



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 6560

December 11, 2014

David Bargmann, Administrator
Good Samaritan Society - Idaho Falls Village
840 East Elva Street
Idaho Falls, ID 83401-2899

Provider #: 135092

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

Dear Mr. Bargmann:

On **December 2, 2014**, a Facility Fire Safety and Construction survey was conducted at **Good Samaritan Society - Idaho Falls Village** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

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

David Bargmann, Administrator
December 11, 2014
Page 2 of 4

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 **December 24, 2014**. Failure to submit an acceptable PoC by **December 24, 2014**, may result in the imposition of civil monetary penalties by **January 13, 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 **January 6, 2015**, (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 **January 6, 2015**. A change in the seriousness of the deficiencies on **January 6, 2015**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **January 6, 2015**, includes the following:

David Bargmann, Administrator
December 11, 2014
Page 3 of 4

Denial of payment for new admissions effective **March 2, 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 **June 2, 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 **December 2, 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>

David Bargmann, Administrator
December 11, 2014
Page 4 of 4

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

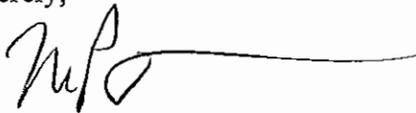
BFS Letters (06/30/11)

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

This request must be received by **December 24, 2014**. If your request for informal dispute resolution is received after **December 24, 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', followed by a long horizontal line 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: 12/10/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135092	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE STRUCTURE B. WING _____	(X3) DATE SURVEY COMPLETED 12/02/2014
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - IDAHO FALLS	STREET ADDRESS, CITY, STATE, ZIP CODE 840 EAST ELVA STREET IDAHO FALLS, ID 83401
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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) sprinklered building with a partial basement. It has a composite pitched roof and multiple exits to grade. Original construction was June 1964 with an addition in 1985 and a major renovation in 1995. A new fire alarm/smoke detection system was installed in November 2009. Currently the facility is licensed for 113 beds. The following deficiencies were cited during the annual fire/life safety survey conducted on December 2, 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 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 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure the continuity of smoke barriers. Failure to maintain smoke barriers could allow the passage of smoke and dangerous gases between smoke compartments and reduce detection or suppression system response during a fire event. This deficient practice affected 8 residents, staff and visitors in 1 of 8 smoke	K 000	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the state operations manual. K 012 The missing ceiling tile that was found during inspection of the business office has been replaced. All transfer grills located in the ceiling of the business office and the 200 wing has also been replaced with the proper ceiling tile. This was completed on 12/4/14,	
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RECEIVED
DEC 22 2014
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X8) DATE 12/22/14
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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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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - IDAHO FALLS		STREET ADDRESS, CITY, STATE, ZIP CODE 840 EAST ELVA STREET IDAHO FALLS, ID 83401	
(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 012	<p>Continued From page 1</p> <p>compartments. The facility is licensed for 113 SNF/NF beds and had a census of 53 on the day of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on December 2, 2014 from 10:30 AM to 4:30 PM, observation of the grid ceiling in the Business Office found five (5) missing ceiling tiles and three (3) honeycomb style transfer grilles which were open to the space above. Interview of the Environmental Services Director found he was aware that these ceiling tiles were a required part of the building construction.</p> <p>2) During the facility tour conducted on December 2, 2014 from 10:30 AM to 4:30 PM, observation of the grid ceiling in the secured portion of the 200 wing found three (3) honeycomb style transfer grilles installed in place of solid grid ceiling tiles. When asked, the Environmental Services Director stated he was not sure why these transfer grilles had been installed in place of solid ceiling tiles.</p> <p>Actual NFPA standard:</p> <p>8.3.2* Continuity. Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces. Exception: A smoke barrier required for an occupied space below an interstitial space shall not be required to extend through the interstitial</p>	K 012	<ul style="list-style-type: none"> All residents, staff, and visitors have the potential to be affected by the deficient practice. Inspection of all ceiling tiles to have the proper fit and no use of transfer grilles have been included on a TELS program as a monthly task to be completed by the Environmental Services Director or designee. Compliance will be monitored by performing audits monthly x3. Audits will be compiled and information forwarded to QA for additional monitoring/modification. Compliance will be met on or before 1/6/15.

