



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

February 9, 2018

Daniel Kennick, Administrator
Teton Post Acute Care & Rehabilitation
3111 Channing Way
Idaho Falls, ID 83404-7534

Provider #: 135138

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Mr. Kennick:

On **January 31, 2018**, a Facility Fire Safety and Construction survey was conducted at **Teton Post Acute Care & Rehabilitation** 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 **February 22, 2018**. Failure to submit an acceptable PoC by **February 22, 2018**, may result in the imposition of civil monetary penalties by **March 14, 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 inposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **March 7, 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 **March 7, 2018**. A change in the seriousness of the deficiencies on **March 7, 2018**, 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 **March 7, 2018**, includes the following:

Denial of payment for new admissions effective **May 1, 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 31, 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 31, 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:

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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:

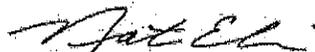
BFS Letters (06/30/11)

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

This request must be received by **February 22, 2018**. If your request for informal dispute resolution is received after **February 22, 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

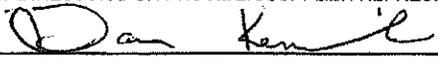
Printed: 02/09/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135138	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - TETON POST ACUTE CARE & REHABILITATION B. WING _____	(X3) DATE SURVEY COMPLETED 01/31/2018
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NAME OF PROVIDER OR SUPPLIER TETON POST ACUTE CARE & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 3111 CHANNING WAY IDAHO FALLS, ID 83404
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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	<p>INITIAL COMMENTS</p> <p>The Facility is a single story Type V (III) structure, approximately 43,000 square feet in size, and is composed of a service wing, a center core, and four resident wings. The building was originally built in 1988, but was unoccupied and re-licensed in May of 2013. The facility is fully sprinklered with quick response heads covering the resident care areas and has a manual, interconnected fire alarm system, which is off site monitored. The building is served by a natural gas powered generator, automatic transfer switches and two branch circuits. The facility is currently licensed for 88 SNF/NF beds and had a census of 60 on the day of the survey.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on January 30 and 31, 2018. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Chapter 19 Existing Health Care Occupancy in accordance with 42 CFR 483.70</p> <p>The Survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction</p>	K 000	<p>Preparation and/or execution of this plan of correction does not constitute the provider's admission of or agreement with the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law</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, the facility failed to demonstrate implementation of a water</p>	K 100	<p>Corrective Action: The IDT team will conduct a facility-based risk assessment to determine where the facility is at risk for waterborne pathogens such as Legionella. The risk assessment will be completed no later than 3/2/2018.</p>	3/2/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE NNA	(X6) DATE 2/21/18
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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 100	<p>Continued From page 1</p> <p>management program for waterborne pathogens such as Legionella, in accordance with 42 CFR 483.80. Failure to conduct a facility based risk assessment as part of the water management program, has the potential to limit relevant facility awareness and expose residents to Legionella and other water source bacterium based on inconclusive data. This deficient practice affected 60 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During review of provided maintenance and inspection records conducted on 1/30/18 from approximately 8:30 - 10:00 AM, records provided for the facility's water management plan, failed to demonstrate it had completed the facility based risk assessment. Review of provided documents showed a generic sample of where possible sources of Legionella might occur, but no information as to how this applied to the facility system as to what risks or potential of exposure existed in the system.</p> <p>CFR standard: 42 CFR 483.80</p> <p>§ 483.80 Infection control. The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>Additional reference: Center for Medicaid/Medicare Services S & C letter 17-30</p>	K 100	<p>Other Residents: The alleged deficiency and corrective action listed above will potentially impact all residents, staff and visitors within the facility.</p> <p>Systematic Changes: Effective 3/2/18, a comprehensive review of the water management program, including the risk-based assessment, will be conducted by the interdisciplinary team with each update and no less than quarterly.</p> <p>Monitor: Interdisciplinary team review of the water management program and risk-based assessment will be scheduled in conjunction with the quarterly QAPI meeting, beginning with the next meeting tentatively scheduled for 3/21/18. The NHA will validate that the review is completed and that the program is comprehensive and relevant to the facility.</p> <p>Responsibility: Nursing Home Administrator, Maintenance Supervisor</p>		
K 293 SS=F	<p>Exit Signage</p> <p>CFR(s): NFPA 101</p>	K 293			

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K 293	<p>Continued From page 2</p> <p>Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure means of egress signage was provided in accordance with NFPA 101. Failure to provide exit signs which are clear and identifiable has the potential to confuse residents and hinder egress during an emergency. This deficient practice affected 60 residents in 4 of 6 smoke compartments on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 1/30/18 from approximately 2:30 - 3:00 PM, observation of installed exit signs, revealed the following locations were not equipped with exit signs identifying the path of egress during a fire or other emergency:</p> <p>1) The bulkhead above the east to northeast path of travel in the 100 corridor located at rooms 102/104, was missing an exit sign that indicated a continued path of travel when the smoke doors were closed.</p> <p>2) The Occupational Therapy, Physical Therapy, Chapel and Medical Records were each equipped with a double door system as the single exit that led to the corridor and was</p>	K 293	<p>Corrective Action Exit signs will be placed in the occupational therapy gym, physical therapy gym, Chapel, and Medical Records Office and the bulkhead above the east to northeast path of travel in the 100 hall NLT 3/2/18</p> <p>Other Residents: The alleged deficiency and corrective action listed above will potentially impact all residents, staff and visitors within the facility.</p> <p>A thorough inspection of the facility was conducted by the facility maintenance supervisor on 2/16/18 to validate that every set of fire doors attached to the fire panel has an exit sign and indicates a continues path of travel. No other areas were found to be absent of exit signs as required.</p>	3/2/18

