



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 18, 2017

Dallas Clinger, Administrator
Power County Nursing Home
PO Box 420
American Falls, ID 83211-0420

Provider #: 135066

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

Dear Mr. Clinger:

On **July 10, 2017**, a Facility Fire Safety and Construction survey was conducted at **Power County Nursing Home** 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 20, 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 14, 2017**, (Opportunity to Correct). Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **August 14, 2017**. A change in the seriousness of the deficiencies on **August 14, 2017**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **August 14, 2017**, includes the following:

Denial of payment for new admissions effective **October 10, 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 10, 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 10, 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: 07/18/2017
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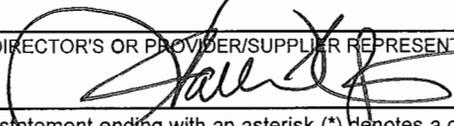
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135066	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 07/10/2017
NAME OF PROVIDER OR SUPPLIER POWER COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 510 ROOSEVELT STREET (83211-1362) AMERICAN FALLS, ID 83211	
(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	<p>INITIAL COMMENTS</p> <p>The nursing facility portion of the building occupies the east wing of both the lower and upper levels and is attached to the hospital building. The original building's construction was completed in early 1961. A two level addition was completed in early 1967 extending the upper level hospital patient wing to the east. The nursing facility was extended into the upper level east wing sleeping rooms in the fall of 1987. Both the existing and addition building construction elements are fire resistive. Wall construction varies depending upon location and is either concrete block; concrete; concrete with brick veneer; and/or 4"/6" metal studs w/lath & plaster. Supporting beams are combination steel w/fire proofing and/or concrete. The floor/ceiling assembly between the lower and upper levels consist of steel joist with 5/8" gyp steel channel below and metal decking and poured concrete flooring above. The roof assembly is steel joists with lath/plaster attached to the underside and a metal deck with poured concrete above. There are a total of three (3) exits from the lower level nursing facility wing; two (2) directly to the exterior at grade and the third through the hospital's main entry lobby. There are two (2) exits from the upper level east nursing wing; one is an enclosed stairway at the east end of the wing and the other is accessible through the west hospital portion of the building. The building is provided with a fire alarm system with off site monitoring and system smoke detection in the exit access corridors and the open dining room on the lower level. Emergency power and lighting are provided by the hospital's diesel powered, automatic generator. The facility was retrofitted on October 4, 2010 with automatic fire sprinklers, a Halon</p>	K 000		

RECEIVED
AUG 14 2017
FACILITY STANDARDS

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

TITLE

(X6) DATE



CEO/ADMINISTRATOR

11 AUG 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 000	Continued From page 1 system was also installed in the IT room, both systems are interconnected with the building fire alarm system. The facility is currently licensed for 20 SNF/NF beds. The following deficiencies were cited during the annual life safety code survey conducted on July 10, 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			11Aug2017	
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, operational testing and interview, the facility failed to maintain the means of egress free of obstructions and failed to ensure that written records were available to show inspections of fire and smoke doors assemblies. Failure to inspect and test fire and smoke doors and maintain the means of egress could prevent occupants ability to safely evacuate and defend in place during an emergency. This deficient practice affected all		K211 NFPA 101 K 000 Means of Egress- General What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice? 1.) The Maintenance Supervisor talked with the nursing staff about keeping corridors and exit areas clear, particularly watching for items to remove after the therapists are done working with patients. The Maintenance Staff also placed a "Do Not Block Doors" sign on the exit doors. This was done on 7/23/2017 (see photo). 2.) The Maintenance Staff replaced the door threshold of the SNF stairwell exit, added silicone to secure the edges, and also checked and oiled the hinges for better door opening/operation. This work was done on 7/23/2017 (see photos). 3.) The Maintenance Staff rechecked the facility's fire and smoke doors with an updated fire door comprehensive checklist on 8/10/2017. A fire door check-off note was also added to the monthly fire drill checklist. How you will identify others having the potential to be affected by the same deficient practice and what corrective action(s) will be taken? All residents, staff, and visitors have the potential to be affected by this deficiency. What measure will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur?		

