



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 12, 2018

Remick "Micky" Clark, Administrator
Good Samaritan Society - Idaho Falls Village
840 East Elva Street
Idaho Falls, ID 83401-2899

Provider #: 135092

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Mr. Clark:

On **February 1, 2018**, a Facility Fire Safety and Construction survey was conducted at **Good Samaritan Society - Idaho Falls Village** 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.

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

Remick "Micky" Clark, Administrator
February 12, 2018
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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 26, 2018**. Failure to submit an acceptable PoC by **February 26, 2018**, may result in the imposition of civil monetary penalties by **March 17, 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 **March 8, 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 8, 2018**. A change in the seriousness of the deficiencies on **March 8, 2018**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **March 8, 2018**, includes the following:

Remick "Micky" Clark, Administrator
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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 **August 1, 2018**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Nate Elkins, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, option 3; Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **February 1, 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:

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

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Go to the middle of the page to Information Letters section and click on State and select the following:

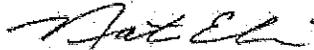
BFS Letters (06/30/11)

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

This request must be received by **February 26, 2018**. If your request for informal dispute resolution is received after **February 26, 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: 135092	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE STRUCTURE B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2018
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RECEIVED

NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - IDAHO FALLS	STREET ADDRESS, CITY, STATE, ZIP CODE 840 EAST ELVA STREET IDAHO FALLS, ID 83401	FEB 26 2018
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FACILITY STANDARDS

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	INITIAL COMMENTS The facility is a single story, Type V (111) sprinklered building with a partial basement. The facility was constructed in 1964, with an addition completed in 1985 and further renovation in 1995. The building is sprinklered throughout and a new fire alarm/smoke detection system was installed in November 2009. Currently the facility is licensed for 113 SNF/NF beds and had a census of 41 on the date of the survey. The following deficiencies were cited during the annual fire/life safety survey conducted on January 31, 2018 and February 1, 2018. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70. The Survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction	K 000	Preparation and Execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of 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. For the purposes of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations manual.	
K 100 SS=F	General Requirements - Other CFR(s): NFPA 101 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 management program for waterborne pathogens such as Legionella, in accordance with 42 CFR 483.80. Failure to conduct a facility based risk	K 100	1. The facility has a contract with NALCO, a division of ECOLAB, to create a site specific water management plan complete with facility based risk assessment. Facility is expected to receive the water management plan on or before 2/23/18. 2. All residents have the potential to be affected by this practice.	3/8/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Kevin W. Clark</i>	TITLE <i>Administrator</i>	(X6) DATE <i>2/23/18</i>
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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	Continued From page 1 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. Findings include: During review of provided maintenance and inspection records conducted on 1/31/18 from approximately 10:30 AM - 12:00 PM, records provided for the facility's water management plan, failed to demonstrate it had completed the facility based risk assessment that demonstrated what facility specific areas were identified as potential risks and what level of risks those areas presented. CFR standard: 42 CFR 483.80 § 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. Additional reference: Center for Medicaid/Medicare Services S & C letter 17-30	K 100	3. NALCO representative will come to the facility to train Administrator, Director of Environmental Services and maintenance on contents of plan and tasks to be completed on or before 3/8/18. 4. Compliance will be monitored by Director of Environmental Services or designee performing audits that all preventative maintenance actions have been completed and documented weekly x4, monthly x2, quarterly x2. Audit results will be reported to the QAPI committee and the committee will determine if further auditing is needed.	
K 161 SS=D	Building Construction Type and Height CFR(s): NFPA 101 Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by	K 161	1. The penetration found on the ceiling of the IT closet has been covered with 5/8 in rated sheetrock and fire caulked for better seal on 2/2/18.	3/8/18

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K 161	Continued From page 2 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that the fire and smoke resistive properties of the structure were maintained.	K 161	2. All residents have the potential to be affected by this practice. 3. Inspection of all IT areas to be free of penetrations has been added to the facility TEL's program as a monthly task to be completed by the Director of Environmental Services or designee. 4. Compliance will be monitored by Director of Environmental Services or designee performing audits on all IT areas to be free of unsealed penetrations monthly x3, quarterly x2. Audit results will be reported to the QAPI committee and the committee will determine if further auditing is needed.	

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K 161	<p>Continued From page 3</p> <p>Failure to seal penetrations in rated construction assemblies has the potential to allow fire, smoke and dangerous gases to pass between compartments. 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 1/31/18 from approximately 12:30 - 1:30 PM, observation of the ceiling in the IT closet outside the nurse's station at the 100/200 hall intersection revealed a two inch by three inch hole cut in the ceiling, exposing the space above.</p> <p>When asked, the Environmental Services Director stated he was not aware of this hole prior to the date of the survey.</p> <p>Actual NFPA standard:</p> <p>19.1.6 Minimum Construction Requirements. 19.1.6.1 Health care occupancies shall be limited to the building construction types specified in Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7. (See 8.2.1.)</p> <p>8.2 Construction and Compartmentation. 8.2.1 Construction. 8.2.1.1 Buildings or structures occupied or used in accordance with the individual occupancy chapters, Chapters 11 through 43, shall meet the minimum construction requirements of those chapters.</p> <p>8.2.2.2 Fire compartments shall be formed with fire barriers that comply with Section 8.3.</p> <p>8.3.5.6 Membrane Penetrations. 8.3.5.6.1 Membrane penetrations for cables,</p>	K 161		

