



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

March 7, 2017

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 **February 28, 2017**, 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. 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 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

Lori Bentzler, Administrator  
March 7, 2017  
Page 2 of 4

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 **March 20, 2017**. Failure to submit an acceptable PoC by **March 20, 2017**, may result in the imposition of civil monetary penalties by **April 9, 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 **April 4, 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 **April 4, 2017**. A change in the seriousness of the deficiencies on **April 4, 2017**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **April 4, 2017**, includes the following:

Lori Bentzler, Administrator  
March 7, 2017  
Page 3 of 4

Denial of payment for new admissions effective **May 28, 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 28, 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 28, 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:

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

Lori Bentzler, Administrator  
March 7, 2017  
Page 4 of 4

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

BFS Letters (06/30/11)

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

This request must be received by **March 20, 2017**. If your request for informal dispute resolution is received after **March 20, 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: 03/06/2017  
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  02/28/2017
NAME OF PROVIDER OR SUPPLIER  TWIN FALLS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 674 EASTLAND DRIVE TWIN FALLS, ID 83301	
(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) structure, comprised of six (6) smoke compartments, built in 1987. Primary heating is achieved through a boiler system, with supplemental heating provided by cadet heaters. 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 February 28, 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	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 deficiencies 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 deficiencies.”	
K 161 SS=D	NFPA 101 Building Construction Type and Height  Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5  Construction Type 1 I (442), I (332), II (222) Any number of stories  non-sprinklered and sprinklered	K 161	RECEIVED MAR 17 2017 FACILITY STANDARDS	

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

*Linda Chaney*

TITLE

Center Executive Director

(X6) DATE

3/15/17

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135104</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/28/2017</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>TWIN FALLS CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>674 EASTLAND DRIVE TWIN FALLS, ID 83301</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 161	Continued From page 1  2 II (111) One story non-sprinklered sprinklered Maximum 3 stories  3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111)  7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. 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 maintain the fire resistive properties of the structure by sealing penetrations in walls and ceilings, could result in fire and smoke passing between compartments during a fire event. This deficient practice affected 18 residents, staff and visitors on the date of the survey. The facility is licensed for 116 SNF/NF beds and had a census of 74 on the day of the survey.	K 161	<b><u>K161</u></b>  <b><u>Specific Residents Identified</u></b>  The attic access door in the soiled linen room next to the maintenance shop was replaced with a new door that meets the requirements of the NFPA code on or before 4/3/17.  The 2 holes in the wall and 1 hole in the ceiling in the phone room were sealed with fireproof drywall by the Maintenance Supervisor on or before 4/3/17. The pipe passing through the ceiling in the phone room was sealed with fireproof drywall by the Maintenance Supervisor on or before 4/3/17.  The bundles of cabling passing through the ceiling into the attic space in the copy room were sealed with fireproof drywall by the Maintenance Supervisor on or before 4/3/17.  <b><u>Identification of Other Residents</u></b>  An above the ceiling inspection of the facility was completed on or before 4/3/17 by the Maintenance Supervisor to identify any unsealed penetrations in the smoke barrier walls. Any	
-------	--	-------	--	--

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  02/28/2017
NAME OF PROVIDER OR SUPPLIER  TWIN FALLS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 674 EASTLAND DRIVE TWIN FALLS, ID 83301		
(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 161	Continued From page 2  Findings include:  During the facility tour on February 28, 2017, from approximately 10:30 AM to 1:00 PM, observation revealed the following penetrations: 1.) The soiled linen room next to the maintenance shop had approximately sixty one (61), one inch holes drilled into the attic access door in the ceiling. 2.) The phone room had an approximately 2-1/2" x 4" hole in the wall, an approximately 1/2" hole in the ceiling and a pipe penetrating the ceiling in which the annular space around the pipe was not sealed. 3.) The ceiling of the copy room revealed bundles of cabling passing through the ceiling into the attic space above through unsealed penetrations.  When asked, the Maintenance Supervisor stated he had just noticed the attic access door and had planned to replace the board with the holes with a solid board. However, he was unaware of the other penetrations.  Actual NFPA standard:  19.1.6 Minimum Construction Requirements. 19.1.6.1 Health care occupancies shall be limited to the building construction types specified in Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7. (See 8.2.1.)  8.2 Construction and Compartmentation. 8.2.1 Construction. 8.2.1.1 Buildings or structures occupied or used in accordance with the individual occupancy chapters, Chapters 11 through 43, shall meet the minimum construction requirements of those	K 161	findings were corrected by the Maintenance Supervisor by sealing the openings with fireproof drywall on or before 4/3/17. An environmental inspection was completed by the Maintenance Supervisor on or before 4/3/17 to identify any openings in the walls or ceilings in the facility. Any findings were corrected by the Maintenance Supervisor on or before 4/3/17.  <u>Systematic Changes</u>  The Maintenance Supervisor was re educated on or before 4/3/17 by the Center Executive Director regarding the requirement that any openings in the smoke barrier walls and ceilings must be sealed with fireproof material and that any holes/openings in the walls of the facility must be closed and sealed.  <u>Monitoring</u>  Starting the week of 4/4/17, the Maintenance Supervisor or designee 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		

