



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 3467

August 15, 2014

Nancy Trout, Administrator
Monte Vista Hills Healthcare Center
1071 Renee Avenue
Pocatello, ID 83201-2508

Provider #: 135018

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

Dear Ms. Trout:

On **August 4, 2014**, a Facility Fire Safety and Construction survey was conducted at **Monte Vista Hills Healthcare Center** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies 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

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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 28, 2014**. Failure to submit an acceptable PoC by **August 28, 2014**, may result in the imposition of civil monetary penalties by **September 17, 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 **September 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 **September 8, 2014**. A change in the seriousness of the deficiencies on **September 8, 2014**, may result in a change in the remedy.

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

Denial of payment for new admissions effective **November 4, 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 **February 4, 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 **August 4, 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:

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<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 28, 2014**. If your request for informal dispute resolution is received after **August 28, 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.P. Grimes', with a long horizontal flourish extending to the right.

Mark P. Grimes, Supervisor
Facility Fire Safety and Construction

MPG/lj
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135018	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2014
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NAME OF PROVIDER OR SUPPLIER MONTE VISTA HILLS HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1071 RENEE AVENUE POCATELLO, ID 83201
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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 single story, type V (III) construction. The building is fully sprinklered with quick response heads. New smoke detectors were installed in 2009. There are multiple exits to grade and a small basement. The facility plans were approved in 1962 and final construction completed in January of 1963. Currently the facility is licensed for 113 SNF/NF beds.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on August 4, 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: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	K 000	<p>“This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Monte Vista Hills Healthcare Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.”</p>	
K 012 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that smoke barrier walls and ceilings maintained at least a one half hour fire resistive rating. Failure to ensure smoke barrier continuity would allow smoke and dangerous gases to pass freely between smoke compartments during a fire. This deficient practice affected 27 residents, staff and visitors in 7 of 7 smoke compartments on the date of the</p>	K 012	<p><u>K-012</u></p> <ol style="list-style-type: none"> 1. Penetrations that were not sealed in the Special Care Unit, floor in the dishwashing area, oxygen room on the 200 hall, and 7 areas in the basement have been sealed. 2. The Maintenance Director inspected all rooms in the facility by 9/5/14 to ensure no further penetrations were found. 3. The Maintenance Director or designee will follow up with any contractor doing work in the facility to ensure all penetrations, if any, are properly sealed. 	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

[Signature]

[Signature]

8/24/14

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	<p>Continued From page 1 survey. The facility is licensed for 113 SNF/NF beds and had a census of 42 on the day of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on August 4, 2014 from 1:15 PM to 1:30 PM, observation of the ceiling located in the Special Care Unit hallway outside of room 124 found a four inch by four inch electrical box missing its cover leaving an approximate 1/2 inch gap between the box and suspended ceiling tile. Further observation noted that the gap exposed the attic space above the ceiling line. When asked, the Maintenance Supervisor stated he was not aware this cover was missing.</p> <p>2) During the facility tour conducted on August 4, 2014 from 1:15 PM to 1:30 PM, observation of the hall shower in the Special Care Unit between rooms 130 and 131 found it had been converted to a storage closet. Further investigation found a four inch square electrical box installed in the ceiling with an approximate 1/2" gap surrounding the box. This gap was found to expose the attic space above. Interview of the Maintenance Supervisor found he was not aware the area surrounding this box was not sealed.</p> <p>3) During the facility tour conducted on August 4, 2014 from 1:30 PM to 2:30 PM, observation of the floor in the dishwashing area of the main Kitchen found an approximate 3 inch diameter unsealed penetration from an installed electrical conduit. Further observation revealed this installation left an approximately 1/4" gap between the conduit and the flooring exposing the basement below.</p>	K 012	<p>4. The Administrator or designee will conduct a monthly audit for 3 months then quarterly audit for 3 quarters to walk through the building to inspect penetrations to ensure they are sealed. Results will be reviewed by QAA committee until it has been determined by the committee that the systems are effective.</p> <p>5. 9/8/14</p>	

