



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

September 11, 2017

Richard Strong, Administrator
Meridian Center Genesis Healthcare
1351 West Pine Avenue
Meridian, ID 83642-5031

Provider #: 135125

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

Dear Mr. Strong:

On **August 31, 2017**, a Facility Fire Safety and Construction survey was conducted at **Meridian Center Genesis Healthcare** 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 **September 25, 2017**. Failure to submit an acceptable PoC by **September 25, 2017**, may result in the imposition of civil monetary penalties by **October 14, 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 **October 5, 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 **October 5, 2017**. A change in the seriousness of the deficiencies on **October 5, 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 **October 5, 2017**, includes the following:

Denial of payment for new admissions effective **December 1, 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 **March 1, 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 **August 31, 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 **September 25, 2017**. If your request for informal dispute resolution is received after **September 25, 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

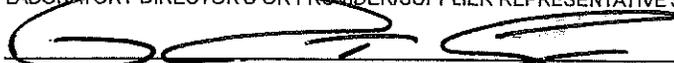
PRINTED: 09/11/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135125	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 08/31/2017
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NAME OF PROVIDER OR SUPPLIER MERIDIAN CENTER GENESIS HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1351 WEST PINE AVENUE MERIDIAN, ID 83642
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	INITIAL COMMENTS The facility is a single story Type V (III) construction completed in March 1997. The facility is fully sprinklered and has a complete fire alarm system with smoke detection and fire dampers throughout. There is an upper level of the facility and is only used for classrooms, medical records, marketing and board room. The facility is currently licensed for 139 SNF/NF beds. The following deficiencies were cited during the annual life safety code survey conducted on August 31, 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	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Genesis HealthCare - Meridian 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." K291	
K 291 SS=F	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9.18.2.9.1, 19.2.9.1 This STANDARD is not met as evidenced by: Based on record review, interview, and operational testing, the facility failed to provide operational emergency lighting and monthly emergency lighting test documentation. Failure to maintain and test the emergency lighting could inhibit egress of residents during an emergency. This deficient practice affected all residents, staff and visitors on the day of survey. The facility is licensed for 139 SNF/NF beds with a census of	K 291	Identified: Logs of functional 30 second monthly testing was added to Life Safety Binder to show functional testing is being completed on a monthly basis by Director of Maintenance or Designee on or before 10/05/2017. Emergency lighting on four units not working were repaired and replaced on 09/14/2017 by Director of Maintenance. These units were as follows: -Generator area. -Hallway Upstairs near rear stairwell. -Dining Room. -Upstairs Classroom.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE ADMINISTRATOR	(X6) DATE 9/25/2017
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 291	<p>Continued From page 1 95 on the date of survey.</p> <p>Findings include:</p> <p>1.) During review of the emergency lighting test logs on August 31, 2017, from approximately 9:00 AM to 1:45 PM, records revealed that the last monthly thirty (30) second test of the emergency lighting was conducted in December 2016. No documentation for testing during 2017 could be produced.</p> <p>2.) During the facility tour, from approximately 2:00 PM to 4:00 PM, operational testing of the emergency lighting in the following areas revealed that it was not operational:</p> <ul style="list-style-type: none"> a. Generator area b. Hallway upstairs near rear stairwell c. Dining room d. Upstairs Classroom <p>When asked, the Maintenance Director stated the facility had done the 30 second monthly testing of the emergency lighting, but it was documented in the TELS system. A paper copy was not produced. He also stated that the last time the emergency lighting was tested, it was operational. The facility was unaware that the four units were not working.</p> <p>Actual NFPA reference:</p> <p>NFPA 101 19.2.9 Emergency Lighting. 19.2.9.1 Emergency lighting shall be provided in accordance with Section 7.9. 7.9.3 Periodic Testing of Emergency Lighting Equipment. 7.9.3.1 Required emergency lighting systems shall be tested in accordance with one of the three options offered by 7.9.3.1.1, 7.9.3.1.2, or</p>	K 291	<p>Audits: Facility Wide: All Emergency Lighting was tested by Director of Maintenance or Designee for functional operation (30 second test) on 09/14/2017. Any Emergency Lighting not operation was repaired on 09/14/2017.</p> <p>Education/Systematic Change: Logs of functional 30 second monthly testing was added to Life Safely Binder to show functional testing is being completed on a monthly basis by Director of Maintenance or Designee on or before 10/05/2017.</p> <p>Audits & Monitors: Logs of functional 30 second monthly testing was added to Life Safely Binder to show functional testing is being completed on a monthly basis by Director of Maintenance or Designee on or before 10/05/2017.</p> <p>Date of Compliance: 10/05/2017</p>		

