



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 2125 6607

December 2, 2014

Adam Smith, Administrator
Grangeville Health & Rehabilitation Center
410 East North Second Street
Grangeville, ID 83530-2258

Provider #: 135080

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

Dear Mr. Smith:

On **November 19, 2014**, a Facility Fire Safety and Construction survey was conducted at **Grangeville Health & Rehabilitation 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 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

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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 **December 15, 2014**. Failure to submit an acceptable PoC by **December 15, 2014**, may result in the imposition of civil monetary penalties by **January 4, 2015**.

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 **December 24, 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 **December 24, 2014**. A change in the seriousness of the deficiencies on **December 24, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **December 24, 2014**, includes the following:

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Denial of payment for new admissions effective **February 19, 2015**.
42 CFR §488.417(a)

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **May 19, 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 **November 19, 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 **December 15, 2014**. If your request for informal dispute resolution is received after **December 15, 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 'MPG', 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: 11/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135080	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2014
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NAME OF PROVIDER OR SUPPLIER GRANGEVILLE HEALTH & REHABILITATION C	STREET ADDRESS, CITY, STATE, ZIP CODE 410 EAST NORTH 2ND STREET GRANGEVILLE, ID 83530
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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	INITIAL COMMENTS The facility is a single story, Type V(111) fully sprinklered structure built in 1967. It has smoke detection throughout corridors and open spaces. Currently the facility is licensed for 60 NF beds. The following deficiencies were cited during the annual fire/life safety survey conducted on November 19, 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 000	<p>"This plan of Correction is submitted as required under Federal and State regulations and statutes applicable to skilled nursing facilities. This plan of correction does not constitute an admission of liability, and such liability is hereby specifically denied. The submission of this plan does not constitute agreement by the facility that the surveyor's conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied."</p> <p>Please accept this plan of correction as our credible allegation of compliance</p>	
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 with self-closing doors. Failure to provide self-closing doors to	K 029		

RECEIVED
DEC 17 2014
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 12/15/14
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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 029	<p>Continued From page 1</p> <p>hazardous areas would allow smoke and dangerous gases to pass freely into corridors affecting egress during a fire event. This deficient practice affected 16 residents, staff and visitors in 2 of 5 smoke compartments on the date of the survey. The facility is licensed for 60 SNF/NF beds and had a census of 44 on the day of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on November 19, 2014 from 10:30 AM to 1:30 PM, observation of the Medical Records Room found the room was over 100 square feet of combustible storage. Operational testing of the door revealed it was not equipped with a self-closing device.</p> <p>2) During the facility tour conducted on November 19, 2014 from 10:30 AM to 1:30 PM, observation of the Copy Room found it contained two (2) 32 gal recycling containers and contained over 62 square feet of additional combustible storage. Operational testing of the door revealed it was not equipped with a self-closing device.</p> <p>3) During the facility tour conducted on November 19, 2014 from 10:30 AM to 1:30 PM, observation of the Janitorial closet abutting the Administration Office found it measured approximately 55 square feet and contained storage of approximately five (5) liters of alcohol based hand rub; chemicals and paper supplies in quantities greater than that of the general occupancy. Operational testing of this door found it was not equipped with a self-closing device. Interview of the Maintenance Supervisor found he was not aware that this storage would be considered a hazardous area and would required a self-closing door.</p>	K 029	<p>K 029</p> <p>Resident Specific:</p> <p>Please see systemic changes.</p> <p>Other Residents:</p> <p>Please see systemic changes.</p> <p>Systemic Changes:</p> <p>A self-closing mechanism has been placed on the medical records room, the copy room and the Janitorial closet.</p> <p>Monitors:</p> <p>The Administrator or his designee will perform monthly rounds times six to ensure that the self-closing mechanisms are in place and functioning.</p> <p>He will report his findings at the Q.A. meetings and will make changes to the above plan of corrections as needed.</p> <p>Date of Compliance:</p> <p>12/12/2014</p>		

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K 029	Continued From page 2 Actual NFPA standard: NFPA 101 3.3.13.2 Area, Hazardous. An area of a structure or building that poses a degree of hazard greater than that normal to the general occupancy of the building or structure, such as areas used for the storage or use of combustibles or flammables; toxic, noxious, or corrosive materials; or heat-producing appliances. 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 ft ² (9.3 m ²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft ² (4.6 m ²), 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	K 029		

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K 029	Continued From page 3 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, operational testing and interview, the facility failed to maintain doors with readily accessible means of exit access. Failure to allow rapid means of exit access has the potential to impede the safe egress of occupants during a fire or other emergency. This deficient practice affected staff and vendors of the main Kitchen on the date of survey. The facility is licensed for 60 SNF/NF beds and had a census of 44 on the day of survey. Findings include: During the facility tour conducted on November 19, 2014 from 10:30 AM to 1:30 PM, observation and operational testing of the exit door leading from the kitchen to the dining room found a slide bolt installed on the egress side. Interview of both the Maintenance Supervisor and the Administrator found they were not aware this installation was not allowed. Actual NFPA standard:	K 038	K 038 Resident Specific: Please see systemic changes. Other Residents: Please see systemic changes. Systemic Changes: The slide bolt on the exit door between the kitchen and dining room has been removed. Monitors: The Administrator or his designee will perform monthly rounds times six to ensure that no slide bolts are utilized on exit doors. He will report his findings at the Q.A. meetings and will make changes to the above plan of corrections as needed.	

