for 139 SNF/NF beds.		The Meridian Center provides this plan of correction without admitting or denying the validity or existence of the alleged deficiencies. The Plan of Correction is prepared and executed solely because it is required by federal and state law. RECEIVED AUG 15 2014 DIV OF LIC & CERT	
	The following deficiencies were cited during the annual fire/life safety survey conducted on July 25, 2014. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70. The Survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	K 012 - F	1) The missing escutcheons, compartment penetrations, medication room hole and damaged or dislodged ceiling tiles found by the state surveyor were replaced or repaired by 8/29/14. 2) A review of the whole facility was completed by the maintenance manager and any missing escutcheons, compartment penetrations, ceiling holes and damaged or dislodged ceiling tiles not found by the state surveyor were replaced or repaired by 8/29/14. 3) Weekly documentation for missing escutcheons, compartment penetrations, ceiling holes and damaged or dislodged ceiling tiles will be included in the maintenance managers TELS system. This builds a reminder to the maintenance manager. The maintenance staff has received education from the administrator regarding the importance of repairing or replacing missing escutcheons, compartment penetrations, ceiling holes and damaged or dislodged ceiling tiles 4) The first 5 weekly audits, the results will be reviewed by the QI safety committee in the September and October meetings. The QAPI meeting will also review the results and act on the information as indicated.	8/29/14
K 012 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 RECEIVED AUG 15 2014 DIV OF LIC & CERT This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure smoke and fire compartments were maintained. Failure to ensure continuity in smoke and fire compartments would allow smoke and dangerous gases to pass freely during a fire. This deficient practice affected all residents, staff and visitors in 15 of 15 smoke compartments on the date of the survey. The facility is licensed for			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 8/14/14

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 012	Continued From page 1 139 SNF/NF beds and had a census of 96 on the day of the survey. Findings include: 1) During the facility tour conducted on July 25, 2014 from 11:00 AM to 3:00 PM, observation by the surveyor and staff of the second floor conference room, the main Dining Room, Dietary Services office, Employee Lounge and the storage closet abutting resident room #401 revealed (5) sprinkler escutcheons missing from the ceiling; (1) at each location. Interview of the Maintenance Assistant indicated he was not aware of the missing components. Based on the number of observations by the surveyor and the Maintenance staff, further documentation was deemed unnecessary. 2) During the facility tour conducted on July 25, 2014 from 3:00 PM to 4:00 PM, an above the ceiling inspection of the smoke compartment walls intersecting the 500, 600 and 700 wing revealed (7) penetrations. Based on the number of observations by the surveyor and the Maintenance staff, further documentation was deemed unnecessary. Interview of the Maintenance Assistant found that he was unaware of these penetrations. 3) During the facility tour conducted on July 25, 2014 from 3:00 PM to 4:00 PM, inspection of the Med Room in the Nurse's station of the 100, 200, 300 and 400 wing intersection revealed a hole approximately ten inches square cut into the ceiling. When asked, the Maintenance Assistant stated this hole was cut for a leak repair. 3) During the facility tour conducted on July 25, 2014 from 10:00 AM to 4:00 PM, ceiling tiles of the facility were observed damaged and dislodged throughout all wings indicating a systemic fault of the grid ceiling. Based on the	K 012		

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K 012	Continued From page 2 number of observations by the surveyor and the Maintenance staff, further documentation was deemed unnecessary. This finding was acknowledged by the Administrator at the exit conference conducted on July 25, 2014 from 4:45 PM to 5:00 PM. Actual NFPA standard: 8.2.2.1 Where required by Chapters 12 through 42, every building shall be divided into compartments to limit the spread of fire and restrict the movement of smoke.	K 012		
K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This Standard is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure that smoke compartment doors equipped with positive latching hardware were maintained. Failure to ensure positive latching hardware would engage where provided would allow smoke and dangerous gases to pass freely between smoke compartments. This deficient practice affected 9 residents, staff and visitors in 1 of 15 smoke	K 027 - E	1) The corridor door by the conference room and the doors attached to the physical therapy room were repaired and properly working by 8/29/14. 2) A review of the whole facility was completed by the maintenance manager and any self-closure doors not found by the state surveyor were repaired and properly working by 8/29/14. 3) Weekly documentation of testing of self-closure doors will be included in the maintenance managers TELS system. This builds a reminder to the maintenance manager. 4) The first 5 weekly audits, the results will be reviewed by the QI safety committee in the September and October meetings. The QAPI meeting will also review the results and act on the information as indicated.	8/29/14