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OMB NO. 0938-0391

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K 012	<p>Continued From page 2</p> <p>4) During the facility tour conducted on August 4, 2014 from 1:30 PM to 2:30 PM, observation of the oxygen storage room in the 200 wing found an approximately one inch conduit from the electrical panel had not been sealed as it penetrated the ceiling. Interview of the Maintenance Supervisor revealed he was not aware of this condition.</p> <p>5) During the facility tour conducted on August 4, 2014 from 3:00 PM to 3:30 PM, inspection of the attic area above the main facility ceiling found it to be open and with no compartmentation from one end of the facility to the other. When asked, the Maintenance Supervisor acknowledged that the smoke compartments of the main floor stopped at the ceiling.</p> <p>6) During the facility tour conducted on August 4, 2014 from 3:45 PM to 4:00 PM, inspection of the basement area found (7) areas of the drywall ceiling with approximately two foot square areas of the drywall missing and exposing the underside of the subfloor above. When asked, the Maintenance Supervisor stated he was not sure how these areas had become exposed. Further investigation of the basement area found the unsealed electrical conduit cited in item 3 above.</p> <p>Actual NFPA standard:</p> <p>8.2.3.2.4.2*</p> <p>Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows:</p> <p>(1) The space between the penetrating item and the fire barrier shall meet one of the following conditions:</p>	K 012		

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K 012	<p>Continued From page 3</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(3) * Insulation and coverings for pipes and ducts shall not pass through the fire barrier unless one of the following conditions is met:</p> <p>a. The material shall be capable of maintaining the fire resistance of the fire barrier.</p> <p>b. The material shall be protected by an approved device that is designed for the specific purpose.</p> <p>(4) Where designs take transmission of vibration into consideration, any vibration isolation shall meet one of the following conditions:</p> <p>a. It shall be made on either side of the fire barrier.</p> <p>b. It shall be made by an approved device that is designed for the specific purpose.</p> <p>8.2.4.4.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through smoke partitions shall be protected as follows:</p> <p>(1) The space between the penetrating item and the smoke partition shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable</p>	K 012		

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K 012	Continued From page 4 of limiting the transfer of smoke. 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 partition, the sleeve shall be solidly set in the smoke partition, 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 limiting the transfer of smoke. b. It shall be protected by an approved device that is designed for the specific purpose. (3) Where designs take transmission of vibrations into consideration, any vibration isolation shall meet one of the following conditions: a. It shall be made on either side of the smoke partitions. b. It shall be made by an approved device that is designed for the specific purpose.	K 012	<p><u>K-018</u></p> <ol style="list-style-type: none"> Doors for rooms 114, 127, 202, 217, and 221 have been adjusted to latch properly. All other doors in the facility were inspected by the Maintenance Director on 9/5/14 to ensure they closed properly. The Maintenance Director or designee will inservice staff that if they notice any door that does not close properly inform the maintenance department. The Administrator or designee will conduct a monthly audit for 3 months then quarterly audit for 3 quarters to verify all resident doors latch properly. Results will be reviewed by QAA committee until it has been determined by the committee that the systems are effective. 9/8/14 	
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD 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 Roller latches are prohibited by CMS regulations in all health care facilities.	K 018		

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K 018	<p>Continued From page 5</p> <p>This Standard is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure that resident room doors would close and latch. Failure to ensure corridor doors latch would allow smoke and dangerous gases to pass freely and hinder egress. This deficient practice affected 5 residents, staff and visitors in 5 of 7 smoke compartments on the date of the survey. The facility is licensed for 113 SNF/NF beds and had a census of 42 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on August 4, 2014 from 1:15 PM to 3:30 PM, observation and operational testing of resident room doors 114, 127, 202, 217 and 221 found they would not close and latch. When asked, the Maintenance Supervisor stated he was not aware of this condition.</p> <p>Actual NFPA standard:</p> <p>19.3.6.3 Corridor Doors 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.2.</p>	K 018		