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K 161	Continued From page 4 cable trays, conduits, pipes, tubes, combustion vents and exhaust vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a membrane of a wall, floor, or floor/ceiling assembly constructed as a fire barrier shall be protected by a firestop system or device and shall comply with 8.3.5.1 through 8.3.5.2.	K 161		
K 325 SS=F	Alcohol Based Hand Rub Dispenser (ABHR) CFR(s): NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 This REQUIREMENT is not met as evidenced by: Based on record review, observation and	K 325	1. The facility is now documenting the refilling of hand sanitizer and inspection of the manually operated hand sanitizer dispenser to be in good working order. This is a housekeeping task starting on 2/24/18. 2. All residents have the potential to be affected by this practice. 3. Housekeeping staff will be educated by the Director of Environmental Services on or before 2/24/18 on the required documentation of sanitizer refill and dispenser inspection. All staff will also be educated on this process by the Director of Environmental Services on 3/5/18. 4. Compliance will be monitored by Director of Environmental Services or designee performing audits of the documentation of sanitizer refills and	3/8/18

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K 325	<p>Continued From page 5</p> <p>interview, the facility failed to ensure manually operated Alcohol Based Hand Rub Dispensers (ABHR), were maintained in accordance with NFPA 101. Failure to install, test and document operation of ABHR dispensers under manufacturer's recommendations and in accordance with the standard, has the potential of increasing the risk of fires from flammable liquids. This deficient practice affected 41 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>1) During review of facility maintenance and inspection records conducted on 1/31/18 from approximately 11:00 AM - 12:30 PM, no records were available indicating procedures performed for installed ABHR dispensers when refilling. Asked what documentation was done during this process, the Environmental Services Director stated the facility was not documenting the refill process and he was not aware of the requirement to test ABHR dispensers each time a refill was installed.</p> <p>2) During the facility tour conducted on 1/31/18 from 1:00 PM to 4:30 PM, observation of installed ABHR dispensers revealed manually activated dispensers had been installed in 9 of 9 smoke compartment corridors.</p> <p>Actual NFPA standard:</p> <p>NFPA 101</p> <p>19.3.2.6* Alcohol-Based Hand-Rub Dispensers. Alcohol-based hand-rub dispensers shall be protected in accordance with 8.7.3.1, unless all of the following conditions are met:</p>	K 325	<p>dispenser inspection weekly x4, monthly x2, quarterly x2. Audit results will be reported to the QAPI committee and the committee will determine if further auditing is needed.</p>	

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K 325	Continued From page 6 (1) Where dispensers are installed in a corridor, the corridor shall have a minimum width of 6 ft (1830 mm). (2) The maximum individual dispenser fluid capacity shall be as follows: (a) 0.32 gal (1.2 L) for dispensers in rooms, corridors, and areas open to corridors (b) 0.53 gal (2.0 L) for dispensers in suites of rooms (3) Where aerosol containers are used, the maximum capacity of the aerosol dispenser shall be 18 oz. (0.51 kg) and shall be limited to Level 1 aerosols as defined in NFPA30B, Code for the Manufacture and Storage of Aerosol Products. (4) Dispensers shall be separated from each other by horizontal spacing of not less than 48 in. (1220 mm). (5) Not more than an aggregate 10 gal (37.8 L) of alcohol-based hand-rub solution or 1135 oz (32.2 kg) of Level 1 aerosols, or a combination of liquids and Level 1 aerosols not to exceed, in total, the equivalent of 10 gal (37.8 L) or 1135 oz (32.2 kg), shall be in use outside of a storage cabinet in a single smoke compartment, except as otherwise provided in 19.3.2.6(6). (6) One dispenser complying with 19.3.2.6 (2) or (3) per room and located in that room shall not be included in the aggregated quantity addressed in 19.3.2.6(5). (7) Storage of quantities greater than 5 gal (18.9 L) in a single smoke compartment shall meet the requirements of NFPA 30, Flammable and Combustible Liquids Code. (8) Dispensers shall not be installed in the following locations: (a) Above an ignition source within a 1 in. (25	K 325		

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K 325	Continued From page 7 mm) horizontal distance from each side of the ignition source (b) To the side of an ignition source within a 1 in. (25mm) horizontal distance from the ignition source (c) Beneath an ignition source within a 1 in. (25 mm) vertical distance from the ignition source (9) Dispensers installed directly over carpeted floors shall be permitted only in sprinklered smoke compartments. (10) The alcohol-based hand-rub solution shall not exceed 95 percent alcohol content by volume. (11) Operation of the dispenser shall comply with the following criteria: (a) The dispenser shall not release its contents except when the dispenser is activated, either manually or automatically by touch-free activation. (b) Any activation of the dispenser shall occur only when an object is placed within 4 in. (100 mm) of the sensing device. (c) An object placed within the activation zone and left in place shall not cause more than one activation. (d) The dispenser shall not dispense more solution than the amount required for hand hygiene consistent with label instructions. (e) The dispenser shall be designed, constructed, and operated in a manner that ensures that accidental or malicious activation of the dispensing device is minimized. (f) The dispenser shall be tested in accordance with the manufacturer ' s care and use instructions each time a new refill is installed.	K 325		
K 353 SS=F	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	K 353	1. The facility is now conducting and documenting weekly inspections of the dry system gauges. This was started on 2/16/18.	3/8/18

