



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

C.L. "BUTCH" OTTER – Governor  
RICHARD M. ARMSTRONG – Director

TAMARA PRISOCK-- ADMINISTRATOR  
DIVISION OF LICENSING & CERTIFICATION  
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 16, 2016

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

Provider #: 135080

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

Dear Mr. Burt:

On **December 6, 2016**, a Facility Fire Safety and Construction survey was conducted at **Grangeville Health & Rehabilitation Center** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided 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

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you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office. If a State Form with deficiencies was issued, it should be signed, dated and returned along with the CMS-2567 Form.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **December 29, 2016**. Failure to submit an acceptable PoC by **December 29, 2016**, may result in the imposition of civil monetary penalties by **January 18, 2017**.

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. If a State Form was issued as well, it should also be signed, dated and returned.

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 10, 2017**, (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 10, 2017**. A change in the seriousness of the deficiencies on **January 10, 2017**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **January 10, 2017**, includes the following:

Denial of payment for new admissions effective **March 6, 2017**.  
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 6, 2017**, 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 Nate Elkins, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, option 3; 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 6, 2016**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

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<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

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

BFS Letters (06/30/11)

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

This request must be received by **December 29, 2016**. If your request for informal dispute resolution is received after **December 29, 2016**, 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, option 3.

Sincerely,



Nate Elkins, Supervisor  
Facility Fire Safety and Construction

NE/lj  
Enclosures

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

Printed: 12/15/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135080</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - ENTIRE BUILDING</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/06/2016</b>
NAME OF PROVIDER OR SUPPLIER <b>GRANGEVILLE HEALTH &amp; REHABILITATION C</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>410 EAST NORTH SECOND STREET GRANGEVILLE, ID 83530</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS  The facility is a single story, Type V(111) fully sprinklered structure built in 1967. It has smoke detection throughout corridors and open spaces. Currently the facility is licensed for 60 SNF/NF beds.  The following deficiencies were cited during the annual fire/life safety survey conducted on December 6, 2016. The facility was surveyed under the LIFE SAFETY CODE, 2012 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 submitted as required under Federal and State regulations and statutes applicable to skilled nursing facilities. This plan of correction does not constitute an admission of liability, and such liability is hereby specifically denied. The submission of this plan does not constitute agreement by the facility that the surveyor's conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied."	
K 100 SS=E	NFPA 101 General Requirements - Other  General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure the smoke and fire resistive properties of the structure were maintained. Failure to seal penetrations in walls and ceilings would allow smoke, fire and dangerous gases to pass between compartments, allowing fires to grow beyond incipient stages. This deficient practice affected residents, staff and visitors using the dining room on the date of the survey. The facility is licensed for 60 SNF/NF beds and had a census of 48 on the day of the survey.	K 100	Please accept this plan of correction as our credible allegation of compliance  K 100  Resident Specific:  Please see systemic changes.  Other Residents:  Please see systemic changes.	

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

TITLE

(X6) DATE

12/28/16

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 100	Continued From page 1  Findings include:  During the facility tour conducted on December 6, 2016 from approximately 10:00 AM to 3:00 PM, observation of the facility structure revealed the following:  Smoke barrier in the attic above the Kitchen/Dining revealed a two foot by four foot hole was broken through the barrier. The ceiling of the IT closet inside the Director of Nursing office revealed an approximately two (2) inch bundle of cabling passing into the attic space above through an unsealed penetration. The ceiling area of the cabinet housing the anti-freeze sprinkler loop riser in the main dining room revealed the annular space around the riser pipe entering the ceiling was unsealed.  Interview of the Maintenance Tech revealed he was not aware of these unsealed penetrations.  Actual NFPA standard:  8.4.4 Penetrations. The provisions of 8.4.4 shall govern the materials and methods of construction used to protect through-penetrations and membrane penetrations of smoke partitions.  8.4.4.1 Penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a smoke partition shall be protected by a system or material that is capable of limiting the transfer of smoke.	K 100	Systemic Changes:  This deficiency affected all residents, staff and visitors who use the dining room on a daily basis. To correct this we have hired a contractor that will repair the two foot by four foot hole located in the barrier in the attic. Additionally, the two inch bundle of cabling passing into the attic space from the DON office and also the ceiling area of the cabinet housing the anti-freeze sprinkler will be sealed with fire caulking.  Monitors:  The administrator or designee will perform monthly rounds times four to ensure there are no unsealed penetrations in the facility. The administrator will report findings at the QA meeting and make changes to the above plan of correction as needed.  Date of Compliance: January 10, 2017	
K 200 SS=F	NFPA 101 Means of Egress Requirements - Other	K 200		

