



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

February 10, 2017

Darrin Radeke, Administrator
Mini-Cassia Care Center
PO Box 1224
Burley, ID 83318

Provider #: 135081

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

Dear Mr. Radeke:

On **February 1, 2017**, a Facility Fire Safety and Construction survey was conducted at **Mini-Cassia Care 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 **February 23, 2017**. Failure to submit an acceptable PoC by **February 23, 2017**, may result in the imposition of civil monetary penalties by **March 15, 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 **March 8, 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 **March 8, 2017**. A change in the seriousness of the deficiencies on **March 8, 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 **March 8, 2017**, includes the following:

Denial of payment for new admissions effective **May 1, 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 **August 1, 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 **February 1, 2017**, 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 **February 23, 2017**. If your request for informal dispute resolution is received after **February 23, 2017**, 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

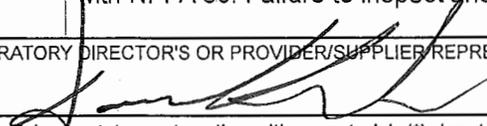
NE/lj
Enclosures

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

PRINTED: 02/10/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135081	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE BLDG-BEHAVIOR CARE UNIT B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2017
NAME OF PROVIDER OR SUPPLIER MINI-CASSIA CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1729 MILLER AVENUE BURLEY, ID 83318	
(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 (000) building built in 1974, and is currently licensed for 68 SNF/NF beds, with controlled access for clinical need. The building is covered by fire alarm/smoke detection and is fully sprinklered. There is a basement that houses the laundry, maintenance shop, break room central supply, and miscellaneous offices. The facility completed a cosmetic upgrades of floors and walls in 2001. The following deficiencies were cited during the annual fire/life safety survey conducted on February 1, 2017. 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: Linda Chaney Health Facility Surveyor Facility Fire Safety and Construction NFPA 101 Means of Egress - General	K 000		
K 211 SS=F	Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure fire rated assemblies that protect openings in walls were inspected in accordance with NFPA 80. Failure to inspect and test fire	K 211	K 211 The facility will ensure means of egress are maintained as evidenced by showing proof of fire rated assembly on fire rated doors in accordance with NFPA 80. All fire rated door will be inspected and tested for appropriate fire proof assembly using approved fire rated assembly checklist at least annually by the maintenance manager.	2/1/17

RECEIVED
FEB 23 2017
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE ADMINISTRATOR (X6) DATE 2/22/17

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 211	<p>Continued From page 1</p> <p>rated doors could result in a lack of system performance as designed. This deficient practice affected all residents, staff and visitors on the date of the survey. The facility is licensed for 68 SNF/NF beds and had a census of 51 on the day of the survey.</p> <p>Findings include:</p> <p>During record review on February 1, 2017, from approximately 9:30 AM to 11:00 PM, the facility was unable to produce documentation demonstrating an initial inspection and testing of the fire rated assemblies had been conducted. When asked about the missing documentation, the Maintenance Supervisor stated the facility was not aware of this requirement.</p> <p>Actual NFPA standard:</p> <p>NFPA 101</p> <p>19.2.1 General. Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7, unless otherwise modified by 19.2.2 through 19.2.11.</p> <p>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</p>	K 211	The documentation will be brought to the quality assurance committee monthly X 3 months to ensure that process is functioning properly.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 211	Continued From page 2 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. 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.	K 211			
K 325 SS=F	NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR) Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments	K 325	K 325 The facility will ensure that alcohol based hand rub dispensers are maintained as evidenced by showing inspection and testing of ABHR dispensers in accordance with NFPA 101. All dispensers will be labeled and monitored by the housekeeping supervisor on the Hand Sanitizer Check sheet. The documentation and process will be monitored by the quality assurance committee monthly X 3 months to ensure that process is functioning properly.	2/3/17	