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K 038	Continued From page 4 NFPA 101.7.2 MEANS OF EGRESS COMPONENTS 7.2.1.5.4* A latch or other fastening device on a door shall be provided with a releasing device having an obvious method of operation and that is readily operated under all lighting conditions. The releasing mechanism for any latch shall be located not less than 34 in. (86 cm), and not more than 48 in. (122 cm), above the finished floor. Doors shall be operable with not more than one releasing operation. Exception No. 1*: Egress doors from individual living units and guest rooms of residential occupancies shall be permitted to be provided with devices that require not more than one additional releasing operation, provided that such device is operable from the inside without the use of a key or tool and is mounted at a height not exceeding 48 in. (122 cm) above the finished floor. Existing security devices shall be permitted to have two additional releasing operations. Existing security devices other than automatic latching devices shall not be located more than 60 in. (152 cm) above the finished floor. Automatic latching devices shall not be located more than 48 in. (122 cm) above the finished floor. Exception No. 2: The minimum mounting height for the releasing mechanism shall not be applicable to existing installations.	K 038	Date of Compliance: 12/12/2014	
K 072 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10	K 072	K 072 Resident Specific: Please see systemic changes.	

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K 072	<p>Continued From page 5</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure exits were maintained free of obstructions at all times. Failure to keep exits clear of impediments to full and instant use would hinder the safe evacuation of occupants during an emergency. This deficient practice affected 44 residents, staff and visitors on the date of the survey. The facility is licensed for 60 SNF/NF beds and had a census of 44 on the day of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on November 19, 2014 from 10:30 AM to 1:30 PM, observation of the exit ramps located at the northeast and northwest sides of the building found both snow-covered and icy and the area had not received a new accumulation of snowfall in the past 24 hours. When asked, the Maintenance Supervisor stated he was aware that exits should be free of snow and ice.</p> <p>2) During the facility tour conducted on November 19, 2014 from 10:30 AM to 1:30 PM, observation of operational testing by the Maintenance Supervisor of the delayed egress door at the southwest exit, found it would not activate when pressure was applied to the panic hardware. Further testing revealed the door lock dropped when activated by the keypad. Interview of the Maintenance Supervisor and the Administrator indicated this door had been having problems due to a new lock installation.</p>	K 072	<p>Other Residents:</p> <p>Please see systemic changes.</p> <p>Systemic Changes:</p> <p>The snow was removed and the exit is now cleared. Maintenance has been inserviced on clearing snow from exit areas.</p> <p>The delayed egress door has been repaired.</p> <p>Snow will be cleared to the sidewalk after all snow events until a concrete path can be poured. A request for an extension waiver has been requested so bids may be obtained and approval through planning and zoning etc.</p>		

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K 072	<p>Continued From page 6</p> <p>Additional inspection of this exit discharge found that it did not terminate directly at a public way, but rather onto the northwest lawn area. This observation was acknowledged by the Administrator, Director of Nurses and the Maintenance Supervisor during the exit conference conducted on November 19, 2014 from 1:30 PM to 2:30 PM.</p> <p>Actual NFPA standard: Finding (1) NFPA 101 7.1.10 Means of Egress Reliability. 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.</p> <p>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. Finding (2) 7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed-egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met. (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not</p>	K 072	<p>Monitors:</p> <p>The Administrator or his designee will perform rounds after each snowfall for the rest of the winter season to ensure that exit areas have been cleared of ice and snow.</p> <p>The Administrator or his designee will perform monthly audits times six to ensure that the delayed egress doors function properly.</p> <p>The Administrator or his designee will perform rounds after each snowfall for the rest of the winter to ensure that a path has been cleared to the sidewalk.</p> <p>He will report his findings at the Q.A. meetings and will make changes to the above plan of correction as needed.</p> <p>Date of Compliance: 07/15/2015 Please see attached Extension Waiver Request</p>	

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K 072	<p>Continued From page 7</p> <p>more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6.</p> <p>(b) The doors shall unlock upon loss of power controlling the lock or locking mechanism.</p> <p>(c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only.</p> <p>Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.</p> <p>(d) * On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS</p> <p>7.7 DISCHARGE FROM EXITS 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.</p> <p>Exception No. 1: This requirement shall not apply to interior exit discharge as otherwise provided in 7.7.2.</p> <p>Exception No. 2: This requirement shall not apply to rooftop exit discharge as otherwise provided in 7.7.6.</p> <p>Exception No. 3: Means of egress shall be</p>	K 072		

