



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

May 8, 2017

Brent Schneider, Administrator
Avamere Transitional Care & Rehabilitation - Boise
1001 South Hilton Street
Boise, ID 83705-1925

Provider #: 135077

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

Dear Mr. Schneider:

On **April 24, 2017**, a Facility Fire Safety and Construction survey was conducted at **Avamere Transitional Care & Rehab - Boise** 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 **May 22, 2017**. Failure to submit an acceptable PoC by **May 22, 2017**, may result in the imposition of civil monetary penalties by **June 7, 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 **May 29, 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 **May 29, 2017**. A change in the seriousness of the deficiencies on **May 29, 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 **May 29, 2017**, includes the following:

Denial of payment for new admissions effective **July 24, 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 **October 24, 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 **April 24, 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 **May 22, 2017**. If your request for informal dispute resolution is received after **May 22, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135077	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 04/24/2017
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NAME OF PROVIDER OR SUPPLIER AVAMERE TRANSITIONAL CARE & REHAB - BOISE	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The facility construction is Type V(111) and was built in 1978. It is fully sprinklered with a complete fire alarm/smoke detection system including smoke detection in sleeping rooms. The facility is currently licensed for 111 SNF/NF beds. The following deficiencies were cited during the annual fire/life safety survey conducted on April 24, 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 & Construction	K 000	This Plan of Correction is prepared and submitted as required by law. By submitting this plan of correction, Avamere Transitional Care and Rehab of Boise, does not admit that the deficiencies listed on Form CMS 2567 exist, nor does the Facility admit to any statements, binding, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, bindings, facts, and conclusions that form the basis for the deficiency.	135
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 sprinklered non-sprinklered and 2 II (111) One story non-sprinklered sprinklered Maximum 3 stories	K 161	*All penetrations noted have been filled. The Maintenance Director completed an inspection of the building and no other penetrations were found. No other residents are affected by this. The Maintenance Director will complete yearly inspections of the building to make sure no other penetrations exist. This inspection will be documented. The administrator will review the penetration inspection documentation to make sure it has been completed.	5/15/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 5-18-17
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135077	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 04/24/2017
NAME OF PROVIDER OR SUPPLIER AVAMERE TRANSITIONAL CARE & REHAB - BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705	
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K 161	Continued From page 1 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, 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 into walls, crawl spaces and attic spaces, could result in fire and smoke passing between compartments during a fire. This deficient practice affected 16 residents in the 100 Hallway, staff and visitors on the date of the survey. The facility is licensed for 111 SNF/NF beds and had a census of 66 on the day of the survey. Findings include: During the facility tour on April 24, 2017 from	K 161		

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K 161	Continued From page 2 approximately 11:00 AM to 3:00 PM, penetrations were observed in the following areas: 1.) The exterior hot water heater room on the back side of the 100 Hallway had approximately 3/4" to 1-1/2" annular spaces around four (4) pipes penetrating the wall and one (1) pipe penetrating the ceiling. 2.) The exterior hot water heater room by the laundry had an approximately 1" x 12" penetration in the floor around the pipes going into the crawl space. 3.) The exterior riser room had two (2), approximately 4" plastic conduits penetrating the ceiling with IT cables that were not properly sealed. 4.) Business Manager's office had penetrations around cables going through the wall. Actual NFPA standard: NFPA 101 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 chapters.	K 161		
K 211 SS=F	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges,	K 211	x The maintenance director will test and inspect all fire and smoke door assemblies during fire drills. The inspection will be documented on the fire drill inspection form.	5/15/17