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K 200	<p>Continued From page 2</p> <p>Means of Egress Requirements - Other List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 18.2, 19.2</p> <p>This Standard is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure that fire rated assemblies were inspected in accordance with NFPA 80. Failure to inspect and test fire rated doors could result in a lack of system performance as designed. This deficient practice affected 29 residents, staff and visitors on the date of the survey. The facility is licensed for 60 SNF/NF beds and had a census of 32 on the day of the survey.</p> <p>Findings include:</p> <p>1) During review of provided facility annual inspection records conducted on December 6, 2016 from approximately 9:00 AM to 10:00 AM, no record was available demonstrating any initial or annual inspection and testing indicating type and function of fire rated door assemblies had been conducted.</p> <p>2) During the facility tour conducted on December 6, 2016 from approximately 10:00 AM to 3:30 PM, observation of smoke barrier doors revealed the installed fire labels had been painted over and were no longer visible.</p>	K 200	<p>K 200</p> <p>Resident Specific:</p> <p>Please see systemic changes.</p> <p>Other Residents:</p> <p>Please see systemic changes.</p> <p>Systemic Changes:</p> <p>This deficiency affected 29 residents on the day of survey. To protect these residents and all other residents in the facility, we will inspect all fire rated doors annually and will document the findings. Additionally, the paint has been removed from the labels on the fire doors and they are now visible.</p> <p>Monitors:</p> <p>The administrator or designee will perform monthly rounds times four to ensure that all fire rated doors labels are visible, also the administrator or designee will inspect all fire rated doors in the facility and will document those findings.</p>	

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K 200	Continued From page 3  3) During the facility tour conducted on December 6, 2016 from approximately 10:00 AM to 3:30 PM, observation of doors entering the attic space from the 300 hall Housekeeping storage; Laundry room and Business office revealed the doors were labeled at 1-1/2 hours fire resistive. Interview of the Maintenance Tech indicated he was not aware of the requirement to inspect and test these assemblies annually.  Actual NFPA standard:  NFPA 101  19.2 Means of Egress Requirements 19.2.2.2 Doors. 19.2.2.2.1 Doors complying with 7.2.1 shall be permitted.  7.2.1 Door Openings. 7.2.1.15 Inspection of Door Openings. 7.2.1.15.1* Where required by Chapters 11 through 43, the following door assemblies shall be inspected and tested not less than annually in accordance with 7.2.1.15.2 through 7.2.1.15.8: (1) Door leaves equipped with panic hardware or fire exit hardware in accordance with 7.2.1.7 (2) Door assemblies in exit enclosures (3) Electrically controlled egress doors (4) Door assemblies with special locking arrangements subject to 7.2.1.6  7.2.1.15.2 Fire-rated door assemblies shall be inspected and tested in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Smoke door assemblies shall be inspected and tested in accordance with NFPA 105, Standard for Smoke Door Assemblies and Other Opening Protectives.	K 200	The administrator will report findings at the QA meeting and make changes to the above plan of correction as needed.  Date of Compliance: January 10, 2017	

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K 200	Continued From page 4	K 200		
K 353 SS=F	<p>NFPA 80 5.2* Inspections. 5.2.1* Fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ.</p> <p>NFPA 101 Sprinkler System - Maintenance and Testing</p> <p>Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This Standard is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure that fire suppression systems were maintained in accordance to NFPA 25. Failure to maintain fire suppression sprinkler systems could result in a lack of system performance during a fire event. This deficient practice affected 48 residents, staff and visitors on the date of the survey. The facility is licensed for 60 SNF/NF beds and had a census of 48 on the day of the survey.</p>	K 353	<p>K 353</p> <p>Resident Specific:</p> <p>Please see systemic changes.</p> <p>Other Residents:</p> <p>Please see systemic changes.</p> <p>Systemic Changes:</p> <p>This deficiency affected all residents, visitors and staff in the facility. To protect our residents, visitors and staff we have hired a contractor that will replace the 5 sprinkler heads that were found to be corroded and 2 sprinkler heads that were found to be painted. Additionally the anti-freeze will be replaced with an appropriate pre-mixed glycerin solution.</p> <p>Monitors:</p> <p>Administrator or designee will perform monthly rounds times four to ensure that all sprinkler heads are without corrosion or paint. Sprinkler tech will test</p>	