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K 353	<p>Continued From page 8 with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that fire suppression systems were maintained in accordance with 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 41 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During review of provided facility inspection and testing records conducted on 1/31/18 from 11:30 AM - 12:30 PM, no records were available indicating a weekly inspection of dry system gauges had been conducted. Interview of the Environmental Services Director revealed he was not aware of the weekly inspection requirement for dry system gauges.</p> <p>Actual NFPA standard:</p>	K 353	<p>2. All residents have the potential to be affected by this practice.</p> <p>3. The weekly inspection of the dry system gauges has been added to the facility's TELs program as a weekly task to be completed.</p> <p>4. Compliance will be monitored by Director of Environmental Services or designee performing an audit of the completion and documentation of the inspection of the dry system gauges weekly x4, monthly x2, quarterly x2. Audit results will be reported to the QAPI committee and the committee will determine if further auditing is needed.</p>	

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K 353	Continued From page 9 13.3 Control Valves in Water-Based Fire Protection Systems. 13.3.2 Inspection. 13.3.2.1 All valves shall be inspected weekly. 13.3.2.1.1 Valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly. 13.3.2.2* The valve inspection shall verify that the valves are in the following condition: (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		
K 374 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of	K 374	1. The annual inspection of the four automatic roll-down fire doors equipped with fusible links will be inspected by a contractor on or before 3/7/18. 2. All residents have the potential to be affected by this practice.	3/8/18

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K 374	<p>Continued From page 10</p> <p>egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure smoke and fire barriers were maintained to limit the transfer of smoke, fire and dangerous gases between compartments. Failure to maintain installed fire rated assemblies that limit transfer of combustion products, has the potential to hinder egress and the ability to shelter in place. This deficient practice affected staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>1) During review of facility maintenance and inspection records conducted on 1/31/18 from approximately 11:00 AM - 12:30 PM, no records were provided indicating automatic roll-down fire doors equipped with fusible links were inspected and tested annually in accordance with NFPA 80 guidelines.</p> <p>2) During the facility tour conducted on 1/31/18 from 2:00 - 3:30 PM, the following locations were observed to have automatic roll-down fire doors equipped with fusible links:</p> <p>Two (2) roll-up steel fire doors were installed at the pass-thru windows of the Business Office. One (1) roll-up steel fire door was installed at the pass-thru window of the main Kitchen. One (1) roll-up steel fire door was installed at the pass-thru window of the identified "Reception" office adjacent to "Family Lounge".</p>	K 374	<p>3. The annual inspection of all automatic roll-down fire doors to be completed by a contractor has been added to the facility TELs program.</p> <p>4. Compliance will be monitored by Director of Environmental Services or designee performing audits of the documentation that the annual inspection is completed quarterly x4. Audit results will be reported to the QAPI committee and the committee will determine if further auditing is needed.</p>	

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K 374	<p>Continued From page 11</p> <p>Further observation of these doors demonstrated each was equipped with a fusible link control, automatic operation interconnected to the fire alarm system and labels requiring annual testing in accordance with NFPA 80 standards. When asked if these doors had been tested annually, the Environmental Services Director stated they had not been tested and he was unaware of the annual testing requirement.</p> <p>Actual NFPA standard:</p> <p>19.3.7.7 Reserved.</p> <p>19.3.7.8* Doors in smoke barriers shall comply with 8.5.4 and all of the following:</p> <p>(1) The doors shall be self-closing or automatic-closing in accordance with 19.2.2.2.7.</p> <p>(2) Latching hardware shall not be required</p> <p>(3) The doors shall not be required to swing in the direction of egress travel.</p> <p>8.5.4.4* Doors in smoke barriers shall be self-closing or automatic-closing in accordance with 7.2.1.8 and shall comply with the provisions of 7.2.1.</p> <p>7.2.1.15.2 Fire-rated door assemblies shall be inspected and tested in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Smoke door assemblies shall be inspected and tested in accordance with NFPA 105, Standard for Smoke Door Assemblies and Other Opening Protectives.</p> <p>NFPA 80</p> <p>5.2* Inspections.</p> <p>5.2.1* Fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept</p>	K 374		

