



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

January 23, 2018

Trent Alder, Administrator
Franklin County Transitional Care
44 North First East
Preston, ID 83263-1326

Provider #: 135059

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

Dear Mr. Alder:

On **January 11, 2018**, a Facility Fire Safety and Construction survey was conducted at **Franklin County Transitional Care** 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

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 **February 5, 2018**. Failure to submit an acceptable PoC by **February 5, 2018**, may result in the imposition of civil monetary penalties by **February 25, 2018**.

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 may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **February 15, 2018**, (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 **February 15, 2018**. A change in the seriousness of the deficiencies on **February 15, 2018**, may result in a change in the remedy.

Trent Alder, Administrator
January 23, 2018
Page 3 of 4

The remedy, which will be recommended if substantial compliance has not been achieved by **February 15, 2018**, includes the following:

Denial of payment for new admissions effective **April 11, 2018**.
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 **July 11, 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 **January 11, 2018**, 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:

Trent Alder, Administrator
January 23, 2018
Page 4 of 4

<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:

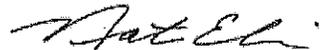
BFS Letters (06/30/11)

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

This request must be received by **February 5, 2018**. If your request for informal dispute resolution is received after **February 5, 2018**, 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: 01/19/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135059	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE NF BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 01/11/2018
NAME OF PROVIDER OR SUPPLIER FRANKLIN COUNTY TRANSITIONAL CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 44 NORTH FIRST EAST PRESTON, ID 83263	
(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 facility is a single story Type II (111) building with a complete sprinkler system that was installed in July 2012. The plans for the building were approved in 1970 and construction completed in 1971. There have been subsequent remodels. The facility is licensed for 35 SNF/NF beds and had a census of 32 on the day of the survey.</p> <p>The following deficiencies were cited at the above facility during the annual fire/life safety code survey conducted on January 11, 2018. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Chapter 19, Existing Healthcare Occupancies, in accordance with 42 CFR 483.70, 42 CFR 483.80 and 42 CFR 483.65.</p> <p>The survey was conducted by:</p> <p>Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction</p>	K 000	<p>RECEIVED</p> <p>FEB - 8 2018</p> <p>FACILITY STANDARDS</p>	
K 100 SS=F	<p>General Requirements - Other CFR(s): NFPA 101</p> <p>General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General 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. This REQUIREMENT is not met as evidenced by: Based on record review, and interview, the facility failed to develop and implement a water management plan. Failure to develop and</p>	K 100	<ol style="list-style-type: none"> All residents were identified as having been affected by this. Any new admission during the time a plan was not in place would be affected as well. To ensure compliance the Water Management Plan was developed on 1/17/18 and will be in place by February 1, 2018. Monitoring and reporting will be conducted and reported to QM and Infection Control Committee on a 	2/2/2018

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Linda Chaney* TITLE *Nursing Home Administrator* (X6) DATE *2/5/18*

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 100	Continued From page 1 implement a facility specific water management plan could increase the risk of growth and spread of Legionella and other opportunistic pathogens in building water systems. This deficient practice could potentially affect all residents, visitors and staff on the date of the survey. Findings include: Review of facility records on January 11, 2018, from approximately 9:00 AM to 12:00 PM, revealed the water management plan was incomplete. All of the required elements of the plan, facility risk assessment, control measures, and testing protocols were not included in the plan. When asked, the Administrator stated the facility was currently working on the water management plan and had a meeting scheduled to complete it that afternoon. Actual Standard: 42 CFR § 483.80 Infection control. The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Additional Reference: Centers for Medicare/Medicaid Services S&C Letter 17-30.	K 100	Quarterly basis. Nursing Home Administrator or designee will be responsible to review reports and ensure compliance with Maintenance and Infection Control. Maintenance Department will provide any corrective action necessary and will maintain records of testing/ remediation. After three quarters QM Committee will determine compliance and need for continued monitoring. 5. 2/5/2018 (See Water Management Policy)	
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101	K 355		

