



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

December 26, 2014

Lori Bentzler, Administrator
Twin Falls Center
674 Eastland Drive
Twin Falls, ID 83301-6846

Provider #: 135104

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

Dear Ms. Bentzler:

On **December 16, 2014**, a Facility Fire Safety and Construction survey was conducted at **Twin Falls 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 **January 8, 2015**. Failure to submit an acceptable PoC by **January 8, 2015**, may result in the imposition of civil monetary penalties by **January 28, 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 20, 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 20, 2015**. A change in the seriousness of the deficiencies on **January 20, 2015**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **January 20, 2015**, includes the following:

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Denial of payment for new admissions effective **March 16, 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 16, 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 16, 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 **January 8, 2015**. If your request for informal dispute resolution is received after **January 8, 2015**, 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

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

Printed: 12/23/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135104	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 12/16/2014
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NAME OF PROVIDER OR SUPPLIER TWIN FALLS CARE & REHABILITATION CENTI	STREET ADDRESS, CITY, STATE, ZIP CODE 674 EASTLAND DRIVE TWIN FALLS, ID 83301
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K 000	INITIAL COMMENTS The facility is a single story Type V(111) structure that was built in 1987. The building is protected throughout by an automatic fire extinguishing system and is covered by a fire alarm/smoke detection system. The facility is currently licensed for 116 SNF/NF beds. The following deficiencies were cited during the annual fire/life safety survey conducted on December 16, 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	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Genesis HealthCare Twin Falls Center, does not admit that the deficiency listed on this form exists, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiencies. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiencies, statements, facts, and conclusions that form the basis for the deficiency." RECEIVED JAN - 6 2015 FACILITY STANDARDS	
K 012 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure the smoke resistive properties of the building was maintained. Failure to ensure the continuity of construction could result in smoke and dangerous gases passing between smoke compartments during a fire event. This deficient practice affected 62 residents, staff and visitors on the date of the survey. The facility is licensed for 116 SNF/NF beds and had a census of 73 on the day of the survey.	K 012		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Joie Bennett</i>	TITLE <i>Administrator</i>	(X6) DATE <i>1/5/15</i>
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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 012	Continued From page 1 Findings include: 1) During the facility tour conducted on December 16, 2014 from 12:30 PM to 3:30 PM, an above the ceiling inspection of the smoke barrier walls at the 100 and 400 wings found three (3) unsealed 2-inch pipes passing through the wall above the smoke compartment doors at rooms 425/404. 2) During the facility tour conducted on December 16, 2014 from 12:30 PM to 3:30 PM, an above the ceiling inspection of the smoke barrier walls at the 100 and 400 wings found a four inch unsealed pipe passing through the wall above the smoke compartment doors at rooms 420/408 and a four inch unsealed pipe passing through the wall above the ceiling from the riser room, through the corridor and into the conference room. 3) During the facility tour conducted on December 16, 2014 from 12:30 PM to 3:30 PM, an above the ceiling inspection of the smoke barrier walls at the 100 and 400 wings found an unsealed 2-inch pipe passing from the suspended ceiling through the one hour separation into the attic above at the smoke compartment doors at rooms 104/124. 4) During the facility tour conducted on December 16, 2014 from 10:30 AM to 12:30 PM, observation of the soiled linen room across from room 306 revealed an approximately twelve inch by twelve inch opening cut into the wall exposing copper plumbing pipes. Interview of the Maintenance Supervisor found he was not aware of any of the penetrations noted in findings 1 through 4 prior to the survey.	K 012	<u>K012</u> <u>Specific Residents Identified</u> The three unsealed 2 inch pipes passing through the wall above the smoke compartment doors at rooms 425/404 were sealed with fireproof drywall by the Maintenance Supervisor on or before 1/19/15. The four inch unsealed pipe passing through the wall above the smoke compartment doors at rooms 420/408 and the four inch unsealed pipe passing through the wall above the ceiling from the riser room, through the corridor and into the conference room were sealed with fireproof drywall by the Maintenance Supervisor on or before 1/19/15. The unsealed 2 inch pipe passing from the suspended ceiling through the one hour separation into the attic above the smoke compartment doors at rooms 104/124 was sealed with fireproof drywall by the Maintenance Supervisor on or before 1/19/15. The twelve inch by twelve inch opening in the soiled linen room across from room 306 was covered with drywall and sealed by the Maintenance Supervisor on or before	