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K 374	Continued From page 12 for inspection by the AHJ.	K 374		
K 911 SS=F	<p>Electrical Systems - Other CFR(s): NFPA 101</p> <p>Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567, Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the Essential Electrical System (EES) generator was equipped with a remote manual stop station in accordance with NFPA 110. Failure to provide a remote stop located outside of the room housing the prime mover, potentially hinders staff ability to shut down the generator if required during an emergency. This deficient practice affected 41 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 1/31/18 from approximately 1:30 - 2:30 PM, a remote manual stop station for the EES generator was observed mounted to the side of the generator housed inside a room in the partial basement. When asked about the location of this stop switch, the Environmental Services Director stated this was the location where the facility had mounted the remote stop and he was not aware it was required to be outside the room housing the prime mover.</p> <p>Actual NFPA standard:</p>	K 911	<ol style="list-style-type: none"> 1. The remote manual stop station has been moved from the generator to the adjacent room to allow staff the ability to shut down the generator in an emergency. This was done on 2/5/18. 2. All residents have the potential to be affected by this practice. 3. The placement of the generator emergency stop switch is a permanent correction. All staff will be educated on the new location of the generator emergency stop switch for the generator on 3/5/18 by the Director of Environmental Services. 4. No auditing of the stop switch location is required as this was a permanent one-time correction. This correction will be reported to the QAPI Committee and the committee will determine if any auditing is needed. 	3/8/18

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K 911	Continued From page 13 NFPA 110 5.6.5.6* All installations shall have a remote manual stop station of a type to prevent inadvertent or unintentional operation located outside the room housing the prime mover, where so installed, or elsewhere on the premises where the prime mover is located outside the building. 5.6.5.6.1 The remote manual stop station shall be labeled.	K 911		
K 918 SS=F	Electrical Systems - Essential Electric System 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 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	K 918	1. The generator inspection/repair contractor used by the facility performed a fuel sample test. This was completed on 2/6/18. 2. All residents have the potential to be affected by this practice. 3. The testing of the generator fuel has been added to the facility TELs program as an annual task. 4. Compliance will be monitored by the Director of Environmental Services or designee performing an audit of the generator documentation for annual fuel testing to have been completed quarterly x4. Audit results will be reported to the QAPI committee and the committee will determine if further auditing is needed.	3/8/18

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K 918	Continued From page 14 readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. 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 the EES (Essential Electrical System) generator was maintained in accordance with NFPA 110. Failure to annually test the fuel for diesel powered generators has the potential of hindering system performance during a power loss or other emergency. This deficient practice affected 41 residents, staff and visitors on the date of the survey. Findings include: During review of annual inspection and maintenance records conducted on 1/31/18 from approximately 11:30 AM to 12:30 PM, records provided for the annual generator inspection did not indicate any testing was completed for the fuel supply. When asked, the Environmental Services Director stated he was not aware of the fuel testing requirement for diesel-fired systems. Actual NFPA standard: NFPA 110 8.3.8 A fuel quality test shall be performed at least annually using tests approved by ASTM standards.	K 918		
K 923 SS=D	Gas Equipment - Cylinder and Container Storage CFR(s): NFPA 101	K 923	1. The facility had all but 3 oxygen cylinders removed and now have two	3/8/18

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K 923	<p>Continued From page 15</p> <p>Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3.</p> <p>>300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating.</p> <p>Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING."</p> <p>Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather.</p> <p>11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (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</p>	K 923	<p>storage racks labeled full and empty to segregate the cylinders. This was completed on 2/6/18.</p> <p>2. All residents have the potential to be affected by this practice.</p> <p>3. Inspection of oxygen cylinders to be properly stored in racks and are segregated empty or full has been added to the facility's TELs program as a weekly task.</p> <p>4. Compliance will be monitored by Director of Environmental Services or designee performing audits on the proper storage of oxygen cylinders weekly x4, monthly x2, quarterly x2. Audit results will be reported to the QAPI committee and the committee will determine if further auditing is needed.</p>		

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K 923	<p>Continued From page 16</p> <p>accordance with NFPA 99. Failure to secure oxygen cylinders and segregate empty from full has the potential of using incorrect cylinders during an emergency requiring supplemental oxygen. This deficient practice affected 12 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 1/31/18 from approximately 11:30 AM - 3:30 PM, observation of the oxygen storage area in the 100 east hall of the facility, revealed one (1) unsecured cylinder on the outside of the transfill/storage room. Further observation of the interior of this space revealed approximately twenty-four (24) "E" size oxygen cylinders in storage racks. This area did not contain signs or indications as to whether the stored cylinders were empty or full.</p> <p>When asked how staff differentiates empty and full oxygen cylinders, the Environmental Services Director stated that staff might look at the gauges if one was installed, but there was not specific method he was aware of.</p> <p>Actual NFPA standard:</p> <p>NFPA 99</p> <p>11.6.5 Special Precautions - Storage of Cylinders and Containers.</p> <p>11.6.5.1 Storage shall be planned so that cylinders can be used in the order in which they are received from the supplier.</p> <p>11.6.5.2 If empty and full cylinders are stored within the same enclosure, empty cylinders shall be segregated from full cylinders.</p> <p>11.6.5.3 Empty cylinders shall be marked to avoid</p>	K 923		