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K 291	Continued From page 2 7.9.3.1.3. 7.9.3.1.1 Testing of required emergency lighting systems shall be permitted to be conducted as follows: (1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, except as otherwise permitted by 7.9.3.1.1(2). (2)*The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction. (3) Functional testing shall be conducted annually for a minimum of 1-1?2 hours if the emergency lighting system is battery powered. (4) The emergency lighting equipment shall be fully operational for the duration of the tests required by 7.9.3.1.1(1) and (3). (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. 7.9.3.1.2 Testing of required emergency lighting systems shall be permitted to be conducted as follows: (1) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall be provided. (2) Not less than once every 30 days, self-testing/self-diagnostic battery-operated emergency lighting equipment shall automatically perform a test with a duration of a minimum of 30 seconds and a diagnostic routine. (3) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall indicate failures by a status indicator. (4) A visual inspection shall be performed at intervals not exceeding 30 days. (5) Functional testing shall be conducted annually for a minimum of 1-1?2 hours.	K 291			

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K 291	Continued From page 3 (6) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall be fully operational for the duration of the 1-172-hour test. (7) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. 7.9.3.1.3 Testing of required emergency lighting systems shall be permitted to be conducted as follows: (1) Computer-based, self-testing/self-diagnostic battery-operated emergency lighting equipment shall be provided. (2) Not less than once every 30 days, emergency lighting equipment shall automatically perform a test with a duration of a minimum of 30 seconds and a diagnostic routine. (3) The emergency lighting equipment shall automatically perform annually a test for a minimum of 1-172 hours. (4) The emergency lighting equipment shall be fully operational for the duration of the tests required by 7.9.3.1.3(2) and (3). (5) The computer-based system shall be capable of providing a report of the history of tests and failures at all times.	K 291		
K 321 SS=D	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be		K321 K 321 Identified: Self-closing doors in the following areas was repaired and/or installed by Director of Maintenance or Designee on or before 10/05/2017. -Laundry Door. -Records Storage in Transitional Care Area. -400 Hall resident room converted into storage areas; 410,411,412,413,414,415.	

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K 321	<p>Continued From page 5</p> <ol style="list-style-type: none"> 1.) Laundry door (self-closing device had been disabled) 2.) Records Storage in Transitional Care area 3.) Resident rooms in the 400 hallway that have been converted to permanent storage. (410, 411, 412, 413, 414 and 415) Each of the storage rooms were measured to be over 50 square feet and contained supplies/equipment. <p>When asked, the Maintenance Director stated the facility was not aware the doors were required to be self-closing.</p> <p>Actual NFPA standard:</p> <p>NFPA 101 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.7.1.</p> <p>19.3.2.1.3 The doors shall be self-closing or automatic-closing.</p> <p>19.3.2.1.5 Hazardous areas shall include, but shall not be restricted to, the following:</p> <ol style="list-style-type: none"> (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft² (9.3 m²) (3) Paint shops (4) Repair shops (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 	K 321		

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.K 321	Continued From page 6			
K 325 SS=F	<p>(8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR)</p> <p>Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met:</p> <ul style="list-style-type: none"> * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 <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</p>	K 321	<p>K325</p> <p>Identified: On or before 10/05/2017, all Alcohol Based Hand Run Dispensers (ABHR) were tested and documented by Director of Environmental Services or Designee for correct operation in accordance with the manufacturer's care and use instructions. Any ABHR found not functional will be replaced by Director of Maintenance or Designee on or before 10/05/2017.</p> <p>Audits Facility Wide: On or before 10/05/2017, all Alcohol Based Hand Run Dispensers (ABHR) were tested and documented by Director of Environmental Services or Designee for correct operation in accordance with the manufacturer's care and use instructions.</p> <p>Education/Systematic Change: On or before 10/05/2017, all housekeeping staff was educated by Director of Environmental Services on testing all ABHR's each time a refill in installed.</p> <p>On or before 10/05/2017, ABHR testing training and the requirement for testing each time a refill is</p>	

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K 325	<p>Continued From page 7</p> <p>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 95 residents, staff and visitors on the date of the survey. The facility is licensed for 139 SNF/NF residents and had a census of 95 on the day of the survey.</p> <p>Findings include:</p> <p>During the review of facility inspection records conducted on August 31, 2017 from approximately 9:00 AM to 1:45 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 Director stated the facility was not aware of the requirement to test ABHR dispensers each time a new refill is installed.</p> <p>Actual NFPA standard:</p> <p>NFPA 101</p> <p>19.3.2.6* Alcohol-Based Hand-Rub Dispensers. Alcohol-based hand-rub dispensers shall be protected in accordance with 8.7.3.1, unless all of the following conditions are met:</p> <p>(1) Where dispensers are installed in a corridor, the corridor shall have a minimum width of 6 ft (1830 mm).</p> <p>(2) The maximum individual dispenser fluid capacity shall be as follows:</p> <p>(a) 0.32 gal (1.2 L) for dispensers in rooms, corridors, and areas open to corridors</p> <p>(b) 0.53 gal (2.0 L) for dispensers in suites of rooms</p>	K 325	<p>installed will be added to new hire training for housekeeping staff by Director of Environmental Services.</p> <p>Audits & Monitors: Beginning the week of 10/02/2017 a weekly audit will be conducted by the Director of Environmental Services or Designee to insure housekeeping staff are testing all ABHR that are refilled to manufacturer's care and use instructions. These audits will be conducted weekly x 4 weeks and then monthly at the end of each month hereafter.</p> <p>Date of Compliance: 10/05/2017</p>		

