



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSSELL S. BARRON – 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

July 10, 2017

James Hayes, Administrator
Payette Center
1019 Third Avenue South
Payette, ID 83661-2832

Provider #: 135015

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

Dear Mr. Hayes:

On **June 26, 2017**, a Facility Fire Safety and Construction survey was conducted at **Payette 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 24, 2017**. Failure to submit an acceptable PoC by **July 24, 2017**, may result in the imposition of civil monetary penalties by **August 12, 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 31, 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 31, 2017**. A change in the seriousness of the deficiencies on **July 31, 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 31, 2017**, includes the following:

Denial of payment for new admissions effective **September 26, 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 26, 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 26, 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:

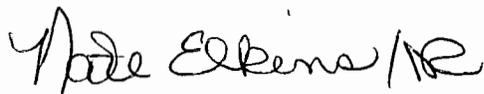
BFS Letters (06/30/11)

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

This request must be received by **July 24, 2017**. If your request for informal dispute resolution is received after **July 24, 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,

A handwritten signature in black ink that reads "Nate Elkins" followed by a stylized monogram "NE".

Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosures

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

PRINTED: 07/24/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135015	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 06/26/2017
NAME OF PROVIDER OR SUPPLIER PAYETTE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1019 THIRD AVENUE SOUTH PAYETTE, ID 83661	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The facility is a single story, type V(111) construction. The facility was originally built in 1961 and is fully sprinklered. The facility is equipped with an EPSS system in accordance with NFPA 110, is fully sprinklered and equipped with automatic fire detection system and manual pull stations. Currently the facility is licensed for 80 SNF/NF beds. The laundry is located in a separately detached building. The following deficiencies were cited during the annual life safety code survey conducted on June 26, 2017. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Chapter 19, Existing Health Care Occupancy, in accordance with 42 CFR 483.70. The Survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction 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, exceptions 1-5. 19.2.3.4, 19.2.3.5 This STANDARD is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure that means of egress were in accordance with NFPA 101.	K 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, River Ridge Care and Rehabilitation 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." K 232 NFPA 101 Aisle, Corridor or Ramp Width On July 20, 2017, Kitchen and Maintenance staff were provided in-service by the Food Service Director regarding the designated storage area to be used for the wheeled meal carts, and the need to relocate those carts to the storage area as soon as they are unloaded and cleaned. On or before June 26, 2017, the Food Service Director or designee will include daily observation of the utility hallway after meals to insure carts are repositioned. On or before July 29, 2017, in-service will be provided to facility staff by the Director of Environmental Services regarding the immediate repositioning of the carts to the storage area in the event of a fire.	08/31/17
K 232 SS=E		K 232		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE 07-23-17

James H. Noyes Executive Director

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 232	<p>Continued From page 1</p> <p>Failure to provide training and a specific location for the relocation of wheeled equipment stored in corridors, impedes egress of residents during an emergency. This deficient practice had the potential to affect 15 residents of the 200/300 east corridor, staff and visitors on the date of the survey. The facility is licensed for 80 SNF/NF beds and had a census of 28 on the day of the survey.</p> <p>Findings include:</p> <p>1) During review of the facility emergency preparedness policies conducted on June 26, 2017 from approximately 9:00 AM to 10:00 AM, no records were provided which included the location of where wheeled equipment would be placed in the event of an emergency.</p> <p>2) During the facility tour conducted on June 26, 2017 from approximately 10:00 AM to 11:00 AM and 1:00 PM to 1:30 PM, observation of the corridor outside the Kitchen revealed four dietary carts were stored outside the Kitchen on both sides of the corridor, with thirty-two (32) inches of clearance from these carts to the wall. Further observation at approximately 1:15 PM of a non-ambulatory resident in a wheelchair, revealed the resident appeared to have difficulty negotiating past these carts with the remaining space available.</p> <p>Interview of the Dietary Manager revealed these carts were stored at this location when being cleared rather than the cart storage area across the hall and that she was not aware of any training or specific location for the relocation of wheeled equipment during an emergency.</p>	K 232	<p>On or before July 29, 2017, the fire drill policy will be amended by the Director of Environmental Services to include the direction to immediately check and clear the utility hallway</p> <p>On or before July 29, 2017 the Director of Environmental Services will include observation of the cart repositioning during each fire drill. At the post-drill in-service, the Director of Environmental Services will include the issue of cart repositioning.</p> <p>On or before August 31, 2017, fire drill actions will be reported by the Director of Environmental Services in the QAPI Safety meeting and reviewed in the full QAPI meeting, monthly for 4 months. The Executive Director will be responsible for monitoring compliance.</p>	

