



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 25, 2017

Tom De Oro, Administrator
Lacrosse Health & Rehabilitation Center
210 West Lacrosse Avenue
Coeur D'Alene, ID 83814-2403

Provider #: 135042

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

Dear Mr. De Oro:

On **May 15, 2017**, a Facility Fire Safety and Construction survey was conducted at **Lacrosse Health & Rehabilitation Center** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. Please provide **ONLY ONE** completion date for each federal and state tag in column (X5) Completion Date to signify when

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **June 7, 2017**. Failure to submit an acceptable PoC by **June 7, 2017**, may result in the imposition of civil monetary penalties by **June 27, 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 **June 19, 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 **June 19, 2017**. A change in the seriousness of the deficiencies on **June 19, 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 **June 19, 2017**, includes the following:

Denial of payment for new admissions effective **August 15, 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 **November 15, 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 **May 15, 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 **June 7, 2017**. If your request for informal dispute resolution is received after **June 7, 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: 05/25/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135042	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE FACILITY BUILDINGS 1 & 2 B. WING _____	(X3) DATE SURVEY COMPLETED 05/15/2017
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NAME OF PROVIDER OR SUPPLIER LACROSSE HEALTH & REHABILITATION CEN	STREET ADDRESS, CITY, STATE, ZIP CODE 210 WEST LACROSSE AVENUE COEUR D'ALENE, ID 83814
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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
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K 000	<p>INITIAL COMMENTS</p> <p>The facility is a single story, fully sprinklered structure of type V(111) construction. It is equipped with an automatic fire alarm system, with smoke detection in corridors and areas open to the corridor. The 300 hall and the 600 hall have additional smoke detection in each resident sleeping room. The facility is equipped with a ventilator unit wing which was approved in November of 2011, and has a Type 1 Emergency Electrical System with a 96 hour fuel supply. The facility was built in 1967 and is currently is licensed for 100 SNF/NF beds.</p> <p>The following deficiencies were cited during the annual Fire/Life Safety survey conducted on May 15, 2017. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy in accordance with 42 CFR 483.70.</p> <p>The survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	K 000	<p style="text-align: center;">RECEIVED JUN 08 2017 FACILITY STANDARDS</p> <p>K 324</p> <ol style="list-style-type: none"> 1. Bi annual hood suppression Inspection has been added To tels to correlate with the Months that lacrosse needs The inspections done. 2. Inspections will be on the Hood on a bi annual basis As they are flagged on tels To remind that the action Must be taken in accordance With K 324 3. Tels has been updated to the In accordance to the months On which lacrosse needs to have The hood inspected by a licensed Contractor. 4. Tels will monitor along with Vender and maintenance Director to ensure that the Inspection on the hood is being Done on a bi monthly basis. 5. Date of completion will be done By May 15, 2017 	
K 324 SS=D	<p>NFPA 101 Cooking Facilities</p> <p>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,</p>	K 324		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Sam Burbank</i>	TITLE <i>ED</i>	(X6) DATE <i>6-07-17</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 324	<p>Continued From page 1</p> <p>or</p> <p>* cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.</p> <p>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 corridor.</p> <p>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</p> <p>This Standard is not met as evidenced by: Based on record review and interview, the facility failed to ensure cooking exhaust hood suppression systems were maintained in accordance with NFPA 96 and NFPA 17A. Failure to inspect suppression systems in exhaust hoods on a biannual basis could delay early identification problems and hinder system response during a fire. This deficient practice affected staff and vendors of the main Kitchen on the date of the survey. The facility is licensed for 100 SNF/NF beds and had a census of 82 on the day of the survey.</p> <p>Findings include:</p> <p>During review of the facility inspection and testing records conducted on May 15, 2017 from approximately 10:00 AM to 12:00 PM, records provided revealed an eight-month gap between inspections. When asked, the Maintenance Supervisor stated he was aware of the gap between inspections.</p> <p>Actual NFPA standard:</p>	K 324		

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K 324	Continued From page 2 NFPA 96 11.2 Inspection, Testing, and Maintenance of Fire-Extinguishing Systems. 11.2.1* Maintenance of the fire-extinguishing systems and listed exhaust hoods containing a constant or fire-activated water system that is listed to extinguish a fire in the grease removal devices, hood exhaust plenums, and exhaust ducts shall be made by properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction at least every 6 months.	K 324		
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 * 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	K 325		