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K 355	Continued From page 2 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the class K portable fire extinguisher was installed, and maintained in accordance with NFPA 10. Failure to install and maintain the class K fire extinguisher could result in improper use in the event of a fire. This deficient practice affected staff and visitors on the date of the survey. Findings include: During the facility tour on January 11, 2018, from approximately 12:00 PM to 1:00 PM, observation of the Class K fire extinguisher in the kitchen revealed no placard instructing user to activate the hood suppression system prior to its use. When asked, the Maintenance Supervisor stated the class K never had a placard and the facility was unaware of the requirement. Actual NFPA standard: NFPA 10 5.5.5.3* A placard shall be conspicuously placed near the extinguisher that states that the fire protection system shall be actuated prior to using the fire extinguisher.	K 355	1. All residents had the potential of being affected by this. 2. Facility wide inspection was performed to determine and other areas where class K extinguisher might be used and none were found within the facility. 3. Placard was placed on 1/18/18 and staff instruction performed to ensure no recurrence of this issue. The placard instructs staff how to initiate the fire suppression system prior to use of the class K extinguisher. Staff were instructed in this process at staff meeting on 1/31/18. New employees will be trained upon hire and during annual training. The sign will be inspected monthly when the Cass K extinguisher is inspected. 4. These inspections will be reported to Safety Committee Monthly and QM Quarterly until QM determines compliance has been reached. 5. 2/2/18 (See picture of sign and training)	2/2/2018
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101	K 511		

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K 511	<p>Continued From page 3</p> <p>Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that electrical systems were installed, maintained and used in accordance with NFPA 70. Failure to ensure proper electrical installations and follow manufacture recommendations for intended use could result in electrocution or fire. This deficient practice affected staff and visitors on the date of the survey.</p> <p>Findings include: During the facility tour on January 11, 2018 from approximately 12:00 PM to 1:00 PM, observation of the facility revealed the following: 1.) The Kitchen had two RPTs (Relocatable Power Taps) being used as permanent wiring for a full sized upright freezer, and cold carts. 2.) Sun room office had a small refrigerator and microwave plugged in to an RPT in the closet. 3.) Staff break room had a microwave plugged in to an RPT. 4.) There was a missing blank in the electrical panel labeled "K" in the kitchen dish room.</p> <p>When asked, the Maintenance Supervisor stated</p>	K 511	<ol style="list-style-type: none"> All residents in the facility could have been affected by the use of relocatable power taps (rpt's). A sweep of the facility was performed on 2/1/18 by the maintenance department to ensure that no relocatable power taps were being used with any other kitchen appliances in the facility. The department heads of the facility with purchasing power were educated on the appropriate use of relocatable power taps on 2/2/18, to include: Director of Nursing, Nursing home Administrator, Maintenance Director, Information Technology Director, Dietary Manager and the Purchasing Director. They were also instructed that they must have the permission of the Maintenance Director or designee before using a relocatable power tap. The Maintenance Director or designee will perform weekly sweeps of the facility to ensure the proper usage of all relocatable power taps. These weekly sweeps will occur for three months and then be turned over to the QM Committee to determine future time frames. 2/2/2018 (see pictures of Kitchen x2, Sunroom, Dining Room, Kitchenette 	2/2/2018

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K 511	<p>Continued From page 4</p> <p>the facility was unaware of the inappropriate use of relocatable power taps and missing blank at the electrical panel in the kitchen.</p> <p>Actual NFPA standard:</p> <p>NFPA 70 400.8 Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following:</p> <p>(1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of 388.8. (5) Where concealed by walls, floors, or ceilings or located above suspended or dropped ceilings (6) Where installed in raceways, except as otherwise permitted in this Code</p> <p>110.12 Mechanical Execution of Work. Electrical equipment shall be installed in a neat and workmanlike manner. (A) Unused Openings. Unused cable or raceway openings in boxes, raceways, auxiliary gutters, cabinets, cutout boxes, meter socket enclosures, equipment cases, or housings shall be effectively closed to afford protection substantially equivalent to the wall of the equipment. Where metallic plugs or plates are used with nonmetallic enclosures, they shall be recessed at least 6 mm (¼ in.) from the outer surface of the enclosure.</p>	K 511		

