



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 29, 2017

Steve Lish, Administrator
Discovery Care Center
600 Shanafelt Street
Salmon, ID 83467-4261

Provider #: 135129

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

Dear Mr. Lish:

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

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

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **July 12, 2017**. Failure to submit an acceptable PoC by **July 12, 2017**, may result in the imposition of civil monetary penalties by **August 1, 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 20, 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 20, 2017**. A change in the seriousness of the deficiencies on **July 20, 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 20, 2017**, includes the following:

Denial of payment for new admissions effective **September 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 **December 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 **June 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 **July 12, 2017**. If your request for informal dispute resolution is received after **July 12, 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: 135129	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 06/15/2017
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NAME OF PROVIDER OR SUPPLIER DISCOVERY CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 600 SHANAFELT STREET SALMON, ID 83467
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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 facility is a type V(III) fully sprinkled, single story structure with detection in hallways and open areas. The building was built in 1997 and has multiple exits to grade. Emergency power is supplied by a Type I, propane generator. The building is currently licensed for 45 SNF/NF beds with an attached assisted living with a two-hour separation on the east side. The following deficiencies were cited during the annual fire/life safety survey conducted on June 15, 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: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	K 000	RECEIVED JUL 14 2017 FACILITY STANDARDS	
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, observation and interview, the facility failed to ensure that rated assemblies were inspected in accordance with NFPA 80 and/or NFPA 105, as applicable. Failure to inspect and test rated assemblies has the potential to hinder system performance as designed. This deficient practice affected 32	K 211		<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Discovery Care Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Sam Burbank* TITLE **Executive Director** (X6) DATE **07/11/2017**

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>residents, staff and visitors on the date of the survey. The facility is licensed for 45 SNF/NF beds and had a census of 32 on the day of the survey.</p> <p>Findings include:</p> <p>1) During review of provided facility annual inspection records conducted on June 15, 2017 from approximately 9:00 AM to 10:00 AM, no records were available demonstrating an initial or annual inspection and testing of rated assemblies had been conducted. When asked about the missing documentation, the Maintenance Supervisor stated he was not aware of this requirement.</p> <p>2) During the facility tour conducted on June 15, 2017 from approximately 10:00 AM to 12:30 PM, observation of installed doors revealed doors in the facility were labeled as smoke or fire resistive, and ranged in fire/smoke protective ratings from 20 minutes to 90 minutes.</p> <p>Actual NFPA standard:</p> <p>NFPA 101</p> <p>19.2 Means of Egress Requirements 19.2.2.2 Doors. 19.2.2.2.1 Doors complying with 7.2.1 shall be permitted.</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</p>	K 211	<p>A. Corrective Actions</p> <p>The Means of Egress (General) noted as the fire-rated door assemblies have now been inspected and tested in accordance with NFPA 80, Standard for Fire Doors and Other opening Protectives. Additionally, the Smoke door assemblies have been inspected and tested in accordance with NFPA 105, Standard for Smoke Door Assemblies and Other Opening Protectives. Both Inspections and Testing will be conducted not less than annually with a written record signed and dated.</p> <p>B. Identification of others affected and corrective actions:</p> <p>Information has been obtained, providing guidance for inspection criteria. The facility's Plant Operations Manager has reviewed and identified no further issues or others affected.</p> <p>C. Measures to ensure that the deficient practice does not happen again:</p> <p>The facility will provide the Plant Operations Manager a resource subscription (TELS Program) to alert such new requirements for continued compliance.</p>	

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K 211	Continued From page 2 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	D. Monitor corrective actions: The Executive Director or his designee will conduct a semi-annual audit prior to the next annual inspection and testing. The results will be reported to the QAA committee which meets monthly. Any identified concerns will be addressed before the actual annual inspection and testing for continued compliance. E. Corrective action(s) will be completed or substantially completed by: 07/20/17		
K 232 SS=D	NFPA 101 Aisle, Corridor, or Ramp Width Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by .19.2.3.4,	K 232			

