



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 20, 2018

Dawn Meyer, Administrator
Lincoln County Care Center
PO Box 830
Shoshone, ID 83352

Provider #: 135056

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Ms. Meyer:

On **February 6, 2018**, a Facility Fire Safety and Construction survey was conducted at **Lincoln County Care Center** 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

Dawn Meyer, Administrator
February 20, 2018
Page 2 of 4

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 **March 5, 2018**. Failure to submit an acceptable PoC by **March 5, 2018**, may result in the imposition of civil monetary penalties by **March 21, 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 13, 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 13, 2018**. A change in the seriousness of the deficiencies on **March 13, 2018**, may result in a change in the remedy.

Dawn Meyer, Administrator
February 20, 2018
Page 3 of 4

The remedy, which will be recommended if substantial compliance has not been achieved by **March 13, 2018**, includes the following:

Denial of payment for new admissions effective **May 6, 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 6, 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 6, 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:

Dawn Meyer, Administrator
February 20, 2018
Page 4 of 4

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

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

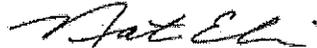
BFS Letters (06/30/11)

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

This request must be received by **March 5, 2018**. If your request for informal dispute resolution is received after **March 5, 2018**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626, option 3.

Sincerely,



Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosures

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

PRINTED: 02/16/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135056	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 02/06/2018
NAME OF PROVIDER OR SUPPLIER LINCOLN COUNTY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 511 EAST FOURTH STREET SHOSHONE, ID 83352	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	<p>INITIAL COMMENTS</p> <p>The facility is a single story, type V(111) construction built in 1958. It is fully sprinklered building with smoke detection coverage throughout the facility. There is a partial basement that contains the boiler room, storage, and employee lounge. Currently the facility is licensed for 36 SNF/NF beds, and had a census of 34 on the dates of the survey.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on February 5 - 6, 2018. The facility was surveyed under the LIFE SAFETY CODE 2012 Edition, Chapter 19, Existing Healthcare Occupancies, in accordance with 42 CFR 483.70, 42 CFR 483.80 and 42 CFR 483.65.</p> <p>The survey was conducted by:</p> <p>Linda Chaney Health Facility Surveyor Facility Fire Safety and Construction</p> <p>K 291 SS=F Emergency Lighting CFR(s): NFPA 101</p> <p>Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9.18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to provide annual emergency lighting test documentation. Failure to test the emergency lighting could inhibit egress of residents during an emergency. This deficient practice affected 34 residents, staff and visitors on the dates of the</p>	K 000	<p style="text-align: center;">RECEIVED FEB 28 2018 FACILITY STANDARDS</p> <p>291 Emergency Lighting Specific Residents: No specific Residents were identified</p> <p>Affected residents: All residents have the potential to be affected by this deficient practice: Measures that will be put in place to ensure that deficient practice does not recur:</p> <p>Maintenance supervisor was in-serviced on 7.9.3.12 of Emergency Lighting for functional testing annually for not less than 1 ½ hours annually. In-serviced completed by Senior Maintenance Director completed on 2/14/18.</p> <p>How the corrective actions will be monitored:</p> <p>Audited forms were changed to reflect the need of annual lighting checks. Administrator will monitor audits quarterly. All audits to be reviewed monthly and quarterly in QAPI Corrective actions completed: 2/23/18</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X8) DATE

Dawn Meyer Administrator 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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K 291	<p>Continued From page 1 survey.</p> <p>Findings include:</p> <p>During review of the facility emergency lighting test logs on February 5, 2018, from approximately 12:00 PM to 4:30 PM, no documentation could be produced for a 90 minute test of the emergency lighting in the past 12 months.</p> <p>When asked, the Maintenance Supervisor stated the facility was unaware the test was required.</p> <p>Actual NFPA reference:</p> <p>NFPA 101 19.2.9 Emergency Lighting. 19.2.9.1 Emergency lighting shall be provided in accordance with Section 7.9. 7.9.3 Periodic Testing of Emergency Lighting Equipment. 7.9.3.1 Required emergency lighting systems shall be tested in accordance with one of the three options offered by 7.9.3.1.1, 7.9.3.1.2, or 7.9.3.1.3. 7.9.3.1.1 Testing of required emergency lighting systems shall be permitted to be conducted as follows: (1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, except as otherwise permitted by 7.9.3.1.1(2). (2)*The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction. (3) Functional testing shall be conducted annually for a minimum of 1-1 1/2 hours if the emergency lighting system is battery powered.</p>	K 291		

