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 22, 2018

Darwin Royeca, Administrator
Bell Mountain Village & Care Center
620 N 6th St
Bellevue, ID 83313-5174

Provider #: 135069

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

Dear Mr. Royeca:

On **February 7, 2018**, a Facility Fire Safety and Construction survey was conducted at **Bell Mountain Village & 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

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 7, 2018**. Failure to submit an acceptable PoC by **March 7, 2018**, may result in the imposition of civil monetary penalties by **March 27, 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 12, 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 12, 2018**. A change in the seriousness of the deficiencies on **March 12, 2018**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **March 12, 2018**, includes the following:

Denial of payment for new admissions effective **May 8, 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 **June 8, 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:

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 7, 2018**. If your request for informal dispute resolution is received after **March 7, 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
Enclosures

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

PRINTED: 02/21/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135069		02/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL MOUNTAIN VILLAGE & CARE CENTER	620 NORTH SIXTH STREET BELLEVUE, ID 83313

(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	E 000		

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 comprised of two (2) SNF/NF small house model buildings, identical in design. Construction of the two SNF/NF buildings was completed in January 2015. The buildings are defined as buildings Galena and Hemmingway which house residential sleeping rooms. Building Edelweiss houses the physical therapy occupancy which serves the SNF/NF residents, administrative offices and an assisted living facility separated by two-hour construction.

All buildings are type II (000) construction equipped with automatic sprinkler protection, corridor smoke detection. Type 2 Emergency Electrical Systems with automatic transfer switching is provided for building Galena and Hemmingway. Building Edelweiss EES provides emergency power for the Assisted Living, Physical Therapy and Administrative offices. Both buildings A and C have commercial kitchens which are separated by one-hour construction. The facility is licensed for 32 SNF/NF beds, and had a census of 31 on the dates of the survey.

The following deficiencies were cited during the Emergency Preparedness (EP) Survey conducted on February 6 - 7, 2018. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.

RECEIVED
MAR 12 2018
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dawn Royce | TITLE: Administrator | (X6) DATE: 3/9/18

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 000	Continued From page 1	E 000		
	The survey was conducted by: Linda Chaney Health Facility Surveyor Facility Fire Safety and Construction			
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 section.* The emergency preparedness program must include, but not be limited to, the following elements: *[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. *[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 EP program which includes	E 001	**E 001 ESTABLISHMENT OF THE EMERGENCY PROGRAM (EP)** This facility will ensure to establish and maintain a current, comprehensive EP program which includes policies and procedures in accordance with 42 CFR 483.73. All resident have the potential to be affected by this practice. **E 001** Citation is in reference to missing requirements for **E 037** and **E 039.** **Please refer to E 037 and E 039.**	3/9/18

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E 001	Continued From page 2 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 31 residents, staff and visitors on the dates of the survey. Findings include: On February 6, 2018, from 12:00 PM to 5:30 PM, review of the provided emergency plan, policies and procedures, revealed the facility had not developed a current policy or EP plan that complied with all applicable Federal, State and Local EP requirements. When asked, the Administrator stated the facility was currently working on the missing requirements and would be completing the policies and procedures soon. a. Refer to E 0037 as it relates to the emergency training program and the staff knowledge of emergency procedures. b. Refer to E 0039 as it relates to required annual exercises to test the emergency plan. CFR reference: 42 CFR 483.73	E 001		
E 037 SS=F	EP Training Program CFR(s): 483.73(d)(1) (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing	E 037	**E 037 EP TRAINING PROGRAM** The facility will ensure that a written training plan for facility EP program are implemented for initial training on new and existing staff and individuals providing services.	3/9/18

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E 037	Continued From page 3 staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least annually. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and	E 037	All resident have the potential to be affected by this practice. The facility EP program will be included in the new hire orientation program. Letters containing the facility EP program information will be sent out to all current employee with their payroll check for the month of March 2018 and letter will be mailed for individuals that are providing on site services. An In service will be scheduled monthly for at least three months to include EP program as topic. And to address questions staff may have about the EP program. Disaster drill will scheduled at least annually to test staff's knowledge of the facility's emergency plan and for facility to evaluate the program and make changes when needed. All records of training will be maintained in the business office and or to individual staff's employee record.	