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K 353	Continued From page 5  Findings include:  1) During review of facility fire suppression system inspection records dated December 6, 2016 from approximately 9:00 AM to 10:00 AM, records provided indicated the anti-freeze area of the annual report from March 10, 2016 indicated "NA" (not applicable) in the area where required indicating if the anti-freeze solution having been tested.  2) During review of facility fire suppression system inspection records provided on December 6, 2016 from approximately 9:00 AM to 10:00 AM, review of a fire suppression system inspection report provided from December 22, 2015 indicated the anti-freeze solution in the system was 50%, but no indication as to what type of anti-freeze was installed.  3) During the facility tour conducted on December 6, 2016 from approximately 10:00 AM to 3:00 PM, observation of the installed fire suppression system revealed the following:  The identified anti-freeze loop was marked with an inspection tag dated December 22, 2015 and indicated a 50% anti-freeze concentration, but no information attached to the riser as to what type of anti-freeze was installed or indicating at which points of the system the anti-freeze concentration was tested.  Inspection of the main riser located in the boiler room revealed only eight (8) sprinkler pendants were available in the spare sprinkler box which was on the floor of the room. Further inspection revealed only one style of fusible-link type pendants was available.  Observation of installed sprinkler pendants	K 353	annually the anti-freeze levels in the sprinkler system. Administrator will report findings at QA and make changes to the above plan of correction as needed.  Date of Compliance: January 10, 2017	

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K 353	<p>Continued From page 6</p> <p>revealed a painted head in the Lobby; painted head in Central Supply; Four (4) corroded heads in the 100 hall tub room and a corroded head in the janitor's closet of the service corridor by the Kitchen.</p> <p>Interview of the Maintenance Tech indicated he was not aware of the fire suppression system deficiencies prior to the date of the survey. When asked as to the type of anti-freeze solution in the system and when the system was last fully drained, the Maintenance Tech stated he did not know what type of anti-freeze was installed and believed it was drained fully on the last service.</p> <p>Actual NFPA standard:</p> <p>NFPA 25 2011 Edition</p> <p>5.2* Inspection. 5.2.1 Sprinklers. 5.2.1.1* Sprinklers shall be inspected from the floor level annually.</p> <p>5.2.1.1.1* Sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., upright, pendent, or sidewall).</p> <p>5.2.1.1.2 Any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical damage (4) Loss of fluid in the glass bulb heat responsive element (5)*Loading (6) Painting unless painted by the sprinkler</p>	K 353		