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K 923	<p>Continued From page 17</p> <p>confusion and delay if a full cylinder is needed in a rapid manner.</p> <p>11.6 Operation and Management of Cylinders. 11.6.2.3 Cylinders shall be protected from damage by means of the following specific procedures:</p> <p>(1) Oxygen cylinders shall be protected from abnormal mechanical shock, which is liable to damage the cylinder, valve, or safety device. (2) Oxygen cylinders shall not be stored near elevators or gangways or in locations where heavy moving objects will strike them or fall on them. (3) Cylinders shall be protected from tampering by unauthorized individuals. (4) Cylinders or cylinder valves shall not be repaired, painted, or altered. (5) Safety relief devices in valves or cylinders shall not be tampered with. (6) Valve outlets clogged with ice shall be thawed with warm - not boiling - water. (7) A torch flame shall not be permitted, under any circumstances, to come in contact with a cylinder, cylinder valve, or safety device. (8) Sparks and flame shall be kept away from cylinders. (9) Even if they are considered to be empty, cylinders shall not be used as rollers, supports, or for any purpose other than that for which the supplier intended them. (10) Large cylinders (exceeding size E) and containers larger than 45 kg (100 lb) weight shall be transported on a proper hand truck or cart complying with 11.4.3.1. (11) Freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. (12) Cylinders shall not be supported by radiators, steam</p>	K 923		

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K 926 K 926 SS=F	Continued From page 18 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 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 1/31/18 from approximately 11:00 AM - 12:30 PM, no records were provided for annual oxygen training. Interview of 4 of 4 staff members on 2/1/18 from 9:00 AM to 12:30 PM, revealed none had participated in any continuing education program on the risks associated with the storage, handling or use of medical gases. Additionally, interview of the Staff Development Coordinator from approximately 9:30 - 10:00 AM, revealed she was not aware of any current program of	K 926 K 926	1. The DNS provided oxygen training to staff that included facility policy and procedures on oxygen handling, oxygen safety and oxygen administration. This was completed on 2/15/18. 2. All residents have the potential to be affected by this procedure. 3. Training will be held annually an during new hire orientation for oxygen handling and safety. This training will be provided by the Staff Development Coordinator or designee. 4. Compliance will be monitored by Staff Development Coordinator or designee performing audits to ensure that staff have received annual oxygen training weekly x4, monthly x2, quarterly x2. Audit results will be reported to the QAPI committee and the committee will determine if further auditing is needed.	3/8/18

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135092	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE STRUCTURE B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2018
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - IDAHO FALLS			STREET ADDRESS, CITY, STATE, ZIP CODE 840 EAST ELVA STREET IDAHO FALLS, ID 83401		
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K 926	Continued From page 19 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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135092	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ RECEIVED B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2018
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - IDAHO FALLS			STREET ADDRESS, CITY, STATE, ZIP CODE 840 EAST ELVA STREET IDAHO FALLS, ID 83401		
			FEB 26 2018		
			FACILITY STANDARDS		
(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 000	Initial Comments The facility is a single story, Type V (111) building with a partial basement. Original construction was June 1964 with an addition in 1985 and a major renovation in 1995. A new fire alarm/smoke detection system was installed in November 2009. The facility is situated in a municipal fire district and is currently licensed for 113 SNF/NF beds with a census of 41 on the day of the survey. The following deficiencies were cited during the Emergency Preparedness survey conducted on January 31 and February 1, 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	Preparation and Execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of 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. For the purposes of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations manual.		
E 006 SS=F	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, facility-based and community-based risk assessment, utilizing an all-hazards approach.* *[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.	E 006	1. The facility Emergency Management Plan (EMP) Interdisciplinary Team (IDT) reviewed the Hazard Vulnerability Assessment (HVA) and updated it on 2/19/18. The IDT referenced the Community HVA created by the Eastern Idaho Healthcare Coalition when considering any changes to the facility HVA. 2. All residents have the potential to be affected by this practice.	3/8/18	

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

Renit W. Clark

TITLE

Administrator

(X6) DATE

2/23/18

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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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - IDAHO FALLS		STREET ADDRESS, CITY, STATE, ZIP CODE 840 EAST ELVA STREET IDAHO FALLS, ID 83401		
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E 006	<p>Continued From page 1</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 41 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>On 1/31/18 from 11:30 AM - 12:30 PM, review of provided emergency plan, policies and procedures, did not reveal the risk assessment included input from local or regional emergency management officials that included a community based component. Interview of the Environmental Services Director on 1/31/18 from 1:30 - 2:00 PM found the facility risk assessment was done by him through information he considered relevant to</p>	E 006	<p>3. The facility EMP IDT will meet quarterly to review the HVA and update EMP to reflect changes as needed. All staff will be educated on the changes to the EMP on 3/5/18.</p> <p>4. Audits to be completed by the Director of Environmental Services or designee quarterly x4 to ensure IDT reviewed the EMP on a quarterly basis. Audit results will be reported to the QAPI committee and the committee will determine if further auditing is needed.</p>	

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E 006	Continued From page 2 the facility risks, and did not contain input from the local emergency management officials, or a community based component. Reference: 42 CFR 483.73 (a) (1) - (2)	E 006		
E 013 SS=F	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 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. *[For ESRD Facilities at §494.62(b):] Policies and	E 013	1. The facility Emergency Management Plan (EMP) Interdisciplinary Team (IDT) reviewed the Hazard Vulnerability Assessment (HVA) and updated it on 2/19/18. The IDT referenced the Community HVA created by the Eastern Idaho Healthcare Coalition when considering any changes to the facility HVA. 2. All residents have the potential to be affected by this practice. 3. The facility EMP IDT will meet quarterly to review the HVA and update EMP to reflect changes as needed. All staff will be educated on the changes to the EMP on 3/5/18. 4. Audits to be completed by the Director of Environmental Services or designee quarterly x4 to ensure IDT reviewed the EMP on a quarterly basis. Audit results will be reported to the QAPI committee and the committee will determine if further auditing is needed.	3/8/18.