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K 232	<p>Continued From page 2 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 ii. Medical emergency equipment not in use iii. Patient lift and transport equipment</p> <p>(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:</p> <p>(a) The fixed furniture is securely attached to the</p>	K 232	

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K 232	Continued From page 3 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			
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	K 325	K 325 NFPA 101 Alcohol Based Hand Rub Dispenser On or before July 29, 2017, Housekeeping staff will receive in-service from the Housekeeping Director regarding the process of refilling and operation testing of the hand rub dispensers. On or before July 29, 2017, the Housekeeping Director will begin the hand rub testing audits, testing and documenting the operation of the alcohol-based hand rub dispensers at the time of refill. Issues with faulty operation will be corrected immediately by the individual testing the units. On or before August 31, 2017, the Housekeeping Director will present the results of the hand rub testing audits in the QAPI Safety meeting. Results will be reviewed in the full QAPI meeting, monthly for four months. The Executive Director will be responsible for monitoring compliance.	08/31/17	

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K 325	<p>Continued From page 4</p> <ul style="list-style-type: none"> * 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 Alcohol Based Hand Rub Dispensers (ABHR) were maintained in accordance with NFPA 101. Failure to test and document operation of ABHR dispensers has the potential for inadvertently spilling flammable liquids increasing the risk of fires. This deficient practice affected 28 residents, staff and visitors on the date of the survey. The facility is licensed for 80 SNF/NF residents and had a census of 28 on the day of the survey.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1) During the review of facility inspection records conducted on June 26, 2017 from approximately 9:00 AM to 10:00 AM, no records were available indicating inspection and testing of ABHR dispensers was performed when refills were installed. 2) During the facility tour conducted on June 26, 	K 325			

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K 325	<p>Continued From page 5</p> <p>2017 from approximately 10:00 AM to 3:00 PM, observation of installed ABHR dispensers revealed manual dispensers had been installed in each resident room of the facility. When asked if ABHR dispensers were tested for proper operation and mechanical integrity, the Maintenance Supervisor stated the Housekeeping staff refilled the dispensers.</p> <p>Further interview of a Housekeeping staff member outside of room 120 on June 26, 2017 at approximately 11:15 AM, the staff stated she was not aware of the requirement for testing of dispensers each time a 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 gal) and shall be limited to Level 1</p>	K 325			

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K 325	<p>Continued From page 6</p> <p>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> <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. (25mm) 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>	K 325		

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K 325	Continued From page 7 (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		
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 _____	K 353	K 353 NFPA 101 Sprinkler System Maintenance and Testing On or before August 31, 2017, three identified pendants will be repaired or replaced by the fire safety system contractor. On or before August 31, 2017, all sprinkler heads will be inspected by the fire safety system contractor for leakage, corrosion, physical damage, loss of fluid in the glass bulb, loading, and aftermarket painting. <u>On or before September 15, 2017</u> , any sprinkler heads not meeting the above criteria will be replaced or repaired by the fire safety system contractor. On or before August 31,2017, the Director of Environmental Services will inspect the sprinkler heads monthly as per facility policy. Results of the inspections will be reported in the Safety QAPI meeting and reviewed in the full QAPI meeting, monthly for 4 months. The Executive Director will be responsible for monitoring compliance.	08/31/17 P&I WITH ADMIN

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K 353	<p>Continued From page 8</p> <p>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: Based on observation, 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 has the potential to hinder system performance during a fire event. This deficient practice affected staff and visitors on the date of the survey. The facility is licensed for 80 SNF/NF beds and had a census of 28 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on June 26, 2017 from approximately 10:00 AM to 3:00 PM, observation of the installed fire sprinkler pendants revealed the following:</p> <p>Dishwashing area: two (2) corroded pendants Housekeeping storage area by room 210: one (1) corroded pendant</p> <p>Actual NFPA standard:</p> <p>NFPA 25</p> <p>5.2.1 Sprinklers.</p> <p>5.2.1.1* Sprinklers shall be inspected from the floor level annually.</p> <p>5.2.1.1.1* Sprinklers shall not show signs of leakage; shall be</p>	K 353			

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K 353	Continued From page 9 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	K 353		
K 923 SS=E	NFPA 101 Gas Equipment - Cylinder and Container Storage Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient	K 923	K 923 NFPA 101 Gas Equipment – Cylinder and Container Storage On June 26, 2017, the Director of Environmental Services separated the empty "E" cylinder from the full cylinder rack, and secured the two identified unsecured "E" cylinders. On or before July 29, 2017, the Director of Environmental Services will present in-service to staff involved in handling oxygen regarding proper storage and handling. On or before August 31 the Director of Environmental Services will conduct daily audits of the oxygen storage area, daily for four weeks, and weekly for four months, noting any issues. On or before August 31, 2017 the Dir. of environmental services will report the results of the oxygen storage area audits in the QAPI Safety meeting. Results will be reviewed in the full QAPI meeting, monthly for four months. The Executive Director will be responsible for monitoring compliance.	08/31/17