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K 353	<p>Continued From page 7 manufacturer</p> <p>5.4.1.4* A supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have operated or been damaged in any way can be promptly replaced.</p> <p>5.4.1.5 The stock of spare sprinklers shall include all types and ratings installed and shall be as follows: (1) For protected facilities having under 300 sprinklers - no fewer than 6 sprinklers (2) For protected facilities having 300 to 1000 sprinklers - no fewer than 12 sprinklers (3) For protected facilities having over 1000 sprinklers - no fewer than 24 sprinklers</p> <p>5.4.1.4.1 The sprinklers shall correspond to the types and temperature ratings of the sprinklers in the property.</p> <p>5.4.1.4.2 The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100°F (38°C).</p> <p>NFPA 25 2011 Edition TIA 11-1</p> <p>5.3.4.1 The use of antifreeze solutions shall be in conformity with state and local health regulations.</p> <p>5.3.4.1.1* Listed CPVC sprinkler pipe and fittings shall be protected from freezing with glycerin only. The use of diethylene, ethylene, or propylene glycols shall be specifically prohibited.</p> <p>5.3.4.2* Antifreeze solutions shall comply with one of the following: (1) The concentration of a glycerin solution</p>	K 353		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135080</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/06/2016</b>
NAME OF PROVIDER OR SUPPLIER <b>GRANGEVILLE HEALTH &amp; REHABILITATION C</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>410 EAST NORTH SECOND STREET GRANGEVILLE, ID 83530</b>	
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K 353	Continued From page 8 measured in an existing system shall be limited to 50% by volume. (2) Newly introduced solutions shall be factory premixed antifreeze solutions of glycerin (chemically pure or United States Pharmacopoeia 96.5%) at a maximum concentration of 48% by volume. (3) The concentration of a propylene glycol solution measured in an existing system shall be limited to 40% by volume. (4) Newly introduced solutions shall be factory premixed antifreeze solutions of propylene glycol (chemically pure or United States Pharmacopoeia 96.5%) at a maximum concentration of 38% by volume. (5) Other solutions listed specifically for use in fire protection systems.  5.3.4.3 The antifreeze solution shall be tested at its most remote portion and where it interfaces with the wet pipe system.	K 353		
K 364 SS=D	NFPA 101 Corridor - Openings  Corridor - Openings Transfer grilles are not used in corridor walls or doors. Auxiliary spaces that do not contain flammable or combustible materials are permitted to have louvers or be undercut. In other than smoke compartments containing patient sleeping rooms, miscellaneous openings are permitted in vision panels or doors, provided the openings per room do not exceed 20 square inches and are at or below half the distance from floor to ceiling. In sprinklered rooms, the openings per room do not exceed 80 square inches. Vision panels in corridor walls or doors shall be fixed window assemblies in approved frames. (In fully sprinklered smoke compartments, there are no restrictions in the area and fire resistance of glass and frames.)	K 364	K 364  Resident Specific:  Please see systemic changes.  Other Residents:  Please see systemic changes.  Systemic Changes:  This deficiency affected all residents, visitors and staff. To protect our residents, visitors and staff, the holes drilled through the wall into the laundry room have been sealed.  Monitors:  Administrator or designee will perform monthly rounds times four to ensure corridor wall integrity throughout the facility. Administrator will report findings at QA and make changes to the above plan of correction as needed.  Date of Compliance: January 10, 2017	

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K 364	Continued From page 9 18.3.6.5.1, 19.3.6.5.2, 8.3 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that transfer grilles were not created or installed in corridor walls. Failure to maintain corridor wall integrity could allow smoke and dangerous gases to pass into corridors affecting egress during a fire. This deficient practice affected staff and visitors on the date of the survey. The facility is licensed for 60 SNF/NF beds and had a census of 48 on the day of the survey.  Findings include:  During the facility tour conducted on December 6, 2016 from approximately 1:00 PM to 3:00 PM, observation of the corridor wall outside the main Laundry revealed approximately nine holes drilled through the wall into the Laundry from behind a computer time-clock, which appeared to be used to transfer air from the Laundry room to cool the computer unit.  When asked when these holes were installed, the Housekeeping staff stated they were installed approximately one to two months prior to the survey at the time the time clock was installed.  Actual NFPA standard:  19.3.6.4 Transfer Grilles. 19.3.6.4.1 Transfer grilles, regardless of whether they are protected by fusible link-operated dampers, shall not be used in corridor walls or doors.	K 364		
K 372 SS=D	NFPA 101 Subdivision of Building Spaces - Smoke Barrie  Subdivision of Building Spaces - Smoke Barrier	K 372		