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K 293	Continued From page 3 interconnected to the fire alarm. Further observation revealed no exit sign was installed indicating a clear path of travel leading out of these spaces when the doors were activated. Actual NFPA standard: 7.10.1.2 Exits. 7.10.1.2.1* Exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign that is readily visible from any direction of exit access.	K 293	Systematic Changes: Beginning 3/2/18, a monthly facility inspection will be conducted by the NHA and maintenance supervisor concurrently. During the inspection, all exit signs will be checked to validate that they are present where required and that there is a continuous path of travel marked by exit signs.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ 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 REQUIREMENT is not met as evidenced by: Based on record review and observation, the facility failed to ensure that fire suppression systems were maintained in accordance with	K 353	Monitor: The results of the facility inspection will be reviewed monthly at the Quality Assurance Performance Improvement (QAPI) meeting for a minimum of 3 months, beginning with the next QAPI meeting tentatively scheduled for 3/21/18. After 3 months, the need for continued review of these audits will be re-evaluated. Responsibility: Nursing Home Administrator, Facility Maintenance Supervisor	

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K 353	<p>Continued From page 4</p> <p>NFPA 25. Failure to maintain sprinkler system control valves and inspect gauges has the potential to hinder system performance during a fire event. This deficient practice affected 60 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>1) During review of provided facility inspection and testing records conducted on 1/30/18 from 8:30 AM - 10:00 AM, no records were available indicating a weekly inspection of dry system gauges had been conducted.</p> <p>2) During the facility tour conducted on 1/30/18 from 1:00 PM - 3:00 PM, observation of the Maintenance office revealed a task schedule board displayed above the desk with sections identified for daily, weekly and monthly tasks. Further examination of the section marked "weekly", revealed no information documenting weekly inspection of the dry gauges was being performed.</p> <p>Actual NFPA standard:</p> <p>13.3 Control Valves in Water-Based Fire Protection Systems. 13.3.2 Inspection.</p> <p>13.3.2.1 All valves shall be inspected weekly.</p> <p>13.3.2.1.1 Valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly.</p> <p>13.3.2.2* The valve inspection shall verify that the valves are in the following condition:</p>	K 353	<p>Corrective Action: The maintenance supervisor conducted an inspection of the dry gauges on 2/6/18. The inspection validated that the air pressure in the system was within the correct PSI range.</p> <p>Other Residents: The alleged deficiency and corrective action listed above will potentially impact all residents, staff and visitors within the facility.</p> <p>Systematic Changes: An audit tool was developed by the maintenance supervisor. Effective 2/6/18, the dry gauges will be checked by the maintenance supervisor or designee no less than weekly and the results of the checks will be logged on the audit tool.</p>	3/2/18

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K 353	Continued From page 5 (1) In the normal open or closed position (2)*Sealed, locked, or supervised (3) Accessible (4) Provided with correct wrenches (5) Free from external leaks (6) Provided with applicable identification 5.2.4 Gauges. 5.2.4.2 Gauges on dry, preaction, and deluge systems shall be inspected weekly to ensure that normal air and water pressures are being maintained.	K 353	Monitor: The results of the weekly audit will be reviewed monthly at the Quality Assurance Performance Improvement (QAPI) meeting for a minimum of 3 months, beginning with the next QAPI meeting tentatively scheduled for 3/21/18. After 3 months, the need for continued review of these audits will be re-evaluated.	
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors	K 363	Responsibility: Nursing Home Administrator, Facility Maintenance Supervisor Corrective Action: The maintenance supervisor will adjust and/or repair the door to room #110 NLT 3/2/18 to ensure that the door will stay latched when closed and when five pounds of pressure is applied.	3/2/18