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E 037	Continued From page 4 others. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.	E 037	Maintenance/Safety Director will ensure that all requirement for E 037 are met and a random audit will be done by the Administrator to ensure compliance.	

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E 037	Continued From page 5 (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency	E 037		

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E 037	Continued From page 6 procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to implement an EP training program. Failure to implement training on the new EP plan, has the potential to hinder staff response during a disaster. This deficient practice affected 31 residents, staff and visitors on the date of the survey. Findings include: On February 6, 2018, from 12:00 PM to 5:30 PM, review of the facility EP documentation revealed a written training plan, but there was no documentation that initial training for all new and existing staff, or individuals providing services under arrangement had taken place. Interview of the Administrator confirmed the facility had not implemented their training program for EP. Reference: 42 CFR 483.73 (d) (1)	E 037		
E 039 SS=F	EP Testing Requirements CFR(s): 483.73(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing.	E 039	**E 039 EP TESTING REQUIREMENTS** The facility will ensure to conduct exercises to test the facility's emergency plan at least annually, including unannounced staff drills using emergency procedures.	3/9/18

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E 039	Continued From page 7 The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (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. *[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	E 039	All resident have the potential to be affected by this practice. Disaster drill will scheduled at least annually to test staff's knowledge of the facility's emergency plan and for facility to evaluate the program and make changes when needed. Full –scale community based or facility based exercise will be scheduled for 2018 Facility administrator and other facility staff member have attended a table top exercise on March 8, 2018 and participated in an active shooter discussion emergency scenario. Documented staffs' response of all drills, tabletop exercises, and emergency event will be analyze by the Facility Safety Director and Administrator. All records of training will be maintained in the business office and or to individual staff's employee record. Emergency plan will be reviewed annually and will be revised as needed.	

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E 039	Continued From page 8 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. (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. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to implement an EP testing program. Failure to test the EP plan, has the potential to hinder staff response during a disaster. This deficient practice affected 31 residents, staff and visitors on the date of the survey. Findings Include: Review of the facility EP plan on February 6, 2018, from 12:00 PM to 5:30 PM, revealed a written EP testing program, however, there was no documentation that specific testing, to include an annual exercise on the EP plan had been conducted. When asked, the Administrator stated the facility had not yet participated in a community-based full-scale exercise, or completed a facility-based exercise. Reference: 42 CFR 483.73 (d) (2)	E 039	Maintenance/Safety Director will ensure that all requirements for E 039 are met and a random audit will be done by the Administrator to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 04 - ENTIRE STRUCTURE B. WING	(X3) DATE SURVEY COMPLETED
	135069		02/06/2018

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K 000	INITIAL COMMENTS The facility is comprised of two (2) SNF/NF small house model buildings, identical in design. Construction of the two SNF/NF buildings was completed in January 2015. The buildings are defined as buildings Galena and Hemmingway which house residential sleeping rooms. Building Edelweiss houses the physical therapy occupancy which serves the SNF/NF residents, administrative offices and an assisted living facility separated by two-hour construction. All buildings are type II (000) construction equipped with automatic sprinkler protection, corridor smoke detection. Type 2 Emergency Electrical Systems with automatic transfer switching is provided for building Galena and Hemmingway. Building Edelweiss EES provides emergency power for the Assisted Living, Physical Therapy and Administrative offices. Both buildings A and C have commercial kitchens which are separated by one-hour construction. The facility is licensed for 32 SNF/NF beds, and had a census of 31 on the dates of the survey. The following deficiencies were cited during the annual fire/life safety survey conducted on February 6 - 7, 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. The survey was conducted by: Linda Chaney Health Facility Surveyor Facility Fire Safety and Construction	K 000	RECEIVED MAR 12 2018 FACILITY STANDARDS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dawn Royce	Administrator	3/9/18