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K 012	<p>Continued From page 2 Actual NFPA standard:</p> <p>19.1.6.2 Health care occupancies shall be limited to the types of building construction shown in Table 19.1.6.2. (See 8.2.1.) Exception*: Any building of Type I(443), Type I(332), Type II(222), or Type II(111) construction shall be permitted to include roofing systems involving combustible supports, decking, or roofing, provided that the following criteria are met: (a) The roof covering meets Class C requirements in accordance with NFPA 256, Standard Methods of Fire Tests of Roof Coverings. (b) The roof is separated from all occupied portions of the building by a noncombustible floor assembly that includes not less than 2 1/2 in. (6.4 cm) of concrete or gypsum fill. (c) The attic or other space is either unoccupied or protected throughout by an approved automatic sprinkler system.</p> <p>8.2.1* Construction. Buildings or structures occupied or used in accordance with the individual occupancy chapters (Chapters 12 through 42) shall meet the minimum construction requirements of those chapters. NFPA 220, Standard on Types of Building Construction, shall be used to determine the requirements for the construction classification. Where the building or facility includes additions or connected structures of different construction types, the rating and classification of the structure shall be based on either of the following: (1) Separate buildings if a 2-hour or greater vertically-aligned fire barrier wall in accordance with NFPA 221, Standard for Fire Walls and Fire</p>	K 012	<p>1/19/15 so that the copper plumbing pipes are not exposed.</p> <p><u>Identification of Other Residents</u></p> <p>An above the ceiling inspection of the facility was completed on or before 1/19/15 by the Maintenance Supervisor to identify any unsealed penetrations in the smoke barrier walls. Any findings were corrected by the Maintenance Supervisor by sealing the openings with fireproof drywall on or before 1/19/15. An environmental inspection was completed by the Maintenance Supervisor on or before 1/19/15 to identify any openings in the walls in the facility. Any findings were corrected by the Maintenance Supervisor on or before 1/19/15.</p> <p><u>Systematic Changes</u></p> <p>The Maintenance Supervisor was re educated on or before 1/19/15 by the administrator regarding the requirement that any openings in the smoke barrier walls must be sealed with fireproof material and that any holes/openings in the walls of the facility must be closed and sealed.</p>	

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K 012	<p>Continued From page 3</p> <p>Barrier Walls, exists between the portions of the building Exception: The requirement of 8.2.1(1) shall not apply to previously approved separations between buildings. (2) The least fire-resistive type of construction of the connected portions, if no such separation is provided</p> <p>8.2.3.2.4.2* 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: (1) The space between the penetrating item and the fire barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (2) Where the penetrating item uses a sleeve to penetrate the 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: a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (3) * Insulation and coverings for pipes and ducts shall not pass through the fire barrier unless one of the following conditions is met: a. The material shall be capable of maintaining the fire resistance of the fire barrier. b. The material shall be protected by an approved device that is designed for the specific purpose.</p>	K 012	<p><u>Monitoring</u></p> <p>Starting the week of 1/20/15, the Maintenance Supervisor will complete audits of the smoke barrier walls weekly x 4 weeks and then monthly for two months to ensure that there are not any openings in the smoke barrier walls. Starting the week of 1/20/15, the Maintenance Supervisor or designee will complete environmental audits of the walls in the facility weekly x 4 weeks and then monthly for two months to ensure there are not any openings or holes in the walls in the facility. Audits will be reviewed by the Safety Committee monthly for compliance. A report will be submitted to the Performance Improvement Committee monthly for three months. The Maintenance Supervisor is responsible for monitoring and follow up.</p> <p><u>Date of Compliance</u></p> <p>1/19/15</p>	

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K 012	<p>Continued From page 4</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>K 021 NFPA 101 LIFE SAFETY CODE STANDARD SS=D</p> <p>Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure hazardous area doors were equipped with an approved hold-open device. Failure to properly hold open hazardous area doors could allow smoke and dangerous gases to pass freely hindering egress during a fire event. This deficient practice affected staff, vendors and residents occupying the dining hall on the date of the survey. The facility is licensed for 116 SNF/NF</p>	K 012	<p><u>K021</u></p> <p><u>Specific Residents Identified</u></p> <p>The door stops under the double doors to the kitchen from the dining room were removed on or before 1/19/15 by the maintenance supervisor. Mag locks (automatic release devices) that are connected to the fire system were in place on or before 1/19/15 on the doors between the kitchen and dining room to hold the doors open.</p> <p><u>Identification of Other Residents</u></p> <p>Environmental rounds have been completed on or before 1/19/15 by the Maintenance Supervisor to ensure that doors in the facility are not held open with door stops. Any findings were corrected.</p>