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K 291	<p>Continued From page 2</p> <p>(4) The emergency lighting equipment shall be fully operational for the duration of the tests required by 7.9.3.1.1(1) and (3).</p> <p>(5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction.</p> <p>7.9.3.1.2 Testing of required emergency lighting systems shall be permitted to be conducted as follows:</p> <p>(1) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall be provided.</p> <p>(2) Not less than once every 30 days, self-testing/self-diagnostic battery-operated emergency lighting equipment shall automatically perform a test with a duration of a minimum of 30 seconds and a diagnostic routine.</p> <p>(3) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall indicate failures by a status indicator.</p> <p>(4) A visual inspection shall be performed at intervals not exceeding 30 days.</p> <p>(5) Functional testing shall be conducted annually for a minimum of 1-1/2 hours.</p> <p>(6) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall be fully operational for the duration of the 1-1/2-hour test.</p> <p>(7) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction.</p> <p>7.9.3.1.3 Testing of required emergency lighting systems shall be permitted to be conducted as follows:</p> <p>(1) Computer-based, self-testing/self-diagnostic battery-operated emergency lighting equipment shall be provided.</p> <p>(2) Not less than once every 30 days, emergency lighting equipment shall automatically perform a test with a duration</p>	K 291		

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K 291	Continued From page 3 of a minimum of 30 seconds and a diagnostic routine. (3) The emergency lighting equipment shall automatically perform annually a test for a minimum of 1-172 hours. (4) The emergency lighting equipment shall be fully operational for the duration of the tests required by 7.9.3.1.3(2) and (3). (5) The computer-based system shall be capable of providing a report of the history of tests and failures at all times.	K 291		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2	K 324	K324 NFPA 101 Cooking Facilities Specific Residents: No specific Residents were identified Affected residents: All residents have the potential to be affected by this citation The hood was inspected and cleaned on 2/22/18 Measures that will be put in place to ensure that deficient practice does not recur: The maintenance Director and Dietary Manager, logged current cleaning and scheduled the next semi annual inspection for August 2018. How the corrective actions will be monitored: The review of correction will be reviewed monthly and quarterly in the QAPI meetings. The Maintenance Director is responsible for compliance. Corrected actions completed: 2/23/18	2/23/18

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K 324	<p>Continued From page 4</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a semi-annual inspection of the Kitchen hood was conducted in accordance with NFPA 96. Failure to conduct semi-annual inspections of cooking ventilation systems could increase the risk of fires due to excessive build-up of grease laden vapors. This deficient practice affected staff and visitors in the kitchen on the dates of the survey.</p> <p>Findings include:</p> <p>Review of inspection records on February 5, 2018, from approximately 12:00 PM to 4:30 PM, revealed the last known kitchen hood inspection was completed on April 26, 2017. When asked, the Maintenance Supervisor stated the facility was unaware that the hood inspection was not completed as required in October of 2017.</p> <p>Actual NFPA standard:</p> <p>NFPA 96</p> <p>11.4* Inspection for Grease Buildup The entire exhaust system shall be inspected for grease buildup by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction and in accordance with Table 11.4.</p> <p>11.6 Cleaning of Exhaust Systems</p> <p>11.6.1 Upon inspection, if the exhaust system is found to be contaminated with deposits from</p>	K 324		

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K 324	Continued From page 5 grease-laden vapors, the contaminated portions of the exhaust system shall be cleaned by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction.	K 324		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide documentation of fire drills on all shifts quarterly. Failure to perform fire drills on each shift quarterly could result in confusion and hinder the safe evacuation of residents during a fire event. This deficient practice affected 34 residents, staff and visitors on the dates of the survey. Findings Include: Review of fire drill records on February 5, 2018, from approximately 12:00 PM to 4:30 PM, revealed missing fire drill documentation. No documentation could not be produced for a fire drill during second and third quarter 2017, on third shift. There was also no documentation for	K 712	K712 NFPA 101 Fire Drills: Specific Residents: No specific Residents were identified Affected residents: All residents have the potential to be affected by this citation We will have documented fire drills on all shifts quarterly to ensure all the staff have adequate practice and training on what to do in case of a fire. It was found that no fire drill was documented on second and third quarter for third shift. Measures that will be put in place to ensure that deficient practice does not recur: Maintenance Director was in-serviced on NFPA 19.7.1.4,19.7.1.5,19.7.1.6,19.7.1.7,19.7.1.8, by Senior Maintenance Director, on 2/14/18. How the corrective actions will be monitored: The maintenance director will have the Administrator sign off on all fire drills, and will have them reviewed in QAPI. Corrected actions completed: 2/23/18	2/23/18