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K 325	<p>Continued From page 3</p> <p>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 Alcohol Based Hand Rub Dispensers (ABHR) were maintained in accordance with NFPA 101. Failure to test and document operation of ABHR dispensers per manufacturer's specifications, could result in inadvertently spilling flammable liquids increasing the risk of fires. This deficient practice affected 82 residents, staff and visitors on the date of the survey. The facility is licensed for 100 SNF/NF residents and had a census of 82 on the day of the survey.</p> <p>Findings include:</p> <p>1) During the review of facility inspection records conducted on May 15, 2017 from approximately 10:00 AM to 12:00 PM, no records were available indicating inspection and testing of ABHR dispensers was conducted in accordance with manufacturer's care and use instructions during the refill process.</p> <p>2) During the facility tour conducted on May 15, 2017 from approximately 1:00 PM to 2:00 PM, interview of the Housekeeping staff outside room 100 revealed she was not testing dispensers according to manufacturer's recommendations each time a refill was installed and was not aware of the code requirement to do so. Further observation of the facility corridors revealed ABHR dispensers were installed throughout each corridor.</p> <p>Actual NFPA standard: NFPA 101</p>	K 325	<p>K 325</p> <ol style="list-style-type: none"> Alcohol based hand rub Replacement form will Be used in accordance to K 325 to identify the chemical Being changed out in the Dispensers to ensure that the Chemical is being change out In accordance to manufactures Guide lines. The hand sanitizer form will Be used to ensure that the Right chemical is being used In the dispenser it is require in. That there is no damage to the Insert. The dispenser is tested After refilled and working properly Ensuring that both resident, visitors And staffs are ok to use it. Hand sanitizer replacement form Will be used each and every time A sanitizer is refilled. Date and location Will be added to the form to ensure the Proper change out has been done. Documentation will be collected and filed By the housekeeping manager. Copy's will Be collected monthly by the maintenance Director and filed in the maintenance manual Monthly. Any damage to the sanitizer dispenser Upon refiling and testing with be refer to The maintenance director per work order and Replace. Both the housekeeping manager and The maintenance director will review the Change out forms to ensure they are being Used property and done consistently Date of compliance May 19. 2017 	

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K 325	Continued From page 4 19.3.2.6* Alcohol-Based Hand-Rub Dispensers. Alcohol-based hand-rub dispensers shall be protected in accordance with 8.7.3.1, unless all of the following conditions are met: (1) Where dispensers are installed in a corridor, the corridor shall have a minimum width of 6 ft (1830 mm). (2) The maximum individual dispenser fluid capacity shall be as follows: (a) 0.32 gal (1.2 L) for dispensers in rooms, corridors, and areas open to corridors (b) 0.53 gal (2.0 L) for dispensers in suites of rooms (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. (4) Dispensers shall be separated from each other by horizontal spacing of not less than 48 in. (1220 mm). (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). (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). (7) Storage of quantities greater than 5 gal (18.9	K 325		

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K 325	Continued From page 5 L) in a single smoke compartment shall meet the requirements of NFPA 30, Flammable and Combustible Liquids Code. (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		

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K 511 K 511 SS=D	Continued From page 6 NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This Standard is not met as evidenced by: Based on observation, the facility failed to ensure safe electrical installations in accordance with NFPA 70. Installing flexible electrical cords through doors or walls could damage cords, resulting in fires by arcing or electrocution. This deficient practice affected 16 residents, staff and visitors in the 500 hall on the date of the survey. The facility is licensed for 100 SNF/NF beds and had a census of 82 on the day of the survey. Findings include: During the facility tour conducted on May 15, 2017 from approximately 1:30 PM to 2:00 PM, observation of the Social Services office revealed a relocatable power tap (RPT) being used to supply power to installed electric decorations. Upon inspection of this installation, the flexible cord of the RPT was observed wedged between the face of the door and the doorframe before entering the closet. Further observation of the interior of the closet revealed the RPT was plugged in series (daisy-chained) to an extension cord, before being plugged into the outlet.	K 511 K 511	K 511 1. Orange utility cord and Power strip were remove From the social service office 2. Inspection of all occupied and Unoccupied offices is conducted By the maintenance director to Located and identify the proper Use of electrical corded power Strips. Those that have been Identified will be removed From operation 3. In-services to both office staff And facility staff 4. In-services along with routine Inspections off occupied and unoccupied Office spaces 5. Date of compliance May 19, 2017	

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K 511	Continued From page 7 Actual NFPA standard: NFPA 70 Chapter 4 Equipment for General Use ARTICLE 400 Flexible Cords and Cables 400.8 Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces Exception to (4): Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of 368.56(B) (5) Where concealed by walls, floors, or ceilings or located above suspended or dropped ceilings (6) Where installed in raceways, except as otherwise permitted in this Code (7) Where subject to physical damage	K 511		
K 920 SS=D	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	K 920		