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K 021	<p>Continued From page 5 beds and had a census of 73 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on December 16, 2014 from 10:30 AM to 3:30 PM, observation and operational testing of the doors into the Kitchen found they were double-acting, bar style swing doors. These doors were found chocked open with a rubber door chock on both leaves. When asked, the Food Services Supervisor stated this was how the facility held the doors open to move carts in and out of the Kitchen. In addition, refer to K 029.</p> <p>Actual NFPA standard:</p> <p>19.2.2.2.6* Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier, or hazardous area enclosure shall be permitted to be held open only by an automatic release device that complies with 7.2.1.8.2. The automatic sprinkler system, if provided, and the fire alarm system, and the systems required by 7.2.1.8.2 shall be arranged to initiate the closing action of all such doors throughout the smoke compartment or throughout the entire facility.</p> <p>K 029 NFPA 101 LIFE SAFETY CODE STANDARD SS=F 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</p>	K 021	<p><u>Systematic Changes</u></p> <p>The Maintenance Supervisor and Dietary Manager were re educated on or before 1/19/15 by the administrator regarding the requirement that doors in the facility cannot be held open with door stops.</p> <p><u>Monitoring</u></p> <p>Starting the week of 1/20/15 environmental rounds will be completed weekly x 4 weeks and then monthly for 2 months by the Maintenance Supervisor or designee to ensure that doors are not propped open by door stops. Audits will be reviewed monthly for three months by the Safety Committee for compliance. A report will be submitted to the Performance Improvement Committee monthly for three months. The Maintenance Supervisor is responsible for monitoring and follow up.</p> <p><u>Date of Compliance</u></p> <p>1/19/15</p>

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K 029	<p>Continued From page 6</p> <p>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 doors to hazardous areas were equipped to self-close and resist the passage of smoke. Lack of self-closing doors to hazardous areas and failure for these to self-close would allow smoke and dangerous gases to pass into corridors affecting egress during a fire event. This deficient practice affected 38 residents, staff and visitors in 3 of 6 smoke compartments on the date of the survey. The facility is licensed for 116 SNF/NF beds and had a census of 73 on the day of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on December 16, 2014 from 10:30 AM to 3:30 PM, observation and operational testing of the door into the Copy Room from the main Business Office found it was equipped with self-closing hinges which had been disabled. This room measured approximately eight feet by ten feet and contained combustible storage of paper supplies and recycling containers.</p> <p>Further investigation of the area found that the door to the main Business Office connected directly to the corridor and was not equipped to self-close. Interview of the Maintenance Supervisor found he was not aware of the self-closing requirement of the Copy Room door.</p> <p>2) During the facility tour conducted on December</p>	K 029	<p><u>K029</u></p> <p><u>Specific Residents Identified</u></p> <p>The closures on the door into the copy room from the main business office and the door to the main business office from the corridor were changed by the Maintenance Supervisor or designee on or before 1/19/15 to a self closure that would not allow the passage of smoke.</p> <p>The closures on the doors to the soiled utility closets in between rooms 407/408 and the storage room abutting room 422 were changed by the Maintenance Supervisor or designee on or before 1/19/15 to a self closure that would not allow the passage of smoke.</p> <p>The doors between the kitchen and dining room were repaired so that they will close completely. A sweep was placed on the edge of the doors to ensure that there is not a gap between the two doors. This was completed on or before 1/19/15 by the Maintenance Supervisor.</p>		

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K 029	<p>Continued From page 7</p> <p>16, 2014 from 10:30 AM to 3:30 PM, observation of the soiled utility closets in between rooms 407/408 and the storage room abutting room 422 found they had been converted to medical records storage, measuring approximately ten feet by six feet (60 sq. ft.). Operational testing of each of these doors found they would not self-close.</p> <p>When asked, the Maintenance Supervisor stated these areas had been converted to Medical Records storage as the facility was lacking sufficient storage capabilities.</p> <p>3) During the facility tour conducted on December 16, 2014 from 10:30 AM to 3:30 PM, observation and operational testing of the doors into the Kitchen found they were double-acting, bar style swing doors. These doors were found chocked open and when activated, they would not close completely, overlapping at the leading edge with a gap of approximately 3/8" to 1/2" along the bottom half of the doors. In addition, refer to K 021.</p> <p>Interview of both the Maintenance Supervisor found he was not aware of the substantial gap between the doors.</p> <p>4) During the facility tour conducted on December 16, 2014 from 10:30 AM to 3:30 PM, observation and operational testing of the door from the Laundry Room into the service corridor found it was not self-closing.</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</p>	K 029	<p>The closure on the door from the laundry room into the service corridor was changed to a self closure on or before 1/19/15 by the Maintenance Supervisor or designee.</p> <p><u>Identification of Other Residents</u></p> <p>Environmental rounds have been completed on or before 1/19/15 by the Maintenance Supervisor to ensure that doors to hazardous areas have a self closure on them. Any findings were corrected.</p> <p><u>Systematic Changes</u></p> <p>The Maintenance Supervisor was re educated on or before 1/19/15 by the administrator regarding the requirement that doors to hazardous areas are equipped to self close.</p>	