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K 363	<p>Continued From page 6</p> <p>meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.</p> <p>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485</p> <p>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and operational testing, the facility failed to ensure that resident room doors that open onto the corridor would latch when closed. Failure of corridor doors to latch has the potential to allow smoke and dangerous gases to pass between compartments, hindering resident egress and shelter in place during a fire. This deficient practice affected fourteen (14) residents, staff and visitors in 1 of 6 smoke compartments on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on January 30, 2018 from approximately 2:00 - 3:30 PM, observation and operational testing of the door to resident room 110 revealed the door would not stay latched when closed.</p> <p>Actual NFPA standard:</p> <p>19.3.6.3.5* Doors shall be provided with a means for keeping the door closed that is acceptable to the authority having jurisdiction, and the following</p>	K 363	<p>Other Residents: As there may be other doors to resident rooms that do not latch properly, the maintenance supervisor or designee will conduct a 100% inspection of the resident room doors NLT 3/2/18. Any doors that are identified as not latching properly or not staying latched when 5 lbs of pressure is applied will be adjusted and/or repaired at that time.</p> <p>Systematic Changes: Starting 3/2/2018 the maintenance director will conduct weekly walking rounds for three months to validate that all resident room doors latch properly</p> <p>Monitor: The results of the weekly inspection will be reviewed monthly at the Quality Assurance Performance Improvement (QAPI) meeting for a minimum of 3 months, beginning with the next QAPI meeting tentatively scheduled for 3/21/18. After 3 months, the need for continued review of the weekly audits will be re-evaluated.</p> <p>Responsibility: Maintenance Director</p>	

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K 363	Continued From page 7 requirements also shall apply: (1) The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. (2) Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.7.	K 363		
K 521 SS=D	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure HVAC (Heating Vacuum and Air Conditioning) systems were maintained in accordance with NFPA 101. Failure to maintain HVAC fire dampers and maintain clearances from radiant wall heaters to combustibles has the potential to increase the risk of fires and their communication between smoke compartments. This deficient practice affected 60 residents, staff and visitors on the date of the survey. Findings include: 1) During review of facility maintenance and inspection records conducted on 1/30/18 from 8:30 - 10:00 AM, records indicated fire dampers installed throughout the facility were last	K 521	Corrective Action: The Maintenance Director or designee will schedule an inspection of the fire dampers NLT 3/2/18. The cadet heater in room #205 was turned off on 1/30/18. The prosthetic device and dresser were moved so that there was 3 feet of space between the heater face and the items. Other Residents: The alleged deficiency and corrective action listed above will potentially impact all residents, staff and visitors within the facility. A comprehensive inspection of the facility will be conducted by the maintenance supervisor NLT 3/2/18 to validate that there are no more cadet wall heaters in the facility. If heaters are present, the maintenance supervisor will validate that the heater face is clear of any combustible materials and/or the heater is turned off.	3/2/18

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K 521	<p>Continued From page 8 inspected on 3/18/13.</p> <p>2) During the facility tour conducted on 1/30/18 from 2:30 - 3:30 PM, observation of the cadet wall heater installed in room 205 revealed a prosthetic device with a fabric covering placed within twelve (12) inches of the face of the heater and a wood dresser adjacent to the heater with approximately three (3) inches clearance from the side of the dresser to the heater. Further observation revealed the manufacturer's sticker placed on the top of the heater recommended three (3) feet clearance to combustibles.</p> <p>Actual NFPA standard:</p> <p>19.5.2 Heating, Ventilating, and Air-Conditioning.</p> <p>19.5.2.1 Heating, ventilating, and air-conditioning shall comply with the provisions of Section 9.2 and shall be installed in accordance with the manufacturer's specifications, unless otherwise modified by 19.5.2.2.</p> <p>19.5.2.2* Any heating device, other than a central heating plant, shall be designed and installed so that combustible material cannot be ignited by the device or its appurtenances, and the following requirements also shall apply:</p> <p>(1) If fuel-fired, such heating devices shall comply with the following:</p> <p>(a) They shall be chimney connected or vent connected.</p> <p>(b) They shall take air for combustion directly from the outside.</p> <p>(c) They shall be designed and installed to provide for complete separation of the combustion system from the atmosphere of the occupied area.</p> <p>(2) Any heating device shall have safety features</p>	K 521	<p>Systematic Changes: The maintenance supervisor was educated on the requirement to have the fire dampers inspected no less than every 4 years per NHPA standards. The cadet heater in room # 205, as well as any other cadet heaters found in the facility, will be disconnected and removed from the facility NLT 3/2/18.</p> <p>Monitor: The maintenance supervisor or designee will place a copy of the fire damper inspection in the facility fire and life safety maintenance binder upon receipt of the inspection report. The maintenance supervisor will annotate on his routine maintenance schedule the need to have the dampers inspected at a minimum of every 4 years to remind him when the inspection is due again.</p> <p>Responsibility: Maintenance Supervisor</p>		

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K 521	<p>Continued From page 9</p> <p>to immediately stop the flow of fuel and shut down the equipment in case of either excessive temperature or ignition failure.</p> <p>9.2 Heating, Ventilating, and Air-Conditioning. 9.2.1 Air-Conditioning, Heating, Ventilating Ductwork, and Related Equipment. Air-conditioning, heating, ventilating ductwork, and related equipment shall be in accordance with</p> <p>NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems, or NFPA 90B, Standard for the Installation of Warm Air Heating and Air-Conditioning Systems, as applicable, unless such installations are approved existing installations, which shall be permitted to be continued in service.</p> <p>NFPA 90A 4.3.9 Fire Dampers. 4.3.9.1 Approved fire dampers shall be provided as required in Chapter 5.</p> <p>5.4.8 Maintenance. 5.4.8.1 Fire dampers and ceiling dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives.</p> <p>NFPA 80 Chapter 19 Installation, Testing, and Maintenance of Fire Dampers</p> <p>19.4* Periodic Inspection and Testing. 19.4.1 Each damper shall be tested and inspected 1 year after installation. 19.4.1.1 The test and inspection frequency shall then be every 4 years, except in hospitals, where the frequency shall be every 6 years.</p>	K 521		