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K 211	<p>Continued From page 3</p> <p>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</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure fire and smoke door assemblies were inspected in accordance with NFPA 80 and NFPA 105. Failure to inspect and test fire and smoke assemblies, could pose a greater life risk, and property damage due to fire. This deficient practice affected 66 residents, staff and visitors on the date of the survey. The facility is licensed for 111 SNF/NF beds and had a census of 66 on the day of the survey.</p> <p>Findings include:</p> <p>During record review on April 24, 2017, from approximately 8:00 AM to 11:00 AM, no record was available demonstrating an inspection and testing of fire and smoke door assemblies. When asked about the missing documentation, the Maintenance Supervisor stated the facility was unaware of the requirement for annual inspection and testing of fire and smoke door assemblies.</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>	K 211	<p>assemblies will be documented on the fire drill documentation form,</p> <p>The administrator will review all fire drill documentation forms and confirm the documentation of the fire and smoke door assemblies inspection</p>	

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K 211	<p>Continued From page 4</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 arrangements subject to 7.2.1.6</p> <p>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.</p> <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 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.</p>	K 211			

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K 222 K 222 SS=E	Continued From page 5 NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be	K 222 K 222	The exit door at the end of the X300 hall will be fixed to release and unlock without the wand/guard. All residents will be affected until this is corrected. This door and all other exit doors will be inspected quarterly to determine they unlock and allow egress. This inspection will be documented on the fire drill form. The administrator will Review all fire drill documentation forms and confirm the doors were inspected to determine they unlock and allow egress.	5/26/17	

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K 222	<p>Continued From page 6</p> <p>permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4</p> <p>ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4</p> <p>ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4</p> <p>This STANDARD is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure that special locking arrangements were in accordance with NFPA 101. Failure to provide operational locking arrangements for magnetically controlled means of egress, could hinder the evacuation of residents during a fire. This deficient practice affected 24 residents, staff and visitors on the date of the survey. The facility is licensed for 111 SNF/NF beds and had a census of 66 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on April 24, 2017, from approximately 11:00 AM to 3:00 PM, observation of the exit doors at the end of the 300</p>	K 222			

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K 222	<p>Continued From page 7</p> <p>hallway, revealed the doors were equipped with a Wanderguard magnetic locking arrangement. When operated without the Wanderguard, the door locks would not release and required special knowledge to egress. When asked, the Maintenance Supervisor and Administrator stated the facility was not aware the doors were not operational.</p> <p>Actual NFPA standard:</p> <p>7.2.1.6* Special Locking Arrangements. 7.2.1.6.1 Delayed-Egress Locking Systems. 7.2.1.6.1.1 Approved, listed, delayed-egress locking systems shall be permitted to be installed on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6 or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 11 through 43, provided that all of the following criteria are met:</p> <p>(1) The door leaves shall unlock in the direction of egress upon actuation of one of the following:</p> <p>(a) Approved, supervised automatic sprinkler system in accordance with Section 9.7</p> <p>(b) Not more than one heat detector of an approved, supervised automatic fire detection system in accordance with Section 9.6</p> <p>(c) Not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6</p> <p>(2) The door leaves shall unlock in the direction of egress upon loss of power controlling the lock or locking mechanism.</p> <p>(3)*An irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds</p>	K 222		

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K 222	Continued From page 8 where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions: (a) The force shall not be required to exceed 15 lbf (67 N). (b) The force shall not be required to be continuously applied for more than 3 seconds. (c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening. (d) Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only. (4)*A readily visible, durable sign in letters not less than 1 in. (25 mm) high and not less than 178 in. (3.2 mm) in stroke width on a contrasting background that reads as follows shall be located on the door leaf adjacent to the release device in the direction of egress: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS (5) The egress side of doors equipped with delayed-egress locks shall be provided with emergency lighting in accordance with Section 7.9.	K 222		
K 291 SS=D	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9.18.2.9.1, 19.2.9.1 This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to provide monthly and annual emergency lighting test documentation. Failure to test the emergency lighting could inhibit egress of	K 291	<i>X</i> The batteries in all emergency lights were replaced and the lights will work properly when needed. All residents have the potential to be affected by this. The maintenance director will conduct monthly 30 second tests and annual 90 minute test of the emergency lights	5/15/17