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K 325	<p>Continued From page 3</p> <p>* ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485</p> <p>This STANDARD is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure automatic operated Alcohol Based Hand Rub Dispensers (ABHR) were maintained in accordance with NFPA 101. Failure to test and document the operation of automatic dispensing ABHR dispensers could result in inadvertently spilling flammable liquids increasing the risk of fires. This deficient practice affected 51 residents, staff and visitors on the date of the survey. The facility is licensed for 68 SNF/NF residents and had a census of 51 on the day of the survey.</p> <p>Findings include:</p> <p>During the review of facility inspection records on February 1, 2017, from approximately 9:30 AM to 11:00 AM, no records were available indicating inspection and testing of ABHR dispensers was performed when refilling dispensers in accordance with manufacturer's care and use instructions. Further observation revealed a total of thirty four (34) automatic dispensers installed throughout the facility.</p> <p>Actual NFPA standard:</p> <p>NFPA 101</p> <p>19.3.2.6* Alcohol-Based Hand-Rub Dispensers. Alcohol-based hand-rub dispensers shall be protected in accordance with</p>	K 325		

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K 325	<p>Continued From page 4</p> <p>8.7.3.1, unless all of the following conditions are met:</p> <p>(1) Where dispensers are installed in a corridor, the corridor shall have a minimum width of 6 ft (1830 mm).</p> <p>(2) The maximum individual dispenser fluid capacity shall be as follows:</p> <p>(a) 0.32 gal (1.2 L) for dispensers in rooms, corridors, and areas open to corridors</p> <p>(b) 0.53 gal (2.0 L) for dispensers in suites of rooms</p> <p>(3) Where aerosol containers are used, the maximum capacity of the aerosol dispenser shall be 18 oz. (0.51 kg) and shall be limited to Level 1 aerosols as defined in NFPA30B, Code for the Manufacture and Storage of Aerosol Products.</p> <p>(4) Dispensers shall be separated from each other by horizontal spacing of not less than 48 in. (1220 mm).</p> <p>(5) Not more than an aggregate 10 gal (37.8 L) of alcohol-based hand-rub solution or 1135 oz (32.2 kg) of Level 1 aerosols, or a combination of liquids and Level 1 aerosols not to exceed, in total, the equivalent of 10 gal (37.8 L) or 1135 oz (32.2 kg), shall be in use outside of a storage cabinet in a single smoke compartment, except as otherwise provided in 19.3.2.6(6).</p> <p>(6) One dispenser complying with 19.3.2.6 (2) or (3) per room and located in that room shall not be included in the aggregated quantity addressed in 19.3.2.6(5).</p> <p>(7) Storage of quantities greater than 5 gal (18.9 L) in a single smoke compartment shall meet the requirements of NFPA 30, Flammable and Combustible Liquids Code.</p>	K 325		

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K 325	Continued From page 5 (8) Dispensers shall not be installed in the following locations: (a) Above an ignition source within a 1 in. (25 mm) horizontal distance from each side of the ignition source (b) To the side of an ignition source within a 1 in. (25mm) horizontal distance from the ignition source (c) Beneath an ignition source within a 1 in. (25 mm) vertical distance from the ignition source (9) Dispensers installed directly over carpeted floors shall be permitted only in sprinklered smoke compartments. (10) The alcohol-based hand-rub solution shall not exceed 95 percent alcohol content by volume. (11) Operation of the dispenser shall comply with the following criteria: (a) The dispenser shall not release its contents except when the dispenser is activated, either manually or automatically by touch-free activation. (b) Any activation of the dispenser shall occur only when an object is placed within 4 in. (100 mm) of the sensing device. (c) An object placed within the activation zone and left in place shall not cause more than one activation. (d) The dispenser shall not dispense more solution than the amount required for hand hygiene consistent with label instructions. (e) The dispenser shall be designed, constructed, and operated in a manner that ensures that accidental or malicious activation of the dispensing device is minimized. (f) The dispenser shall be tested in accordance with the manufacturer ' s care and use instructions each time a new refill is installed.	K 325		
K 363	NFPA 101 Corridor - Doors	K 363		