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E 013	<p>Continued From page 3</p> <p>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 conduct a facility-based and community-based risk assessment in the policies and procedures that includes identified strategies in the development of the emergency plan. Failure to conduct a risk assessment that incorporates both a facility based and a community based component, potentially hinders facility response to localized disasters and emergencies. This deficient practice affected 41 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>On 1/31/18 from 11:30 AM - 12:30 PM, review of provided policies and procedures as addressed in the emergency plan on page 2, indicated the importance of addressing "all potential hazards", however review of the included HVA (Hazard Vulnerability Analysis), did not reveal inclusion of input from local or regional emergency management officials, or a community based component. Interview of the Environmental Services Director on 1/31/18 from 1:30 - 2:00 PM</p>	E 013			

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E 013	Continued From page 4 found the facility risk assessment was done by him through information he considered relevant to the facility risks, and did not contain input from the local emergency management officials, or a community based component.	E 013		
E 015 SS=D	Reference: 42 CFR 483.73 (a) (1) - (2) Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) [(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.] At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for	E 015	1. The EMP IDT met on 2/19/18 and created a sewage and waste disposal procedure that allows the facility to provide safe and sanitary continuity of care in an emergency. 2. All residents have the potential to be affected by this practice. 3. All staff will be educated by the Director of Environmental Services or designee on sewage and waste disposal procedure as well as all other EMP updates on 3/5/18. Staff will also receive annual training and during orientation on the EMP. 4. Compliance will be monitored by Director of Environmental Services or designee performing audits of the EMP to include sewage and waste procedure and the staff have knowledge of the procedure weekly x4, monthly x2 and quarterly x2. Audit results will be reported to the QAPI committee and the committee will determine if further auditing is needed.	3/8/18

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E 015	<p>Continued From page 5</p> <p>hospice-operated inpatient care facilities only. The policies and procedures must address the following:</p> <p>(iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following:</p> <p>(A) Food, water, medical, and pharmaceutical supplies.</p> <p>(B) Alternate sources of energy to maintain the following:</p> <p>(1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.</p> <p>(2) Emergency lighting.</p> <p>(3) Fire detection, extinguishing, and alarm systems.</p> <p>(C) Sewage and waste disposal.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, the facility failed to provide an emergency plan, policy and procedure of subsistence to ensure sewage and waste disposal was provided in the event of sheltering in place or evacuation. Failure to provide sewage and waste disposal in the event of a disaster has the potential to limit the facility's ability of providing safe and sanitary continuity of care in an emergency. This deficient practice affected 41 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>On 1/31/18 from 11:30 AM - 12:30 PM, review of provided emergency plan, policies and procedures for the facility did not indicate the ability of the facility to provide sewage and waste disposal for residents and staff in the event of evacuation or while sheltering in place during a</p>	E 015			

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E 015	Continued From page 6 disaster.	E 015		
E 018 SS=F	<p>Reference: 42 CFR 483.73 (b) (1)</p> <p>Procedures for Tracking of Staff and Patients CFR(s): 483.73(b)(2)</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>(2) A system to track the location of on-duty staff 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</p>	E 018	<ol style="list-style-type: none"> 1. The facility has established and updated the EMP with a system to track the location of on-duty staff and sheltered residents. 2. All residents have the potential to be affected by this practice. 3. All staff will be educated by the Director of Environmental Services or designee on the system to track the location of on-duty staff and sheltered residents that has been updated in the EMP on 3/5/18. Staff will also receive training in new hire orientation and annually on the EMP. 4. Compliance will be monitored by Director of Environmental Services or designee performing audits of the EMP to include a on-duty staff and resident tracking system in the event of an evacuation weekly x4, quarterly x2. Audit results will be reported to the QAPI committee and the committee will determine if further auditing is needed. 	3/8/18

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E 018	<p>Continued From page 7</p> <p>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.</p> <p>(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 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 and interview, it was determined the facility failed to provide a policy for tracking of staff and sheltered residents during an emergency, or if relocated, a policy for</p>	E 018		

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E 018	Continued From page 8 documentation of the receiving facility or other location for those relocated individuals. Lack of a tracking policy has the potential to hinder the facility's ability to provide continuity of care during an emergency. This deficient practice affected 41 residents, staff and visitors on the date of the survey. Findings include: On 1/31/18 from 11:30 AM - 12:30 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 revealed the section identified for tracking sheltered residents and on-duty staff on page 9 of 11, section F, item numbers 6 and 8, had not been completed and contained a generic, canned response for both sections: "Facility is not equipped or have any current agreements with other facilities to receive any other residents at this time. Facility is actively attempting to partner with other organizations in emergency preparedness." Interview of the Environmental Services Director revealed the facility had not yet developed this section for tracking. Reference: 42 CFR 483.73 (b) (2)	E 018			
E 022 SS=F	Policies/Procedures for Sheltering in Place CFR(s): 483.73(b)(4) [(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	E 022	1. The facility EMP IDT reviewed the EMP on 2/19/18. IDT completed the section of the EMP that is relevant to sheltering. 2. All residents have the potential to be affected by this practice.	3/8/18	