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K 018	Continued From page 6 Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: Existing roller latches demonstrated to keep the door closed against a force of 5 lbf (22 N) shall be permitted to be kept in service.	K 018		
K 022 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that exit signs clearly identified exits. Failure to ensure that exits are identified clearly would hinder egress during an emergency. This deficient practice affected 42 residents, staff and visitors in 7 of 7 smoke compartments on the date of the survey. The facility is licensed for 113 SNF/NF beds and had a census of 42 on the day of the survey. Findings include: 1) During the facility tour conducted on August 4, 2014 from 1:15 PM to 2:30 PM, observation by the surveyor and the Maintenance Supervisor of	K 022	K-022 1. North/South corridor bulkhead doors had exit signs installed on both sides on 8/28/14. 2. All other bulkhead doors were inspected by the Maintenance Director on 8/28/14 to ensure that exit signs are prominent. 3. The Administrator or designee will conduct a monthly audit for 3 months then quarterly audit for 3 quarters to verify all resident doors latch properly. Results will be reviewed by QAA committee until it has been determined by the committee that the systems are effective. 4. 9/8/14	<i>EAST-WEST PER FINDING (1) ALSO INSTALLED PER ADMIN 8/28/14</i>

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K 022	<p>Continued From page 7</p> <p>the east/west corridor revealed that no exit signs were installed at the smoke compartment doors between rooms 116 and 115 indicating the path of egress. Further observation of the corridor facing west from room 114 found that the exit sign at the main entrance was obscured by the hall lighting. Investigation further revealed that when the smoke compartment doors were activated, the exit sign at the front entry was not visible from any rooms on the east side of the doors.</p> <p>2) During the facility tour conducted on August 4, 2014 from 1:15 PM to 2:30 PM, observation of the north/south corridor revealed no exit signs were installed at the smoke compartment doors between room 137 and the Laundry. Further observation found that when the smoke compartment doors were activated for this corridor, no exit signs were visible indicating the path of egress in either a north or south direction of travel. Interview of the Maintenance Supervisor found he was not aware of the missing signs prior to the date of the survey.</p> <p>Actual NFPA standard:</p> <p>7.10.1.4* Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. Sign placement shall be such that no point in an exit access corridor is in excess of 100 ft (30 m) from the nearest externally illuminated sign and is not in excess of the marked rating for internally illuminated signs. Exception: Signs in exit access corridors in existing buildings shall not be required to meet the placement distance requirements.</p>	K 022		
K 029	NFPA 101 LIFE SAFETY CODE STANDARD SS=F	K 029		

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K 029	<p>Continued From page 8</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, operational testing and interview, the facility failed to ensure that hazardous areas were protected with self-closing doors. Failure to protect hazardous areas would allow smoke and dangerous gases to pass freely into corridors hindering egress during a fire. This deficient practice affected 32 residents, staff and visitors on the date of the survey. The facility is licensed for 113 SNF/NF beds and had a census of 42 on the day of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on August 4, 2014 from 1:15 PM to 2:00 PM, observation and operational testing of the door to room 120 found that it was not equipped with a self-closing device. Further investigation found this room had been converted to storage and measured approximately ten feet by seventeen feet (one hundred seventy square feet). When asked, the Maintenance Supervisor stated the room had been converted during recent renovations of the facility.</p>	K 029	<p><u>K-029</u></p> <ol style="list-style-type: none"> 1. Self-closures were installed on the doors for room 120, Special Care Unit shower room, room 225, central supply closet, storage room across from the resident phone station and the Social Services Director office on by 8/29/14. 2. All other facility doors requiring self-closure were inspected by the Maintenance Director by 8/29/14 to ensure that closures were in place. 3. The Administrator or designee will conduct a monthly audit for 3 months then quarterly audit for 3 quarters to verify all resident doors latch properly. Results will be reviewed by QAA committee until it has been determined by the committee that the systems are effective. 4. 9/8/14 	