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K 363 SS=E	Continued From page 6 Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is not met as evidenced by: Based on observation, operational testing, and interview the facility failed to maintain doors that protect corridor openings. Failure to maintain	K 363	K 363 The facility will ensure that corridor doors will resist smoke and dangerous gases from passing freely and allowing defend in place practice by maintaining doors on a monthly basis and ensuring inspection in accordance with NFPA 101. Rooms 23, 24, 25, 27, 29, and 33 have had the gaps closed, and rooms 11 and 23 have been adjusted to ensure proper latching. Corridor doors will be checked and adjusted to ensure proper latching by the facility maintenance manger on monthly facility rounding sheet. The documentation will be brought to the quality assurance committee monthly X 3 months to ensure that process is functioning properly.	2/3/17

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K 363	<p>Continued From page 7</p> <p>corridor doors could allow smoke and dangerous gases to pass freely, preventing defend in place. This deficient practice has the potential to affect 30 residents, staff, and visitors on the date of survey. The facility is licensed for 68 SNF/NF beds with a census of 51 on the day of survey.</p> <p>Findings include:</p> <p>During the facility tour on February 1, 2017, from approximately 11:00 AM to 2:30 PM, observation and operational testing of the corridor doors to the following resident rooms revealed gaps at the top of the doors approximately 1/2" that would not resist the passage of smoke when fully closed:</p> <ul style="list-style-type: none"> a. Room 23 b. Room 24 c. Room 25 d. Room 27 e. Room 29 f. Room 33 <p>Further observation and operational testing, revealed the doors to resident rooms 11 and 23 would not latch. When asked, the Maintenance Supervisor stated the facility was unaware of the door gaps, and the doors that would not latch.</p> <p>Actual NFPA Standards:</p> <p>NFPA 101</p> <p>19.3.6.3* Corridor Doors. 19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be doors constructed to resist the passage of smoke and shall be constructed of materials such as the following: (1) 1 3/4 in. (44 mm) thick, solid-bonded core</p>	K 363		

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K 363	Continued From page 8 wood (2) Material that resists fire for a minimum of 20 minutes 19.3.6.3.5* Doors shall be provided with a means for keeping the door closed that is acceptable to the authority having jurisdiction, and the following requirements also shall apply: (1) The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. (2) Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.7.	K 363		
K 916 SS=F	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the EES (Essential Electrical System) was installed in accordance with NFPA 99. Failure to provide an alarm annunciator for the EES could hinder early notification of equipment failures, leaving the facility without emergency power during an outage. This deficient practice affected all residents, staff and	K 916	K 916 The facility will ensure that a remote annunciator is installed in accordance with NFPA 70 electrical code. The installation process will be monitored by the quality assurance committee monthly X 3 months to ensure that we are on schedule for a completely functional system within the 70 days provided.	2/1/17

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135081	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE BLDG-BEHAVIOR CARE UNIT B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2017	
NAME OF PROVIDER OR SUPPLIER MINI-CASSIA CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1729 MILLER AVENUE BURLEY, ID 83318		
(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 916	<p>Continued From page 9</p> <p>visitors on the date of the survey. The facility is licensed for 68 SNF/NF beds and had a census of 51 on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour on February 1, 2017 from approximately 11:00 AM to 2:30 PM, observation of all of the work stations inside the facility, did not reveal an alarm annunciator for the EES. When asked, the Maintenance Supervisor stated that the facility was aware that they did not have a generator annunciator, and a new generator had been ordered for the facility and would be installed with an annunciator.</p> <p>Actual NFPA standard:</p> <p>NFPA 99 Chapter 6 Electrical Systems 6-4 Essential Electrical System Requirements - Type 1. 6.4.1.1.17 Alarm Annunciator. A remote annunciator that is storage battery powered shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station (see 700.12 of NFPA 70, National Electrical Code). The annunciator shall be hard-wired to indicate alarm conditions of the emergency or auxiliary power source as follows: (1) Individual visual signals shall indicate the following: (a) When the emergency or auxiliary power source is operating to supply power to load (b) When the battery charger is malfunctioning (2) Individual visual signals plus a common audible signal to warn of an engine generator alarm condition shall indicate the following:</p>	K 916		

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K 916	Continued From page 10 (a) Low lubricating oil pressure (b) Low water temperature (below that required in 6.4.1.1.11) (c) Excessive water temperature (d) Low fuel when the main fuel storage tank contains less than a 4-hour operating supply (e) Overcrank (failed to start) (f) Overspeed	K 916		