



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

March 12, 2018

Chanse Powell, Administrator
Madison Carriage Cove Short Stay Rehabilitation
410 West 1st North
Rexburg, ID 83440-1406

Provider #: 135140

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Mr. Powell:

On **February 28, 2018**, a Facility Fire Safety and Construction survey was conducted at **Madison Carriage Cove Short Stay Rehabilitation** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. Please provide **ONLY ONE** completion date for each federal and state tag in column (X5) Completion Date to signify when

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you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office. If a State Form with deficiencies was issued, it should be signed, dated and returned along with the CMS-2567 Form.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **March 26, 2018**. Failure to submit an acceptable PoC by **March 26, 2018**, may result in the imposition of civil monetary penalties by **April 14, 2018**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.
- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567. If a State Form was issued as well, it should also be signed, dated and returned.

All references to federal regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Remedies may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **April 4, 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 **April 4, 2018**. A change in the seriousness of the deficiencies on **April 4, 2018**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **April 4, 2018**, includes the following:

Denial of payment for new admissions effective **May 28, 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 28, 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 28, 2018**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

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

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

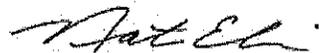
BFS Letters (06/30/11)

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

This request must be received by **March 26, 2018**. If your request for informal dispute resolution is received after **March 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: 03/19/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135140	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - MADISON CARRIAGE COVE SHORT STAY REHABILITATION B. WING _____	(X3) DATE SURVEY COMPLETED 02/28/2018
NAME OF PROVIDER OR SUPPLIER MADISON CARRIAGE COVE SHORT STAY REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST 1ST NORTH REXBURG, ID 83440	
(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	INITIAL COMMENTS Madison Carriage Cove Short Stay Rehabilitation is a single story, Type V(111) construction, approximately 35,874 square feet in size, with a separated mechanical loft on the partial second floor. Plans were approved in May of 2013 and construction completed in July of 2014. The facility is fully sprinklered, with complete smoke detection and fire alarm system. There is a Type 2 Essential Electrical Service, piped medical gas system and is comprised of five smoke compartments, with both fire and smoke dampers in fire-rated wall assemblies. Currently the facility is licensed for 35 SNF/NF beds, with a census of 35 on the date of the survey. The following deficiencies were cited during the annual fire/life safety survey conducted on February 28, 2017. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy in accordance with 42 CFR 483.70.a The survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction	K 000		
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.	K 100	(Please see attached Plan of Correction.)	

APR 03 2018
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* ADMINISTRATOR 3/22/18 TITLE: _____ (X6) DATE: _____

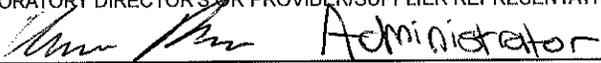
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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 000	<p>INITIAL COMMENTS</p> <p>Madison Carriage Cove Short Stay Rehabilitation is a single story, Type V(111) construction, approximately 35,874 square feet in size, with a separated mechanical loft on the partial second floor. Plans were approved in May of 2013 and construction completed in July of 2014. The facility is fully sprinklered, with complete smoke detection and fire alarm system. There is a Type 2 Essential Electrical Service, piped medical gas system and is comprised of five smoke compartments, with both fire and smoke dampers in fire-rated wall assemblies. Currently the facility is licensed for 35 SNF/NF beds, with a census of 35 on the date of the survey.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on February 28, 2017. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy in accordance with 42 CFR 483.70.a</p> <p>The survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction</p>	K 000	<p>10 on FLS</p> <p>RECEIVED</p> <p>MAR 27 2018</p> <p>FACILITY STANDARDS</p>	
K 100 SS=F	<p>General Requirements - Other CFR(s): NFPA 101</p> <p>General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by:</p>	K 100		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 3/23/18
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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OMB NO. 0938-0391