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K 372	<p>Continued From page 10</p> <p><b>Construction</b> <b>2012 EXISTING</b> Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This Standard is not met as evidenced by: Based on observation and operational testing, the facility failed to ensure that smoke barrier doors would fully self-close and resist the passage of smoke as designed. Smoke compartment doors which do not resist the passage of smoke could allow smoke and byproducts of combustion to pass between compartments during a fire. This deficient practice affected 7 residents, staff and visitors in the 100 hall and 1 of 3 identified smoke compartments in the attic. The facility is licensed for 60 SNF/NF beds and had a census of 48 on the day of the survey.</p> <p>Findings include:</p> <p>1) During an above the ceiling inspection of the attic conducted on December 6, 2016 from approximately 2:30 PM to 3:30 PM, observation revealed a self-closing door installed in a dual-layered, sheetrocked truss above the Dining room. Operational testing of this door revealed the door would not fully self-close when activated and left a gap of approximately one inch between the face of the door and the leading edge of the sheetrocked truss.</p>	K 372	<p><b>K 372</b></p> <p><b>Resident Specific:</b></p> <p>Please see systemic changes.</p> <p><b>Other Residents:</b></p> <p>Please see systemic changes.</p> <p><b>Systemic Changes:</b></p> <p>This deficiency affected seven identified residents on the day of survey. To protect these seven residents and additionally all of our residents in the facility, we have hired a contractor that will re-run the data cable so that it will not interfere with the fire door. Additionally, the facility has fixed the gap at the bottom of the 100 hall fire door.</p> <p><b>Monitors:</b></p> <p>Administrator or designee will perform monthly rounds times four to ensure all self-closing doors are working properly. Additionally, will perform monthly rounds to ensure there is no more</p>	

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K 372	Continued From page 11 Further observation revealed an approximately two (2) inch gap along the width of the bottom of the door. This opening appeared to be used as a data cable raceway.  2) During the facility tour conducted on December 6, 2016 from approximately 10:00 AM to 2:30 PM, observation and operational testing of the 100 hall smoke barrier doors revealed an approximately 1-1/2 inch to 2 inch gap from the bottom of the doors to the flooring when activated.  Actual NFPA standard:  8.5.4 Opening Protectives. 8.5.4.1* Doors in smoke barriers shall close the opening, leaving only the minimum clearance necessary for proper operation, and shall be without louvers or grilles. The clearance under the bottom of a new door shall be a maximum of 3/4 in. (19 mm).	K 372	than a 3/4 inch gap at the bottom of the fire doors when activated. Administrator will report findings at QA and make changes to the above plan of correction as needed.  Date of Compliance: January 10, 2017	
K 511 SS=E	NFPA 101 Utilities - Gas and Electric  Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2  This Standard is not met as evidenced by: Based on observation and interview, the facility failed to provide safe electrical installations in accordance with NFPA 70. Failure to provide safe electrical connections and labeling, exposes	K 511		

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K 511	<p>Continued From page 12</p> <p>users to potential electrical shock. This deficient practice affected staff needing access to electrical panels and residents, staff and visitors utilizing the tub room in the 100 hall on the date of the survey. The facility is licensed for 60 SNF/NF beds and had a census of 48 on the day of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on December 6, 2016 from approximately 10:00 AM to 3:30 PM, the following deficiencies were observed in the facility electrical panels:</p> <p>Breakers labeled 7, 17, 24 in the Kitchen breaker panel were not labeled. Breakers labeled 19 and 23 in the Soiled Linen Room breaker panel were not labeled. Breaker panel "B" missing cover for empty breaker knockout, exposing wiring inside.</p> <p>2) During the facility tour conducted on December 6, 2016 from approximately 10:00 AM to 3:23 PM, observation of the service corridor revealed wires for newly installed computer time clock ran through the wall into Laundry room and connected to the outlet</p> <p>3) During the facility tour conducted on December 6, 2016 from approximately 10:00 AM to 3:23 PM, observation of the 100 hall tub room revealed a relocatable power tap used for supplying power to fan. Further observation revealed this was not a connection rated for a wet environment. Interview of the Maintenance Tech and Director of Nursing indicated both were aware this installation was not allowed.</p> <p>Actual NFPA standard:</p>	K 511	<p>K 511</p> <p>Resident Specific:</p> <p>Please see systemic changes.</p> <p>Other Residents:</p> <p>Please see systemic changes.</p> <p>Systemic Changes:</p> <p>This deficiency affected all residents in the facility. To protect our residents that facility has correctly labeled all breakers in the facility. The relocatable power tap in the 100 hall tub room has been removed and an outlet has been installed. The relocatable power tap in the laundry room has been removed and an outlet has been installed, additionally the power chord from the time clock that ran through the wall into the laundry room has been sealed and plugged into the newly installed outlet.</p> <p>Monitors:</p> <p>Administrator or designee will</p>	