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K 291	<p>Continued From page 9</p> <p>residents during an emergency. This deficient practice affected all residents, staff and visitors on the day of survey. The facility is licensed for 111 SNF/NF beds with a census of 66 on the date of survey.</p> <p>Findings include:</p> <p>During record review on April 24, 2017, from approximately 8:00 AM to 11:00 AM, review of the emergency lighting test logs revealed the last monthly thirty (30) second test of the emergency lighting was conducted in December 2016. The last annual ninety (90) minute test was conducted August 26, 2015. When asked, the Maintenance Supervisor stated the facility was unaware the tests were not completed or documentation maintained.</p> <p>Actual NFPA reference:</p> <p>NFPA 101 19.2.9 Emergency Lighting. 19.2.9.1 Emergency lighting shall be provided in accordance with Section 7.9. 7.9.3 Periodic Testing of Emergency Lighting Equipment. 7.9.3.1 Required emergency lighting systems shall be tested in accordance with one of the three options offered by 7.9.3.1.1, 7.9.3.1.2, or 7.9.3.1.3. 7.9.3.1.1 Testing of required emergency lighting systems shall be permitted to be conducted as follows: (1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, except as otherwise permitted by 7.9.3.1.1(2).</p>	K 291	<p><i>and document all tests.</i></p> <p><i>The administrator will inspect the documentation of the emergency lighting tests on a monthly basis to determine their completion.</i></p>		

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K 291	<p>Continued From page 10</p> <p>(2)*The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction.</p> <p>(3) Functional testing shall be conducted annually for a minimum of 11?2 hours if the emergency lighting system is battery powered.</p> <p>(4) The emergency lighting equipment shall be fully operational for the duration of the tests required by 7.9.3.1.1(1) and (3).</p> <p>(5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction.</p> <p>7.9.3.1.2 Testing of required emergency lighting systems shall be permitted to be conducted as follows:</p> <p>(1) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall be provided.</p> <p>(2) Not less than once every 30 days, self-testing/self-diagnostic battery-operated emergency lighting equipment shall automatically perform a test with a duration of a minimum of 30 seconds and a diagnostic routine.</p> <p>(3) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall indicate failures by a status indicator.</p> <p>(4) A visual inspection shall be performed at intervals not exceeding 30 days.</p> <p>(5) Functional testing shall be conducted annually for a minimum of 11?2 hours.</p> <p>(6) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall be fully operational for the duration of the 11?2-hour test.</p> <p>(7) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction.</p> <p>7.9.3.1.3 Testing of required emergency lighting systems shall be permitted to be conducted as follows:</p>	K 291		

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K 291	Continued From page 11 (1) Computer-based, self-testing/self-diagnostic batteryoperated emergency lighting equipment shall be provided. (2) Not less than once every 30 days, emergency lighting equipment shall automatically perform a test with a duration of a minimum of 30 seconds and a diagnostic routine. (3) The emergency lighting equipment shall automatically perform annually a test for a minimum of 11?2 hours. (4) The emergency lighting equipment shall be fully operational for the duration of the tests required by 7.9.3.1.3(2) and (3). (5) The computer-based system shall be capable of providing a report of the history of tests and failures at all times.	K 291		
K 324 SS=D	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the	K 324	x The missing required components of the kitchen cooking ventilation system were replaced on the day of the survey. Because the components were replaced no other residents will be affected by this. The Dietary Manager will inspect the kitchen cooking ventilation system daily to make sure all required components are present and in use. The administrator will conduct weekly inspection of the kitchen ventilation system to make sure all required components are present and in use.	5/15/17