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K 926 K 926 SS=D	Continued From page 10 Gas Equipment - Qualifications and Training CFR(s): NFPA 101 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on record review, and interview, the facility failed to ensure continuing education and staff training was provided on the risks associated with the storage, handling and use of medical gases and their cylinders. Failure to provide training of safety and the risks associated with medical gases, hinders staff response and affects those residents utilizing supplemental oxygen. This deficient practice potentially affected oxygen dependent residents, staff and visitors on the date of the survey. Findings include: During review of provided training records on 1/30/18 from 8:30 - 10:00 AM and 1/31/18 from 11:00 AM - 11:30 PM, no records were provided for annual oxygen training. Interview of 5 of 5 staff members on 1/30/18 from 10:00 AM - 4:00 PM, revealed none had participated in any continuing education program on the risks associated with the storage, handling or use of medical gases. Further interview of the Staff Development Coordinator from approximately 4:00 - 4:30 PM, revealed she was not aware of	K 926 K 926	Corrective Action: Staff will receive training on the risks associated with storing, handling and use of medical gases by the Director of Nursing or designee NLT 3/2/18. Other Residents: The alleged deficiency and corrective action listed above will potentially impact all residents, staff and visitors within the facility. Systematic Changes: Effective 3/2/18, training on the storage, handling and use of medical gases will be included in the new hire orientation training. Additionally, the Staff Development Coordinator will add education on the storage, handling and use of medical gases to the list of annual education requirements for the staff.	3/2/18

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K 926	Continued From page 11 any current program of continued education for the handling, use and storage of medical gases. Actual NFPA standard: NFPA 99 11.5.2 Gases in Cylinders and Liquefied Gases in Containers. 11.5.2.1 Qualification and Training of Personnel. 11.5.2.1.1* Personnel concerned with the application and maintenance of medical gases and others who handle medical gases and the cylinders that contain the medical gases shall be trained on the risks associated with their handling and use. 11.5.2.1.2 Health care facilities shall provide programs of continuing education for their personnel. 11.5.2.1.3 Continuing education programs shall include periodic review of safety guidelines and usage requirements for medical gases and their cylinders.	K 926	Monitor: Validation that present staff and newly hired staff receive education on the storage, handling and use of medical gases will be done at the monthly Quality Assurance Performance Improvement (QAPI) meeting x 3 months beginning with the next meeting tentatively scheduled for 3/21/18. After 3 months, the need for continued review will be determined. Responsibility: Staff Development Coordinator	
K 927 SS=D	Gas Equipment - Transfilling Cylinders CFR(s): NFPA 101 Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 927	Corrective Action: The VCT tile in the oxygen storage room was removed to expose bare concrete by the Maintenance Supervisor and Assistant NHA on 2/15/18. The fan in the oxygen transfer room was repaired on 2/14/18. Other Residents: The alleged deficiency and corrective action listed above will potentially impact all residents, staff and visitors within the facility.	3/2/18

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K 927	<p>Continued From page 12</p> <p>Based on observation and operational testing, the facility failed to ensure liquid oxygen transfilling was conducted in accordance with NFPA 99. Transfilling liquid oxygen without sufficient mechanical ventilation and in the presence of a contaminate hydrocarbon such as VCT (vinyl composite tile), has the potential to increase the risks of combustion and explosions. This deficient practice affected staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on January 30, 2018 from approximately 1:30 - 3:30 PM, observation and operational testing of the fan for the oxygen storage/transfill area abutting the dining room, revealed the fan was operational, but lacked exhaust airflow when tested with a sheet of standard note paper placed against the exhaust vent. Further examination of this space revealed transfilling was performed over VCT flooring, not concrete or ceramic tile.</p> <p>Actual NFPA standard:</p> <p>NFPA 99</p> <p>11.5.2.3 Transfilling Liquid Oxygen. Transfilling of liquid oxygen shall comply with 11.5.2.3.1 or 11.5.2.3.2, as applicable.</p> <p>11.5.2.3.1 Transfilling to liquid oxygen base reservoir containers or to liquid oxygen portable containers over 344.74 kPa (50 psi) shall include the following:</p> <p>(1) A designated area separated from any portion of a facility wherein patients are housed, examined, or treated by a fire barrier of 1 hour fire-resistive construction.</p> <p>(2) The area is mechanically ventilated, is</p>	K 927	<p>Systematic Changes: Staff will be in-serviced by the Staff Development Coordinator or designee on the requirement that trans filling of oxygen takes place over bare concrete and not on VCT tile or other combustible flooring material NLT 3/2/18. The flooring and fan in the oxygen room will be inspected by the Maintenance Supervisor as a part of his monthly facility inspection beginning 2/15/18.</p> <p>Monitor: The results of the monthly inspection will be reviewed monthly at the Quality Assurance Performance Improvement (QAPI) meeting for a minimum of 3 months, beginning with the next QAPI meeting tentatively scheduled for 3/21/18. After 3 months, the need for continued review of the monthly inspection will be re-evaluated.</p> <p>Responsibility: Nursing Home Administrator</p>	