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K 211	<p>Continued From page 2</p> <p>residents, staff and visitors on the date of the survey. The facility is licensed for 20 SNF/NF beds and had a census of 18 on the day of the survey.</p> <p>Findings include:</p> <p>1.) During the facility tour on July 10, 2017, from approximately 1:30 PM to 3:30 PM, observation of the exit door at the end of the corridor (near resident rooms 1-5) revealed it was blocked by two chairs that had been placed in front of the door. The Maintenance Supervisor immediately removed the chairs and stated they were being used for therapy.</p> <p>2.) During the facility tour on July 10, 2017, from approximately 1:30 PM to 3:30 PM, observation and operational testing of the stairwell exit in the skilled nursing facility, revealed the threshold had been damaged and the door was not operational. When asked, the Maintenance Supervisor stated the threshold must have been damaged during the harsh winter months and the facility was unaware the exit door was not working properly.</p> <p>3.) During record review on July 10, 2017, from approximately 10:30 AM to 1:30 PM, no record was available demonstrating inspections and testing of the fire and smoke door assemblies. 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.</p>	K 211	<p>1.) The Maintenance Staff will inspect for cleared doorway areas with their daily walk-around and remove items if necessary; and remind nursing staff to keep doorways and corridors clear.</p> <p>2.) & 3.) The Maintenance Staff will use the new comprehensive fire door checklist to check doorways for proper operation and safety as part of their annual reviews.</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place?</p> <p>1.) The Administrator will check doorways and corridors weekly for 1 month; then monthly for 3 months for compliance.</p> <p>2.) & 3.) The Maintenance Staff will check fire doors for operation monthly with the fire drill checklist documentation.</p> <p>All checks will begin 8/14/17 with deficiencies reported to the Maintenance Supervisor for fixes; and reported to the QI Director at quarterly meetings.</p>	

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K 211	<p>Continued From page 3</p> <p>Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7, unless otherwise modified by 19.2.2 through 19.2.11.</p> <p>7.1.10.1* General. Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.</p> <p>7.2.1 Door Openings.</p> <p>7.2.1.15 Inspection of Door Openings.</p> <p>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:</p> <p>(1) Door leaves equipped with panic hardware or fire exit hardware in accordance with 7.2.1.7</p> <p>(2) Door assemblies in exit enclosures</p> <p>(3) Electrically controlled egress doors</p> <p>(4) Door assemblies with special locking arrangements subject to 7.2.1.6</p> <p>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.</p> <p>NFPA 80</p> <p>5.2* Inspections.</p> <p>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.</p>	K 211			

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K 321	<p>Continued From page 5</p> <p>f. Combustible Storage Rooms/Spaces (over 50 square feet)</p> <p>g. Laboratories (if classified as Severe Hazard - see K322)</p> <p>This STANDARD is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure that hazardous areas were protected with self-closing doors. Failure to provide self-closing doors for hazardous areas would allow smoke and dangerous gases to pass freely into corridors and hinder egress of occupants during a fire event. This deficient practice affected staff and visitors on the date of the survey. The facility is licensed for 20 SNF/NF beds with a census of 18 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour on July 10, 2017, from approximately 1:30 PM to 3:30 PM, observation and operational testing of the two (2) doors to the laboratory revealed they were not self-closing. When asked, the Maintenance Supervisor stated the facility was not aware of the requirement for laboratory doors to be self-closing.</p> <p>Actual NFPA standard:</p> <p>19.3.2 Protection from Hazards. 19.3.2.1.3 The doors shall be self-closing or automatic-closing. 19.3.2.1.5 Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft² (9.3 m²) (3) Paint shops (4) Repair shops</p>	K 321	checks will begin 8/14/17 with deficiencies reported to the Maintenance Supervisor for fixes; and reported to the QI Director at quarterly meetings.	