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135092	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2018	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - IDAHO FALLS		STREET ADDRESS, CITY, STATE, ZIP CODE 840 EAST ELVA STREET IDAHO FALLS, ID 83401		
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E 022	<p>Continued From page 9 procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:]</p> <p>(4) A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility].</p> <p>*[For Inpatient Hospices at §418.113(b):] Policies and procedures.</p> <p>(6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following:</p> <p>(i) A means to shelter in place for patients, hospice employees who remain in the hospice. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to provide a policy procedure or plan for sheltering in place. Failure to provide a plan for sheltering in place has the potential to leave residents and staff without resources to continue care during an emergency. This deficient practice affected 41 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>On 1/31/18 from 11:30 AM - 12:30 PM, review of provided policies, procedures and emergency plan, found the section identified as relevant to sheltering on page(s) 8 of 11 and 9 of 11, section F, item numbers 1-9, had the following generic, canned response:" Facility is not equipped or have any current agreements with other facilities to receive any other residents at this time. Facility is actively attempting to partner with other</p>	E 022	<p>3. All staff will be educated by the Director of Environmental Services or designee on the updates made to the section titled "Sheltering" in the EMP on 3/5/18. Staff will also receive training in new hire orientation and annually.</p> <p>4. Compliance will be monitored by the Director of Environmental Services or designee performing audits that all sections of the EMP are completed quarterly x4. Audit results will be reported to the QAPI committee and the committee will determine if additional auditing is needed.</p>	

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E 022	Continued From page 10 organizations in emergency preparedness." When asked about these sections, the Environmental Services Director stated he was unsure at the time of development of the plan as to what this section needed for completion. Reference: 42 CFR 483.73 (b) (4)	E 022		
E 026 SS=F	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) [(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:] (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. *[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	E 026	1. The facility EMP IDT review the EMP on 2/19/18. During review the IDT completed the section of the EMP related to seeking a waiver (1135 waiver) from the Agency for Healthcare Administration to allow for the sheltering of evacuees if the number exceeds the operating capacity of the host location. 2. All residents have the potential to be affected by this practice. 3. All staff will be educated by the Director of Environmental Services or designee on the updates made to the section identifying when the location will seek a waiver from the Agency for Health Care Administration. 4. Compliance will be monitored by the Director of Environmental Services or designee performing audits that all sections of the EMP are completed quarterly x4. Audit	3/8/18

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E 026	Continued From page 11 provisions of care at an alternate site 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 41 residents, staff and visitors housed on the date of the survey. Findings include: On 1/31/18 from 11:30 AM - 12:30 PM, review of the provided emergency plan, policies and procedures, revealed a section on page 9 of 11, item number 7, defining what action would be taken under waiver from "the Agency for Health Care Administration" was contained in the plan, but no references for plan, policies and procedure for the facility role under declaration of an 1135 waiver by the Secretary. Reference: 42 CFR 483.73 (b) (8)	E 026	results will be reported to the QAPI committee and the committee will determine if additional auditing is needed.	
E 031 SS=F	Emergency Officials Contact Information CFR(s): 483.73(c)(2) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact	E 031	1. The EMP IDT met on 2/19/18 to review the EMP. At this time the IDT updated the EMP contact information to include the state and local ombudsman, state licensing agency and federal/local emergency management contacts. 2. All residents have the potential to be affected by this practice.	3/8/18

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E 031	<p>Continued From page 12 information for the following:</p> <p>(i) Federal, State, tribal, regional, or local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance.</p> <p>*[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to ensure current contact information for emergency management officials and other resources of assistance was provided in the emergency communication plan. Failure to provide updated information for resources available to the facility has the potential to hinder facility response and continuity of care for the 41 residents in the facility on the date of the survey.</p> <p>Findings include:</p> <p>On 1/31/18 from 11:30 AM - 12:30 PM, review of the emergency plan, policies and procedures, revealed the plan did not include contact information for federal emergency management officials, the Ombudsman and State Licensing Agency. In the facility "flip chart", the listed contacts for emergency management officials did not include the Ombudsman, State Licensing agency, or federal emergency management contact information.</p>	E 031	<p>3. All staff will be educated on the updated emergency contacts located in the EMP on 3/5/18. Staff will also receive annually and during orientation training on the EMP.</p> <p>4. Compliance will be monitored by Director of Environmental Services or designee performing audits that the EMP includes information for the ombudsman, state licensing and federal/local emergency management contacts quarterly x4. Audit results will be reported to the QAPI committee and the committee will determine if additional auditing is needed.</p>	