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K 325	Continued From page 8 (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 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	K 325			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135125	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 08/31/2017
NAME OF PROVIDER OR SUPPLIER MERIDIAN CENTER GENESIS HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1351 WEST PINE AVENUE MERIDIAN, ID 83642	
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K 325	Continued From page 9 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 911 SS=F	NFPA 101 Electrical Systems - Other Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567, Chapter 6 (NFPA 99) This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the Essential Electrical System (EES) generator was equipped with a remote manual stop station in accordance with NFPA	K 911	K911 Identified: A remote stop station will be installed by EC Power Systems during the week of 10/16/2017. Installation will be completed no later than 10/27/2017.	

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K 911	Continued From page 10 110. Failure to provide a remote stop, potentially hinders staff ability to shut down the generator if required. This deficient practice affected 95 residents, staff and visitors on the date of the survey. The facility is licensed for 139 SNF/NF beds and had a census of 95 on the day of the survey. Findings include: During the facility tour conducted on August 31, 2017 from approximately 2:00 PM to 4:00 PM, a remote manual stop station for the EES generator was not located in the facility. When asked, the Maintenance Director stated the facility was not equipped with a remote stop station. Actual NFPA standard: NFPA 110 5.6.5.6* All installations shall have a remote manual stop station of a type to prevent inadvertent or unintentional operation located outside the room housing the prime mover, where so installed, or elsewhere on the premises where the prime mover is located outside the building. 5.6.5.6.1 The remote manual stop station shall be labeled. NFPA 99 6.4.1.1.16.2 Safety indications and shutdowns shall be in accordance with Table 6.4.1.1.16.2. (SEE TABLE)	K 911	Education/Systematic Change: All Staff will be educated on the Emergency Stop Station by Center Executive Director or Director of Maintenance on or before 10/31/2017. Date of Compliance: 10/05/2017		
K 918 SS=F	NFPA 101 Electrical Systems - Essential Electric Syste	K 918			

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K 918	<p>Continued From page 11</p> <p>Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.</p> <p>Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure Emergency Power Supply Systems (EPSS) were maintained in accordance to NFPA 110. Failure to test diesel fuel annually for quality could hinder the performance of the</p>	K 918	<p>K918</p> <p>Identified: A diesel fuel quality test will be completed the week of 10/16/2017 by EC Power Systems.</p> <p>Education/Systematic Change: A fuel quality test will be added to annual Emergency Generator Servicing. EC Power Systems will conduct annual fuel test.</p> <p>Date of Compliance: 10/05/2017</p>		

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K 918	Continued From page 12 equipment during an emergency. This deficient practice affected 95 residents, staff and visitors on the date of the survey. The facility is currently licensed for 139 SNF/NF beds, with a census of 95 on the day of survey. Findings include: During review of the EPSS annual inspection and testing documentation provided on August 31, 2017 from approximately 9:00 AM to 1:45 PM, there was no indication that the diesel fuel for the generator had been tested for quality. When asked, the Maintenance Director stated the facility was not aware that a fuel quality test was required annually. Actual NFPA standard: NFPA 110 8.3 Maintenance and Operational Testing. 8.3.8 A fuel quality test shall be performed at least annually using tests approved by ASTM standards.	K 918		
K 927 SS=D	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	K 927	K927 Identified: Ventilation fan for the oxygen storage/transfill station area was repaired by Electrician on or before 10/05/2017. Audits Facility Wide: An audit of ventilation fans in Oxygen storage/transfill station areas was conducted by Director of Maintenance	

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K 927	<p>Continued From page 13</p> <p>conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99)</p> <p>This STANDARD is not met as evidenced by: Based on observation and operational testing, the facility failed to ensure liquid oxygen transfilling was conducted in accordance with NFPA 99. Failure to transfill liquid oxygen with mechanical ventilation could result in creating a oxygen rich environment, increasing the potential for combustion. This deficient practice affected staff and visitors on the date of the survey. The facility is licensed for 139 SNF/NF beds and had a census of 95 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on August 31, 2017 from approximately 2:00 PM to 4:00 PM, observation and operational testing of the ventilation fan for the oxygen storage/transfill area revealed the fan was not operational.</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 sprinklered, and has ceramic or concrete flooring.</p>	K 927	<p>or Designee on or before 10/05/2017. All other ventilation fans were operational.</p> <p>Education/Systematic Change: A semi-annual audit log was added to Life Safety Binder to insure all ventilation fans in Oxygen Storage/Transfill Areas are functioning properly.</p> <p>Audits & Monitors: Beginning the month of October 2017 audits will be conducted by Director of Maintenance or Designee to insure that ventilation fans in Oxygen Storage/Transfill areas are functioning properly. These audits will be conducted monthly for 3 months and semi-annually hereafter.</p> <p>Date of Compliance: 10/05/2017.</p>

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K 927	Continued From page 14 (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			