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K 927	Continued From page 13 sprinklered, and has ceramic or concrete flooring. (3) The area is posted with signs indicating that transfilling is occurring and that smoking in the immediate area is not permitted. (4) The individual transfilling the container(s) has been properly trained in the transfilling procedures. 9.3.7.5.3.2 Mechanical exhaust shall be at a rate of 1 L/sec of airflow for each 300 L (1 cfm per 5 ft3 of fluid) designed to be stored in the space and not less than 24 L/sec (50 cfm) nor more than 235 L/sec (500 cfm).	K 927		
K 930 SS=D	Gas Equipment - Liquid Oxygen Equipment CFR(s): NFPA 101 Gas Equipment - Liquid Oxygen Equipment The storage and use of liquid oxygen in base reservoir containers and portable containers comply with sections 11.7.2 through 11.7.4 (NFPA 99). 11.7 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure medical gases were stored in accordance with NFPA 99. Failure to secure oxygen cylinders has the potential increasing the risks of injury and explosions due to falling cylinders. This deficient practice affected 13 residents in 1 of 6 smoke compartments, staff and visitors on the date of the survey. Findings include: During the facility tour conducted on 1/30/18 from approximately 2:00 - 3:15 PM, observation of the oxygen storage area in the 300 wing of the facility, revealed six (6) LOX (Liquid oxygen) cylinders that were not secured in a rack or	K 930	Corrective Action: Wheeled oxygen assemblies were provided by the oxygen supply company on 1/31/18 and the oxygen cylinders were properly secured at that time. Other Residents: This deficiency and subsequent corrective action had the potential to affect all residents, staff and visitors within the smoke compartment.	3/2/18

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K 930	Continued From page 14 restraint. Actual NFPA standard: NFPA 99 11.7 Liquid Oxygen Equipment. 11.7.3.3* Liquid oxygen base reservoir containers shall be secured by one of the following methods while in storage or use to prevent tipping over caused by contact, vibration, or seismic activity: (1) Securing to a fixed object with one or more restraints (2) Securing within a framework, stand, or assembly designed to resist container movement (3) Restraining by placing the container against two points of contact	K 930	Systematic Changes: Staff will be in-serviced by the Staff Development Coordinator or designee NLT 3/2/18 on the requirement that oxygen cylinders are secured in a framework or secured to a fixed object with 1 or more restraint devices. Beginning 2/15/18, the facility maintenance supervisor will validate that the oxygen cylinders are properly secured as a part of the monthly facility maintenance inspection. Monitor: The results of the monthly inspection will be reviewed at the Quality Assurance Performance Improvement (QAPI) meeting for a minimum of 3 months, beginning with the next QAPI meeting tentatively scheduled for 3/21/18. After 3 months, the need for continued review of the monthly inspection will be re-evaluated. Responsibility: Nursing Home Administrator	

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E 000	Initial Comments The facility is a single story Type V (111) structure originally built in 1988. The building is equipped with a natural gas emergency power generator system, is fully sprinklered and equipped with smoke detection throughout. The facility is situated in a municipal fire district and is currently licensed for 88 SNF/NF beds with a census of 60 on the day of the survey. The following deficiencies were cited during the Emergency Preparedness survey conducted on January 30 and 31, 2018. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73. The Survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	E 000	Disclaimer Clause Preparation and/or execution of this plan of correction does not constitute the provider's admission of or agreement with the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. FEB 22 2018 FACILITY STANDARDS		
E 004 SS=D	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) [The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.] * [For hospitals at §482.15 and CAHs at §485.625(a):] The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.	E 004	Corrective Action: The Emergency Disaster Plan Program will be reviewed by the Interdisciplinary team NLT 3/2/18. The Executive Director, Director of Nursing and Medical Director will sign and date the EDP signature page to validate that the review has been completed. Other Residents: The alleged deficiency and corrective action listed above will potentially impact all residents, staff and visitors within the facility.	3/2/18	