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K 029	<p>Continued From page 3</p> <p>100 square feet in size and had been converted to storage of miscellaneous items such as mattresses, wheelchairs and construction supplies. Operational testing of these doors as well as the door to the Maintenance Shop found none were equipped with self-closing devices. Interview of the Environmental Services Director found he was not aware that these doors were required to self-close.</p> <p>2) During the facility tour conducted on December 2, 2014 from 10:30 AM to 4:30 PM, observation of the main dining area abutting the Kitchen found it had an approximately six foot by four foot opening used as a pass through. The main dining hall was found to be open to the corridor flow and approximately fifty (50) feet by sixty (60) feet, or three thousand square feet (3000 sq. ft.) in size. This pass through was not equipped with any door or smoke resistive self-closing device that would resist the passage of smoke. (Refer also to K051)</p> <p>Actual NFPA standard:</p> <p>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.</p> <p>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.</p>	K 029	<ul style="list-style-type: none"> • Inspection of all storage room doors to be self-closing with a positive latch have been included on a TELS program as a monthly task to be completed by the Environmental Services Director or designee. The installation of the fire/smoke shutter is a permanent fix that has also been included in the TELS program to inspect proper operation as a monthly task. • Compliance will be monitored by performing audits weekly x2 weeks, bi-weekly x 2 weeks and

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K 029	Continued From page 4 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 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	monthly x3 thereafter. Audits will be compiled and information forwarded to QA for additional monitoring/modification. • Compliance for the self-closing doors will be met on or before 1/6/15. Compliance for the fire/smoke shutter will be met on or before 2/15/15; 2-10-15 + David Sangman 12-22-14
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	K 038	K 038 • The dead bolt locks found on the public restrooms in the front entrance have been removed. This was completed on 12/4/14.

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

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K 038	<p>Continued From page 5</p> <p>interview, the facility failed to ensure that locks were arranged to be operable with one releasing operation from the egress side. Failure to provide exits which are readily accessible could limit egress capabilities during an emergency. This deficient practice affected staff and visitors utilizing the public bathrooms in the main entrance on the date of the survey. The facility is licensed for 113 SNF/NF beds and had a census of 53 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on December 2, 2014 from 10:30 AM to 4:30 PM, observation and operational testing of the exit doors from the public bathrooms located at the main entrance found both were equipped with a privacy lock and an additional single throw deadbolt. Interview of the Environmental Services Director found he was not aware of the restriction to doors having only one releasing method of operation.</p> <p>Actual NFPA standard:</p> <p>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.</p> <p>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</p>	K 038	<ul style="list-style-type: none"> All residents, staff, and visitors have the potential to be affected by the deficient practice. Inspection of all doors in the facility to not have dead bolts has been included on a TELS program as a monthly task to be completed by the Environmental Services Director or designee. Compliance will be monitored by performing audits monthly x3. Audits will be compiled and information forwarded to QA for additional monitoring/modification. Compliance will be met on or before 1/6/15.

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K 038	Continued From page 6 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	
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This Standard is not met as evidenced by: Based on record review and interview, the facility failed to conduct fire drills for each required	K 050	K 050 • The facility has been compliant with fire drills since 7/31/14. Performing fire drills quarterly on each shift to ensure that facility staff is trained in the event of an emergency.

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K 050	<p>Continued From page 7</p> <p>quarter. Failure to provide sufficient staff training with adequate fire drills could result in staff being unprepared in the event of a fire. This deficient practice affected 53 residents, staff and visitors on the date of the survey. The facility is licensed for 113 beds and had a census of 53 on the day of the survey.</p> <p>Findings include:</p> <p>During record review at the facility conducted on December 2, 2014 from 8:30 AM to 10:30 AM, review of the facility fire drills found the facility failed to conduct any fire drills in the first quarter of 2014 and failed to perform a fire drill for the first and second shift of the second quarter of 2014. When interviewed, the Environmental Services Director stated that he was aware of the drills not being performed.</p> <p>Actual NFPA standard:</p> <p>19.7.1.2* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms.</p> <p>Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building.</p>	K 050	<ul style="list-style-type: none"> • All residents, staff, and visitors have the potential to be affected by the deficient practice. • The Environmental Services Director will continue completing and documenting the fire drills quarterly on each shift to maintain compliance. • Compliance will be monitored by performing audits monthly x6. Audits will be compiled and information forwarded to QA for additional monitoring/modification. • Compliance will be met on or before 1/6/15.
K 051	NFPA 101 LIFE SAFETY CODE STANDARD SS=F	K 051	