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K 511	Continued From page 13  NFPA 70 110.22 Identification of Disconnecting Means. (A) General. Each disconnecting means shall be legibly marked to indicate its purpose unless located and arranged so the purpose is evident. The marking shall be of sufficient durability to withstand the environment involved.  110.27 Guarding of Live Parts. (A) Live Parts Guarded Against Accidental Contact. Except as elsewhere required or permitted by this Code, live parts of electrical equipment operating at 50 volts or more shall be guarded against accidental contact by approved enclosures or by any of the following means: (1) By location in a room, vault, or similar enclosure that is accessible only to qualified persons. (2) By suitable permanent, substantial partitions or screens arranged so that only qualified persons have access to the space within reach of the live parts. Any openings in such partitions or screens shall be sized and located so that persons are not likely to come into accidental contact with the live parts or to bring conducting objects into contact with them. (3) By location on a suitable balcony, gallery, or platform elevated and arranged so as to exclude unqualified persons. (4) By elevation of 2.5 m (8 ft) or more above the floor or other working surface.  400.3 Suitability. Flexible cords and cables and their associated fittings shall be suitable for the conditions of use and location.  400.8 Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall	K 511	perform monthly rounds times four to ensure no relocatable power taps are used in a wet environment, and that all breakers are correctly labeled in the facility. Administrator will report findings at QA and make changes to the above plan of correction as needed.  Date of Compliance: January 10, 2017	

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K 511	Continued From page 14 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 to (4): Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of 368.56(B) (5) Where concealed by walls, floors, or ceilings or located above suspended or dropped ceilings (6) Where installed in raceways, except as otherwise permitted in this Code (7) Where subject to physical damage	K 511		

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C 000	16.03.02 INITIAL COMMENTS  The facility is a single story type V (111) building with a small basement which includes a maintenance shop and boiler room. The facility is protected by a complete sprinkler system and was built in 1969. The fire alarm system was replaced in 2001. Currently the facility is licensed for 60 beds.  The following deficiencies were cited during the annual life safety code survey conducted on December 6, 2016. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70 and IDAPA 16.03.02, Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities.  The Survey was conducted by:  Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	C 000		
C 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: Refer to federal tags on CMS 2567:  K-161 Building construction	C 226	C 226  Please see POC for tags K 100, K 200, K 353, K 364, K 372 and K 511.  Date of Compliance: January 10, 2017	

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(X6) DATE  
**12/28/16**

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C 226	Continued From Page 1  K-200 Means of Egress K-353 Sprinkler Maintenance K-364 Transfer Grilles K-372 Smoke Barrier Construction K-511 Electrical Installations	C 226	C 419  Resident Specific:  Please see systemic changes.	
C 419	02.120,05,p,iv  iv. All inside bathrooms and toilet rooms shall have forced ventilation to the outside. This Rule is not met as evidenced by: Based on observation and interview the facility failed to ensure ventilation for bathrooms exhausted to the exterior of the building. Ducting moist, humid air into attic spaces could result in bio-organic material deposits above the ceiling of the facility. This deficient practice affected residents, staff and visitors on the date of the survey. The facility is licensed for 60 SNF/NF beds and had a census of 48 on the day of the survey.  Findings include:  During the facility tour conducted on December 6, 2016 from approximately 2:30 PM to 3:30 PM, and above the ceiling inspection in the attic revealed the bath fan installed in the 300 hall tub room was not vented to the exterior of the building, but discharging into the insulation.  When asked, the Maintenance Tech and the Director of Nursing stated they did not know of the deficiency prior to the survey and believed the lack of venting was due to the vendor not connecting the vents when the fans were installed.  Actual IDAPA standard:  IDAPA 16.03.02.120.05.p (iv)	C 419	Other Residents:  Please see systemic changes.  Systemic Changes:  This deficiency affected all residents in the facility, to protect our residents the facility has hired a contractor to properly vent the 300 hall tub room to the exterior of the building.  Monitors:  Administrator or designee will perform monthly rounds times four to ensure the tub rooms are vented correctly to the exterior of the facility and are working properly. Administrator will report findings at QA and make changes to the above plan of correction as needed.  Date of Compliance: January 10, 2017	

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C 419	Continued From Page 2  All inside bathrooms and toilet rooms shall have forced ventilation to the outside.	C 419		