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K 027	Continued From page 3 compartments on the date of the survey. The facility is licensed for 139 SNF/NF beds and had a census of 96 on the day of the survey. Findings include: 1) During the facility tour conducted on July 25, 2014 from 12:00 PM to 1:00 PM, observation and operational testing of the corridor door to the conference room on the second floor revealed it would not self-close. Interview of the Maintenance Director and the Administrator indicated they were aware this was a smoke compartment door. 2) During the facility tour conducted on July 25, 2014 from 2:00 PM to 3:00 PM, observation and operational testing of the two self-closing doors to Physical Therapy in the 500 wing revealed that both doors would not self-close when released. This observation was confirmed by the Maintenance Assistant. Actual NFPA standard: 19.3.7.6* Doors in smoke barriers shall comply with 8.3.4 and shall be self-closing or automatic-closing in accordance with 19.2.2.2.6. Such doors in smoke barriers shall not be required to swing with egress travel. Positive latching hardware shall not be required. 4.6.12 Maintenance and Testing. 4.6.12.1 Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature	K 027		

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K 027	Continued From page 4 shall thereafter be continuously maintained in accordance with applicable NFPA requirements or as directed by the authority having jurisdiction.	K 027		
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD 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 This Standard is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure that hazardous areas were protected by self-closing doors. Failure to ensure protection of hazardous areas would allow smoke and dangerous gases to pass freely into corridors affecting egress. This deficient practice affected 26 residents in 3 of 15 smoke compartments on the date of the survey. The facility is licensed for 139 SNF/NF beds and had a census of 96 on the day of the survey. Findings include: 1) During the facility tour conducted on July 25, 2014 from 1:30 PM to 2:00 PM, observation and operational testing of the self-closing door to the Housekeeping storage in the 100 wing found it would not self-close. This finding was acknowledged by the Maintenance Assistant.	K 029 - E	1) The self-closure doors to the housekeeping storage, laundry room and mechanical room were repaired and properly working by 7/28/14. 2) A review of the whole facility was completed by the maintenance manager and any self-closure doors not found by the state surveyor were repaired and properly working by 8/29/14. 3) Weekly documentation of testing of self-closure doors will be included in the maintenance managers TELS system. This builds a reminder to the maintenance manager. 4) The first 5 weekly audits, the results will be reviewed by the QI safety committee in the September and October meetings. The QAPI meeting will also review the results and act on the information as indicated.	8/29/14

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K 029	Continued From page 5 2) During the facility tour conducted on July 25, 2014 from 11:30 AM to 12:00 PM, observation and operational testing of the corridor door into the Laundry across from the Kitchen found it would not self-close. Interview of the Maintenance Director revealed he was not aware this door was not self-closing. 3) During the facility tour conducted on July 25, 2014 from 12:00 PM to 1:00 PM, observation and operational testing of the mechanical room adjacent to the second floor conference room found the door would not self close. This finding was acknowledged by the Administrator and the Maintenance Director. Actual NFPA standard: 19.3.2 Protection from Hazards. 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 self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (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	K 029		

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

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K 029	Continued From page 6 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.	K 029		
K 038 SS=D	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 ensure that exits were readily accessible at all times. Failure to ensure exits are clear and unobstructed would prevent evacuation of occupants during an emergency. This deficient practice affected no residents, staff and visitors in 1 of 15 smoke compartments on the date of the survey. The facility is licensed for 139 SNF/NF beds and had a census of 96 on the day of the survey. Findings include: 1) During the initial facility tour conducted on July 25, 2014 from 9:00 AM to 10:00 AM, observation of the exit access located between the Maintenance shop and the Central Supply storage revealed it was obstructed by a delivery	K 038 - D	1) The storage of items being picked up by vendors or deliveries coming into the building was taken care of after the exit conference with the state surveyor on 7/25/14. 2) A review of the whole facility was completed by the maintenance manager and none of the other 13 exit accesses was found to have items stored in the hallways by the doors. 3) Increase signage has been put into place by the 1 exit access in question. Weekly documentation of observations of exit access will be included in the maintenance managers TELS system. This builds a reminder to the maintenance manager. 4) The first 5 weekly audits, the results will be reviewed by the QI safety committee in the September and October meetings. The QAPI meeting will also review the results and act on the information as indicated.	8/29/14

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K 038	Continued From page 7 of supplies, (2) oxygen concentrators and a disassembled medical bed with air mattress. 2) During the facility tour conducted on July 25, 2014 from 11:00 AM to 12:30 PM, the listed items in finding #1 above were noted still observed stored in this location. Interview of the Administrator and the Maintenance Director indicated these items were not normally stored in a path of egress. 3) During the facility tour conducted on July 25, 2014 from 3:00 PM to 4:00 PM, the items noted in finding #1 above were still stored in the exit access between the Maintenance shop and Central Supply storage. Actual NFPA standard: 19.2 MEANS OF EGRESS REQUIREMENTS 19.2.1 General. Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7. Exception: As modified by 19.2.2 through 19.2.11. 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K 038		
K 054 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This Standard is not met as evidenced by:	K 054 - D	1) The heat detector was repaired by 7/28/14. 2) A review of the whole facility was completed by the maintenance manager and no other broken heat detectors were found. 3) Weekly documentation of observations of heat detectors will be included in the maintenance managers TELS system. This builds a reminder to the maintenance manager. 4) The first 5 weekly audits, the results will be reviewed by the QI safety committee in the September and October meetings. The QAPI meeting will also review the results and act on the information as indicated.	8/29/14