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

Dan Kenneth

TITLE

NHA

(X6) DATE

2/21/18

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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E 004	<p>Continued From page 1</p> <p>The emergency preparedness program must include, but not be limited to, the following elements:] (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least annually.</p> <p>* [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least annually. This REQUIREMENT is not met as evidenced by: Based on review of provided emergency plan, policies and procedures, the facility failed to document review of the Emergency Plan program was conducted annually. Failure to review the EP program annually has the potential to hinder situational awareness using information that is not consistent with the facility's actual actions to be undertaken during emergencies. This deficient practice affected 60 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>1) Review of provided emergency plan, policies and procedures conducted on 1/30/18 8:30 AM - 3:30 PM and 1/31/18 from 8:30 - 10:00 AM, revealed the EDP signature page located in Section A1 of the plan, was not signed demonstrating initial review of the plan had been conducted.</p> <p>2) Review of a provided emergency management committee meeting form on page 3.04B conducted on 1/31/18 from 11:00 - 11:30 AM,</p>	E 004	<p>Systematic Changes: Effective 3/2/18, a comprehensive review of the Emergency Disaster Plan will be conducted by the interdisciplinary team with each update and no less than annually. The signature page validating that the review was completed will be signed following each review.</p> <p>Monitor: The Nursing Home Administrator will schedule the review of the Emergency Disaster Plan in conjunction with the quarterly QAPI meeting. As a part of the QAPI meeting, the Nursing Home Administrator will validate that a review has been completed and appropriate signatures are documented on the Signature Review Page.</p> <p>Responsibility: Nursing Home Administrator</p>		

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E 004	Continued From page 2 revealed the following sections had not been documented as having been reviewed or addressed: Page 1 of 3, section 2 as it relates to the NFPA 99 Risk Assessment Form contained in the plan was not documented as having been reviewed. Section 3 of the aforementioned relating to full scale exercises, was not documented as having been reviewed. Section 5 of the aforementioned relating to Incident Command Center and Emergency Area Locations was not documented as having been reviewed. Page 2 of 3, section 6 relating to emergency exits was not documented as having been reviewed. Section 7 of the aforementioned was missing dates for listed emergencies. Section 9b of the aforementioned was not documented as having been reviewed. Section 11b of the aforementioned was not documented as having been reviewed and verifying it was current, along with provisions provided for continued need. Page 3 of 3, section 11e was not documented as having been reviewed that transportation contracts were up to date and in place in the EDP. Reference: 42 CFR 483.73 (a)	E 004			
E 006 SS=E	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (1) Be based on and include a documented,	E 006	Corrective Action: The facility will conduct a facility and community based all-hazards risk assessment including strategies for response NLT 3/2/18.	3/2/18	

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E 006	<p>Continued From page 3</p> <p>facility-based and community-based risk assessment, utilizing an all-hazards approach.*</p> <p>*[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents.</p> <p>*[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients.</p> <p>(2) Include strategies for addressing emergency events identified by the risk assessment.</p> <p>* [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to conduct a facility-based and community-based risk assessment which includes identified strategies for response. Failure to conduct a risk assessment which includes a community based component, potentially hinders facility response to localized disasters and emergencies. This deficient practice affected 60 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>1) On 1/30/18 from 8:30 AM - 3:00 PM, review of</p>	E 006	<p>Other Residents: The alleged deficiency and corrective action listed above will potentially impact all residents, staff and visitors within the facility.</p> <p>Systematic Changes: Effective 3/2/18, subsequent all-hazard risk assessments will include input from local and/or regional emergency management to provide a community-based component.</p> <p>Monitor: The all hazards risk assessment will be reviewed no less than quarterly by the IDT in conjunction with the facility QAPI meeting beginning with the next QAPI meeting tentatively scheduled for 3/21/18 to validate that a thorough and up-to-date community-based component is included in the assessment.</p> <p>Responsibility: Nursing Home Administrator</p>		

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E 006	Continued From page 4 provided emergency plan, policies and procedures, did not reveal the risk assessment included input from local or regional emergency management officials that would provide a community based component. Interview of the Administrator on 1/30/18 from 11:30 AM - 12:00 PM found the facility risk assessment was done internally during a staff round table, and did not contain a community based component. 2) Review of provided emergency plan, policies and procedures conducted on 1/30/18 and 1/31/18 showed the risk assessment identified no risk of Tsunami for the facility, however the plan included procedures for a Tsunami in section TSU-1, pages 1 and 2. Reference: 42 CFR 483.73 (a) (1) - (2)	E 006			
E 013 SS=D	Development of EP Policies and Procedures CFR(s): 483.73(b) (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this	E 013	Corrective Action: The Emergency Disaster Plan Program will be reviewed by the Interdisciplinary team NLT 3/2/18. The Executive Director, Director of Nursing and Medical Director will sign and date the EDP signature page to validate that the review has been completed. Other Residents: The alleged deficiency and corrective action listed above will potentially impact all residents, staff and visitors within the facility.	3/2/18	

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E 013	<p>Continued From page 5</p> <p>section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least annually.</p> <p>*[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, it was determined the facility failed to document review of the Emergency Plan policies and procedures was conducted annually. Failure to review the EP program policies and procedures annually, has the potential to implement policies and/or procedures that are inconsistent with staff actions during emergencies. This deficient practice affected 60 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p>	E 013	<p>Systematic Changes: Effective 3/2/18, a comprehensive review of the Emergency Disaster Plan will be reviewed by the interdisciplinary team with each update and no less than annually. The signature page validating that the review took place will be signed following each review.</p> <p>Monitor: The Nursing Home Administrator will schedule the review of the Emergency Disaster Plan in conjunction with the quarterly QAPI meeting. As a part of the QAPI meeting, the Nursing Home Administrator will validate that review is completed and appropriate signatures are documented on the Signature Review Page.</p> <p>Responsibility: Nursing Home Administrator</p>		