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K 712	Continued From page 6 fire drills during fourth quarter 2017, on first and third shifts. When asked, the Maintenance Supervisor stated that he was new to his position and was unaware that fire drills had not been performed during those time frames. Actual NFPA Standard: NFPA 101 19.7.1.4* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. 19.7.1.6 Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions.	K 712			
K 911 SS=F	Electrical Systems - Other CFR(s): NFPA 101 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 switch. Failure to provide a remote stop switch prohibits the protection from the	K 911			

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K 911	<p>Continued From page 7</p> <p>impact of adverse generator conditions. This deficient practice affected 34 residents, staff and visitors on the dates of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on February 6, 2018, from approximately 8:30 AM to 10:30 AM, observation revealed the facility did not provide a remote manual stop switch for the EES generator. When asked, both the Maintenance Supervisor and the Administrator stated the facility was not equipped with a remote stop switch.</p> <p>Actual NFPA standard:</p> <p>NFPA 110</p> <p>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.</p> <p>5.6.5.6.1 The remote manual stop station shall be labeled.</p> <p>NFPA 99 6.4.1.1.16.2 Safety indications and shutdowns shall be in accordance with Table 6.4.1.1.16.2. (SEE TABLE)</p>	K 911	<p>K911 Electrical Systems NFPA 101</p> <p>Specific Residents: No specific Residents were identified</p> <p>Affected residents: All residents have the potential to be affected by this citation.</p> <p>Measures that will be put in place to ensure that deficient practice does not recur:</p> <p>We have requested Bid from Cummins Sales and Services, to place a Remote stop switch to the Emergency Generator located on the Northwest side of building. Remote stop Switch to be installed on the North side of building. Just across from Generator. The ESS will be assessable by all LCCC employee. Job completion no later than 4/2/18</p> <p>How the corrective actions will be monitored:</p> <p>The Maintenance director will monitor Remote stop during monthly and weekly generator checks. Maintenance director will be assigned monitoring and progress on implementation of Remote stop. Plan of correction will be reviewed in QAPI Q</p> <p>monthly and Quarterly</p> <p>Corrective action to be completed no later than 4/2/18</p>	4/2/18
K 918 SS=F	<p>Electrical Systems - Essential Electric System CFR(s): NFPA 101</p> <p>Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source</p>	K 918		

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K 918	<p>Continued From page 8</p> <p>and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.</p> <p>Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, 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.</p> <p>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure the generator for the EES (Essential Electrical System) was maintained in accordance with NFPA 110. Failure to inspect and test EES generators could result in a lack of system reliability during a power loss. This</p>	K 918	<p>K918 Electrical Systems NFPA 110</p> <p>Specific Residents: No specific Residents were identified</p> <p>Affected residents: All residents have the potential to be affected by this citation.</p> <p>Measures that will be put in place to ensure that deficient practice does not recur:</p> <p>Maintenance Director was instructed by Senior Maintenance director on how to monitor and conduct weekly and monthly load test for generator. In-serviced completed on 2/14/18 New audit and maintenance logs were established to demonstrate compliance.</p> <p>How the corrective actions will be monitored:</p> <p>Weekly and Monthly generator logs will be signed off by Administrator, and brought to QAPI for team to review.</p> <p>Corrective action to be completed on 2/14/18</p>	2/23/18	

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

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K 918	<p>Continued From page 9</p> <p>deficient practice affected 34 residents, staff and visitors on the dates of the survey.</p> <p>Findings include:</p> <p>During review of the facility generator inspection and testing records on February 5, 2018, from approximately 12:00 PM to 4:30 PM, the facility failed to provide weekly generator inspection logs for the week of 7/2/17-7/8/17, and no documentation of weekly inspections prior to June 1, 2017. They were also missing monthly load tests for March and April of 2017. When asked, the Administrator explained that some responsibilities had been neglected by a staff member that no longer works there. See (E 0041)</p> <p>Actual NFPA standard:</p> <p>NFPA 110 8.4 Operational Inspection and Testing. 8.4.1* EPSSs, including all appurtenant components, shall be inspected weekly and exercised under load at least monthly. 8.4.9* Level 1 EPSS shall be tested at least once within every 36 months.</p>	K 918			