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K 100	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>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 assessment or define testing protocols 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 35 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During review of provided maintenance inspection and policy documentation conducted on 2/28/18 from approximately 8:30 AM - 3:00 PM, failed to demonstrate implementation of a water management plan for the transmission of waterborne pathogens such as Legionella that included a risk assessment; identified control measures and specified testing protocols as determined by evaluation of the system.</p> <p>Further review of the provided infection control policy on Legionella revealed the following:</p> <p>Item 3 directed the Facility to "conduct and document a facility risk assessment", however no risk assessment was documented.</p> <p>Item 4 stated referenced "Preventative measures will be taken", but no documentation was provided as to what measures were in place based on a facility risk assessment.</p> <p>CFR standard:</p>	K 100		

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K 100	Continued From page 2 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		
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, the facility failed to ensure emergency lighting was tested in accordance with NFPA 101. Failure to perform testing of emergency lighting for 30 seconds monthly and 90 minutes annually, potentially hinders identification of exits affecting resident egress during an emergency. This deficient practice affected 35 residents, staff and visitors in 5 of 6 smoke compartments on the date of the survey. Findings include: During review of facility inspection and maintenance records conducted on 2/28/18 from approximately 8:30 - 10:00 AM, records provided for battery backup emergency light testing did not	K 291		4/2/18

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K 291	<p>Continued From page 3</p> <p>indicate any time duration for the testing of emergency lights, but either an "OK" or "Pass".</p> <p>When asked about the time duration emergency lighting was tested for, the Maintenance Director stated she was not aware of the requirement of testing based on a specific time duration.</p> <p>Actual NFPA standard:</p> <p>19.2.9 Emergency Lighting. 19.2.9.1 Emergency lighting shall be provided in accordance with Section 7.9.</p> <p>7.9 Emergency Lighting. 7.9.1 General. 7.9.1.1* Emergency lighting facilities for means of egress shall be provided in accordance with Section 7.9 for the following:</p> <p>(1) Buildings or structures where required in Chapters 11 through 43 (2) Underground and limited access structures as addressed in Section 11.7 (3) High-rise buildings as required by other sections of this Code (4) Doors equipped with delayed-egress locks (5) Stair shafts and vestibules of smokeproof enclosures, for which the following also apply: (a) The stair shaft and vestibule shall be permitted to include a standby generator that is installed for the smokeproof enclosure mechanical ventilation equipment. (b) The standby generator shall be permitted to be used for the stair shaft and vestibule emergency lighting power supply. (6) New access-controlled egress doors in accordance with 7.2.1.6.2</p>	K 291		

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K 291	Continued From page 4 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 11.2 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.	K 291		
K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.)	K 293		4/2/18

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K 293	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure means of egress signage was provided in accordance with NFPA 101. Failure to provide exit signs which are clear and identifiable has the potential to confuse residents and hinder egress during an emergency. This deficient practice affected staff and visitors on the date of the survey. Findings include: During the facility tour conducted on 2/28/18 from approximately 3:00 - 4:00 PM, observation of installed exit signs, revealed the exit sign at the smoke barrier bulkhead outside the director of rehab office and the fire barrier of the 100 wing, both indicated the path of travel would direct egress to the wall when the doors were released during activation of the fire alarm. Actual NFPA standard: 7.10.1.2 Exits. 7.10.1.2.1* Exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign that is readily visible from any direction of exit access.	K 293		
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	K 325		4/2/18

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K 325	<p>Continued From page 6</p> <p>gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols</p> <ul style="list-style-type: none"> * 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 <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, observation and 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 35 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 2/28/18 from approximately 8:30 - 10:00 AM, no records were</p>	K 325		

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K 325	<p>Continued From page 7</p> <p>available indicating procedures performed for installed ABHR dispensers when refilling. Asked what documentation was done during this process, the Maintenance Director stated the facility was not documenting the refill process and 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 2/28/18 from 3:00 - 4:00 PM, observation of installed ABHR dispensers revealed both automatic dispensers had been installed throughout the facility.</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> <p>(1) Where dispensers are installed in a corridor, the corridor shall have a minimum width of 6 ft (1830 mm).</p> <p>(2) The maximum individual dispenser fluid capacity shall be as follows:</p> <p>(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</p> <p>(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</p>	K 325		