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

Printed: 12/23/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135104	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 12/16/2014
NAME OF PROVIDER OR SUPPLIER TWIN FALLS CARE & REHABILITATION CENTI			STREET ADDRESS, CITY, STATE, ZIP CODE 674 EASTLAND DRIVE TWIN FALLS, ID 83301	
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K 029	Continued From page 8 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. 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 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	<u>Monitoring</u> Starting the week of 1/20/15 environmental rounds will be completed weekly x 4 weeks and then monthly for 2 months by the Maintenance Supervisor or designee to ensure that doors to hazardous areas self close. Audits will be reviewed monthly for three months by the Safety Committee for compliance. A report will be submitted to the Performance Improvement Committee monthly for three months. The Maintenance Supervisor is responsible for monitoring and follow up. <u>Date of Compliance</u> 1/19/15	
K 062	NFPA 101 LIFE SAFETY CODE STANDARD	K 062		

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K 062 SS=F	<p>Continued From page 9</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This Standard is not met as evidenced by: Based on record review and interview, the facility failed to ensure sprinkler systems were inspected quarterly. Failure to inspect sprinkler systems on a quarterly basis could result with inadequate sprinkler system operation during a fire event. This deficient practice affected 73 residents, staff and visitors on the date of the survey. The facility is licensed for 116 SNF/NF beds and had a census of 73 on the day of the survey.</p> <p>Findings include:</p> <p>During record review conducted on December 16, 2014 from 8:30 AM to 10:30 AM, facility records found that the quarterly sprinkler inspection for the third quarter of 2014 was missed. When interviewed, the Maintenance Supervisor indicated he was aware of this inspection having been missed and that it was due to a switch in vendors which occurred during that timeframe.</p> <p>Actual NFPA standard:</p> <p>4.6.12 Maintenance and Testing. 4.6.12.1 Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition,</p>	K 062	<p><u>K062</u></p> <p><u>Specific Residents Identified</u></p> <p>A quarterly inspection of the sprinkler system was completed on or before 1/19/15 by Delta Fire Systems.</p> <p><u>Identification of Other Residents</u></p> <p>A quarterly inspection of the sprinkler system was completed on or before 1/19/15. The Maintenance Supervisor has a copy of this inspection.</p> <p><u>Systematic Changes</u></p> <p>The Maintenance Supervisor was re educated on or before 1/19/15 by the Administrator regarding the requirement that the automatic fire sprinkler system must have quarterly inspections completed.</p> <p><u>Monitoring</u></p> <p>Quarterly monitoring starting in January, 2015 will be completed by the administrator to ensure that the quarterly sprinkler inspections are completed and annually to ensure that</p>	

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K 062	Continued From page 10 arrangement, level of protection, or other feature shall thereafter be continuously maintained in accordance with applicable NFPA requirements or as directed by the authority having jurisdiction. 2-3.3* Alarm Devices. Waterflow alarm devices including, but not limited to, mechanical water motor gongs, vane-type waterflow devices, and pressure switches that provide audible or visual signals shall be tested quarterly.	K 062	annual sprinkler inspections are completed. The Maintenance Supervisor is responsible for monitoring and follow up. <u>Date of Compliance</u> 1/19/15	
K 064 SS=F	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 that fire extinguishers were installed per NFPA 10. Failure to install fire extinguishers at the proper height could hinder emergency response by staff. This deficient practice affected 73 residents, staff and visitors on the date of the survey. The facility is licensed for 116 SNF/NF beds and had a census of 73 on the day of the survey. Findings include: During the facility tour conducted on December 16, 2014 from 10:30 AM to 3:30 PM, examination of fire extinguishers installed in the recessed cabinets in the corridors found that the height to the top of eight extinguishers examined was sixty three and one-half (63-1/2") inches. Interview of	K 064	<u>K064</u> <u>Specific Residents Identified</u> The portable fire extinguishers in the facility have been lowered by the Maintenance Supervisor on or before 1/19/15 to meet the requirement that the height of the top of the extinguishers is not more than 60 inches above the floor. <u>Identification of Other Residents</u> Environmental rounds have been completed by the Maintenance Supervisor on or before 1/19/15 to ensure that the height of the top of the portable fire extinguishers in the facility are not more than 60 inches above the floor.	

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K 064	Continued From page 11 the Maintenance Supervisor found he was not aware of the height requirement for fire extinguishers. Actual NFPA standard: NFPA 10 1-6.10 Fire extinguishers having a gross weight not exceeding 40 lb (18.14 kg) shall be installed so that the top of the fire extinguisher is not more than 5 ft (1.53 m) above the floor. Fire extinguishers having a gross weight greater than 40 lb (18.14 kg) (except wheeled types) shall be so installed that the top of the fire extinguisher is not more than 3 1/2 ft (1.07 m) above the floor. In no case shall the clearance between the bottom of the fire extinguisher and the floor be less than 4 in. (10.2 cm).	K 064	<u>Systematic Changes</u> The Maintenance Supervisor was re educated on or before 1/19/15 by the Administrator regarding the requirement that the top of the fire extinguishers are not more than 60 inches above the floor. <u>Monitoring</u> Starting the week of 1/20/15, the Maintenance Supervisor will complete audits weekly x 4 weeks and then monthly for two months to ensure that the top of the fire extinguishers are not more than 5 feet above the floor. Audits will be reviewed at the monthly safety committee meeting for three months for compliance. A report will be submitted to the Performance Improvement Committee monthly for three months. The Maintenance Supervisor is responsible for monitoring and follow up.	
K 072 SS=D	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 This Standard is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure that means of egress were not affected by impediments to their full instant use. Failure to ensure that doors are maintained free of obstructions would hinder safe egress during a fire or emergency. This deficient practice affected staff and vendors on the date of the survey. The facility is licensed for	K 072	<u>Date of Compliance</u> 1/19/15	