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K 321	Continued From page 6 (5) Rooms with soiled linen in volume exceeding 64 gal (242 L) (6) Rooms with collected trash in volume exceeding 64 gal (242 L) (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard	K 321	K325 NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR) What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice? The Housekeeping Supervisor numbered all of the facility ABHR dispensers and created a check list of the dispensers. All dispensers were checked and fixed on 8/8/2017 for working batteries, refill replacements, and operability according to new NFPA 19.3.2.6* standards.	11Aug2017
K 325 SS=F	NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR) Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access	K 325	How you will identify others having the potential to be affected by the same deficient practice and what corrective action(s) will be taken? All residents, staff, and visitors have the potential to be affected by this deficiency. What measure will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur? The Housekeeping Supervisor will inspect all facility ABHR dispensers monthly with a checklist for batteries, refill replacements, and operability and work with the Maintenance Staff for repairs or replacements needed. How will the corrective action(s) be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place? The Housekeeping Supervisor will monitor the ABHR dispensers monthly hereafter for proper maintenance and compliance. These checks will begin September 2017 with deficiencies reported to the Maintenance	

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K 325	<p>Continued From page 7</p> <p>18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485</p> <p>This STANDARD is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure Alcohol Based Hand Rub Dispensers (ABHR) were maintained in accordance with NFPA 101. Failure to test and document the operation of ABHR dispensers in accordance with the manufacturer's care and use instructions each time a new refill is installed could result in inadvertently spilling flammable liquids, increasing the risk of fires. This deficient practice affected all residents, staff and visitors on the date of the survey. The facility is licensed for 20 SNF/NF beds and had a census of 18 on the day of the survey.</p> <p>Findings include:</p> <p>During the review of facility inspection records conducted on July 10, 2017 from approximately 10:30 AM to 1:30 PM, no records were available indicating ABHR dispensers are tested in accordance with manufacturer's care and use instructions when a new refill is installed. ABHR dispensers were observed throughout the facility and when asked, the Maintenance Supervisor stated the facility was not aware of the requirement to test ABHR dispensers each time a new refill is installed.</p> <p>Actual NFPA standard:</p> <p>NFPA 101</p> <p>19.3.2.6* Alcohol-Based Hand-Rub Dispensers. Alcohol-based hand-rub dispensers shall be protected in accordance with 8.7.3.1, unless all of the following conditions are met:</p>	K 325	Supervisor for fixes, and reported to the QI Director at quarterly meetings.	

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K 325	Continued From page 8 (1) Where dispensers are installed in a corridor, the corridor shall have a minimum width of 6 ft (1830 mm). (2) The maximum individual dispenser fluid capacity shall be as follows: (a) 0.32 gal (1.2 L) for dispensers in rooms, corridors, and areas open to corridors (b) 0.53 gal (2.0 L) for dispensers in suites of rooms (3) Where aerosol containers are used, the maximum capacity of the aerosol dispenser shall be 18 oz. (0.51 kg) and shall be limited to Level 1 aerosols as defined in NFPA30B, Code for the Manufacture and Storage of Aerosol Products. (4) Dispensers shall be separated from each other by horizontal spacing of not less than 48 in. (1220 mm). (5) Not more than an aggregate 10 gal (37.8 L) of alcohol-based hand-rub solution or 1135 oz (32.2 kg) of Level 1 aerosols, or a combination of liquids and Level 1 aerosols not to exceed, in total, the equivalent of 10 gal (37.8 L) or 1135 oz (32.2 kg), shall be in use outside of a storage cabinet in a single smoke compartment, except as otherwise provided in 19.3.2.6(6). (6) One dispenser complying with 19.3.2.6 (2) or (3) per room and located in that room shall not be included in the aggregated quantity addressed in 19.3.2.6(5). (7) Storage of quantities greater than 5 gal (18.9 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	K 325		

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K 325	Continued From page 9 in. (25 mm) horizontal distance from the ignition source (c) Beneath an ignition source within a 1 in. (25 mm) vertical distance from the ignition source (9) Dispensers installed directly over carpeted floors shall be permitted only in sprinklered smoke compartments. (10) The alcohol-based hand-rub solution shall not exceed 95 percent alcohol content by volume. (11) Operation of the dispenser shall comply with the following criteria: (a) The dispenser shall not release its contents except when the dispenser is activated, either manually or automatically by touch-free activation. (b) Any activation of the dispenser shall occur only when an object is placed within 4 in. (100 mm) of the sensing device. (c) An object placed within the activation zone and left in place shall not cause more than one activation. (d) The dispenser shall not dispense more solution than the amount required for hand hygiene consistent with label instructions. (e) The dispenser shall be designed, constructed, and operated in a manner that ensures that accidental or malicious activation of the dispensing device is minimized. (f) The dispenser shall be tested in accordance with the manufacturer's care and use instructions each time a new refill is installed.	K 325		
K 353 SS=F	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance	K 353		