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K 325	Continued From page 8 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 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	K 325		

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K 325	Continued From page 9 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 with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for	K 353		4/2/18

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K 353	<p>Continued From page 10</p> <p>any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on record review and observation, the facility failed to ensure that fire suppression systems were maintained in accordance with NFPA 25. Failure to inspect system components and provide the correct number of spare sprinkler pendants, has the potential to hinder system performance during a fire event and/or render the facility not fully sprinklered after an activation or repair. This deficient practice affected 35 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>1) During review of provided facility inspection and testing records conducted on 2/28/18 from 8:30 AM - 10:00 AM, the following documentation was not available: No records indicating a weekly inspection of dry system gauges had been conducted, No records indicating a third quarter sprinkler inspection had been completed.</p> <p>2) During the facility tour conducted on 2/28/18 from approximately 3:00 - 4:00 PM, observation of the riser room spare sprinkler pendant box, revealed only ten (10) spare pendants.</p> <p>Actual NFPA standard:</p> <p>NFPA 25</p> <p>5.2.4 Gauges. 5.2.4.2 Gauges on dry, preaction, and deluge</p>	K 353		

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K 353	Continued From page 11 systems shall be inspected weekly to ensure that normal air and water pressures are being maintained.	K 353			
K 711 SS=F	5.4.1.5 The stock of spare sprinklers shall include all types and ratings installed and shall be as follows: (1) For protected facilities having under 300 sprinklers - no fewer than 6 sprinklers (2) For protected facilities having 300 to 1000 sprinklers - no fewer than 12 sprinklers (3) For protected facilities having over 1000 sprinklers - no fewer than 24 sprinklers Evacuation and Relocation Plan CFR(s): NFPA 101 Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to ensure the fire safety plan contained all nine elements, in accordance with NFPA 101. Failure to provide a written fire safety plan which includes a call to the local fire department could hinder response by emergency personnel in the event of	K 711		4/2/18	

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K 711	Continued From page 12 a fire. This deficient practice affected 35 residents, staff and visitors on the date of the survey. Findings include: During review of the facility emergency preparedness policies conducted on 2/28/18 from approximately 8:30 AM to 3:00 PM, review of the Fire Safety Plan provided did not indicate the plan included an emergency phone call by the facility to the fire department in the event of a fire. Actual NFPA standard: 19.7.2.2 Fire Safety Plan. A written health care occupancy fire safety plan shall provide for all of the following: (1) Use of alarms (2) Transmission of alarms to fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire	K 711		
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	K 712		4/2/18

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K 712	Continued From page 13 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, 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, hindering the safe evacuation of residents during a fire. This deficient practice affected 35 residents, staff and visitors on the date of the survey. Findings include: During review of provided facility fire drills conducted on 2/28/18 from approximately 8:30 AM to 3:00 PM, fire drill documentation revealed the facility failed to conduct any fire drills during the third quarter of 2017. Actual NFPA standard: 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 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	K 918		4/2/18	

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K 918	Continued From page 14 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 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 inspect diesel powered generator systems weekly, test for load monthly and annually test the fuel, has the potential of	K 918		

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K 918	<p>Continued From page 15</p> <p>hindering system performance during a power loss or other emergency. This deficient practice affected 35 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During review of annual inspection and maintenance records conducted on 2/28/18 from approximately 8:30 - 10:00 AM, records provided for the annual generator inspection did not indicate any testing was completed for the fuel supply. Further review revealed the following missing weekly inspections and monthly load tests:</p> <p>No weekly inspections documented from 12/21/16 to 3/3/17 No weekly inspections documented from 3/30/17 to 12/12/17 No monthly load test documented from January 2017 to July 2017. Load test documentation for 2017 began on 7/6/17. No monthly load test documented from 8/15/17 to 12/18/17</p> <p>When asked, the Maintenance Director stated she was not aware of the missing inspection reports and the fuel testing requirement for diesel-fired systems.</p> <p>Actual NFPA standard:</p> <p>NFPA 110</p> <p>8.3.8 A fuel quality test shall be performed at least annually using tests approved by ASTM standards.</p>	K 918			