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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(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 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, and interview, the facility failed to develop and implement a water management plan. Failure to develop and implement a facility specific water management plan could increase risk of growth and spread of Legionella and other opportunistic pathogens in building water systems. This deficient practice could potentially affect all residents, visitors and staff on the date of the survey. Findings include: Review of the water management plan on February 6, 2018, from 12:00 PM to 5:30 PM, revealed the plan was incomplete. The plan did not include a facility risk assessment, control measures, or testing protocols. When asked, the Administrator stated the facility was still working on the development of the plan. Actual Standard: 42 CFR § 483.80 Infection control. The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the	K 100	**K 100 GENERAL REQUIREMENTS - OTHER** This facility will ensure to develop and implement water management plans. All resident have the potential to be affected by this practice Facility had developed and implemented a water management plan. Water management team with infection control or nursing team will ensure that all preventative, monitoring, testing and etc. will be conducted in accordance to the water management plan. Documentation audit will be done by the Administrator to ensure compliance. **Please see exhibit A for Water management plan.**	3/9/18

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K 100	Continued From page 2 development and transmission of communicable diseases and infections. Additional Reference: Centers for Medicare/Medicaid Services S&C Letter 17-30.	K 100		
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 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	K 161	**K 161 BUILDING CONSTRUCTION TYPE AND HEIGHT.** The facility will ensure that smoke and fire resistive properties of the structure were maintained. All resident have the potential to be affected by this practice. The maintenance /Safety director have been educated regarding the deficient practice. The two (2) approximately 2-1/2" circular hole in the both kitchen have been covered/sealed.	3/9/18

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K 161	Continued From page 3 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 the smoke and fire resistive properties of the structure were maintained. Failure to maintain the fire resistive properties of the structure by sealing penetrations in walls and ceilings, could result in fire and smoke passing between compartments during a fire event. This deficient practice affected staff and visitors on the date of the survey. Findings include: During the facility tour on February 7, 2018, from approximately 12:30 PM to 3:00 PM, observation revealed two (2) approximately 2-1/2" circular holes in the kitchen ceiling of both buildings. Power cords for the drop-down doors were running through the holes. When asked, the Maintenance Supervisor stated he was unaware that the power cords could not run through the ceiling or that the holes needed to be sealed. Actual NFPA standard: 19.1.6 Minimum Construction Requirements. 19.1.6.1 Health care occupancies shall be limited	K 161	Maintenance/Safety Director will do a facility audit monthly to ensure that all wall and ceiling penetrations are sealed with the use of fire retardant covers or caulking. A random audit will be done by the Administrator to ensure compliance. Please exhibit B.	

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K 161	Continued From page 4 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.) 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.	K 161		
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 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 monthly and annual emergency lighting test documentation. Failure to test the emergency lighting could inhibit egress of residents during an emergency. This deficient practice affected 31 residents, staff and visitors on the day of survey. Findings include: During review of the emergency lighting test logs on February 6, 2018, from 12:00 PM to 5:30 PM, records revealed the thirty (30) second monthly test of the emergency lighting was not documented or completed in January, February, April and June - December 2017. There was also no documentation for January 2018. Upon further review, no documentation could be produced for	K 291	**K 291 EMERGENCY LIGHTING** The facility will ensure that all emergency lighting will be tested monthly for (30) thirty seconds and annually for (90) ninety minutes. All resident have the potential to be affected by this practice. The maintenance /Safety director have been educated regarding the deficient practice. Emergency lighting annual test was conducted on March 1, 2018 and monthly test was conducted on February 2, 2018 and Emergency lighting are now scheduled to be tested monthly.	3/9/18

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K 291	Continued From page 5 an annual ninety (90) minute test of the emergency lighting. When asked, the Maintenance Supervisor stated the facility was unaware the tests were not completed or documentation maintained. Actual NFPA reference: 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?2 hours if the emergency lighting system is battery powered. (4) The emergency lighting equipment shall be fully operational for the duration of the tests required by 7.9.3.1.1(1) and (3). (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. 7.9.3.1.2 Testing of required emergency lighting	K 291	All records of testing will be maintained by the maintenance/safety director in the Life Safety binder. Binder will be kept in the Administrator's office or Business office. Maintenance/Safety Director will ensure that all emergency lighting be tested monthly for (30) thirty seconds and annually for (90) ninety minutes. And records of all test are filed in the binder that is located in the Administrator's office. A random audit will be done by the Administrator to ensure record keeping are accurate and filed and monthly and annual testing are conducted timely.	