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K 232	<p>Continued From page 3</p> <p>exceptions 1-5. 19.2.3.4, 19.2.3.5</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that furniture in a means of egress was in accordance with NFPA 101. Providing furniture in a means of egress which is not fixed to the wall or floor, could impede corridors and potentially hinder egress of residents during a fire or other emergency. This deficient practice affected 4 residents, staff and visitors on the date of the survey. The facility is licensed for 45 SNF/NF beds and had a census of 32 on the day of the survey.</p> <p>Findings include:</p> <p>During the initial tour of the facility conducted on June 15, 2017 from approximately 9:00 AM to 9:15 AM, non-fixed furniture was observed to be placed in the corridor as follows:</p> <p>A section of four chairs and one table, measuring approximately six feet long by twenty-eight and one-half (28-1/2) inches deep, was placed against the wall in the corridor outside the dining room.</p> <p>A section of four chairs measuring approximately five feet by twenty-eight and one-half (28-1/2) inches deep, was placed against the wall in the corridor outside the T.V. Lounge. This was further observed to be approximately eight feet from the bank of furniture outside the dining room.</p> <p>A section of three chairs measuring approximately four feet by twenty-four (24) inches deep, was placed against the wall outside the T.V. Lounge across from the Nurse's station, approximately six feet from the aforementioned section of furniture.</p>	K 232		

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K 232	<p>Continued From page 4</p> <p>Further observation of these corridors revealed them to be eight (8) feet wide and the sections of chairs and table were not fixed to either the floor or the wall. Interview of the Maintenance Supervisor indicated he was aware this furniture was required to be fixed, if it was provided.</p> <p>Actual NFPA standard:</p> <p>19.2.3.4* Any required aisle, corridor, or ramp shall be not less than 48 in. (1220 mm) in clear width where serving as means of egress from patient sleeping rooms, unless otherwise permitted by one of the following:</p> <p>(1) Aisles, corridors, and ramps in adjunct areas not intended for the housing, treatment, or use of inpatients shall be not less than 44 in. (1120 mm) in clear and unobstructed width.</p> <p>(2)*Where corridor width is at least 6 ft (1830 mm), noncontinuous projections not more than 6 in. (150 mm) from the corridor wall, above the handrail height, shall be permitted.</p> <p>(3) Exit access within a room or suite of rooms complying with the requirements of 19.2.5 shall be permitted.</p> <p>(4) Projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met:</p> <p>(a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in. (1525 mm).</p> <p>(b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency.</p> <p>(c)*The wheeled equipment is limited to the following:</p> <p>i. Equipment in use and carts in use</p>	K 232	<p>A. Corrective Actions:</p> <p>The chairs, over-bed table and equipment referenced in the means of egress on the day of the survey that were not fixed to a wall or floor have been removed in accordance with NFPA 101 requirements.</p> <p>B. Identification of others affected and corrective actions:</p> <p>The facility's Plant Operations Manager Supervisor conducted a facility inspection and identified no others to have been affected. See above for corrective action taken for continued compliance.</p> <p>C. Measures to ensure that the deficient practice does not happen again:</p> <p>The facility's Plant Operations Manager and the Executive Director will conduct a one-to-one staff in-service regarding continued compliance.</p>	

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K 232	Continued From page 5 ii. Medical emergency equipment not in use iii. Patient lift and transport equipment (5)*Where the corridor width is at least 8 ft (2440 mm), projections into the required width shall be permitted for fixed furniture, provided that all of the following conditions are met: (a) The fixed furniture is securely attached to the floor or to the wall. (b) The fixed furniture does not reduce the clear unobstructed corridor width to less than 6 ft (1830 mm), except as permitted by 19.2.3.4(2). (c) The fixed furniture is located only on one side of the corridor. (d) The fixed furniture is grouped such that each grouping does not exceed an area of 50 ft ² (4.6 m ²). (e) The fixed furniture groupings addressed in 19.2.3.4(5)(d) are separated from each other by a distance of at least 10 ft (3050 mm). (f)*The fixed furniture is located so as to not obstruct access to building service and fire protection equipment. (g) Corridors throughout the smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the fixed furniture spaces are arranged and located to allow direct supervision by the facility staff from a nurses' station or similar space. (h) The smoke compartment is protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.8.	K 232	D. Monitor corrective actions: The Executive Director or his designee will conduct a daily audit for one week and then a weekly audit for one month to verify that all applicable chairs, over-bed tables and equipment do not compromise or obstruct access/egress means. The results will be reported to the QAA committee which meets monthly. The QAA Committee will review until it has been determined that the system is effective to assure continued compliance. E. Corrective action(s) will be completed or substantially completed by: 07/20/17		
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	K 325			