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K 072	<p>Continued From page 12 116 SNF/NF beds and had a census of 73 on the day of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on December 16, 2014 from 12:30 PM to 3:30 PM, observation of the doors leading from the Kitchen into the dining room found they were double-acting, bar-style swing doors. Operational testing found these doors were equipped with three (3) throwbolts on one leaf and one throwbolt on the second requiring multiple actions to unlock from the egress side.</p> <p>2) During the facility tour conducted on December 16, 2014 from 12:30 PM to 3:30 PM, observation and operational testing of the door to the Social Services office found it was equipped with a keyed lock which would not open from the egress side with a single operation, but required special knowledge to unlock the door. When asked, the Maintenance Supervisor stated he was not aware of the special locking arrangement of this door.</p> <p>Actual NFPA standard:</p> <p>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>7.2.1.5 Locks, Latches, and Alarm Devices. 7.2.1.5.1 Doors shall be arranged to be opened readily from the egress side whenever the building is occupied. Locks, if provided, shall not require the use of a key, a tool, or special knowledge or effort for operation from the egress side.</p>	K 072	<p><u>K072</u></p> <p><u>Specific Residents Identified</u></p> <p>The throwbolts on the doors between the kitchen and the dining room were removed by the Maintenance Supervisor on or before 1/19/15. New locks that meet the Life Safety requirements have been placed by the Maintenance Supervisor on or before 1/19/15 that meet the requirements that the doors can be readily opened from the egress side.</p> <p>The keyed lock on the door to the Social Services office was changed on or before 1/19/15 by the Maintenance Supervisor to a lock that meets the Life Safety requirements.</p> <p><u>Identification of Other Residents</u></p> <p>An environmental tour of the facility was completed by the Maintenance Supervisor on or before 1/19/15 to ensure that the doors do not have locks that would prevent safe egress during a fire or emergency. Any findings have been corrected.</p>

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K 072	Continued From page 13 Exception No. 1: This requirement shall not apply where otherwise provided in Chapters 18 through 23. Exception No. 2: Exterior doors shall be permitted to have key-operated locks from the egress side, provided that the following criteria are met: (a) Permission to use this exception is provided in Chapters 12 through 42 for the specific occupancy. (b) On or adjacent to the door, there is a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high on a contrasting background that reads as follows: THIS DOOR TO REMAIN UNLOCKED WHEN THE BUILDING IS OCCUPIED (c) The locking device is of a type that is readily distinguishable as locked. (d) A key is immediately available to any occupant inside the building when it is locked. Exception No. 2 shall be permitted to be revoked by the authority having jurisdiction for cause. Exception No. 3: Where permitted in Chapters 12 through 42, key operation shall be permitted, provided that the key cannot be removed when the door is locked from the side from which egress is to be made.	K 072	<u>Systematic Changes</u> The Maintenance Supervisor was re educated on or before 1/19/15 by the administrator regarding the requirement that doors must be maintained free of obstructions that would hinder safe egress during a fire or emergency. <u>Monitoring</u> Starting the week of 1/20/15, the Maintenance Supervisor or designee will complete rounds of the facility weekly x 4 weeks and then monthly for two months to ensure that the doors in the facility are maintained free of obstructions that would hinder safe egress during a fire or emergency. Audits will be reviewed by the Safety Committee monthly for compliance. A report will be submitted to the Performance Improvement Committee monthly for three months. The Maintenance Supervisor is responsible for monitoring and follow up. <u>Date of Compliance</u> 1/19/15	
K 130 SS=E	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This Standard is not met as evidenced by: Based on observation, physical examination and interview, the facility failed to ensure that adequate spacing of heat sources to combustible materials was provided. Failure to provide spacing between heat sources and combustible	K 130		