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135018	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2014	
NAME OF PROVIDER OR SUPPLIER MONTE VISTA HILLS HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1071 RENEE AVENUE POCATELLO, ID 83201		
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K 029	<p>Continued From page 9</p> <p>2) During the facility tour conducted on August 4, 2014 from 1:30 PM to 2:30 PM, observation of the shower room at the end of the Special Care Unit hallway found it had been converted to storage and was not equipped with a self-closing device. Measurement of this area found it to be approximately eight feet by ten feet (eighty square feet). Interview of the Maintenance Supervisor revealed he was not aware this area was being used for storage.</p> <p>3) During the facility tour conducted on August 4, 2014 from 2:30 PM to 3:30 PM, observation by the surveyor and Maintenance Supervisor found room 225 was converted into storage. Operational testing of the door found it was not equipped with a self-closing device. Further investigation found that this room measured approximately twenty feet by twenty five feet (five hundred square feet) and when closed, the door would not latch. Interview of the Maintenance Supervisor revealed that this room had been converted to storage during recent renovations.</p> <p>4) During the facility tour conducted on August 4, 2014 from 2:30 PM to 3:30 PM, observation and operational testing of the door to Central Supply found that it was not equipped with a self-closing device. Inspection of the room found it to be approximately ten feet by twelve feet with a combustible content of disposable diapers and paper products. When asked, the Maintenance Supervisor stated he was not aware this door was required to self-close.</p> <p>5) During the facility tour conducted on August 4, 2014 from 2:30 PM to 3:30 PM, observation and operational testing of the storage room door across from the resident phone station found it</p>	K 029		

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K 029	<p>Continued From page 10</p> <p>would not self-close. Further investigation found this storage room measured approximately eight feet by ten feet and contained dietary services storage .</p> <p>Further observation of this area revealed that the back wall of the room had been removed and replaced with a louvered bifold door which was accessible to the Social Service office. When tested, the door to the Social Service office would not self-close. Interview of the Maintenance Supervisor found he was not aware of when the conversion of this room had occurred.</p> <p>Actual NFPA standard:</p> <p>19.3.2.1 Hazardous Areas.</p> <p>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:</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 	K 029		

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K 029	Continued From page 11 (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 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure fire extinguishers were properly signed per NFPA 10. Failure to ensure extinguishers are signed could result in the wrong extinguisher being used for its intended hazard during a fire. This deficient practice affected 14 residents, staff and visitors in 1 of 7 smoke compartments on the date of the survey. The facility is licensed for 113 SNF/NF beds and had a census of 42 on the day of the survey. Findings include: During the facility tour conducted on August 4, 2014 from 1:15 PM to 4:00 PM, observation of the K-style extinguisher located in the Kitchen found that the extinguisher was not properly signed designating its usage as required. When asked, the Maintenance Supervisor stated the extinguisher had been moved, but the sign indicating the extinguisher usage was never	K 064	<u>K-064</u> 1. Sign was placed above the fire extinguisher in the kitchen on 8/18/14. 2. No other extinguishers in the facility require a sign. 3. The Administrator or designee will conduct a monthly audit for 3 months then quarterly audit for 3 quarters to verify all resident doors latch properly. Results will be reviewed by QAA committee until it has been determined by the committee that the systems are effective. 4. 9/8/14	

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K 064	Continued From page 12 relocated with it. Actual NFPA standard: NFPA 10 2-3.2* Fire extinguishers provided for the protection of cooking appliances that use combustible cooking media (vegetable or animal oils and fats) shall be listed and labeled for Class K fires. Exception: Extinguishers installed specifically for these hazards prior to June 30, 1998. 2-3.2.1 A placard shall be conspicuously placed near the extinguisher that states that the fire protection system shall be activated prior to using the fire extinguisher.	K 064	<p><u>K-074</u></p> <ol style="list-style-type: none"> All window curtains 126, 127, 129, 216, 220, and Day Room of the Special Care Unit were removed by 8/29/14. All other window curtains were removed on 8/29/14 as well. The Administrator or designee will conduct a monthly audit for 3 months then quarterly audit for 3 quarters to verify all resident doors latch properly. Results will be reviewed by QAA committee until it has been determined by the committee that the systems are effective. 9/8/14 	
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	K 074		