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K 920	<p>Continued From page 8</p> <p>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.</p> <p>10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5</p> <p>This Standard is not met as evidenced by: Based on observation, the facility failed to ensure relocatable power taps (RPTs) were used in accordance with NFPA 99. Use of RPTs with oxygen concentrators has been historically linked to fires by arcing and electrocution. This deficient practice affected 13 residents, staff and visitors on the date of the survey. The facility is licensed for 100 SNF/NF beds and had a census of 82 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on May 15, 2017 from approximately 1:00 PM to 2:00 PM, observation of resident room 301 revealed a relocatable power tap under the resident bed being used as a substitute to the fixed wiring of the structure, to supply power to an oxygen concentrator.</p> <p>Actual NFPA standard:</p>	K 920	<p>K 920</p> <ol style="list-style-type: none"> 1. Removal of power strip from room 301 bed 1 from the concentrator. Concentrator plugged into wall outlet. 2. Facility inspection was done to ensure That no other resident rooms were using Power strips with oxygen concentrators <hr/> <ol style="list-style-type: none"> 3. In-services 4. <ol style="list-style-type: none"> 1. In-services 2. Routine inspections of resident rooms 5. Date of compliance May 19, 2017 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135042	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE FACILITY BUILDINGS 1 & 2 B. WING _____	(X3) DATE SURVEY COMPLETED 05/15/2017
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K 920	Continued From page 9 NFPA 99 10.2.3.6 Multiple Outlet Connection. Two or more power receptacles supplied by a flexible cord shall be permitted to be used to supply power to plug-connected components of a movable equipment assembly that is rack-, table-, pedestal-, or cartmounted, provided that all of the following conditions are met: (1) The receptacles are permanently attached to the equipment assembly (2)*The sum of the ampacity of all appliances connected to the outlets does not exceed 75 percent of the ampacity of the flexible cord supplying the outlets. (3) The ampacity of the flexible cord is in accordance with NFPA 70, National Electrical Code. (4)*The electrical and mechanical integrity of the assembly is regularly verified and documented. (5)*Means are employed to ensure that additional devices or nonmedical equipment cannot be connected to the multiple outlet extension cord after leakage currents have been verified as safe. NFPA 70 400.8 Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces Exception to (4): Flexible cord and cable shall be	K 920		

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K 920	Continued From page 10 permitted to be attached to building surfaces in accordance with the provisions of 368.56(B) (5) Where concealed by walls, floors, or ceilings or located above suspended or dropped ceilings (6) Where installed in raceways, except as otherwise permitted in this Code (7) Where subject to physical damage	K 920		
K 927 SS=D	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) This Standard is not met as evidenced by: Based on observation and operational testing, the facility failed to ensure liquid oxygen transfilling was conducted in accordance with NFPA 99. Failure to transfill liquid oxygen in spaces equipped with mechanical ventilation could result in creating an oxygen-rich environment, increasing the potential for combustion. This deficient practice affected 22 residents, staff and visitors on the date of the survey. The facility is licensed for 100 SNF/NF beds and had a census of 82 on the day of the survey. Findings include: During the facility tour conducted on May 15, 2017 from approximately 1:00 PM to 3:00 PM, observation and operational testing of the	K 927	<p>K 927</p> <ol style="list-style-type: none"> 200 hallway oxygen room Exhaust fan and vent were inspected For potential problems, issue found Was and obstruction in the duct that Did not allow proper air flow. Obstruction was repaired Exhaust was tested using a feather <p>Recommended by the inspector, 200 hallway oxygen room exhaust Was identified to be working properly</p> <p>600 hallway oxygen room Exhaust fan and vent were inspected For potential problems, issue found That the fan was not working properly And that the duct had a bees nest in it Not allowing proper air flow. Fan motor and blade were replaced, Duct was cleaned out. 600 hallway oxygen room exhaust Was identified to be working properly</p> <ol style="list-style-type: none"> Both exhaust fans were inspected and Repaired and or replaced to ensure Proper function Tels program exhaust fan monthly inspection Tels program exhaust fan monthly inspection Dates of compliance <ol style="list-style-type: none"> 200 hallway oxygen room May 19, 2017 600 hallway oxygen room May 24, 2017 	

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K 927	<p>Continued From page 11</p> <p>mechanical ventilation for the 500 and 200 hall oxygen transfill areas revealed both fans were operational, but lacked exhaust airflow when tested with standard note paper placed within six inches of the exhaust vent.</p> <p>Actual NFPA standard:</p> <p>NFPA 99</p> <p>11.5.2.3 Transfilling Liquid Oxygen. Transfilling of liquid oxygen shall comply with 11.5.2.3.1 or 11.5.2.3.2, as applicable.</p> <p>11.5.2.3.1 Transfilling to liquid oxygen base reservoir containers or to liquid oxygen portable containers over 344.74 kPa (50 psi) shall include the following:</p> <p>(1) A designated area separated from any portion of a facility wherein patients are housed, examined, or treated by a fire barrier of 1 hour fire-resistive construction.</p> <p>(2) The area is mechanically ventilated, is sprinklered, and has ceramic or concrete flooring.</p> <p>(3) The area is posted with signs indicating that transfilling is occurring and that smoking in the immediate area is not permitted.</p> <p>(4) The individual transfilling the container(s) has been properly trained in the transfilling procedures.</p> <p>9.3.7.5.3.2 Mechanical exhaust shall be at a rate of 1 L/sec of airflow for each 300 L (1 cfm per 5 ft3 of fluid) designed to be stored in the space and not less than 24 L/sec (50 cfm) nor more than 235 L/sec (500 cfm).</p>	K 927		