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K 130	<p>Continued From page 14</p> <p>materials could potentially expose occupants to risk of fire or unnecessary evacuation. This deficient practice affected 17 residents, staff and visitors on the date of the survey. The facility is licensed for 116 SNF/NF beds and had a census of 73 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on December 16, 2014 from 10:30 AM to 12:30 PM, observation of a converted storage area for Medical Records abutting room 422 found the cadet style wall heating element installed in the storage area to be blocked a pallet of medical records in boxes which were stored directly against it. When examined, these boxes felt hot to the touch. Interview of the Maintenance Supervisor found he was not aware of why these boxes were stored directly against a heat source.</p> <p>Actual NFPA standard:</p> <p>NFPA 1 3-1 Fundamental Requirements. 3-1.1 Every new and existing building or structure shall be constructed, arranged, equipped, maintained, and operated in accordance with this Code so as to provide a reasonable level of life safety, property protection, and public welfare from the actual and potential hazards created by fire, explosion, and other hazardous conditions.</p>	K 130	<p><u>K130</u></p> <p><u>Specific Residents Identified</u></p> <p>The cadet style wall heating element was removed from the medical records storage room abutting room 422 by the Maintenance Supervisor on or before 1/19/15.</p> <p><u>Identification of Other Residents</u></p> <p>An environmental audit was completed by the Maintenance Supervisor on or before 1/19/15 to verify that the heat sources in the facility have adequate spacing between the heat source and combustible materials. Any findings were corrected.</p> <p><u>Systematic Changes</u></p> <p>Medical records staff and the Maintenance Supervisor were inserviced on or before 1/19/15 by the Administrator on the requirement that combustible material must have adequate space between the material and a heat source.</p>	
K 147 SS=F	<p>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>	K 147		

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K 147	<p>Continued From page 15</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that electrical systems were installed in accordance with NFPA 70. Failure to ensure proper electrical installations could result in electrocution or fire. This deficient practice affected 40 residents, staff and visitors on the date of the survey. The facility is licensed for 116 SNF/NF beds and had a census of 73 on the day of the survey.</p> <p>Findings include:</p> <p>1) During record review of the facility conducted on December 16, 2014 from 8:30 AM to 10:30 AM, observation of the conference room found an extension cord with a 3-1 multiple plug converter in use supplying a computer. When shown to the Maintenance Supervisor, he stated he was not sure why this practice had occurred.</p> <p>2) During the facility tour conducted on December 16, 2014 from 10:30 AM to 3:30 PM, observation of the Christmas tree lights installed on trees in the entry lobby an the Lounge at the main intersection of the 100 to 400 wing found the tree in the Lobby using a non-grounded extension cord in conjunction with the Christmas tree lights and the Lounge tree using a relocatable power tap in conjunction with the lighting. When asked, the Maintenance Director stated he was not aware that the lighting for these trees had been installed in this manner.</p> <p>3) During the facility tour conducted on December 16, 2014 from 10:30 AM to 3:30 PM, inspection above the ceiling at rooms 425/404 revealed an open 2 inch by 4 inch electrical junction box with exposed wiring. Interview of the Maintenance Supervisor found he was not aware the junction</p>	K 147	<p><u>Monitoring</u></p> <p>Starting the week of 1/20/15, the Maintenance Supervisor will complete audits of the storage areas of the facility weekly x 4 weeks and then monthly for two months to ensure that there is not combustible material too close to heat sources. Audits will be reviewed by the Safety Committee monthly for compliance. A report will be submitted to the Performance Improvement Committee monthly for three months. The Maintenance Supervisor is responsible for monitoring and follow up.</p> <p><u>Date of Compliance</u></p> <p>1/19/15</p> <p><u>K147</u></p> <p><u>Specific Residents Identified</u></p> <p>The extension cord in the conference room was removed and the cords plugged into the wall by the Maintenance Supervisor on or before 1/19/15.</p>

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K 147	<p>Continued From page 16 box was missing its cover.</p> <p>4) During the facility tour conducted on December 16, 2014 from 10:30 AM to 3:30 PM, observation of the converted Medical Records area of the Soiled Utility room found the pallet of records stored there was blocking the electrical service panel.</p> <p>5) During the facility tour conducted on December 16, 2014 from 10:30 AM to 3:30 PM, observation of the fish tank located in the nook abutting the Beauty Salon found one of the power supply cords from the tank was plugged into a grounded-to-non grounded convertor, which was then plugged into a timer, all of which was then plugged into a relocatable power tap. When asked, the Maintenance Supervisor stated he was not aware of why this method of wiring was being used.</p> <p>Actual NFPA standard: NFPA 70</p> <p>Findings 1 and 2</p> <p>400.8 Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces Exception: Flexible cord and cable shall be</p>	K 147	<p>The Christmas trees in the front lobby and the resident lounge were moved so that the lights were plugged directly into the wall outlets by the Maintenance Supervisor on or before 1/19/15. The relocatable power taps were removed.</p> <p>The electrical junction box above the ceiling at rooms 425/404 was covered by the Maintenance Supervisor on or before 1/19/15 so that the wires are not exposed.</p> <p>The medical records that were blocking the electrical service panel in the Soiled Utility Room were moved to a different storage area in the facility on or before 1/19/15 by the Maintenance Supervisor.</p> <p>The power supply cord for the lights in the fish tank was plugged directly into the wall outlet by the Maintenance Supervisor on or before 1/19/15.</p>	