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K 325	<p>Continued From page 6</p> <p>gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols</p> <ul style="list-style-type: none"> * 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 <p>This Standard is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure automatically activated Alcohol Based Hand Rub dispensers (ABHR) were maintained in accordance with NFPA 101. Failure to test and document operation of automatic dispensing ABHR dispensers has the potential to inadvertently spill flammable liquids, increasing the risk of fires. This deficient practice affected 32 residents, staff and visitors on the date of the survey. The facility is licensed for 45 SNF/NF residents and had a census of 32 on the day of the survey.</p> <p>Findings include:</p> <p>1) During the review of facility inspection records conducted on June 15, 2017 from approximately 9:00 AM to 10:00 AM, no records were available</p>	K 325		

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K 325	<p>Continued From page 7</p> <p>indicating inspection and testing of ABHR dispensers was performed when refilling dispensers.</p> <p>2) During the facility tour conducted on June 15, 2017 from approximately 10:00 AM to 12:30 PM, observation of installed ABHR dispensers revealed automatic dispensers had been installed in three of three smoke compartments. When asked if the facility tested dispenser operation in accordance with manufacturer's care and use instructions, the Maintenance Supervisor stated he was not aware of the requirement and that dispensers were not tested each time a refill was 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</p>	K 325		

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K 325	Continued From page 8 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 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	K 325	A. Corrective Actions: The facility does not possess automatic dispensers. However, written records by the facility or HCSG, the facility's outside housekeeping/laundry services contractor, will now depict each inspection and testing of ABHR dispensers when refilling. B. Identification of others affected and corrective actions: The facility's Plant Operations Manager and the HCSG Housekeeping/Laundry Supervisor conducted a facility inspection and found no others to have been affected. C. Measures to ensure that the deficient practice does not happen again: The HCSG Supervisor will systematically monitor for continued compliance via review of the daily log/check list completed by housekeeping staff.		

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K 325	Continued From page 9 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	D. Monitor corrective actions: The Executive Director or his designee will communicate daily and review for one week with the HCSG Supervisor regarding the daily inspection log/check list. A weekly audit of the daily log/checklist will be conducted for one month and then a monthly review will continue for a period of one ensuing quarter or three (3) months. The results will be reported to the QAA committee which meets monthly. The QAA Committee will then determine if the system is effective to assure ongoing compliance. E. Corrective action(s) will be completed or substantially completed by: 07/20/17	
K 353 SS=E	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.	K 353		

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K 353	<p>Continued From page 10 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This Standard is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure fire suppression systems were maintained in accordance with NFPA 25. Failure to provide the correct number of spare sprinklers and maintain sprinkler pendants free of obstructions such as paint or corrosion, potentially hinders system performance and/or leave the facility not fully sprinkled during a fire or repair. This deficient practice affected staff and vendors of the main Kitchen on the date of the survey. The facility is licensed for 45 SNF/NF beds and had a census of 32 on the day of the survey.</p> <p>Findings include:</p> <p>1) During review of provided fire suppression system inspection records conducted on June 15, 2017 from approximately 9:00 AM to 10:00 AM, no records were found for replacement or testing of dry barrel pendants within the last ten years.</p> <p>2) During the facility tour conducted on June 15, 2017 from approximately 10:00 AM to 12:30 PM, observation of the installed fire suppression system revealed the following:</p> <p>The inspection of the fire riser spare sprinkler box revealed only nine (9) spare pendants. Observation of Kitchen installed fire suppression pendants in the walk-in cooler and walk-in freezer revealed the pendant installed in the walk-in cooler was dated 1995, and the pendant installed in the walk-in freezer was dated 2002. Observation of the fire suppression system pendant over the dishwashing area revealed the pendant was corroded.</p>	K 353	<p>A. Corrective Actions: The findings listed during the survey pertaining to NFPA 25 and the inspection, testing and maintenance of the fire suppression system had not been fully undertaken. Western States Fire Inspection Company has conducted the dry suppression system inspection on 07/7/2017. Likewise, one of the three sprinkler heads in question has been changed out but the other two are on order. Meanwhile, the other stock spare sprinkler pendants have all been replaced exceeding the 12 required for the facility.</p>		