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K 074	Continued From page 9 Findings include: During the facility tour conducted on November 19, 2014 from 10:30 AM to 1:30 PM observation of resident rooms 103,105,106,107,108,109 and 302 found the window were equipped with honey comb type fabric window blinds with no tag or label indicating flammability requirements. When interviewed, the Administrator stated these were installed during the renovations of these rooms. Actual NFPA standard: NFPA 101 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 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 075 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room	K 075	K 075 Resident Specific: Please see systemic changes Other Residents:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135080	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2014
NAME OF PROVIDER OR SUPPLIER GRANGEVILLE HEALTH & REHABILITATION C		STREET ADDRESS, CITY, STATE, ZIP CODE 410 EAST NORTH 2ND STREET GRANGEVILLE, ID 83530		
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K 075	<p>Continued From page 10 protected as a hazardous area when not attended. 19.7.5.5</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure highly combustible materials were stored in a safe manner. Failure to provide proper protection of hazardous material would result in smoke and dangerous gases passing freely through corridors during a fire, hindering egress capabilities. This deficient practice affected residents staff and visitors utilizing the main shower facilities on the date of the survey. The facility is licensed for 60 SNF/NF beds and had a census of 44 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on November 19, 2014 from 10:30 AM to 1:30 PM, observation of the main showers located at the 200 wing and 300 wing found both had three (3) fifty gallon receptacles for the storage of soiled linen and/or trash stored inside. When asked, the Maintenance Supervisor and Administrator both stated they were not aware these receptacles were required to be stored in a hazardous area.</p> <p>Actual NFPA standard:</p> <p>19.7.5.5 Soiled linen or trash collection receptacles shall not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gal/ft² (20.4 L/m²). A</p>	K 075	<p>Please see systemic changes.</p> <p>Systemic Changes:</p> <p>The fifty gallon receptacles are now stored in a hazardous area when not attended. Staff have been inserviced in regards to storage of fifty gallon receptacles when not in use.</p> <p>Monitors: The Administrator or his designee will perform monthly audits times six to ensure that soiled linen and trash receptacles are stored in a hazardous area when not in use. He will report his findings at the Q.A. meetings and will make changes to the above plan of correction as needed.</p> <p>Date of Compliance: 12/12/2014</p>	

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

Printed: 11/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135080	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2014
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K 075	Continued From page 11 capacity of 32 gal (121 L) shall not be exceeded within any 64-ft ² (5.9-m ²) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) shall be located in a room protected as a hazardous area when not attended. Exception: Container size and density shall not be limited in hazardous areas.	K 075		
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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001230	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2014
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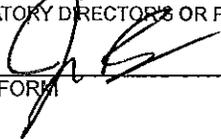
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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The facility is a single story, Type V(111) fully sprinklered structure built in 1967. It has smoke detection throughout corridors and open spaces. Currently the facility is licensed for 60 NF beds.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on November 19, 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.</p> <p>The Survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	C 000		
C 226	<p>02.106 Meet Fire and Life Safety Standards</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 federal "K" tags on CMS 2567</p> <p>K 029 Hazardous Area K 038 Exit Access K 072 Exit Impediments K 074 Flammibility of contents K 075 Combustible storage</p>	C 226	<p>C226</p> <p>Please see K029, K038, K072, K074, and K075.</p>	<p>RECEIVED DEC 17 2014 FACILITY STANDARDS</p>

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE



Administrator

12/15/14

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001230	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2014
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C 434	Continued From page 1	C 434		
C 434	<p>02.120,10,c Plug Adapters/Multiple Outlets Prohibited</p> <p>c. Plug adaptors and multiple outlets are prohibited. This Rule is not met as evidenced by: Based on observation, the facility failed to ensure that multiple outlets and plugs were not in use. Use of multiple plug outlets and adapters increases the risk of electrocution and fires created by overloaded circuits. This deficient practice affected no residents, staff and visitors in Central Supply on the date of the survey. The facility is licensed for 60 SNF/NF beds and had a census of 44 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on November 19, 2014 from 10:30 AM to 1:30 PM, observation of the desk unit in the Central Supply found a 6 - 2 multiple outlet converter in use supplying the computer equipment.</p> <p>State Rule:</p> <p>IDAPA 16.03.02 120.10 (c)</p> <p>120.EXISTING BUILDINGS. These standards shall be applied to all currently licensed health care facilities. Any minor alterations, repairs, and maintenance shall meet these standards. In the event of a change in ownership of a facility, the entire facility shall meet these standards prior to issuance of a new license. (1-1-88)</p> <p>10. Electrical and Lighting. c. Plug adaptors and multiple outlets are</p>	C 434	<p>C 434</p> <p>Resident Specific:</p> <p>Please see systemic changes.</p> <p>Other Residents:</p> <p>Please see systemic changes.</p> <p>Systemic Changes.</p> <p>The 6 plug outlet adapter has been removed.</p>	

Bureau of Facility Standards

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C 434	Continued From page 2 prohibited.	C 434	<p>Staff have been inserviced in regards to not utilizing multiple outlet converters.</p> <p>Monitors:</p> <p>The Administrator or his designee will perform monthly rounds times six to ensure that no multiple outlet converters are utilized. He will report his findings at the Q.A. meetings and will make changes to the above plan on correction as needed.</p> <p>Date of Compliance:</p> <p>12/12/14</p>	