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K 147	<p>Continued From page 17</p> <p>permitted to be attached to building surfaces in accordance with the provisions of 368.8.</p> <p>(5) Where concealed by walls, floors, or ceilings or located above suspended or dropped ceilings</p> <p>(6) Where installed in raceways, except as otherwise permitted in this Code</p> <p>Finding 3</p> <p>110.12 Mechanical Execution of Work. Electrical equipment shall be installed in a neat and workmanlike manner.</p> <p>(A) Unused Openings. Unused cable or raceway openings in boxes, raceways, auxiliary gutters, cabinets, cutout boxes, meter socket enclosures, equipment cases, or housings shall be effectively closed to afford protection substantially equivalent to the wall of the equipment. Where metallic plugs or plates are used with nonmetallic enclosures, they shall be recessed at least 6 mm (¼ in.) from the outer surface of the enclosure.</p> <p>(B) Subsurface Enclosures. Conductors shall be racked to provide ready and safe access in underground and subsurface enclosures into which persons enter for installation and maintenance.</p> <p>(C) Integrity of Electrical Equipment and Connections. Internal parts of electrical equipment, including busbars, wiring terminals, insulators, and other surfaces, shall not be damaged or contaminated by foreign materials such as paint, plaster, cleaners, abrasives, or corrosive residues. There shall be no damaged parts that may adversely affect safe operation or mechanical strength of the equipment such as parts that are broken; bent; cut; or deteriorated by corrosion, chemical action, or overheating.</p> <p>314.17 Conductors Entering Boxes, Conduit Bodies, or Fittings.</p>	K 147	<p><u>Identification of Other Residents</u></p> <p>An environmental round was completed of the facility on or before 1/19/15 by the Maintenance Supervisor to ensure that extension cords are not in use, that Christmas tree lights are plugged directly into a wall plug and that electrical plugs requiring a grounded outlet are plugged into a grounded unit. Any findings were corrected.</p> <p>An above the ceiling facility audit was completed by the Maintenance Supervisor on or before 1/19/15 to ensure that electrical junction boxes have covers and wiring is not exposed. Any findings were corrected.</p> <p>A facility environmental round was completed by the Maintenance Supervisor or designee on or before 1/19/15 to ensure that electrical panels in the facility are not blocked by items. Any findings were corrected.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135104	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 12/16/2014
NAME OF PROVIDER OR SUPPLIER TWIN FALLS CARE & REHABILITATION CENTI		STREET ADDRESS, CITY, STATE, ZIP CODE 674 EASTLAND DRIVE TWIN FALLS, ID 83301		
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K 147	Continued From page 18 Conductors entering boxes, conduit bodies, or fittings shall be protected from abrasion and shall comply with 314.17(A) through (D). (A) Openings to Be Closed. Openings through which conductors enter shall be adequately closed..... Finding 4 110.26 Spaces About Electrical Equipment. Sufficient access and working space shall be provided and maintained about all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons. (A) Working Space. Working space for equipment operating at 600 volts, nominal, or less to ground and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A)(1), (2), and (3) or as required or permitted elsewhere in this Code. Finding 5 200.3 Connection to Grounded System. Premises wiring shall not be electrically connected to a supply system unless the latter contains, for any grounded conductor of the interior system, a corresponding conductor that is grounded. For the purpose of this section, electrically connected shall mean connected so as to be capable of carrying current, as distinguished from connection through electromagnetic induction.	K 147	<u>Systematic Changes</u> The Maintenance Supervisor and facility managers were educated on or before 1/19/15 by the administrator about regulations regarding use of extension cords, Christmas tree lights, and not blocking electrical panels. The Maintenance Supervisor was educated on or before 1/19/15 by the administrator regarding regulations about exposed wiring and electrical junction boxes having covers and electrical plugs requiring a grounded outlet. <u>Monitoring</u> Starting the week of 1/20/15, environmental rounds will be completed weekly x 4 weeks and monthly for two months by the Maintenance Supervisor or designee to ensure that extension cords are not in use, Christmas tree lights are plugged directly into the wall, that electrical wires are not exposed, that electrical panels are not blocked and that electrical plugs requiring a grounded outlet are plugged into the correct outlet.	
K 211 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR)	K 211		

