



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

June 16, 2017

Bonnie Sorensen, Administrator  
Countryside Care & Rehabilitation  
1224 8th St.  
Rupert, ID 83350-1527

Provider #: 135064

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

Dear Ms. Sorensen:

On **June 9, 2017**, a Facility Fire Safety and Construction survey was conducted at **Countryside Care & Rehabilitation** 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 29, 2017**. Failure to submit an acceptable PoC by **June 29, 2017**, may result in the imposition of civil monetary penalties by **July 19, 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 **July 14, 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 **July 14, 2017**. A change in the seriousness of the deficiencies on **July 14, 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 **July 14, 2017**, includes the following:

Denial of payment for new admissions effective **September 9, 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 **December 9, 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 **June 9, 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 29, 2017**. If your request for informal dispute resolution is received after **June 29, 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: 06/16/2017  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - ENTIRE BUILDING</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/09/2017</b>
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NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>
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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	INITIAL COMMENTS  The main Extended Care Facility is a single story, type V(111) construction, with a two hour wall at the 1960 original hospital building. The short term (west unit) portion of the nursing facility occupies a wing of the Hospital building and is separated by a smoke barrier from the remaining hospital building which is type I construction. The entire facility is fully sprinklered with corridor smoke detection and manual fire alarm system. The facility is licensed for 46 SNF beds.  The following deficiencies were cited during the annual life safety code survey conducted on June 9, 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	<i>RECEIVED</i> <i>JUN 26 2017</i> <i>FACILITY STANDARDS</i>  K-211 Corrective Action: The identified areas:  • Fire and smoke door assemblies were not inspected in accordance with NFPA 80 and NFPA 105.  Maintenance Supervisor is aware of the NFPA 101 standard.  Systemic changes – Fire and smoke door assemblies will be inspected in accordance with NFPA 80 and NFPA 105, and will be inspected annually by the Maintenance Supervisor or his designee.  Monitor - Maintenance Supervisor, or designee, will annually monitor Fire and smoke door assemblies to assure 100% compliance is maintained with annual inspection in accordance with NFPA 80 and NFPA 105.  Quality Assurance – Maintenance Supervisor, or designee, will report monitor to the facility's Safety Committee annually, beginning July 2017.	6/29/17
K 211 SS=F	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 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure that fire and smoke door.	K 211		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Bonnie Sorensen</i>	TITLE <i>Administrator</i>	(X6) DATE <i>6-23-17</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 211	<p>Continued From page 1</p> <p>assemblies were inspected in accordance with NFPA 80 and NFPA 105. Failure to inspect and test fire and 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 all residents, staff and visitors on the date of the survey. The facility is licensed for 46 SNF/NF beds and had a census of 38 on the day of the survey.</p> <p>Findings include:</p> <p>During record review on June 9, 2017, from approximately 9:00 AM to 10:30 AM, no record was available demonstrating an initial inspection and testing of the fire and smoke door assemblies. When asked about the missing documentation, the Facilities Director stated the facility thought that compliance for this rule started in July 2017. The facility was unaware they would be surveyed to the new requirement before July and therefore had not done an initial inspection.</p> <p>Actual NFPA standard:</p> <p>NFPA 101</p> <p>19.2.1 General. Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7, unless otherwise modified by 19.2.2 through 19.2.11.</p> <p>7.2.1 Door Openings. 7.2.1.15 Inspection of Door Openings. 7.2.1.15.1* Where required by Chapters 11 through 43, the following door assemblies shall</p>	K 211		

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K 211	Continued From page 2 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 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.  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			
K 325 SS=F	NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR)  Alcohol Based Hand Rub Dispenser (ABHR)	K 325			