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  02/28/2017
NAME OF PROVIDER OR SUPPLIER  TWIN FALLS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 674 EASTLAND DRIVE TWIN FALLS, ID, 83301	
(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 161 K 211 SS=F	Continued From page 3 chapters. NFPA 101 Means of Egress - General 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 18.2.1, 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 that smoke door assemblies were inspected in accordance with NFPA 105. Failure to inspect and test smoke doors, could result in a lack of system performance as designed which could hinder the safe evacuation of residents during a fire or other emergency. This deficient practice affected 74 residents, staff and visitors on the date of the survey. The facility is licensed for 116 SNF/NF beds and had a census of 74 on the day of the survey.  Findings include:  During record review on February 28, 2017, from approximately 9:00 AM to 10:30 AM, no record was available demonstrating an initial inspection and testing of smoke door assemblies. When asked about the missing documentation, the Maintenance Supervisor stated he was starting the process, but was not complete and did not have any documentation at this time.  Actual NFPA standard:  NFPA 101	K 161 K 211	week of 4/4/17, the Maintenance Supervisor or designee will complete environmental audits of the walls and ceilings 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 or ceilings 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.  <u>Date of Compliance</u>  4/3/17  <u>K211</u>  <u>Specific Residents Identified</u>  The smoke doors and assemblies in the facility have been tested and inspected by the Maintenance Supervisor on or before 4/3/17 to ensure that they meet NFPA guidelines. An initial record of this testing and inspection was completed by the Maintenance Supervisor on or before 4/3/17.	

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  02/28/2017
NAME OF PROVIDER OR SUPPLIER  TWIN FALLS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 674 EASTLAND DRIVE TWIN FALLS, ID 83301	
(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 211	Continued From page 4  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.  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.  NFPA 105 5.2 Specific Requirements. 5.2.1* Inspections. 5.2.1.1 Smoke door assemblies shall be inspected annually. 5.2.1.2 Doors shall be operated to confirm full closure. 5.2.1.3 Hardware and gaskets shall be inspected annually, and any parts found to be damaged or inoperative shall be replaced.	K 211	<b><u>Identification of Other Residents</u></b>  The smoke doors and assemblies in the facility have been tested and inspected by the Maintenance Supervisor on or before 4/3/17 to ensure that they meet NFPA guidelines. Any findings were corrected. The Maintenance Supervisor has a copy of this inspection.  <b><u>Systematic Changes</u></b>  The Maintenance Supervisor was educated on or before 4/3/17 by the Center Executive Director regarding the requirement that doors and assemblies need to be inspected and written documentation maintained of the inspection.	

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  02/28/2017
NAME OF PROVIDER OR SUPPLIER  TWIN FALLS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 674 EASTLAND DRIVE TWIN FALLS, ID 83301	
(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 K 916 SS-F	Continued From page 5 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 visitors on the date of the survey. The facility is licensed for 116 SNF/NF beds and had a census of 74 on the date of the survey.  Findings include:  During the facility tour conducted on February 28, 2017, from approximately 10:30 PM to 1:00 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 he was not aware of an alarm panel, or other device which would indicate the facility was under auxiliary power (generator) during a power outage.	K 916 K 916	<u>Monitoring</u>  Starting the week of 4/4/17 environmental rounds will be completed weekly x 4 weeks and then monthly for 2 months by the Maintenance Supervisor or designee to ensure smoke doors and assemblies meet NFPA requirements. 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>  4/3/17	

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  02/28/2017
NAME OF PROVIDER OR SUPPLIER  TWIN FALLS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 674 EASTLAND DRIVE TWIN FALLS, ID 83301	
(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)
K 916	<p>Continued From page 6 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: (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</p>	K 916	<p><b><u>K916</u></b></p> <p><b><u>Specific Residents Identified</u></b></p> <p>An alarm annunciator for the Essential Electric System has been installed at the main nurses station on or before 4/3/17. This alarm indicates when the facility is under auxiliary power.</p> <p><b><u>Identification of Other Residents</u></b></p> <p>The alarm annunciator panel has been installed at the main nurses station on or before 4/3/17. It has been tested and shows when the emergency generator is working and the facility is under auxiliary power.</p> <p><b><u>Systematic Changes</u></b></p> <p>The Maintenance Supervisor was educated by the Center Executive Director on or before 4/3/17 on the NFPA requirements for placement of a remote annunciator for the emergency generator that can be readily observed by facility staff .</p>

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

PRINTED: 03/06/2017  
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  02/28/2017
NAME OF PROVIDER OR SUPPLIER  TWIN FALLS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 674 EASTLAND DRIVE TWIN FALLS, ID 83301		
(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
			<p><b><u>Monitoring</u></b></p> <p>Starting the week of 4/4/17, environmental rounds will be completed weekly x 4 weeks and then monthly for two months to ensure that the annunciator panel is working when the generator is on and staff is able to observe the panel. 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><b><u>Date of Compliance</u></b></p> <p>4/3/17</p>	