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E 013	Continued From page 6 1) Review of provided emergency plan, policies and procedures conducted on 1/30/18 8:30 AM - 3:30 PM and 1/31/18 from 8:30 - 10:00 AM, revealed the EDP signature page located in Section A1 was not signed demonstrating initial review of the plan's policies and procedures had been conducted. 2) Interview of the Administrator and the AIT (Administrator in Training) conducted on 1/30/18 from 11:30 AM - 12:00 PM and 1:30 - 2:00 PM, revealed the risk assessment conducted as required in section (a) (1) of the rule did not include a community based component. 3) Review of provided policies and procedures conducted on 1/30/18 showed the Risk Assessment had indicated no risk of Tsunami for the facility, yet the policies provided included a plan for a Tsunami in section TSU-1, pages 1 and 2. Reference: 42 CFR 483.73 (b)	E 013			
E 018 SS=D	Procedures for Tracking of Staff and Patients CFR(s): 483.73(b)(2) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following: (2) A system to track the location of on-duty staff	E 018	Corrective Action: A policy for tracking on-duty staff and residents within the facility will be developed and added to the Emergency Disaster Plan NLT 3/2/18. Other Residents: The alleged deficiency and corrective action listed above will potentially impact all residents, staff and visitors within the facility.	3/2/18	

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E 018	<p>Continued From page 7</p> <p>and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location.</p> <p>*[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location.</p> <p>*[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location.</p> <p>*[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of</p>	E 018	<p>Systematic Changes: Once developed, the policy for tracking on-duty staff and residents within the facility will become a permanent component of the Emergency Disaster Plan.</p> <p>Monitor: Effective 3/2/18, the NHA will be responsible for validating that the policy for tracking on-duty staff and residents within the facility is present, appropriate and reviewed no less than annually during the comprehensive review of the Emergency Preparedness Plan.</p> <p>Responsibility: Nursing Home Administrator</p>		

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E 018	<p>Continued From page 8.</p> <p>evacuation location(s); and primary and alternate means of communication with external sources of assistance.</p> <p>*[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records.</p> <p>*[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the facility failed to provide a policy for tracking of staff and sheltered residents during an emergency. Lack of a tracking policy for sheltered staff and residents has the potential to hinder continuity of care and essential services during an emergency. This deficient practice affected 60 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>On 1/30/18 from 8:30 AM - 3:00 PM, review of provided emergency plan, policies and procedures, failed to demonstrate the facility had in place a system to track the location of on-duty staff and sheltered residents during an emergency. Further review of the Sheltering in Place policy in section 8.01 and the Shelter in Place Decision Tree located in section 8.01A, demonstrated it included provisions for items needed for sustenance, but did not include tracking policies and procedures for those staff</p>	E 018			

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E 018	Continued From page 9 and residents sheltering in place during a disaster. Reference: 42 CFR 483.73 (b) (2)	E 018			
E 024 SS=F	<p>Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6)</p> <p>[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:]</p> <p>(6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.</p> <p>*[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to develop, document and maintain current emergency policies, procedures and operational plans for the use of volunteers to address surge needs during an emergency. Lack of current plans and policies for the use of volunteers has the potential to</p>	E 024	<p>Corrective Action: The policy and procedures for utilizing volunteers during an emergency was added to the Emergency Disaster Plan on 2/19/18.</p> <p>Other Residents: The alleged deficiency and corrective action listed above will potentially impact all residents, staff and visitors within the facility.</p> <p>Systematic Changes: Effective 2/19/18, the policy and procedures governing the use of volunteers during an emergency will be maintained as a permanent component of the Emergency Disaster Plan.</p>	2/19/18	

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E 024	<p>Continued From page 10</p> <p>hinder the facility's ability to provide continuity of care during a disaster. This deficient practice affected 60 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>1) Review of provided emergency plan, policies and procedures conducted on 1/30/18 from 8:30 AM - 3:00 PM, identified that section 1.01A, under the provision labeled "Response Planning", the final bulletpoint asks the question: "Have you included neighborhood residents and businesses in your response planning?" This question was not responded to and no further documentation of the use of volunteers as described was contained in the plan, policies or procedures.</p> <p>2) Review of provided emergency plan, policies and procedures conducted on 1/30/18 from 8:30 AM - 3:00 PM, identified that section 8.02 entitled "Community Support", subsection 2 refers to completion of the Surge Capacity Plan, but review of that plan located in section 8.03 revealed it had not been completed.</p> <p>Interview of 5 of 5 staff members on 1/30/18 from 11:00 AM to 4:30 PM, did not indicate any knowledge of the facility policy for the use of volunteers during an emergency.</p> <p>Reference: 42 CFR 483.73 (b) (6)</p>	E 024	<p>Monitor: Effective 2/19/18, The NHA will be responsible for validating that the policy for utilizing volunteers during an emergency within the facility is present, appropriate and reviewed no less than annually during the comprehensive review of the Emergency Preparedness Plan.</p> <p>Responsibility: Nursing Home Administrator</p>		
E 026 SS=D	<p>Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8)</p> <p>[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this</p>	E 026			