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K 923 SS=D	<p>Gas Equipment - Cylinder and Container Storage CFR(s): NFPA 101</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. >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. 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." 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. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced</p>	K 923		4/2/18	

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K 923	Continued From page 17 by: Based on observation and interview, the facility failed to ensure cryogenic oxygen cylinders were secured in accordance with NFPA 99. Failure to secure liquid oxygen cylinders has the potential for cylinder damage from falling, increasing the risk of fires and explosions. This deficient practice affected staff and residents on the date of the survey. Findings include: During the facility tour conducted on 2/28/18 from 3:00 - 3:30 PM, observation of the oxygen storage room abutting the Maintenance office in the service corridor, revealed three (3) LOX (Liquid Oxygen) cylinders unsecured by either a cart, rack or chained. Interview of the Maintenance Director revealed she was unaware of the requirement for securing LOX cylinders. Actual NFPA standard: 11.7 Liquid Oxygen Equipment. 11.7.3 Container Storage, Use, and Operation. 11.7.3.3* Liquid oxygen base reservoir containers shall be secured by one of the following methods while in storage or use to prevent tipping over caused by contact, vibration, or seismic activity: (1) Securing to a fixed object with one or more restraints (2) Securing within a framework, stand, or assembly designed to resist container movement (3) Restraining by placing the container against two points of contact	K 923			
K 926 SS=D	Gas Equipment - Qualifications and Training CFR(s): NFPA 101	K 926		4/2/18	

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K 926	Continued From page 18 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on record review, and interview, the facility failed to ensure continuing education and staff training was provided on the risks associated with the storage, handling and use of medical gases and their cylinders. Failure to provide training of safety and the risks associated with medical gases, hinders staff response and affects those residents utilizing supplemental oxygen. This deficient practice potentially affected oxygen dependent residents, staff and visitors on the date of the survey. Findings include: During review of provided training records on 2/28/18 from 8:30 - 10:00 AM, no records were provided for annual oxygen training. Interview of 4 of 4 staff members on 2/28/18 from 12:30 - 3:00 PM, revealed none had participated in any continuing education program on the risks associated with the storage, handling or use of medical gases. Actual NFPA standard: NFPA 99	K 926		

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K 926	Continued From page 19 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		

FIRE AND LIFE SAFETY PLAN OF CORRECTION

February 28th 2018

Preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the accuracy or truthfulness of any facts alleged or any conclusions set forth in this allegation of deficiencies by the State Licensing Authority. Accordingly, the facility has drafted this Plan of Correction in accordance with Federal and State Laws which mandate the submission of a Plan of Correction as a condition for participating in the Medicare and Medicaid program. This Plan of Correction shall constitute this facility's credible allegation compliance with this section.

K 100 SS=F

**General Requirements-Other
CFR(s) NFPA 101**



FACILITY STANDARDS

The facility does ensure that a water management program is fully implemented by conducting a facility risk assessment for Legionella.

Corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice

No residents were found to be affected by this deficient practice.

Identification of other residents having the same potential to be affected by the same practice and what corrective actions taken includes the following:

All residents have the potential to be affected by this deficient practice.

Measures that will be put into place or systematic changes you will make to ensure that the deficient practice does not recur includes the following:

To ensure the deficient practice does not recur,

- A facility legionella risk assessment shall be completed.

How the corrective actions will be monitored to ensure the deficient practice will not recur:

Monitoring will be done through:

The QA committee shall review the risk assessment and water management program at the next QA meeting.

4/2/18

K 291 SS=F

**Emergency Lighting
CFR(s) NFPA 101**

The facility does ensure that emergency lighting is tested monthly for 30 seconds and annually for 90 minutes.

Corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice

No residents were found to be affected by this deficient practice.

Identification of other residents having the same potential to be affected by the same practice and what corrective actions taken includes the following:

All residents have the potential to be affected by this deficient practice.