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K 054	Continued From page 8 Based on observation and interview, the facility failed to ensure that smoke detection systems were maintained to manufacturer's specifications. Failure to ensure maintenance of smoke detection systems would result in the inadequate notification of occupants during a fire event. This deficient practice affected no residents, staff and visitors on the date of the survey. The facility is licensed for 139 SNF/NF beds and had a census of 96 on the day of the survey. Findings include: During the facility tour conducted on July 25, 2014 from 11:30 AM to 12:30 PM, observation of the heat detector in the outside storage closet abutting the Maintenance shop revealed it was hanging from the ceiling by its wiring and missing its cover. When asked, the Maintenance Director stated he was unaware of this condition. Actual NFPA standard: 9.6.1.4 A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm Code, unless an existing installation, which shall be permitted to be continued in use, subject to the approval of the authority having jurisdiction.	K 054		
K 062 SS=D	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	K 062 - D	1) The item blocking the sprinkler pattern spray was removed on 7/25/14. 2) A review of the whole facility was completed by the maintenance manager and no other sprinklers were found to be blocked. The whole building was in compliance by 8/29/14. 3) Weekly documentation of observations of sprinklers will be included in the maintenance managers TELS system. This builds a reminder to the maintenance manager. 4) The first 5 weekly audits, the results will be reviewed by the QI safety committee in the September and October meetings. The QAPI meeting will also review the results and act on the information as indicated.	8/29/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	135125		07/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN CENTER GENESIS HEALTHCARE	1351 WEST PINE AVENUE MERIDIAN, ID 83642

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K 062	Continued From page 9 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that sprinkler spray patterns were maintained free of obstructions. Failure to keep sprinkler heads clear of obstructions would result in possible damage and reduced coverage during a fire. This deficient practice affected no residents, staff and visitors on the date of the survey. The facility is licensed for 139 SNF/NF beds and had a census of 96 on the day of the survey. Findings include: During the facility tour conducted on July 25, 2014 from 3:45 PM to 4:00 PM, observation of the closet located inside the Occupational Therapy kitchen found that the sprinkler head inside the closet was blocked with storage. When asked, the Maintenance Assistant stated he was unaware of this condition. Actual NFPA standard: NFPA 25 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. Exception No. 1*: Sprinklers installed in concealed spaces such as above suspended ceilings shall not require inspection. Exception No. 2: Sprinklers installed in areas that are inaccessible for safety considerations due to	K 062		

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K 062	Continued From page 10 process operations shall be inspected during each scheduled shutdown. 2-2.1.2* Unacceptable obstructions to spray patterns shall be corrected.	K 062		
K 074 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3 This Standard is not met as evidenced by: Based on record review, inspection and interview, the facility failed to ensure that curtain flame-spread ratings were in accordance with NFPA 701. Failure to ensure the flame resistive properties of curtains would allow fires to develop and spread beyond incipient stages. This deficient practice affected all residents, staff and visitors in 15 of 15 smoke compartments on the date of the survey. The facility is licensed for 139	K 074 - F	1) The curtains in the identified areas will be replaced with a product that meets the NFPA 701 standard. The curtains will take 8 to 12 weeks to arrive at the facility. We hereby request a waver extension to 11/10/14. A copy of the waver is being provided with the completed 2567. The building has a working tested sprinkler system in place in the meantime. 2) A review of the whole facility was completed by the maintenance manager to identify untreated curtains. All but the 700 hall curtains were found to need to be replaced. Those found without the NFPA 701 rating attached are included in the waver and are arriving in 8 to 12 weeks. 3) The maintenance manager will do weekly audits of the 4 control valves on the fire risers to see that the valves are properly open. He will also do weekly audits of the pressure gauge to make sure that the pressure is appropriate. 4) The audit results will be reviewed by the QI safety committee in the September, October and November meetings. The QAPI meeting will also review the results and act on the information as indicated.	11/10/14