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K 051	<p>Continued From page 8</p> <p>A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that smoke detection was provided as required by NFPA 72. Failure to provide sufficient smoke detection in all areas could result in lack of early notification during a fire event. This deficient practice affected residents staff and visitors utilizing dining area services on the date of the survey. The facility is licensed for 113 SNF/NF beds and had a census of 53 on the day of the survey.</p> <p>Findings include:</p>	K 051	<p>K 051</p> <ul style="list-style-type: none"> • Fire and Security Systems has been contacted and will be completing the installation of smoke detectors in the main and dementia dining rooms.. Please see attached approved quote and installation schedule. • All residents, staff, and visitors have the potential to be affected by the deficient practice. • The Environmental Services Director will coordinate with Contractors to ensure installation of required smoke detection in the two dining rooms and perform fire watch when necessary per facility policy during installation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135092	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE STRUCTURE B. WING _____	(X3) DATE SURVEY COMPLETED 12/02/2014
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - IDAHO FALLS		STREET ADDRESS, CITY, STATE, ZIP CODE 840 EAST ELVA STREET IDAHO FALLS, ID 83401	
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K 051	<p>Continued From page 9</p> <p>1) During the facility tour conducted on December 2, 2014 from 10:30 AM to 4:30 PM, observation of the main dining area abutting the Kitchen found it was directly open to the Kitchen by an approximately six foot by four foot opening used as a pass through. The main dining hall was found to be open to the corridor flow and approximately fifty (50) feet by sixty (60) feet, or three thousand square feet (3000 sq. ft.) in size. (Refer also to K029)</p> <p>Further inspection found the ceiling of the dining room was over twelve feet high at the area abutting the Kitchen; sloped for approximately one-third of its area; further divided by beams spaced approximately eight (8) feet apart, perpendicular to the Kitchen wall and measuring approximately eighteen (18) inches in depth. No smoke detection was found in this dining area. Interview of the Environmental Services Director found he had not been aware of the absence of detection prior to the survey.</p> <p>2) During the facility tour conducted on December 2, 2014 from 10:30 AM to 4:30 PM, observation of the assisted/dementia dining area abutting the main dining room found it was open to the corridor flow connecting the dining hall to the 200 wing. Observation of the ceiling found it was approximately twelve feet high; sloped for approximately two-thirds of its area; divided by beams approximately eight (8) feet apart and measuring approximately twenty (20) inches in depth. Further investigation of this ceiling area revealed it was not equipped with smoke detection. When asked, the Environmental Services Director stated this area had never had smoke detection.</p>	K 051	<ul style="list-style-type: none"> • Proof of completion will be submitted to the Bureau of Facility Standards and the Quality Assurance Committee to prove compliance. • Compliance will be met on or before 2/15/15 2-16-15 per MRG + Dana Baegum 12-22-14

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K 051	<p>Continued From page 10</p> <p>Actual NFPA standard:</p> <p>NFPA 101 19.3.4 Detection, Alarm, and Communications Systems. 19.3.4.1 General. Health care occupancies shall be provided with a fire alarm system in accordance with Section 9.6.</p> <p>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.</p> <p>NFPA 72 2-3.4 Location and Spacing. 2-3.4.1* General. 2-3.4.1.1 The location and spacing of smoke detectors shall result from an evaluation based on the guidelines detailed in this code and on engineering judgment. Some of the conditions that shall be included in the evaluation are the following: (1) Ceiling shape and surface (2) Ceiling height (3) Configuration of contents in the area to be protected (4) Burning characteristics of the combustible materials present (5) Ventilation (6) Ambient environment</p>	K 051	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 062	<p>Continued From page 12</p> <p>condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.6</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure sprinklers were maintained free of obstructions. Failure to keep sprinklers free of obstructions or physical damage could result in the system not operating during a fire event. This deficient practice affected 17 residents, staff and visitors on the date of the survey. The facility is licensed for 113 SNF/NF beds and had a census of 53 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on December 2, 2014 from 10:30 AM to 4:30 PM, observation of the sprinkler pendants in rooms 108, 110 and the main Kitchen found a total of six (6) painted sprinklers. When asked, the Environmental Services Director stated that he had not noticed these sprinklers were painted before the survey.</p> <p>Actual NFPA standard:</p> <p>NFPA 25 2-2 Inspection. 2-2.1 Sprinklers. 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.</p>	K 062	<p>K 062</p> <ul style="list-style-type: none"> The six sprinkler pendants found to have been painted are located in two different fire compartments. 3 – D fire protection has replaced all pendants with quick response pendants in the compartment that contains rooms 108 and 110. They have also replaced all the pendants in the kitchen. This was completed on 12/19/14. All residents, staff, and visitors have the potential to be affected by the deficient practice. All sprinkler pendants throughout the facility will be inspected monthly by the Environmental Services Director or designee to ensure that all pendants are free of obstructions.