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K 923	<p>Continued From page 10</p> <p>care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING."</p> <p>Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather.</p> <p>11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure medical gases were stored in accordance with NFPA 99. Failure to segregate empty oxygen cylinders from full oxygen cylinders, potentially results in staff using incorrect cylinders during an emergency. This deficient practice affected residents in need of supplemental oxygen, staff and visitors on the date of the survey. The facility is licensed for 80 SNF/NF beds and had a census of 28 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on June 26, 2017 from approximately 10:00 AM to 3:00 PM, observation of the oxygen storage room abutting the Business Office revealed two unsecured "E" cylinders stored in this location. Further observation revealed one (1) "E" cylinder,</p>	K 923		

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K 923	<p>Continued From page 11</p> <p>Identified as empty by the Maintenance Supervisor, stored in a rack with five (5) cylinders identified as full. When asked how the distinction was made between full cylinders versus empty cylinders, the Maintenance Supervisor stated the full cylinders have a plastic cap attached and empty cylinders do not.</p> <p>Actual NFPA standard:</p> <p>NFPA 99</p> <p>11.6.2.3 Cylinders shall be protected from damage by means of the following specific procedures:</p> <p>(1) Oxygen cylinders shall be protected from abnormal mechanical shock, which is liable to damage the cylinder, valve, or safety device.</p> <p>(2) Oxygen cylinders shall not be stored near elevators or gangways or in locations where heavy moving objects will strike them or fall on them.</p> <p>(3) Cylinders shall be protected from tampering by unauthorized individuals.</p> <p>(4) Cylinders or cylinder valves shall not be repaired, painted, or altered.</p> <p>(5) Safety relief devices in valves or cylinders shall not be tampered with.</p> <p>(6) Valve outlets clogged with ice shall be thawed with warm - not boiling - water.</p> <p>(7) A torch flame shall not be permitted, under any circumstances, to come in contact with a cylinder, cylinder valve, or safety device.</p> <p>(8) Sparks and flame shall be kept away from cylinders.</p> <p>(9) Even if they are considered to be empty, cylinders shall not be used as rollers, supports, or for any purpose other than that for which the supplier intended them.</p>	K 923			

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K 927	<p>Continued From page 13</p> <p>the facility failed to ensure liquid oxygen transfilling was conducted in accordance with NFPA 99. Failure to transfill liquid oxygen with mechanical ventilation potentially creates an oxygen rich environment, increasing the risk of combustion. This deficient practice affected 15 residents of the 200/300 corridor, staff and visitors on the date of the survey. The facility is licensed for 80 SNF/NF beds and had a census of 28 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on June 26, 2017 from approximately 10:00 AM to 3:00 PM, observation and operational testing of the fan for the oxygen storage/transfill area abutting the Business Office, revealed the fan was operational, but lacked exhaust airflow when tested with a sheet of standard note paper and a single facial tissue placed within one inch 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</p>	K 927		

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K 923	Continued From page 12 (10) Large cylinders (exceeding size E) and containers larger than 45 kg (100 lb) weight shall be transported on a proper hand truck or cart complying with 11.4.3.1. (11) Freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. (12) Cylinders shall not be supported by radiators, steam pipes, or heat ducts. 11.6.5 Special Precautions - Storage of Cylinders and Containers. 11.6.5.1 Storage shall be planned so that cylinders can be used in the order in which they are received from the supplier. 11.6.5.2 If empty and full cylinders are stored within the same enclosure, empty cylinders shall be segregated from full cylinders. 11.6.5.3 Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed in a rapid manner.	K 923			
K 927 SS=E	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,	K 927	K 927 NFPA 101 Gas Equipment – Transfilling Cylinders On or before August 31, 2017 the identified exhaust fan will be replaced by the Director of Environmental Services, who will report the replacement at the QAPI safety meeting. On or before August 31, 2017, the director of environmental services will inspect the operation of the exhaust fan operation, monthly for four months. He will report results in the QAPI safety meeting, monthly for four months. Results will be reviewed in the full QAPI meeting. The Executive Director will be responsible for compliance.	08/31/17	

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K 927	Continued From page 14 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. 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).	K 927		