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K 353	<p>Continued From page 10 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.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</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 record review, observation and interview, the facility failed to inspect, test and maintain the fire suppression system. Failure to maintain fire suppression systems could hinder system performance during a fire event. This deficient practice affected all residents, staff and visitors on the date of the survey. The facility is licensed for 20 SNF/NF beds and had a census of 18 on the day of the survey.</p> <p>Findings include:</p> <p>1.) During the review of facility inspection records conducted on July 10, 2017 from approximately 10:30 AM to 1:30 PM, documentation could only be produced for an annual sprinkler inspection in September 2015. Observation of the sprinkler riser during the facility tour from approximately 1:30 PM to 3:30 PM, revealed an inspection tag on the riser, also dated September 2015. When asked, the Maintenance Supervisor stated the facility was not aware the 2016 sprinkler</p>	K 353	<p>K353 NFPA 101 Sprinkler System- Maintenance and Testing</p> <p>What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice?</p> <ol style="list-style-type: none"> 1.) The facility annual fire alarm system inspection was completed on 2/24/2017 with a horn failure that was then repaired on 3/30/2017 (<i>see reports</i>). 2.) The Maintenance Supervisor contacted the fire sprinkler system inspection contractor for 5-year inspection records and details. The facility fire sprinkler system was installed in 2010. A full 5-year check of the system was completed, as required, in 2015 (<i>see email</i>). The next 5-year full fire sprinkler system check will be due in 2020. <p>How you will identify others having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?</p> <p>All residents, staff, and visitors have the potential to be affected by this deficiency.</p> <p>What measure will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>The Maintenance Supervisor updated our maintenance annual review records with a copy of the 2017 fire alarm system inspection reports. The Supervisor also notated the 2020 due date for the next 5-year full system inspection. The facility will also be sending all of the Maintenance Staff to the September 2017 IHCA SNF Maintenance Director training for</p>	11Aug2017	

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K 353	<p>Continued From page 11 inspection had not been completed.</p> <p>2.) During the review of facility inspection records conducted on July 10, 2017 from approximately 10:30 AM to 1:30 PM, no documentation could be located for a five (5) year inspection of the sprinkler system to include internal pipes and gauges. When asked, the Maintenance Supervisor stated the facility was not aware that the five (5) year inspection had not been completed.</p> <p>Actual NFPA standard:</p> <p>NFPA 101 9.7.5 Maintenance and Testing. All automatic sprinkler and standpipe systems required by this Code shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. 9.7.7 Documentation. All required documentation regarding the design of the fire protection system and the procedures for maintenance, inspection, and testing of the fire protection system shall be maintained at an approved, secured location for the life of the fire protection system. 9.7.8 Record Keeping. Testing and maintenance records required by NFPA25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, shall be maintained at an approved, secured location.</p> <p>NFPA 25 5.2* Inspection. 5.2.1 Sprinklers. 5.2.1.1* Sprinklers shall be inspected from the floor level annually.</p>	K 353	<p>additional tips and information on proper facility maintenance, codes, and system tracking.</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place?</p> <p>The Maintenance Supervisor will continue to review the maintenance annual review records and schedule fire sprinkler system checks as required. These checks will begin September 2017 with a copy of all annual and required facility fire sprinkler system checks given to the Administrator for compliance; and deficiencies reported at the monthly facility Safety meeting.</p>	

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K 353	Continued From page 12 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 5.2.2* Pipe and Fittings. Sprinkler pipe and fittings shall be inspected annually from the floor level. 5.2.3* Hangers and Seismic Braces. Sprinkler pipe hangers and seismic braces shall be inspected annually from the floor level. 5.2.8* Information Sign. The information sign shall be inspected annually to verify that it is securely attached and is legible. 5.3.4* Antifreeze Systems. The freezing point of solutions in antifreeze shall be tested annually by measuring the specific gravity with a hydrometer or refractometer and adjusting the solutions if necessary. 5.3.2* Gauges. 5.3.2.1 Gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. 14.2 Internal Inspection of Piping. 14.2.1 Except as discussed in 14.2.1.1 and 14.2.1.4 an inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. See Table 5.1.1.2 Summary of Sprinkler System Inspection, Testing, and Maintenance	K 353		
K 907	NFPA 101 Gas and Vacuum Piped Systems -	K 907		