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E 026	<p>Continued From page 11 section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:]</p> <p>(8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.</p> <p>*[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the facility failed to document their role under an 1135 waiver as declared by the Secretary and the provisions of care as required under this action if identified by emergency management officials. Failure to plan for alternate means of care and the role under an 1135 waiver has the potential to limit facility options during an emergency. This deficient practice potentially affects reimbursement and continuity of care for the 60 residents, staff and visitors housed on the date of the survey along with the available surge needs of the community during a disaster.</p> <p>Findings include: On 1/30/18 from 8:30 AM - 3:00 PM, review of the provided emergency plan, policies and</p>	E 026	<p>Corrective Action: The policy documenting the facilities' role in response to declaration of an 1135 waiver was added to the Emergency Disaster Plan on 2/19/18.</p> <p>Other Residents: The alleged deficiency and corrective action listed above will potentially impact all residents, staff and visitors within the facility.</p> <p>Systematic Changes: Effective 2/19/18, the policy detailing the facilities' role following the declaration of an 1135 waiver will be maintained as a permanent component of the Emergency Disaster Plan.</p> <p>Monitor: Effective 2/19/18, The NHA will be responsible for validating that the policy documenting the facilities' role following declaration of an 1135 waiver is present, appropriate and reviewed no less than annually during the comprehensive review of the Emergency Preparedness Plan.</p>	2/19/18

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E 026	Continued From page 12 procedures, did not demonstrate the role of the facility under the declaration of an 1135 waiver, should that condition be enacted by the Secretary. Reference: 42 CFR 483.73 (b) (8)	E 026	Responsibility: Nursing Home Administrator	
E 039 SS=F	EP Testing Requirements CFR(s): 483.73(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set	E 039	Corrective Action: A facilitator-led tabletop exercise will be conducted by the facility NLT 3/2/18. The exercise will utilize a narrated, clinically relevant scenario with a list of problem statements, directed messages or prepared questions designed to challenge the emergency plan. The NHA or designee will contact the Regional Healthcare Coalition NLT 2/16/18 to determine when the next community-based emergency preparedness exercise is being conducted and coordinate so that our facility participates in that exercise. Other Residents: The alleged deficiency and corrective action listed above will potentially impact all residents, staff and visitors within the facility.	3/2/18

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135138	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/31/2018
NAME OF PROVIDER OR SUPPLIER TETON POST ACUTE CARE & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 3111 CHANNING WAY IDAHO FALLS, ID 83404		
(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	
E 039	<p>Continued From page 13 of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.</p> <p>*[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following:</p> <p>(i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to document participation in two full scale exercises that tested the emergency preparedness readiness of the facility. Failure to participate in full-scale, actual, or tabletop events has the potential to reduce the facility's effectiveness to provide continuation of care to residents during an emergency. This deficient practice affected 60 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p>	E 039	<p>Systematic Changes: Effective 2/16/18, the NHA or designee will maintain routine contact with the local Healthcare Coalition and other local or regional Emergency Management organizations as applicable to ascertain when upcoming community-based exercises are being conducted and seek to participate in no fewer than 2 community-based exercises per year as required.</p> <p>Monitor: The Nursing Home Administrator will schedule the review of the Emergency Disaster Plan in conjunction with the quarterly QAPI meeting, beginning with the next QAPI meeting tentatively scheduled for 3/21/18. As a part of the QAPI meeting, the Nursing Home Administrator will validate that the facility participates in 2 community or facility-based emergency preparedness exercises or is scheduled to participate in 2 exercises per year.</p> <p>Responsibility: Nursing Home Administrator</p>		

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E 039	<p>Continued From page 14</p> <p>On 1/30/18 from 8:30 AM - 3:00 PM, review of provided emergency plan documents revealed documentation demonstrating the facility had conducted a facility based evacuation drill on 8/30/17 at 1430 hours, however several key areas were identified as needing improvement, such as communication, along with tracking and security concerns. Further review found no follow-up documentation demonstrating any evaluation, review or update to the plan was performed based on the findings.</p> <p>Interview of the Administrator on 1/30/18 from 11:30 AM - 12:00 PM revealed the facility had only participated in one evacuation drill using a gas leak as the scenario, but no further update or review of the plan was conducted as a result of discovered areas of improvement during this exercise. The Administrator further stated the local AHJ (fire department) was contacted to help facilitate a facility-based full scale exercise, but the AHJ lacked the resources to participate and a second drill was not conducted.</p> <p>Reference: 42 CFR 483.73 (d) (1)</p>	E 039			