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K 325	Continued From page 3 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 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 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 the operation of ABHR dispensers in accordance with the manufacturer's care and use instructions each time a new refill is installed could result in inadvertently spilling flammable liquids, increasing the risk of fires. This deficient practice affected 38 residents, staff and visitors on the date of the survey. The facility is licensed for 46 SNF/NF residents and had a census of 38 on the day of the survey.	K 325	K 325 Corrective Action: The identified areas:  1. Facility failed to ensure Alcohol Based Hand Rub Dispensers (ABHR) were maintained in accordance with NFPA 101.  Environmental Services Director is aware of the NFPA 101 standard.  Systemic changes – The Environmental Services Director has numbered all ABHR dispensers. Environmental Services staff will be trained to maintain ABHR dispensers in accordance with NFPA 101.  Monitor – Environmental Services Director or designee, will do a facility walk through at least monthly to monitor for ABHR dispenser maintenance per NFPA 101, Section 18.3.2.6(11) or 19.2.1.6(11). Monitor will be reported to Facilities Director monthly.  Quality Assurance - Environmental Services Director or designee will report monitor to the facility's Safety Committee quarterly, beginning July 2017.	6/29/17

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K 325	<p>Continued From page 4</p> <p>Findings include:</p> <p>During the review of facility inspection records conducted on June 9, 2017 from approximately 9:00 AM to 10:30 AM, no records were available indicating ABHR dispensers are tested in accordance with manufacturer's care and use instructions when a new refill is installed. ABHR dispensers were observed throughout the facility and when asked, the Facilities Director stated the facility was not aware of the requirement to test ABHR dispensers each time a new refill is installed.</p> <p>Actual NFPA standard:</p> <p>NFPA 101</p> <p>19.3.2.6* Alcohol-Based Hand-Rub Dispensers. Alcohol-based hand-rub dispensers shall be protected in accordance with 8.7.3.1, unless all of the following conditions are met:</p> <p>(1) Where dispensers are installed in a corridor, the corridor shall have a minimum width of 6 ft (1830 mm).</p> <p>(2) The maximum individual dispenser fluid capacity shall be as follows:</p> <p>(a) 0.32 gal (1.2 L) for dispensers in rooms, corridors, and areas open to corridors</p> <p>(b) 0.53 gal (2.0 L) for dispensers in suites of rooms</p> <p>(3) Where aerosol containers are used, the maximum capacity of the aerosol dispenser shall be 18 oz. (0.51 kg) and shall be limited to Level 1 aerosols as defined in NFPA30B, Code for the Manufacture and Storage of Aerosol Products.</p> <p>(4) Dispensers shall be separated from each other by horizontal spacing of not less than 48 in. (1220 mm).</p>	K 325			

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K 325	<p>Continued From page 5</p> <p>(5) Not more than an aggregate 10 gal (37.8 L) of alcohol-based hand-rub solution or 1135 oz (32.2 kg) of Level 1 aerosols, or a combination of liquids and Level 1 aerosols not to exceed, in total, the equivalent of 10 gal (37.8 L) or 1135 oz (32.2 kg), shall be in use outside of a storage cabinet in a single smoke compartment, except as otherwise provided in 19.3.2.6(6).</p> <p>(6) One dispenser complying with 19.3.2.6 (2) or (3) per room and located in that room shall not be included in the aggregated quantity addressed in 19.3.2.6(5).</p> <p>(7) Storage of quantities greater than 5 gal (18.9 L) in a single smoke compartment shall meet the requirements of NFPA 30, Flammable and Combustible Liquids Code.</p> <p>(8) Dispensers shall not be installed in the following locations:</p> <p>(a) Above an ignition source within a 1 in. (25 mm) horizontal distance from each side of the ignition source</p> <p>(b) To the side of an ignition source within a 1 in. (25 mm) horizontal distance from the ignition source</p> <p>(c) Beneath an ignition source within a 1 in. (25 mm) vertical distance from the ignition source</p> <p>(9) Dispensers installed directly over carpeted floors shall be permitted only in sprinklered smoke compartments.</p> <p>(10) The alcohol-based hand-rub solution shall not exceed 95 percent alcohol content by volume.</p> <p>(11) Operation of the dispenser shall comply with the following criteria:</p> <p>(a) The dispenser shall not release its contents except when the dispenser is activated, either manually or automatically by touch-free activation.</p> <p>(b) Any activation of the dispenser shall occur</p>	K 325		