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K 069	<p>Continued From page 14</p> <p>11.2 Inspection of Fire-Extinguishing Systems. 11.2.1* An inspection and servicing of the fire-extinguishing system and listed exhaust hoods containing a constant or fire-actuated water system shall be made at least every 6 months by properly trained and qualified persons.</p> <p>K 143: NFPA 101 LIFE SAFETY CODE STANDARD SS=E: Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>This Standard is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure oxygen transferring was conducted in a ventilated area. Failure to properly ventilate oxygen transfer areas could create an oxygen rich environment which would accelerate fire involvement. This deficient practice 14 residents, staff and visitors in 1 of 8 smoke compartments on the date of the survey.</p>	K 069	<ul style="list-style-type: none"> All residents, staff, and visitors have the potential to be affected by the deficient practice The Environmental Services Director will coordinate with Contractor to ensure completion of the kitchen hood inspection due in January of 2015. The schedule for completion of the semi-annual inspection has been revised in our TELS program to coincide with the inspection due date. Compliance will be monitored by performing audits quarterly x4. Audits will be compiled and information forwarded to QA for additional monitoring/modification. Compliance will be met on or before 1/06/15. <p>See next page for K143</p>

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K 143	<p>Continued From page 15</p> <p>The facility is licensed for 113 SNF/NF beds and had a census of 53 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on December 2, 2014 from 10:30 AM to 4:30 PM, observation and operational testing of the mechanical ventilation of the Oxygen transfill room found it inoperative. Interview of the Environmental Services Director found he was aware this area is required to be mechanically ventilated.</p> <p>Actual NFPA standard:</p> <p>19.3.2.4 Medical Gas. Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities.</p> <p>NFPA 99 8-6.2.5.2 Transferring Liquid Oxygen. Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows:</p> <p>(a) Separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; and</p> <p>(b) The area is mechanically ventilated, is sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) The area is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted.</p> <p>Transferring shall be accomplished utilizing equipment designed to comply with the performance requirements and producers of CGA Pamphlet P-2.6, Transfilling of Low-Pressure</p>	K 143	<p>K 143</p> <ul style="list-style-type: none"> The exhaust fan in the oxygen room has been replaced and is in good working condition to ensure proper ventilation for the transfer of oxygen. This was completed on 12/4/14. All residents, staff, and visitors have the potential to be affected by the deficient practice Inspection of the exhaust fan in the oxygen room has been included on a 'TELS program as a weekly task to be completed by the Environmental Services Director or designee. Compliance will be monitored by performing audits weekly x2 weeks, bi-weekly x 4 weeks and monthly x3 thereafter. Audits will be compiled

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K 144	<p>Continued From page 17</p> <p>aware of the substantial gap in the performance and documentation of generator testing that was missing.</p> <p>Actual NFPA standard:</p> <p>NFPA 99</p> <p>3-4.4.1 Maintenance and Testing of Essential Electrical System.</p> <p>3-4.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches.</p> <p>(a) Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-4.3.1. Maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6.</p> <p>(b) Inspection and Testing.</p> <p>1. * Test Criteria. Generator sets shall be tested twelve (12) times a year with testing intervals between not less than 20 days or exceeding 40 days. Generator sets serving emergency and equipment systems shall be in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6.</p> <p>2. Test Conditions. The scheduled test under load conditions shall include a complete simulated cold start and appropriate automatic and manual transfer of all essential electrical system loads.</p> <p>3. Test Personnel. The scheduled tests shall be conducted by competent personnel. The tests are needed to keep the machines ready to function and, in addition, serve to detect causes of malfunction and to train personnel in operating</p>	K 144	<ul style="list-style-type: none"> Compliance will be monitored by performing audits weekly x2 weeks, bi-weekly x 4 weeks and monthly x3 thereafter. Audits will be compiled and information forwarded to QA for additional monitoring/modification. Compliance will be met on or before 1/6/15.

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K 144	Continued From page 18 procedures. 3-4.4.2 Recordkeeping. A written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction.	K 144	

Bureau of Facility Standards

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C 000	16.03.02 INITIAL COMMENTS The facility is a single story, Type V (111) sprinklered building with a partial basement. It has a composite pitched roof and multiple exits to grade. Original construction was June 1964 with an addition in 1985 and a major renovation in 1995. A new fire alarm/smoke detection system was installed in November 2009. Currently the facility is licensed for 113 beds. The following deficiencies were cited during the annual fire/life safety survey conducted on December 2, 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 Facilities and Intermediate Care Facilities. The Survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	C 000		
C 226	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. This Rule is not met as evidenced by: Please refer to the "K" tags on federal CMS form 2567:	C 226	C 226 – Refer to 2567 Plan of Corrections	

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C 226	Continued From Page 1 K 012 Smoke barrier continuity K 029 Hazardous area doors K 038 Door Locks K 050 Emergency preparedness K 051 Smoke detection installation K 062 Sprinkler maintenance K 069 Kitchen hood suppression maintenance K 143 Oxygen Transfer ventilation K 144 Generator maintenance	C 226	