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K 907	Continued From page 14 medical-surgical vacuum systems could be located. When asked about the missing documentation, the Maintenance Supervisor stated the facility was unaware of this requirement. Actual NFPA standard: NFPA 99 5.1.14.2.1* General. Health care facilities with installed medical gas, vacuum, WAGD, or medical support gas systems, or combinations thereof, shall develop and document periodic maintenance programs for these systems and their subcomponents as appropriate to the equipment installed. 5.1.14.2.2 Maintenance Programs. 5.1.14.2.2.1 Inventories. Inventories of medical gas, vacuum, WAGD, and medical support gas systems shall include at least all source subsystems, control valves, alarms, manufactured assemblies containing patient gases, and outlets. 5.1.14.2.2.2* Inspection Schedules. Scheduled inspections for equipment and procedures shall be established through the risk assessment of the facility and developed with consideration of the original equipment manufacturer recommendations and other recommendations as required by the authority having jurisdiction. 5.1.14.2.2.3 Inspection Procedures. The facility shall be permitted to use any inspection procedure(s) or testing methods established through its own risk assessment. 5.1.14.2.2.4 Maintenance Schedules. Scheduled maintenance for equipment and procedures shall be established through the risk assessment of the facility and developed with consideration of the original equipment manufacturer	K 907	How will the corrective action(s) be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place? The Maintenance Staff will monitor the operation of the gas and vacuum systems, in accordance with our new policy and with their annual review schedule. These checks will begin 8/11/17 with deficiencies reported to the Maintenance Supervisor for fixes; and reported at the monthly facility Safety meeting.	

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K 907 SS=F	Continued From page 13 Maintenance Pr Gas and Vacuum Piped Systems - Maintenance Program Medical gas, vacuum, WAGD, or support gas systems have documented maintenance programs. The program includes an inventory of all source systems, control valves, alarms, manufactured assemblies, and outlets. Inspection and maintenance schedules are established through risk assessment considering manufacturer recommendations. Inspection procedures and testing methods are established through risk assessment. Persons maintaining systems are qualified as demonstrated by training and certification or credentialing to the requirements of AASE 6030 or 6040. 5.1.14.2.1, 5.1.14.2.2, 5.1.15, 5.2.14, 5.3.13.4.2 (NFPA 99) This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure that positive pressure gas central piping systems and medical-surgical vacuum systems have a documented maintenance program. Failure to inventory, inspect, and maintain these systems, by a qualified person, could result in fire, explosion, or a lack of system performance as designed. This deficient practice affected all patients, staff and visitors on the date of the survey. The facility is licensed for 20 SNF/NF beds and had a census of 18 on the day of the survey. Findings include: During record review on July 10, 2017, from approximately 10:30 AM to 1:30 PM, no documentation of a maintenance program for the positive pressure gas central piping systems and	K 907	K907 NFPA 101 Gas & Vacuum Piped Systems- Maintenance Program What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice? A new facility policy was created, in accordance with NFPA guidelines, to outline our facility Maintenance Program for the gas and vacuum piped systems (<i>see policy</i>). A licensed and certified gas-vacuum system inspector is scheduled to come to the facility on 8/24/2017 (the first available appointment we could get) to inspect the full system for compliance with NFPA guidelines. When we receive the report, we will forward it to the Bureau of Facility Standards. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken? All residents, staff, and visitors have the potential to be affected by this deficiency. What measure will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur? The Maintenance Staff will follow the new Gas and Vacuum System policy and procedure to track and monitor the inventory, inspection schedules, testing, and maintenance of our gas and vacuum systems. The facility will also be sending the Maintenance Staff to the September 2017 IHCA SNF Maintenance Director training for additional tips on maintaining these systems and requirements.	11Aug2017