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K 074	<p>Continued From page 13</p> <p>This Standard is not met as evidenced by: Based on record review, physical inspection and interview, the facility failed to ensure that curtains drapes and other loosely hanging fabrics were flame resistant in accordance with NFPA 701. Failure to ensure the flame resistive properties of furnishings and decorations would allow fires to spread beyond incipient stages. This deficient practice affected 42 residents, staff and visitors in 7 of 7 smoke compartments on the date of the survey. The facility is licensed for 113 SNF/NF beds and had a census of 42 on the day of the survey.</p> <p>Findings include:</p> <p>1) During record review conducted at the facility on August 4, 2014 from 11:30 AM to 12:45 PM, the facility failed to provide documented flame retardant treatment for non-tagged curtains and decorative finishes. When asked, the Maintenance Supervisor stated he was not aware of any treatment program being conducted.</p> <p>2) During the facility tour conducted on August 4, 2014 observation and physical inspection of window curtains and awning covers in room 126,127, 129, 216, 220 and the Day Room in Special Care Unit revealed that all non-privacy curtains inspected were neither tagged per NFPA 701 standards, or had been treated with fire retardant to be resistive to flame spread.</p> <p>3) Interview of the Maintenance Supervisor, Administrator and facility staff during the exit conference conducted on August 4, 2014 from 4:30 PM to 5:30 PM indicated none were aware</p>	K 074		

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K 074	<p>Continued From page 14 of any treatment of the curtains having been performed or recorded.</p> <p>Actual NFPA standard:</p> <p>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.</p> <p>K 147 SS=F NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure electrical installations and appliances were maintained and utilized in accordance with NFPA 70. Failure to ensure the proper usage of electrical appliances and installations would result in electrocution and/or fire. This deficient practice affected 42 residents, staff and visitors in 7 of 7 smoke compartments on the date of the survey. The facility is licensed for 113 SNF/NF beds and had a census of 42 on the day of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on August 4, 2014 from 1:15 PM to 1:30 PM, observation of the electrical panel inside the Physical Therapy Pool area found it was obstructed by storage. Further observation of the panel found that the</p>	K 074	<p><u>K-147</u></p> <ol style="list-style-type: none"> 1. <ol style="list-style-type: none"> a. Items causing obstruction of the panel in the PT pool area were removed on 8/15/14. Panel circuits were labeled and breakers not in use were removed on 8/28/14. b. Special Care Unit storage area conduit box cover was replaced on 8/15/14. c. Power strips from rooms 125, 127 and 129 were removed on 8/15/14. d. Heat tape on the outside of the freezer door was removed. Internal heat tape was hard wired into a GFCI outlet. Work was completed on 8/28/14. e. Dishwasher electrical panel had carts removed on 8/5/14. 2. All electrical panels were inspected to make sure there were no items blocking access on 8/15/14. All panel circuits were inspected to ensure for proper 	