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K 324	Continued From page 12 corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the Kitchen hood system in accordance with NFPA 96. Failure to operate the kitchen hood system with all required components could increase the risk of fires due to excessive build-up of grease laden vapors. This deficient practice affected staff and vendors of the Kitchen on the date of the survey. The facility is licensed for 111 SNF/NF beds and had a census of 66 on the day of the survey. Findings include: During the facility tour conducted on April 24, 2017, from approximately 11:00 AM to 3:00 PM, observation of the Kitchen cooking ventilation system revealed two (2) missing grease filters in the hood exhaust system. When asked, the Kitchen Manager stated the filters were taken out due to them constantly falling out of the frame due to the air pressure in the kitchen. Actual NFPA standard: NFPA 96 6.1 Grease Removal Devices. 6.1.1 Listed grease filters, listed baffles, or other listed grease removal devices for use with commercial cooking equipment shall be provided. 6.2.1.5 Grease removal devices supplied as part of listed hood assemblies shall be installed in	K 324		

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K 324	Continued From page 13 accordance with the terms of the listing and the manufacturer ' s instructions. 6.2.3 Grease Filters. 6.2.3.3 Grease filters shall be arranged so that all exhaust air passes through the grease filters.	K 324			
K 920 SS=E	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure electrical wiring was in accordance with the National Electrical Code. Exposure of open electrical connections, wiring, or improper use of flexible cords, could result in	K 920	<i>X On the day of the survey all "daisy chains" were removed in the mentioned residents rooms and the appliances and medical equipment that were plugged into relocatable power taps were plugged into the wall outlet.</i> <i>AN inspection of the facility was conducted and no other "daisy chains" or medical equipment and appliances were found to be plugged into relocatable power taps. No other residents were found to be affected by this.</i> <i>The Administrator and Maintenance Director will each perform weekly inspections to determine no "Daisy Chains" are being used or relocatable power taps are being used for medical equipment or appliances. An in-service was held on 5-15-17 to educate staff on not allowing the use of "daisy chains" and the power use of relocatable power taps.</i>	<i>5/15/17</i>	

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K 920	<p>Continued From page 14</p> <p>fires by arcing or electrocution. The deficient practice was wide spread throughout the facility and affected 50 residents, staff, and visitors on the date of survey. The facility is licensed for 111 SNF/NF beds and had a census of 66 the day of survey.</p> <p>Findings include:</p> <p>1.) During the facility tour conducted on April 24, 2017, from approximately 11:00 AM to 3:00 PM, observation revealed "daisy chains" Relocatable Power Taps (RPTs) plugged in to Relocatable Power Taps (RPTs) or other types of extension cords, being used as a substitute to permanent wiring in the following areas:</p> <ul style="list-style-type: none"> -Resident Room #217, RPT to RPT -Resident Room #218, RPT to RPT -Resident Room #301, RPT to RPT <p>2.) During the facility tour conducted on April 24, 2017, from approximately 11:00 AM to 3:00 PM, observation revealed appliances and/or medical equipment plugged in to Relocatable Power Taps (RPTs) being used as a substitute to permanent wiring in the following areas:</p> <ul style="list-style-type: none"> -Resident Room #305, oxygen concentrator in RPT -Resident Room #312, oxygen concentrator in RPT -Administrative Area, Microwave, Refrigerator, Toaster and Coffee pot in RPT <p>When asked, the Maintenance Supervisor stated he was unaware this was going on in the facility.</p> <p>Actual NFPA standard:</p> <p>NFPA 70, 400-8. Uses Not Permitted Unless specifically permitted in Section 400-7, flexible cords and cables shall not be used for the</p>	K 920		

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K 920	Continued From page 15 following: 1. As a substitute for the fixed wiring of a structure 2. Where run through holes in walls, structural ceilings suspended ceilings, dropped ceilings, or floors 3. Where run through doorways, windows, or similar openings 4. Where attached to building surfaces Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of Section 364-8. 5. Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors 6. Where installed in raceways, except as otherwise permitted in this Code Also refer to UL Online Certifications Directory XBYS.GuideInfo Relocatable Power Taps	K 920			