Measures that will be put into place or systematic changes you will make to ensure that the deficient practice does not recur includes the following:

To ensure the deficient practice does not recur,

- A new test reporting sheet shall be created
- Education shall be provided to the Environmental supervisor on proper testing of emergency lighting

How the corrective actions will be monitored to ensure the deficient practice will not recur:

Monitoring will be done through:

The Administrator or designee shall conduct monthly audits of the emergency lighting checks.

Monitoring will start on 4/2/2018

This will be done monthly x 4 months

The Administrator or Designee will present to the quarterly QA Committee meeting any findings and/or corrective actions taken

4/2/18

K 293 SS=D

Exit Signage

CFR(s) NFPA 101

The facility does ensure that exit signs are clear and identifiable.

Corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice

No residents were found to be affected by this deficient practice.

Identification of other residents having the same potential to be affected by the same practice and what corrective actions taken includes the following:

All residents have the potential to be affected by this deficient practice.

Measures that will be put into place or systematic changes you will make to ensure that the deficient practice does not recur includes the following:

To ensure the deficient practice does not recur,

- Exit sign at the smoke barrier bulkhead located at the fire barrier of the 100 hall shall be fixed to direct travel to the door and not into the wall like it originally did.

How the corrective actions will be monitored to ensure the deficient practice will not recur:

Monitoring will be done through:

The Administrator or Designee shall visually inspect that the sign meets the appropriate specifications.

4/2/18

K 325 SS=F

Alcohol Based Hand Rub Dispenser (ABHR)

CFR(s) NFPA 101

The facility does ensure that Alcohol Based Hand Rub Dispensers are maintained appropriately.

Corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice

No residents were found to be affected by this deficient practice.

Identification of other residents having the same potential to be affected by the same practice and what corrective actions taken includes the following:

All residents have the potential to be affected by this deficient practice.

Measures that will be put into place or systematic changes you will make to ensure that the deficient practice does not recur includes the following:

To ensure the deficient practice does not recur,

- Documentation sheet shall be created that will ensure that on each refill the facility tests and confirms that the ABHR dispenser is working properly

How the corrective actions will be monitored to ensure the deficient practice will not recur:

Monitoring will be done through:

The Administrator or Designee shall conduct monthly audits to verify that ABHR dispensers are working properly, and documentation of maintenance is accounted for

Monitoring will start on 4/2/2018

This will be done monthly x 4

The Administrator or Designee will present to the quarterly QA Committee meeting any findings and/or corrective actions taken

Compliance, continuation/discontinuation of monitoring will be discussed during the QA Committee quarterly meeting.

4/2/18

K 353 SS=F

Sprinkler System-Maintenance and Testing

CFR(s) NFPA 101

The facility does ensure that there are a correct number of spare sprinkler pendants.

Corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice

No residents were found to be affected by this deficient practice.

Identification of other residents having the same potential to be affected by the same practice and what corrective actions taken includes the following:

All residents have the potential to be affected by this deficient practice.

Measures that will be put into place or systematic changes you will make to ensure that the deficient practice does not recur includes the following:

To ensure the deficient practice does not recur,

- The facility shall obtain at least 2 more sprinkler pendants to meet the requirements.
- The Facility shall conduct weekly inspection of dry system gauges
- The Facility shall conduct quarterly sprinkler inspections.
- Environmental supervisor shall be educated on need to conduct the weekly dry system checks and the quarterly sprinkler inspections.

How the corrective actions will be monitored to ensure the deficient practice will not recur:

Monitoring will be done through:

The Administrator or Designee shall visually inspect that the facility has 12 sprinkler pendants.

The Administrator or Designee shall conduct monthly audits to verify that dry system gauges sprinklers are being checked and documented on

Monitoring will start on 4/2/2018

This will be done monthly x 4

The Administrator or Designee will present to the quarterly QA Committee meeting any findings and/or corrective actions taken

Compliance, continuation/discontinuation of monitoring will be discussed during the QA Committee quarterly meeting.