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E 031	Continued From page 13 Reference: 42 CFR 483.73 (c) (2)	E 031		
E 033 SS=F	Methods for Sharing Information CFR(s): 483.73(c)(4)-(6) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care. (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.22(c), CORFs under §485.68(c), and RHCs/FQHCs under §491.12(c).] (6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4). *[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative. *[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the	E 033	1. The facility EMP IDT met on 2/19/18 to review and update the EMP to include how the facility would share information for the care of residents with other healthcare providers in the event of an emergency. 2. All residents have the potential to be affected by this practice. 3. All staff will be educated on how the facility will share information for the care of residents with other healthcare providers on 3/5/18. Staff will also receive annually and during orientation training on the EMP. 4. Compliance will be monitored by Director of Environmental Services or designee performing audits that the EMP includes sharing information with other healthcare providers in an emergency quarterly x4. Audit results will be reported to the QAPI committee and the committee will determine if additional auditing is needed.	3/8/18

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E 033	Continued From page 14 facility's care as permitted under 45 CFR 164.510(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to document a plan demonstrating the method for sharing information during an emergency. Failure to share information with other health care providers has the potential to hinder the facility's ability to continue care during a disaster. This deficient practice affected 41 residents, staff and visitors on the date of the survey. Findings include: On 1/31/18 from 11:30 AM - 12:30 PM, review of provided emergency plan, policies and procedures, failed to demonstrate a policy which identified how the facility would share information for the care of residents with other healthcare providers, release resident information in the event of an evacuation and provide information about the condition and location of residents as required during an emergency. Interview of 5 of 5 staff members on 2/1/18 from 9:00 AM - 12:30 PM, revealed they had no knowledge of a policy or plan for the sharing of information with other healthcare providers. Reference: 42 CFR 483.73 (c) (4)-(6)	E 033		
E 036 SS=D	EP Training and Testing CFR(s): 483.73(d) (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in	E 036	1. The facility has scheduled an all staff meeting to provide education on the most current updated EMP. The Staff Development Coordinator and Director of Environmental Services have created a testing program that is	3/8/18

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E 036	<p>Continued From page 15</p> <p>paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.</p> <p>*[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h).</p> <p>*[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to provide a emergency prep training and testing program. Lack of a facility emergency training and testing program covering the emergency preparedness</p>	E 036	<p>based on the training that will be provided on 3/5/18.</p> <p>2. All residents have the potential to be affected by this practice.</p> <p>3. All staff will be educated on the updated EMP on 3/5/18. Staff will be given a test based on the training to be completed at this time. Staff will also receive annually and during orientation training on the EMP to include a test based on the EMP.</p> <p>4. Compliance will be monitored by Staff Development Coordinator or designee performing audits that the EMP test is completed by all staff after trainings weekly x4, monthly x2, quarterly x3. Audit results will be reported to the QAPI committee and the committee will determine if additional auditing is needed.</p>	

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E 036	<p>Continued From page 16</p> <p>plan, policies and procedures, has the potential to hinder staff response during a disaster. This deficient practice affected 41 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>On 1/31/18 from 11:30 AM - 12:30 PM, review of provided emergency plan, policies and procedures, found no documentation demonstrating the facility had a current testing program for staff based on the training's conducted on the emergency plan.</p> <p>Interview of 6 of 6 staff conducted on 2/1/18 from 9:00 AM - 12:30 PM, established staff had not participated in any specific testing program on the emergency plan contents, only an all-staff inservice of the initial overview of the emergency plan.</p> <p>Additional interview of the SDC on 2/1/18 from 9:30 - 10:00 AM, established the emergency plan was recently updated and staff had not yet undergone testing over the contents of the plan.</p> <p>Reference: 42 CFR 483.73 (d)</p>	E 036		
E 039 SS=F	<p>EP Testing Requirements CFR(s): 483.73(d)(2)</p> <p>(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:</p> <p>*[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including</p>	E 039	<p>1. The Administrator and Director of Environmental Services met with the Administrator and Maintenance Director of Promontory Point Rehabilitation on 2/20/18 to plan and schedule a full scale exercise to challenge the effectiveness of the EMP on 3/2/18.</p>	3/8/18

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E 039	<p>Continued From page 17 unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:]</p> <p>(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.</p> <p>(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 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: (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</p>	E 039	<p>2. All residents have the potential to be affected by this practice.</p> <p>3. The EMP IDT will meet quarterly to review and update the EMP as needed. The IDT will also review/plan all full scale and table top drills to ensure compliance.</p> <p>4. Compliance will be monitored by Administrator or designee performing audits that the EMP IDT meet quarterly to review EMP and schedule any full scale and table top drills to challenge the effectiveness of the EMP quarterly x4.</p>		

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E 039	<p>Continued From page 18 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 participate in two exercises which 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 41 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>On 1/31/18 from 11:30 AM - 12:30 PM, review of provided emergency plan, policies and procedures, revealed no documentation demonstrating the facility had participated in any full scale exercise challenging the effectiveness of the emergency plan.</p> <p>Interview of the Environmental Services Director on 1/31/18 from 1:30 - 2:00 PM, substantiated the facility had not participated in any full-scale events.</p> <p>Reference: 42 CFR 483.73 (d) (1)</p>	E 039			