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K 147	<p>Continued From page 15</p> <p>circuits of the panel were not labeled. Interview of the Maintenance Supervisor found he was not aware of this condition.</p> <p>2) During the facility tour conducted on August 4, 2014 from 1:45 PM to 2:15 PM, observation of the shower area located at the end of the Special Care Unit hallway found it had been converted to storage and inspection of this area revealed a four inch square conduit box was missing the protective cover. When asked, the Maintenance Supervisor stated he was not aware this cover was missing.</p> <p>3) During the facility tour conducted on August 4, 2014 from 1:45 PM to 2:30 PM, observation of resident rooms 125, 127 and 129 found each room had an oxygen concentrator plugged into a relocatable power tap. When interviewed, the Maintenance Supervisor stated he was not aware that relocatable power taps were prohibited in use with patient care equipment.</p> <p>4) During the facility tour conducted on August 4, 2014 from 2:30 PM to 3:00 PM, observation of the Kitchen found an exposed wire in a section of separated electrical conduit above the kitchen sink. Further investigation of the Kitchen refrigerator and freezer area revealed that the door separating the refrigerator from the freezer had (2) extension cords installed through the wall to (2) separate outlets; (1) inside the freezer and (1) inside the refrigerator. This extension cord was further observed to be wired to heat tape around the perimeter of the door and secured to the door with metallic tape. When asked about this installation, the Maintenance Supervisor stated it was installed to prevent icing of the door.</p> <p>5) During the facility tour conducted on August 4,</p>	K 147	<p>labeling on 8/15/14. All conduit box covers were inspected on 8/15/14. All rooms were inspected for use of power strips and any located were removed on 8/15/14.</p> <p>3. Staff were inserviced on the proper use of power strips and not placing any items in front of electrical boxes.</p> <p>4. The Administrator or designee will conduct a monthly audit for 3 months then quarterly audit for 3 quarters to verify all resident doors latch properly. Results will be reviewed by QAA committee until it has been determined by the committee that the systems are effective.</p> <p>5. 9/8/14</p>	

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K 147	<p>Continued From page 16</p> <p>2014 from 2:30 PM to 3:00 PM, observation of the Kitchen dishwashing area found the electrical service panel was blocked by two food service carts. Further observation of the floor in this area found it to be delineated as an area to remain clear of storage. When asked, the dishwashing staff member indicated he was aware of the signage. Interview of the Maintenance Supervisor revealed he was aware the area in front of the electrical panel was to be kept clear.</p> <p>6) During the facility tour conducted on August 4, 2014 from 2:30 PM to 3:30 PM, observation of the Nurses Station located at the intersection of the 100 east to 100 south corridors found a six to two multiple outlet converter in use. Observation of resident room 223 also found a six to two multiple outlet converter in use. When questioned, the Maintenance Supervisor stated he was not aware these multiple outlets were in use.</p> <p>7) During the facility tour conducted on August 4, 2014 from 3:30 PM to 4:00 PM, observation of the basement area found three electrical conduit boxes, four inches square with exposed wiring. When asked, the Maintenance Supervisor stated he was unaware the protective covers were missing.</p> <p>Actual NFPA standard: NFPA 70</p> <p>110.22 Identification of Disconnecting Means. Each disconnecting means shall be legibly marked to indicate its purpose unless located and arranged so the purpose is evident. The marking shall be of sufficient durability to withstand the environment involved.</p>	K 147		

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K 147	<p>Continued From page 17</p> <p>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.</p> <p>400.8 Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following:</p> <ul style="list-style-type: none"> (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 <p>Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of 368.8.</p> <ul style="list-style-type: none"> (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		

Bureau of Facility Standards

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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 single story, type V (III) construction. The building is fully sprinklered with quick response heads. New smoke detectors were installed in 2009. There are multiple exits to grade and a small basement. The facility plans were approved in 1962 and final construction completed in January of 1963. Currently the facility is licensed for 113 SNF/NF beds.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on August 4, 2014. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, 42 CFR 483.70 and IDAPA 16.03.02, Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities.</p> <p>The Survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	C 000	<p>C-226</p> <p>See all Kk012, K018, K022, K 029, K 054, K074 and K147 above.</p> <p style="text-align: center;">RECEIVED AUG 27 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.</p> <p>This Rule is not met as evidenced by: Please refer to CMS 2567 tags:</p>	C 226		

Idaho form

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

TITLE

(X6) DATE

[Signature]

[Signature]

8/20/14

Bureau of Facility Standards

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C 226	Continued From Page 1 K 012 Unprotected penetrations in construction K 018 Corridor doors K 022 Exit signs K 029 Hazardous areas K 064 Fire extinguishers K 074 Flame resistive properties K 147 Electrical	C 226		