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K 211	<p>Continued From page 19</p> <p>dispensers are installed in a corridor:</p> <ul style="list-style-type: none"> o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623 <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that flammable liquids were installed away from ignition sources. Failure to install alcohol based hand rub dispensers are not installed above or near an ignition source could expose occupants to a fire and/or smoke environment. This deficient practice affected residents, staff and visitors using the private dining room on the date of the survey. The facility is licensed for 116 beds and had a census of 73 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on December 16, 2014 from 12:30 PM to 2:00 PM, observation of the private dining room found two (2) alcohol based hand rub dispensers installed directly adjacent to the light switches in the private dining room. Interview of the Maintenance Supervisor</p>	K 211	<p>Audits will be reviewed monthly for three months by the Safety Committee for compliance. A report will be submitted to the Performance Improvement Committee monthly for three months. The Maintenance Supervisor is responsible for compliance.</p> <p><u>Date of Compliance</u></p> <p>1/19/15</p> <p><u>K211</u></p> <p><u>Specific Residents Identified</u></p> <p>The two alcohol based hand rub dispensers in the private dining room were moved away from the light switches by the Maintenance Supervisor or designee on or before 1/19/15.</p> <p><u>Identification of Other Residents</u></p> <p>An environmental audit of the facility was completed by the Maintenance Supervisor or designee on or before 1/19/15 to ensure that alcohol based hand rub dispensers are placed</p>	

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K 211	<p>Continued From page 20 found he was not aware of the requirement of dispenser installations.</p> <p>Actual NFPA standard:</p> <p>19.3.2.7 of the 2000 edition of the LSC as amended:</p> <ul style="list-style-type: none"> · Where dispensers are installed in a corridor, the corridor shall have a minimum width of 6 ft (1.8m). · The maximum individual dispenser fluid capacity shall be: -0.3 gallons (1.2 liters) for dispensers <ul style="list-style-type: none"> · in rooms, corridors, and areas open to corridors. -0.5 gallons (2.0 liters) for dispensers in suites of rooms. · The dispensers shall have a minimum horizontal spacing of 4 ft (1.2m) from each other. · Not more than an aggregate 10 gallons (37.8 liters) of ABHR solution shall be in use in a single smoke compartment outside of a storage cabinet. · Storage of quantities greater than 5 gallons (18.9 liters) in a single smoke compartment shall meet the requirements of NFPA 30, Flammable and Combustible Liquids Code. · The dispensers shall not be installed over or directly adjacent to an ignition source. · In locations with carpeted floor coverings, dispensers installed directly over carpeted surfaces shall be permitted only in sprinklered smoke compartments. 	K 211	<p>according to NFPA requirements. Any findings were corrected.</p> <p><u>Systematic Changes</u></p> <p>The Maintenance Supervisor was re educated by the administrator on or before 1/19/15 on the NFPA requirements for placement of alcohol based hand rub dispensers.</p> <p><u>Monitoring</u></p> <p>Starting the week of 1/20/15, environmental rounds will be completed weekly x 4 weeks and then monthly for two months to ensure that the placement of alcohol based hand rub dispensers meet NFPA requirements. Audits will be reviewed monthly by the Safety Committee for compliance. A report will be submitted to the Performance Improvement Committee monthly for three months. The Maintenance Supervisor is responsible for monitoring and follow up.</p> <p><u>Date of Compliance</u></p> <p>1/19/15</p>	

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C 000	16.03.02 INITIAL COMMENTS The facility is a single story Type V(111) structure that was built in 1987. The building is protected throughout by an automatic fire extinguishing system and is covered by a fire alarm/smoke detection system. The facility is currently licensed for 116 SNF/NF beds. The following deficiencies were cited during the annual fire/life safety survey conducted on December 16, 2014. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70 and IDAPA 16.03.02, Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities. The Survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	C 000	RECEIVED JAN - 5 2015 FACILITY STANDARDS C226 See POC for K012, K021, K029, K062, K064, K072, K0130, K147 K211 Date of Compliance 1/19/15	
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 federal "K" tags on CMS 2567: K 012 Construction continuity K 021 Hold open devices	C 226	C434 See POC for K147 Date of Compliance 1/19/15	

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

Jon Bentler

TITLE

Administrator

(X6) DATE

1/5/15

Bureau of Facility Standards

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C 226	Continued From Page 1 K 029 Hazardous areas K 062 Sprinkler maintenance K 064 Fire extinguisher installations K 072 Means of egress K 130 Blocked heating source K 147 Electrical installations K 211 Alcohol based hand rub dispenser installations	C 226		
C 434	02.120,10,c 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 21 residents, staff and visitors on the date of the survey. The facility is licensed for 116 SNF/NF beds and had a census of 73 on the day of the survey. Findings include: During record review conducted on December 16, 2014 from 8:30 AM to 10:30 AM, observation of the desk unit in the Conference room found a 3 - 1 multiple outlet converter plugged into an extension cord and in use supplying the computer equipment. Refer also to Federal "K" tag K 147. State Rule: IDAPA 16.03.02 120.10 (c) 120.EXISTING BUILDINGS. These standards shall be applied to all currently	C 434		

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C 434	Continued From Page 2 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) 10. Electrical and Lighting. c. Plug adaptors and multiple outlets are prohibited.	C 434		