



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 17, 2017

Dennis Carlson, Administrator
Bear Lake Memorial Skilled Nursing Facility
164 South Fifth Street
Montpelier, ID 83254-1557

Provider #: 135070

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

Dear Mr. Carlson:

On **July 7, 2017**, a Facility Fire Safety and Construction survey was conducted at **Bear Lake Memorial Skilled Nursing Facility** 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 31, 2017**. Failure to submit an acceptable PoC by **July 31, 2017**, may result in the imposition of civil monetary penalties by **August 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 **August 11, 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 **August 11, 2017**. A change in the seriousness of the deficiencies on **August 11, 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 **August 11, 2017**, includes the following:

Denial of payment for new admissions effective **October 7, 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 **January 7, 2018**, 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 **July 7, 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:

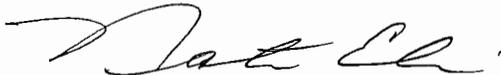
BFS Letters (06/30/11)

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

This request must be received by **July 31, 2017**. If your request for informal dispute resolution is received after **July 31, 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: 07/14/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135070	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE NF B. WING _____	(X3) DATE SURVEY COMPLETED 07/07/2017
NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL SKILLED NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83254	
(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, fully sprinklered and built in 1977. The nursing facility is separated from the existing hospital by a two-hour fire separation wall. The nursing facility has three smoke compartments. Two large compartments divide the facility and a smaller third compartment separates the administrative area from the rest of the building. The facility is currently licensed for 36 SNF/NF beds. The following deficiencies were cited during the annual life safety code survey conducted on July 7, 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		
K 161 SS=E	NFPA 101 Building Construction Type and Height Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered	K 161	RECEIVED JUL 31 2017 FACILITY STANDARDS K 161 The alleged deficiency, K 161, resulted in no specific resident being affected by this deficiency. All residents had the potential to be affected by this deficiency. 1.) The hole identified in the Housekeeping Closet across from room #118 has been repaired as directed. 2.) The open space around the pipe identified in the mechanical room has been filled as directed.	7/27/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

ADMINISTRATOR NHA-818

7/27/17

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 161	Continued From page 1 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the smoke and fire resistive properties of the structure were maintained. Failure to seal penetrations in rated walls will result in fire and smoke passing between compartments during a fire event. This deficient practice affected all residents, staff and visitors on the date of the survey. The facility is licensed for 36 SNF/NF beds and had a census of 33 on the day of the survey.	K 161	To ensure this deficiency doesn't recur, penetrations made in the smoke/fire barrier(s) will be inspected and repaired immediately after the work has been completed in these areas by BLMH Maintenance Staff.	

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K 161	Continued From page 2 Findings include: During the facility tour on July 7, 2017, from approximately 2:00 PM to 4:00 PM, observation revealed the following unsealed penetrations: 1.) The Housekeeping Closet across from resident room #118 had an approximately 24" x 30" hole in the wall. 2.) The mechanical room had an approximately 1/2" annular penetration around the pipe going through the wall. When asked, the Maintenance Supervisor stated the maintenance staff had removed a portion of the wall board in the housekeeping closet to access water pipes for a repair. They had not yet replaced the wall board. The annular penetration in the mechanical room had somehow been overlooked when maintenance staff was sealing penetrations in that area. Actual NFPA standard: 19.1.6 Minimum Construction Requirements. 19.1.6.1 Health care occupancies shall be limited to the building construction types specified in Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7. (See 8.2.1.) 8.2 Construction and Compartmentation. 8.2.1 Construction. 8.2.1.1 Buildings or structures occupied or used in accordance with the individual occupancy chapters, Chapters 11 through 43, shall meet the minimum construction requirements of those chapters.	K 161			
K 211 SS=F	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges,	K 211			