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K 353	<p>Continued From page 11 Actual NFPA standard: NFPA 25</p> <p>5.2* Inspection. 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 (5)*Loading (6) Painting unless painted by the sprinkler manufacturer</p> <p>5.2.1.4 The supply of spare sprinklers shall be inspected annually for the following: (1) The correct number and type of sprinklers as required by 5.4.1.4 and 5.4.1.5 (2) A sprinkler wrench for each type of sprinkler as required by 5.4.1.6</p> <p>5.3.1.1.1.6* Dry sprinklers that have been in service for 10 years shall be replaced or representative samples shall be tested and then retested at 10-year intervals.</p> <p>5.4.1.5 The stock of spare sprinklers shall include all types and ratings installed and shall be as follows: (1) For protected facilities having under 300</p>	K 353	<p>B. Identification of others affected and corrective actions: The facility's Plant Operations Manager upon further inspection of the facility and both aspects cited under NFPA 25 did not identify an others as being affected.</p> <p>C. Measures to ensure that the deficient practice does not happen again: The facility's Plant Operations Manager will both inspect from the floor level the sprinkler pendants and maintaining at least the minimum of the correct number of spare replacement pendants kept on hand. This will be conducted on an annual basis and documented with a new annual checklist/ log.</p> <p>D. Monitor corrective actions: The Executive Director or his designee will conduct an audit review of the required scheduled checklist/log after the pendants arrive and the other two replaced. Another review will be conducted one month prior to the annual inspection. The results will be reported to the QAA committee which meets monthly. The QAA Committee will then determine if the system is effective to ensure ongoing compliance.</p>	

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K 353	Continued From page 12 sprinklers-no fewer than 6 sprinklers (2) For protected facilities having 300 to 1000 sprinklers - no fewer than 12 sprinklers (3) For protected facilities having over 1000 sprinklers - no fewer than 24 sprinklers	K 353	<p>E. Corrective action(s) will be completed or substantially completed by: 07/20/17</p> <p>A. Corrective Actions: The facility was unaware of the requirement for the existing emergency generator to possess a remote manual shut-off per NFPA110. Accordingly, a remote shut-off has been scheduled to be installed nearby and contained within a weather proof enclosure on July 12, 2017.</p> <p>B. Identification of others affected and corrective actions: The Plant Operations Manager has reviewed the citation and determined that no others have been affected. Additionally, the installation of the remote manual shut-off will resolve the matter.</p> <p>C. Measures to ensure that the deficient practice does not happen again: While the installation of the remote manual shut-off will resolve the matter, the facility's Plant Operations Manager will conduct a routine check, during his monthly documented generator "run," verifying the manual shut-off is functioning as required.</p>	
K 911 SS=F	NFPA 101 Electrical Systems - Other Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure the Essential Electrical System (EES) generator was equipped with a remote manual stop station in accordance with NFPA 110. Failure to provide a remote stop, potentially hinders staff ability to shut down the generator if required. This deficient practice affected 32 residents, staff and visitors on the date of the survey. The facility is licensed for 45 SNF/NF beds and had a census of 32 on the day of the survey. Findings include: During the facility tour conducted on June 15, 2017 from approximately 10:00 AM to 12:30 PM, a remote manual stop station for the EES generator was not located in the facility. When asked, both the Maintenance Supervisor and the Administrator stated the facility was not equipped with a remote stop station. Actual NFPA standard:	K 911		

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K 911	Continued From page 13 NFPA 110 5.6.5.6* All installations shall have a remote manual stop station of a type to prevent inadvertent or unintentional operation located outside the room housing the prime mover, where so installed, or elsewhere on the premises where the prime mover is located outside the building. 5.6.5.6.1 The remote manual stop station shall be labeled.	K 911	D. Monitor corrective actions: The Executive Director or designee will conduct an audit review of the inspection from the monthly generator checklist/log in which this inspection will be added to. This will continue for a period of one quarter or three months. The result will be reported to the QAA committee which meets monthly. The QAA Committee will then determine if any further monitoring is necessary to ensure ongoing compliance.	
K 916 SS=D	NFPA 101 Electrical Systems - Essential Electric System Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) This Standard is not met as evidenced by: Based on observation, the facility failed to ensure the Essential Electrical System (EES) was equipped with a remote annunciator readily observed at a regular work station in accordance with NFPA 99. Failure to provide a readily observed remote annunciator has the potential to hinder staff awareness to system failures during a power outage or other emergency. This deficient practice affected 32 residents, staff and visitors on the date of the survey. The facility is licensed for 45 SNF/NF beds and had a census of 32 on the day of the survey. Findings include:	K 916	E. Corrective Actions will be completed by: 07/20/2017	