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K 511	Continued From page 5 (B) Subsurface Enclosures. Conductors shall be racked to provide ready and safe access in underground and subsurface enclosures into which persons enter for installation and maintenance. (C) Integrity of Electrical Equipment and Connections. Internal parts of electrical equipment, including busbars, wiring terminals, insulators, and other surfaces, shall not be damaged or contaminated by foreign materials such as paint, plaster, cleaners, abrasives, or corrosive residues. There shall be no damaged parts that may adversely affect safe operation or mechanical strength of the equipment such as parts that are broken; bent; cut; or deteriorated by corrosion, chemical action, or overheating.	K 511		
K 907 SS=F	Gas and Vacuum Piped Systems - Maintenance Pr CFR(s): NFPA 101 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 REQUIREMENT is not met as evidenced	K 907	1. All residents had the potential to be affected by this. 2. A sweep of nursing home was conducted on 2/2/18 by inspecting resident rooms to ensure that piped oxygen is installed in all rooms. 3. A Medical Gas Maintenance Policy was written to define the process for inspecting the oxygen system. Maintenance department will perform inspections of piped oxygen systems monthly as stated in medical gas policy. 4. To assure compliance the Maintenance Director will complete monthly Gas Inspection Checklist and will report to Safety Committee monthly and to QM quarterly until QM determines compliance has been achieved.	2/1/2018

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K 907	<p>Continued From page 6</p> <p>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.</p> <p>Findings include:</p> <p>During record review on January 11, 2018, from approximately 9:00 AM to 12:00 PM, no documentation of a maintenance program for the positive pressure gas central piping systems and medical-surgical vacuum systems could be located. 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 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,</p>	K 907	5. 2/2/2018/ (see Oxygen Policy and proof of sweep)	

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K 907	Continued From page 7 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 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:	K 907		

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K 907	Continued From page 8 (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 (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.	K 907		

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K 907	Continued From page 9 (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 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	K 907		

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K 907	Continued From page 10 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 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	K 907			

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K 907	Continued From page 11 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. 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 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying	K 918	1. All residents had the potential to be affected by this. 2. No other residents had the potential to be affected as this was resolved the day of survey 1/11/18. Fuel Sample report was received and WNL 1/24/18.	2/2/2018

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K 918	Continued From page 12 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. 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) This REQUIREMENT 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 equipment during an emergency. This deficient practice affected residents, staff and visitors on the date of the survey.	K 918	3. The corrective action was to have the fuel tested and it will continue to be tested during the annual fuel inspection. Maintenance will continue monthly inspections on the generator. 4. To ensure compliance the QM Director has scheduled a reminder for annual fuel testing. This will be conducted January 2019 and results will be reported at following QM Committee. 5. 2/2/2018 (See Fuel Invoice and Sample Results)	

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K 918	Continued From page 13 Findings include: During review of the EPSS annual inspection and testing documentation provided on January 11, 2018, from approximately 9:00 AM to 12:00 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 had a contractor coming in later that day to do the fuel test. 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			

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E 000	<p>Initial Comments</p> <p>The facility is a single story Type II (111) building with a complete sprinkler system that was installed in July 2012. The plans for the building were approved in 1970 and construction completed in 1971. There have been subsequent remodels. Currently the facility is licensed for 35 SNF/NF beds.</p> <p>The facility was found to be in substantial compliance during the initial Emergency Preparedness Survey conducted on January 11, 2018. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.</p> <p>The survey was conducted by:</p> <p>Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction</p>	E 000	<p>RECEIVED</p> <p>FEB - 8 2018</p> <p>FACILITY STANDARDS</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *W. B. Ald* TITLE *Nursing Home Administrator* (X6) DATE *2/5/18*

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.