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E 000	Initial Comments Unless otherwise indicated, the general use of the terms "facility" or "facilities" refers to all provider and suppliers affected by this regulation. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. The facility is a single story, type V(111) construction built in 1958. It is fully sprinklered building with smoke detection coverage throughout the facility. There is a partial basement that contains the boiler room, storage, and employee lounge. Currently the facility is licensed for 36 SNF/NF beds, and had a census of 34 on the dates of the survey. The following deficiencies were cited during the Emergency Preparedness Survey conducted on February 5 and 6, 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: Linda Chaney Health Facility Surveyor Facility Fire Safety and Construction	E 000	RECEIVED FEB 28 2018 FACILITY STANDARDS		
E 001 SS=F	Establishment of the Emergency Program (EP) CFR(s): 483.73 The [facility, except for Transplant Center] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must establish and maintain a comprehensive emergency preparedness program that meets the requirements of this	E 001			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____
Dawn Meyer Administrator 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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E 001	<p>Continued From page 1 section.* The emergency preparedness program must include, but not be limited to, the following elements:</p> <p>*[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.</p> <p>*[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to establish and maintain a current, comprehensive Emergency Preparedness program which includes policies and procedures in accordance with 42 CFR 483.73. Failure to meet this standard has the potential to hinder facility response during an emergency which requires coordination and cooperation with local resources available. This deficient practice affected 34 residents, staff and visitors on the dates of the survey.</p> <p>Findings include: On February 5, 2018, from 12:00 PM to 4:30 PM, review of the provided emergency preparedness (EP) plan, revealed the facility had missing required documentation for the generator. When asked, the Administrator and Maintenance</p>	E 001	<p>E001 Establishment of Emergency Program</p> <p>See attached plan of correction of K918</p> <p>Specific Residents: No specific Residents were identified</p> <p>Affected residents: All residents have the potential to be affected by this citation.</p> <p>Measures that will be put in place to ensure that deficient practice does not recur: Maintenance Director was instructed by Senior Maintenance director on how to monitor and conduct weekly and monthly load test for generator. In-serviced completed on 2/14/18</p> <p>How the corrective actions will be monitored: Weekly and Monthly generator logs will be signed off by Administrator, and brought to QAPI for team to review.</p> <p>Corrective action to be completed on 2/14/18</p>	2/23/18	

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E 001	Continued From page 2 Supervisor stated they were unaware the generator inspection and testing documentation was required for compliance to the EP rule. a. Refer to E 0041 as it relates to generator inspection and testing. CFR reference: 42 CFR 483.73	E 001			
E 041 SS=F	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated.	E 041	E041 Emergency Power See plan of correction for K918 Specific Residents: No specific Residents were identified Affected residents: All residents have the potential to be affected by this citation. Measures that will be put in place to ensure that deficient practice does not recur: Maintenance Director was instructed by Senior Maintenance Director on how to monitor and conduct weekly and monthly load test for generator. In-serviced completed on 2/14/18 How the corrective actions will be monitored: Weekly and Monthly generator logs will be signed off by Administrator, and brought to QAPI for team to review. Corrective action to be completed on 2/14/18	2/23/18	

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E 041	<p>Continued From page 4</p> <p>Quincy, MA 02169, www.nfpa.org, 1.617.770.3000.</p> <p>(i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011.</p> <p>(ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011.</p> <p>(iii) TIA 12-3 to NFPA 99, issued August 9, 2012.</p> <p>(iv) TIA 12-4 to NFPA 99, issued March 7, 2013.</p> <p>(v) TIA 12-5 to NFPA 99, issued August 1, 2013.</p> <p>(vi) TIA 12-6 to NFPA 99, issued March 3, 2014.</p> <p>(vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011.</p> <p>(viii) TIA 12-1 to NFPA 101, issued August 11, 2011.</p> <p>(ix) TIA 12-2 to NFPA 101, issued October 30, 2012.</p> <p>(x) TIA 12-3 to NFPA 101, issued October 22, 2013.</p> <p>(xi) TIA 12-4 to NFPA 101, issued October 22, 2013.</p> <p>(xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure the generator for the EES (Essential Electrical System) was maintained in accordance with NFPA 110. Failure to inspect and test EES generators could result in a lack of system reliability during a power loss. This deficient practice affected 34 residents, staff and visitors on the dates of the survey.</p> <p>Findings Include:</p> <p>During review of the facility generator inspection and testing records on February 5, 2018, from approximately 12:00 PM to 4:30 PM, the facility</p>	E 041			

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E 041	Continued From page 5 failed to provide weekly generator inspection logs for the week of 7/2/17-7/8/17, and no documentation of weekly inspections prior to June 1, 2017. Monthly load tests for March and April of 2017 were not documented or completed. When asked, the Administrator explained that some responsibilities had been neglected by a staff member that no longer works there. See (K 918) Reference: 42 CFR 483.73 (e) (2)	E 041			