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K 916	Continued From page 14 During the facility tour conducted on June 15, 2017 from approximately 10:00 AM to 12:30 PM, the remote annunciator was revealed to be located inside the fire riser room, which was separated from the main facility at the southwest end of the service corridor, and further separated by a door in the back of the Maintenance Office . When asked if this office area was open to staff after hours, the Maintenance Supervisor stated the area was locked down after 5:00 PM. Actual NFPA standard: NFPA 99 6.4.1.1.17 Alarm Annunciator. A remote annunciator that is storage battery powered shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station (see 700.12 of NFPA 70, National Electrical Code). The annunciator shall be hard-wired to indicate alarm conditions of the emergency or auxiliary power source as follows: (1) Individual visual signals shall indicate the following: (a) When the emergency or auxiliary power source is operating to supply power to load (b) When the battery charger is malfunctioning (2) Individual visual signals plus a common audible signal to warn of an engine?generator alarm condition shall indicate the following: (a) Low lubricating oil pressure (b) Low water temperature (below that required in 6.4.1.1.11) (c) Excessive water temperature (d) Low fuel when the main fuel storage tank contains less than a 4-hour operating supply (e) Overcrank (failed to start) (f) Overspeed	K 916	A. Corrective Actions: The emergency generator's remote annunciator that has existed in the same location since the building was opened has been moved to a more occupied area in the Plant Operations Manager office/Central Supply per NFPA 99. This was completed on June 30, 2107. B. Identification of others affected and corrective actions: The facility's Plant Operations Manager has further reviewed the citation and as noted above arranged for the remote annunciator removal and relocation. During this process no others were determined to have been affected. C. Measures to ensure that the deficient practice does not happen again: The physical removal and relocation of the remote annunciator has resolved the matter and no further measures are required. D. Monitor corrective actions: The Executive Director or his designee will report to the QAA committee, which meets monthly, of the required removal and relocation completion. The issue has been remedied and no further measures are required. E. Corrective Actions have been completed: 06/30/2017	

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K 927 K 927 SS=D	Continued From page 15 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 oxygen transfilling was conducted in accordance with NFPA 99. Failure to transfill liquid oxygen with mechanical ventilation potentially creates a oxygen-rich environment, increasing the risk of combustion. This deficient practice affected 4 residents, staff and visitors on the date of the survey. The facility is licensed for 45 SNF/NF beds and had a census of 32 on the day of the survey. Findings include: 1) During the facility tour conducted on June 15, 2017 from approximately 10:00 AM to 12:30 PM, observation of the oxygen transfill area in the main service corridor revealed two HP 180 liquid oxygen cylinders and one 41 liter liquid oxygen cylinder. When asked how the space was used, the Maintenance Supervisor stated the larger HP 180 cylinders were used to transfill into the smaller sized 41 liter cylinders, which the facility further used to transfill portables. Further observation of this transfill area revealed no	K 927 K 927		

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K 927	<p>Continued From page 16 mechanical ventilation was installed.</p> <p>2) During the facility tour conducted on June 15, 2017 from approximately 10:00 AM to 12:30 PM, observation of the oxygen transfill area in the 300 hall revealed the space was equipped with mechanical ventilation and that the fan was operational, but lacked exhaust airflow when tested with standard note paper and a single facial tissue placed within one inch of the exhaust fan vent.</p> <p>Actual NFPA standard: 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. 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: (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. (2) The area is mechanically ventilated, is sprinklered, and has ceramic or concrete flooring. (3) The area is posted with signs indicating that transfilling is occurring and that smoking in the immediate area is not permitted. (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</p>	K 927	<p>A. Corrective Actions: The findings listed during the survey regarding specific aspects of NFPA 99 that pertain to the proper mechanical ventilation for oxygen transfilling in both locations, in the facility, has been scheduled for completion on 07/12/2017.</p> <p>B. Identification of others affected and corrective actions: The facility's Plant Operations Manager has further reviewed the Citation and arranged for the installation of new ventilation fans on that will remedy the issue. In this process no others were determined to have been affected.</p> <p>C. Measures to ensure that the deficient practice does not happen again: The facility's Plant Operations Manager will monitor for continued compliance by conducting and documenting via a monthly scheduled testing/inspection of the ventilation requirements in both transfilling areas.</p> <p>D. Monitor corrective actions: The Executive Director or his designee will conduct an audit review of the required monthly scheduled checklist/log. This will continue for a period of three (3) months. The results will be reported to the QAA committee which meets monthly. The QAA Committee will then determine if the system is effective to ensure ongoing compliance.</p>	

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K 927	Continued From page 17 than 235 L/sec (500 cfm).	K 927	E. Corrective action(s) will be completed or substantially completed by: 07/20/17	