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K 325	Continued From page 6 only when an object is placed within 4 in. (100 mm) of the sensing device. (c) An object placed within the activation zone and left in place shall not cause more than one activation. (d) The dispenser shall not dispense more solution than the amount required for hand hygiene consistent with label instructions. (e) The dispenser shall be designed, constructed, and operated in a manner that ensures that accidental or malicious activation of the dispensing device is minimized. (f) The dispenser shall be tested in accordance with the manufacturer's care and use instructions each time a new refill is installed.	K 325		
K 353 SS=D	NFPA 101 Sprinkler System - Maintenance and Testing  Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked  b) Who provided system test  c) Water system supply source  Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by:	K 353	K 353 Corrective Action: The identified areas:  1. Sprinkler head in the small utility closet in the North Hallway had paint on it.  Maintenance Supervisor is aware of the NFPA 101 standard.  Systemic changes – Simplex Grinnell Fire Systems has been scheduled to replace the effected sprinkler head on 6/26/17.  Maintenance Supervisor, or designee, will inspect all sprinkler heads in areas at the completion of painting of the area to assure compliance with NFPA 25.  Monitor – Maintenance Supervisor or designee, will inspect all sprinkler heads in areas at the completion of painting of the area.  Quality Assurance - Maintenance Supervisor, of designee will report monitor to the facility's Safety Committee quarterly, beginning July 2017 for 3 quarters.	6/29/17

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NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>	
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K 353	<p>Continued From page 7</p> <p>Based on observation and interview, the facility failed to ensure fire suppression system pendants were maintained free of obstructions such as paint or corrosion. Failure to maintain fire sprinkler pendants free of obstructions could hinder system performance during a fire event. This deficient practice affected 14 residents, staff and visitors on the date of the survey. The facility is licensed for 46 SNF/NF beds and had a census of 38 on the day of the survey.</p> <p>Findings include:</p> <p>Observation during the facility tour on June 9, 2017, from approximately 10:30 AM to 12:30 PM, revealed the sprinkler head in the small utility closet in the North Hallway had paint on it. When asked, the Facilities Director stated the facility was not aware that the sprinkler had been painted.</p> <p>Actual NFPA standard:</p> <p>NFPA 25 5.2.1 Sprinklers. 5.2.1.1* Sprinklers shall be inspected from the floor level annually. 5.2.1.1.1* Sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., upright, pendent, or sidewall). 5.2.1.1.2 Any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical damage (4) Loss of fluid in the glass bulb heat responsive element</p>	K 353		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - ENTIRE BUILDING</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/09/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>	
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K 353	Continued From page 8 (5)*Loading (6) Painting unless painted by the sprinkler manufacturer	K 353		
K 712 SS=F	NFPA 101 Fire Drills  Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to provide documentation of required fire drills, one per shift per quarter. Failure to perform fire drills on each shift quarterly could result in confusion and hinder the safe evacuation of residents during a fire event. This deficient practice affected all residents, staff and visitors on the date of the survey. The facility is licensed for 46 SNF/NF beds and had a census of 38 on the day of the survey.  Findings include:  During record review on June 9, 2017 from approximately 9:00 AM to 10:30 AM, fire drill documentation revealed the facility failed to perform the following drills:	K 712	K 712  Corrective Action: The identified areas:  1. Facility failed to perform and provide documentation of required fire drill, one per shift per quarter.  Maintenance Supervisor is aware of the NFPA 101 standard.  Systemic changes – A fire drill schedule was created. Maintenance Supervisor or designee will conduct one per shift per quarter fire drill. Fire Drill Evaluation form will be reviewed by Facilities Director.  Monitor – Facilities Director, Maintenance Supervisor or designee, will review fire drill schedule to monitor for monthly completion of required fire drill per shift per quarter.  Quality Assurance - Maintenance Supervisor, of designee will report monitors to the facility's Safety Committee quarterly, beginning July 2017.	6/29/17

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K 712	Continued From page 9 1.) All drills on all three shifts during the first quarter 2017. 2.) Third shift during the third quarter 2016. 3.) Second and third shifts during the fourth quarter 2016. When asked, the Facilities Director stated the facility was unaware of the missing fire drills.  Actual NFPA standard:  19.7.1.6 Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions.	K 712			