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K 074	Continued From page 11 SNF/NF beds and had a census of 96 on the day of the survey. Findings include: 1) During record review conducted on July 25, 2014 from 9:45 AM to 10:30 AM, records on the flame resistive properties of the curtains in the facility failed to reveal the type of curtain currently installed in facility, the date the curtains were last tested, or to what standard they were being maintained. 2) During the facility tour conducted on July 25, 2014 from 10:30 AM to 3:45 PM, physical inspection of curtains in resident rooms located in the 100, 200, 300, and 400 wing; common areas of the Dining Rooms, Physical Therapy, Activities room and Lounge, revealed that non-privacy curtains inspected did not have tags attached indicating they were compliant with NFPA 701. 3) Further record review conducted during the exit conference found that those curtain descriptors provided indicating materials, could not be cross-referenced by style or location. Record color descriptions provided were undecipherable and confusing. Curtains inspected could not be substantiated as being tested or having had fire retardant treatment. Interview of the Administrator and the Maintenance Director revealed they were not aware of any other documented testing. Actual NFPA standard: NFPA 701 19.7.5.1* Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies shall be in accordance with the	K 074		

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K 074	Continued From page 12 provisions of 10.3.1. (See 19.3.5.5.) Exception: Curtains at showers. 10.3.1* Where required by the applicable provisions of this Code, draperies, curtains, and other similar loosely hanging furnishings and decorations shall be flame resistant as demonstrated by testing in accordance with NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films.	K 074		
K 147 SS=D	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 and interview, the facility failed to ensure that electrical systems were accessible in accordance with NFPA 70. Failure to maintain clear access to electrical equipment would hinder equipment service in an emergency. This deficient practice affected 35 residents, staff and visitors in 3 of 15 smoke compartments on the date of the survey. The facility is licensed for 139 SNF/NF beds and had a census of 96 on the day of the survey. Findings include: 1) During the facility tour conducted on July 25, 2014 from 10:30 AM to 11:30 PM, observation by the surveyor and the Maintenance Director of the mechanical room adjacent to the second floor conference room revealed that the electrical panel was blocked with haphazard storage. 2) During the facility tour conducted on July 25, 2014 from 11:30 AM to 12:30 PM, observation of the storage room located on the outside of the	K 147 - D	1) The blocked electrical panels in 3 areas of the building have been unblocked by 7/28/14. 2) A review of the whole facility was completed by the maintenance manager to any other blocked panels. The whole building was in compliance by 8/29/14. 3) Weekly documentation of electrical panel access will be included in the maintenance managers TELS system. This builds a reminder to the maintenance manager. 4) The first 5 weekly audits, the results will be reviewed by the QI safety committee in the September and October meetings. The QAPI meeting will also review the results and act on the information as indicated.	8/29/14

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K 147	Continued From page 13 Maintenance Shop found that the electrical panel was blocked by housekeeping service equipment. When asked, the Maintenance Director stated he was not aware of this storage. 3) During the facility tour conducted on July 25, 2014 from 1:30 PM to 2:30 PM, observation of the Elevator Equipment/Mechanical Room located in the 200 wing found that the electrical shut-off panels were being blocked by haphazard storage. When interviewed, the Maintenance Director stated that he had placed several signs in attempt to eliminate this practice. Actual NFPA standard: NFPA 70 110.26 Spaces About Electrical Equipment. Sufficient access and working space shall be provided and maintained about all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons. (A) Working Space. Working space for equipment operating at 600 volts, nominal, or less to ground and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A)(1), (2), and (3) or as required or permitted elsewhere in this Code. (1) Depth of Working Space. The depth of the working space in the direction of live parts shall not be less than that specified in Table 110.26(A)(1) unless the requirements of 110.26(A)(1)(a), (b), or (c) are met. Distances shall be measured from the exposed live parts or from the enclosure or opening if the live parts are enclosed.	K 147		

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER MERIDIAN CENTER GENESIS HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1351 WEST PINE AVENUE MERIDIAN, ID 83642		

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C 000	16.03.02 INITIAL COMMENTS 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. The facility is a single story building except for the upper level used for classroom, medical records, marketing and board room. The building is a Type V (III) construction, fully sprinklered and was completed in March 1997. The building is covered by a complete fire alarm system with smoke detectors throughout. The facility is currently licensed for 139 SNF/NF beds. The following deficiencies were cited during the annual fire/life safety survey conducted on July 25 2014. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70 and IDAPA 16.03.02 Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities. The Survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	C 000		
C 225	02.106 FIRE AND LIFE SAFETY 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.	C 226	See the plan of correction steps in the CMS 2567 that address K 012, K 027,K 029, K 038, K 054, K 062, K 074 and K 147 listed above in this document.	

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AUG 28 2014
FACILITY STANDARDS

Idaho form
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE Administrator | (X6) DATE 8/29/14

Bureau of Facility Standards

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C 226	Continued From Page 1 This Rule is not met as evidenced by: Please refer to "K" tags on CMS 2467 K 012 Building continuity K 027 Smoke compartment doors K 029 Hazardous areas K 038 Egress access K 054 Smoke Detection K 062 Sprinkler obstructions K 074 Flame spread ratings K 147 Electrical	C 226		