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

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K 291	Continued From page 7 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 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	K 324	**K 324 COOKING FACILITIES** Facility will ensure a semi-annual inspection of the kitchen hood are conducted in accordance with NFPA 96. All resident have the potential to be affected by this practice. The maintenance /Safety director have been educated regarding the deficient practice. Semi-annual inspection of the kitchen hood was done by a service provider. Maintenance/Safety Director will ensure that all kitchen hood are serviced semi-annually. A random record audit will be done by the Administrator to ensure compliance. Please see exhibit C for service reports and next inspection date.	3/9/18

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K 324	Continued From page 8 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. Findings include: Review of inspection records on February 6, 2018, from 12:00 PM to 5:30 PM, revealed the kitchen hood inspection for the first six months of 2017 had not been completed. When asked, the Maintenance Supervisor stated the facility was unaware the hood inspection was not completed as required in April of 2017. Actual NFPA standard: NFPA 96 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. 11.6 Cleaning of Exhaust Systems 11.6.1 Upon inspection, if the exhaust system is found to be contaminated with deposits from 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	Fire Drills	K 712		

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K 712 SS=F	Continued From page 9 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 required fire drills, one per shift per quarter. 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 31 residents, staff and visitors on the dates of the survey. Findings include: During record review on February 6, 2018, from 12:00 PM to 5:30 PM, fire drill documentation revealed the facility failed to perform fire drills on second shift during the first and second quarters 2017. When asked, the Maintenance Supervisor stated the facility was unaware of the missing fire drills. Actual NFPA standard: 19.7.1.6 Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses,	K 712	**K 712 FIRE DRILLS** Facility will ensure that the required fire drills were conducted and documentations of drills are documented. The maintenance /Safety director have been educated regarding the deficient practice. Required quarterly fire drills per shift have been conducted. Maintenance/Safety Director will ensure that fire drills for all shift were conducted quarterly and documentations of all drills are filed in the binder that is located in the Administrator's office. A random audit will be done by the Administrator to ensure record keeping are accurate and filed and quarterly fire drill per shift are conducted timely.	3/9/18

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K 712	Continued From page 10 interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions.	K 712		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new	K 918	**K 918 Electrical Systems – Essential Electric System** Facility will ensure that all appurtenant components of the generator are inspected weekly, exercise under load at least monthly and a fuel test are performed annually. All resident have the potential to be affected by this practice. The maintenance /Safety director have been educated regarding the deficient practice. Weekly inspections and monthly under load generator exercise have been conducted. Service provider have been scheduled to perform a fuel test for all generators for year 2018.	3/9/18

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K 918	Continued From page 11 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 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 31 residents, staff and visitors on the dates of the survey. Findings include: 1.) During review of the facility generator inspection and testing records on February 6, 2018, from 12:00 PM to 5:30 PM, the facility failed to provide the following weekly generator inspection logs: Galena Building: Hemingway Building: a.) Between 1/14/18 - 1/20/18 a.) Between 12/31/17 - 1/6/18 b.) Between 1/7/18 - 1/13/18 b.) Between 12/17/17 - 12/23/17 c.) Between 12/31/17 - 1/6/18 c.) Between 11/26/17 - 12/2/17 d.) Between 12/17/17 - 12/23/17 d.) Between 10/15/17 - 10/21/17 e.) Between 11/26/17 - 12/2/17 e.) Between 10/8/17 - 10/14/17 f.) Between 10/15/17 - 10/21/17 f.) Between 10/1/17 - 10/7/17 g.) Between 10/8/17 - 10/14/17 h.) Between 10/1/17 - 10/7/17	K 918	Maintenance/Safety Director will ensure that all appurtenant components of the generator are inspected weekly, exercise under load monthly and a fuel test are performed annually. And records of all test are filed in the binder that is located in the Administrator's office. A random audit will be done by the Administrator to ensure record keeping are accurate and filed and weekly inspection, monthly under load exercise and annual fuel testing are conducted timely.	