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K 907	Continued From page 15 recommendations and other recommendations as required by the authority having jurisdiction. 5.1.14.2.2.5 Qualifications. Persons maintaining these systems shall be qualified to perform these operations. Appropriate qualification shall be demonstrated by any of the following: (1) Training and certification through the health care facility by which such persons are employed to work with specific equipment as installed in that facility (2) Credentialing to the requirements of ASSE 6040, Professional Qualification Standard for Medical Gas Maintenance Personnel (3) Credentialing to the requirements of ASSE 6030, Professional Qualification Standard for Medical Gas Systems Verifiers 5.1.14.2.3 Inspection and Testing Operations. 5.1.14.2.3.1 General. The elements in 5.1.14.2.2.2 through 5.1.15 shall be inspected or tested as part of the maintenance program as follows: (1)*Medical air source, as follows: (a) Room temperature (b) Shaft seal condition (c) Filter condition (d) Presence of hydrocarbons (e) Room ventilation (f) Water quality, if so equipped (g) Intake location (h) Carbon monoxide monitor calibration (i) Air purity (j) Dew point (2)*Medical vacuum source - exhaust location (3) WAGD source - exhaust location (4)*Instrument air source - filter condition (5)*Manifold sources (including systems complying with 5.1.3.5.10, 5.1.3.5.11, 5.1.3.5.12, and 5.1.3.5.13), as follows: (a) Ventilation	K 907			

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K 907	Continued From page 16 (b) Enclosure labeling (6) Bulk cryogenic liquid source inspected in accordance with NFPA 55, Compressed Gases and Cryogenic Fluids Code (7) Final line regulation for all positive pressure systems - delivery pressure (8)*Valves - labeling (9)*Alarms and warning systems-lamp and audio operation (10) Alarms and warning systems, as follows: (a) Master alarm signal operation (b) Area alarm signal operation (c) Local alarm signal operation (11)*Station outlets/inlets, as follows: (a) Flow (b) Labeling (c) Latching/delatching (d) Leaks 5.1.14.2.3.2 Manufactured Assemblies Employing Flexible Connection(s) Between the User Terminal and the Piping System. (A) Non-stationary booms and articulating assemblies, other than head walls utilizing flexible connectors, shall be tested for leaks, per manufacturer ' s recommendations, every 18 months or at a duration as determined by a risk assessment. (B) The system pressure to non-stationary booms and articulating arms shall be maintained at operating pressure until each joint has been examined for leakage by effective means of leak detection that is safe for use with oxygen. (C) Safe working condition of the flexible assemblies shall be confirmed. (D) D.I.S.S. connectors internal to the boom and assemblies shall be checked for leakage. (E) Leaks, if any, shall be repaired (if permitted), or the components replaced (if required), and the equipment retested prior to placing the equipment	K 907		

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K 907	Continued From page 17 back into service. (F) Additional testing of non-stationary booms or articulating arms shall be performed at intervals defined by documented performance data. 5.1.14.3 Medical Gas and Vacuum Systems Information and Warning Signs. 5.1.14.3.1 The gas content of medical gas and vacuum piping systems shall be labeled in accordance with 5.1.11.1. 5.1.14.3.2 Labels for shutoff valves shall be in accordance with 5.1.11.2 and updated when modifications are made changing the areas served. 5.1.14.4 Medical Gas and Vacuum Systems Maintenance and Record Keeping. See B.5.2. 5.1.14.4.1 Permanent records of all tests required by 5.1.12.3.1 through 5.1.12.3.14 shall be maintained in the organization ' s files. 5.1.14.4.2 The supplier of the bulk cryogenic liquid system shall, upon request, provide documentation of vaporizer(s) sizing criteria to the facility. 5.1.14.4.3 An annual review of bulk system capacity shall be conducted to ensure the source system has sufficient capacity. 5.1.14.4.4 Central supply systems for nonflammable medical gases shall conform to the following: (1) They shall be inspected annually. (2) They shall be maintained by a qualified representative of the equipment owner. (3) A record of the annual inspection shall be available for review by the authority having jurisdiction. 5.1.14.4.5 A periodic testing procedure for nonflammable medical gas and vacuum and related alarm systems shall be implemented. 5.1.14.4.6 Whenever modifications are made that breach the pipeline, any necessary installer and	K 907		