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K 211	<p>Continued From page 3</p> <p>exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure that fire and smoke door 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 during a fire or other emergency. This deficient practice affected all patients, staff and visitors on the date of the survey. The facility is licensed for 36 SNF/NF beds and had a census of 33 on the day of the survey.</p> <p>Findings include:</p> <p>During record review on July 7, 2017, from approximately 12:30 PM to 2:00 PM, no record was available demonstrating an annual inspection and testing of the fire and smoke door assemblies had been completed. When asked about the missing documentation, the Maintenance Supervisor stated the facility was unaware of this requirement.</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</p>	K 211	<p>K 211</p> <p>The alleged deficiency, K 211, resulted in no specific resident being affected by this deficiency. All residents had the potential to be affected by this deficiency.</p> <p>The alleged deficiency has been corrected by establishing a concurrent monthly inspection of fire doors throughout the facility at the same time the facilities fire extinguishers will be inspected. A log has developed to document this inspection.</p>	7/27/17	

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K 211	Continued From page 4 19.2.2 through 19.2.11. 7.2.1 Door Openings. 7.2.1.15 Inspection of Door Openings. 7.2.1.15.1* Where required by Chapters 11 through 43, the following door assemblies shall be inspected and tested not less than annually in accordance with 7.2.1.15.2 through 7.2.1.15.8: (1) Door leaves equipped with panic hardware or fire exit hardware in accordance with 7.2.1.7 (2) Door assemblies in exit enclosures (3) Electrically controlled egress doors (4) Door assemblies with special locking arrangements subject to 7.2.1.6 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	K 211		

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K 211 K 324 SS=D	Continued From page 5 inoperative shall be replaced. NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to maintain the kitchen hood ventilation and suppression system in accordance with NFPA 96. Failure to maintain the kitchen hood ventilation and suppression system could result in a build-up of grease inside the hood, increasing the risk of fire, and a lack of system performance during a fire event. This deficient practice affected staff	K 211 K 324	K 324 The alleged deficiency, K 324, resulted in no specific resident being affected by this deficiency. All residents had the potential to be affected by this deficiency. This alleged deficiency has been addressed by an inspection of the Fire Suppression System on 07/11/17 by our current Fire Safety vendor. The kitchen hood cleaning component of this deficiency correction 07/28/17. To ensure this deficiency doesn't recur, a calendared reminder will be put in place by BLMH Dietary Supervisor to ensure the timely inspection of the Fire Suppression System and cleaning of the hood take place. Both Maintenance Staff and the Dietary Supervisor will be monitoring that these occur timely.	7/28/17

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K 324	<p>Continued From page 6 and visitors on the date of the survey. The facility is licensed for 36 SNF/NF beds and had a census of 33 on the day of the survey.</p> <p>Findings include:</p> <p>1.) During record review on July 7, 2017, from approximately 12:30 PM to 2:00 PM, review of the documentation for the kitchen hood suppression system revealed the last date of inspection was December 20, 2016.</p> <p>2.) During record review on July 7, 2017, from approximately 12:30 PM to 2:00 PM, review of the documentation for the kitchen hood cleaning revealed the last date of cleaning was December 13, 2016.</p> <p>Both are required semi-annually and were over due on the date of the survey. When asked about the missing documentation, the Maintenance Supervisor stated the facility was in the process of scheduling the inspection and cleaning.</p> <p>Actual NFPA standard:</p> <p>NFPA 101 19.3.2.5 Cooking Facilities. 19.3.2.5.1 Cooking facilities shall be protected in accordance with 9.2.3, unless otherwise permitted by 19.3.2.5.2, 19.3.2.5.3, or 19.3.2.5.4.</p> <p>9.2.3 Commercial Cooking Equipment. Commercial cooking equipment shall be in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless such installations are approved existing installations, which shall be permitted to be continued in service.</p>	K 324		

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K 324	Continued From page 7 NFPA 96 11.2 Inspection, Testing, and Maintenance of Fire-Extinguishing Systems. 11.2.1* Maintenance of the fire-extinguishing systems and listed exhaust hoods containing a constant or fire-activated water system that is listed to extinguish a fire in the grease removal devices, hood exhaust plenums, and exhaust ducts shall be made by properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction at least every 6 months. 11.6 Cleaning of Exhaust Systems. Table 11.4 Schedule of Inspection for Grease Buildup Systems serving moderate-volume cooking operations - Semi-annually	K 324		