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K 918	Continued From page 12 2.) During review of the facility generator inspection and testing records on February 6, 2018, from 12:00 PM to 5:30 PM, the facility failed to provide documentation for a monthly load test for January - February 2017, and October - December 2017. Upon further review, records failed to show a fuel quality test for the diesel fuel stored on site for the generator. When asked, the Maintenance Supervisor stated that the facility was unaware of the missing inspections, load test documents, and fuel quality test. Actual NFPA standard: NFPA 110 1.) 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. 2.) 8.4.2* Diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS nameplate kW rating 8.3 Maintenance and Operational Testing. 8.3.8 A fuel quality test shall be performed at least annually using tests approved by ASTM standards.	K 918		
K 927 SS=D	Gas Equipment - Transfilling Cylinders CFR(s): NFPA 101	K 927		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 04 - ENTIRE STRUCTURE B. WING	(X3) DATE SURVEY COMPLETED
	135069		02/06/2018

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K 927	Continued From page 13 Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and operational testing, the facility failed to ensure liquid oxygen transfilling was conducted in accordance with NFPA 99. Failure to store and transfill liquid oxygen in accordance with NFPA 99, could increase the potential for combustion. This deficient practice had the potential to affect residents, staff and visitors on the dates of the survey. Findings include: During the facility tour on February 7, 2018, from approximately 12:30 PM to 3:00 PM, observation revealed a cadet heater had been installed in the oxygen transfilling room, approximately 12 inches from the floor. Further observation revealed the light switch was also installed below the required 60 inches, at 43-1/2" from the floor. When asked, the Maintenance Supervisor stated he was unaware of the requirement. Actual NFPA standard:	K 927	**K 927 GAS EQUIPMENT – TRANSFILLING CYLINDERS** Facility will ensure that liquid oxygen transfilling are conducted in accordance to NFPA 99. All resident have the potential to be affected by this practice. The maintenance /Safety director have been educated regarding the deficient practice The Cadet Heater that was installed in the liquid oxygen transfilling area/room had been removed and no longer in the room. The light switch in the liquid oxygen transfilling room had been moved up and is now at 62 inches from the floor. Maintenance/Safety Director will ensure that heater will not be located or installed in the liquid oxygen transfilling room and that light switches are not installed below 60 inches. A random environmental rounds will be done by the Administrator to ensure compliance.	3/5/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 04 - ENTIRE STRUCTURE B. WING	(X3) DATE SURVEY COMPLETED
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K 927	Continued From page 14 NFPA 101 19.3.2.4 Medical Gas. Medical gas storage and administration areas shall be in accordance with Section 8.7 and the provisions of NFPA 99, Health Care Facilities Code, applicable to administration, maintenance, and testing. 8.7.3 Flammable Liquids and Gases. 8.7.3.1 The storage and handling of flammable liquids or gases shall be in accordance with the following applicable standards: (1) NFPA 30, Flammable and Combustible Liquids Code (2) NFPA 54, National Fuel Gas Code (3) NFPA 58, Liquefied Petroleum Gas Code NFPA 99 11.7 Liquid Oxygen Equipment. 11.7.3 Container Storage, Use, and Operation. 11.7.3.1* Containers shall be stored, used, and operated in accordance with the manufacturer ' s instructions and labeling. 11.7.3.2 Containers shall not be placed in the following areas: (1) Where they can be tipped over by the movement of a door (2) Where they interfere with foot traffic (3) Where they are subject to damage from falling objects (4) Where exposed to open flames and high-temperature devices	K 927	Please see exhibit D.	