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K 907	Continued From page 18 verification test specified in 5.1.12 shall be conducted on the downstream portions of the medical gas piping system. 5.1.14.4.7 Procedures, as specified, shall be established for the following: (1) Maintenance program for the medical air compressor supply system in accordance with the manufacturer ' s recommendations (2) Facility testing and calibration procedure that ensures carbon monoxide monitors are calibrated at least annually or more often if recommended by the manufacturer (3) Maintenance program for both the medical-surgical vacuum piping system and the secondary equipment attached to medical-surgical vacuum station inlets to ensure the continued good performance of the entire medical-surgical vacuum system (4) Maintenance program for the WAGD system to ensure performance 5.1.14.4.8 Audible and visual alarm indicators shall meet the following requirements: (1) They shall be periodically tested to determine that they are functioning properly. (2) Records of the test shall be maintained until the next test is performed. 5.1.14.4.9 Medical-surgical vacuum station inlet terminal performance, as required in 5.1.12.3.10.4, shall be tested as follows: (1) On a regular preventive maintenance schedule as determined by the facility maintenance staff (2) Based on flow of free air (NI/min or SCFM) into a station inlet while simultaneously checking the vacuum level 5.1.15* Category 1 Maintenance. Facilities shall have a routine maintenance program for their piped medical gas and vacuum systems. 5.2 Category 2 Piped Gas and Vacuum Systems.	K 907			

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NAME OF PROVIDER OR SUPPLIER POWER COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 510 ROOSEVELT STREET (83211-1362) AMERICAN FALLS, ID 83211	
(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 907	Continued From page 19 5.2.1* Applicability. These requirements shall apply to health care facilities that qualify for Category 2 systems as referenced in Chapter 4. 5.2.1.1 Section 5.2 through 5.2.12 shall apply to new health care facilities or facilities making changes that alter the piping. 5.2.1.2 Subsection 5.2.13 5.2.14* Category 2 Maintenance. Facilities shall have a routine maintenance program for their piped medical gas and vacuum systems. 5.3.13.4.2 A periodic testing procedure for Category 3 gas and vacuum systems and related alarm systems shall be implemented.	K 907		
K 908 SS=F	NFPA 101 Gas and Vacuum Piped Systems - Inspection and Testing Operations The gas and vacuum systems are inspected and tested as part of a maintenance program and include the required elements. Records of the inspections and testing are maintained as required. 5.1.14.2.3, B.5.2, 5.2.13, 5.3.13, 5.3.13.4 (NFPA 99) This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure that positive pressure gas central piping systems, medical-surgical vacuum systems are inspected and tested annually as part of a maintenance program. Failure to test and inspect these systems could result in leakage of gases creating an oxygen enriched atmosphere. This deficient practice affected all patients, staff and visitors on the date of the survey. The facility is licensed for 20 SNF/NF beds and had a census of 18 on the day of the survey.	K 908	K908 NFPA 101 Gas & Vacuum Piped Systems- Inspection and Testing What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice? The Maintenance Supervisor contacted a licensed system inspection contractor to complete the full inspection of the facility gas-vacuum piped system. The contractors were scheduled at the earliest available date of 8/24/17 to complete the inspection of the facility oxygen and vacuum systems. We will forward a copy of the completed full inspection report to the FLS survey team upon receipt. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken? All residents, staff, and visitors have the potential to be affected by this deficiency. What measure will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur? The Maintenance Supervisor added the gas-vacuum system check to the annual maintenance review checklist for compliance in scheduling the system inspection with contractors to be done annually.	11Aug2017

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

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K 908	Continued From page 20 Findings include: During record review on July 10, 2017, from approximately 10:30 AM to 1:30 PM, the only documentation that could be produced for an annual inspection and testing of the positive pressure gas central piping systems and medical-surgical vacuum systems was dated February 6, 2013. When asked about the missing documentation, the Maintenance Supervisor stated the facility was unaware the piped system had to be inspected annually. Actual NFPA standard: NFPA 99 5.1.14.4.4 Central supply systems for nonflammable medical gases shall conform to the following: (1) They shall be inspected annually. (2) They shall be maintained by a qualified representative of the equipment owner. (3) A record of the annual inspection shall be available for review by the authority having jurisdiction.	K 908	How will the corrective action(s) be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place? The Maintenance Staff will monitor the schedule of the gas and vacuum systems, in accordance with our new policy and with their annual review schedule. These checks will begin 8/11/17 with deficiencies reported to the Maintenance Supervisor for fixes; and reported at the monthly facility Safety meeting.		