4/2/18

4/2/18

K 711 SS=F

**Evacuation and Relocation Plan
CFR(s) NFPA 101**

The facility does ensure that the fire safety plan contains all nine elements

Corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice

No residents were found to be affected by this deficient practice.

Identification of other residents having the same potential to be affected by the same practice and what corrective actions taken includes the following:

All residents have the potential to be affected by this deficient practice.

Measures that will be put into place or systematic changes you will make to ensure that the deficient practice does not recur includes the following:

To ensure the deficient practice does not recur,

- The Fire Life Safety Plan shall be revised to include an emergency phone number from the facility to the fire department in the event of a fire.

How the corrective actions will be monitored to ensure the deficient practice will not recur:

Monitoring will be done through:

The Administrator or Designee shall visually inspect that the Fire and Life Safety Plan contains the emergency phone number.

4/2/18

K 711 SS=F

**Evacuation and Relocation Plan
CFR(s) NFPA 101**

The facility does ensure that the fire safety plan contains all nine elements

Corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice

No residents were found to be affected by this deficient practice.

Identification of other residents having the same potential to be affected by the same practice and what corrective actions taken includes the following:

All residents have the potential to be affected by this deficient practice.

Measures that will be put into place or systematic changes you will make to ensure that the deficient practice does not recur includes the following:

To ensure the deficient practice does not recur,

- The Fire Life Safety Plan shall be revised to include an emergency phone number from the facility to the fire department in the event of a fire.

How the corrective actions will be monitored to ensure the deficient practice will not recur:

Monitoring will be done through:

The Administrator or Designee shall visually inspect that the Fire and Life Safety Plan contains the emergency phone number.

4/2/18

K 712 SS=F

Fire Drills

CFR(s) NFPA 101

The facility does ensure that fire drills are done each shift per quarter

Corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice

No residents were found to be affected by this deficient practice.

Identification of other residents having the same potential to be affected by the same practice and what corrective actions taken includes the following:

All residents have the potential to be affected by this deficient practice.

Measures that will be put into place or systematic changes you will make to ensure that the deficient practice does not recur includes the following:

To ensure the deficient practice does not recur,

- Education shall be provided to Environmental Supervisor on the need to conduct quarterly fire drills each shift.

How the corrective actions will be monitored to ensure the deficient practice will not recur:

Monitoring will be done through:

The Administrator or Designee shall conduct quarterly audits to verify that fire drills are conducted and documented appropriately.

Monitoring will start on 4/2/2018

This will be done quarterly x 4

The Administrator or Designee will present to the quarterly QA Committee meeting any findings and/or corrective actions taken

Compliance, continuation/discontinuation of monitoring will be discussed during the QA Committee quarterly meeting.

4/2/18

K 918 SS=F

Electrical Systems-Essential Electric Systems

CFR(s) NFPA 101

The facility does ensure that the generator is tested weekly, load monthly and the fuel annually

Corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice

No residents were found to be affected by this deficient practice.

Identification of other residents having the same potential to be affected by the same practice and what corrective actions taken includes the following:

All residents have the potential to be affected by this deficient practice.

Measures that will be put into place or systematic changes you will make to ensure that the deficient practice does not recur includes the following:

To ensure the deficient practice does not recur,

- Education shall be provided to the Environmental Supervisor on the need to conduct weekly, monthly and annual tests on the generator

How the corrective actions will be monitored to ensure the deficient practice will not recur:

Monitoring will be done through:

The Administrator or Designee shall conduct audits to verify that generator checks are completed per the regulation

Monitoring will start on 4/2/2018

This will be done weekly x 4, then q 2 weeks x 4, then monthly x 2

The Administrator or Designee will present to the quarterly QA Committee meeting any findings and/or corrective actions taken

Compliance, continuation/discontinuation of monitoring will be discussed during the QA Committee quarterly meeting.

4/2/18

K 923 SS=D

**Gas Equipment- Cylinder and Container Storage
CFR(s) NFPA 101**

The facility does ensure that cryogenic oxygen cylinders are secured.

Corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice

No residents were found to be affected by this deficient practice.

Identification of other residents having the same potential to be affected by the same practice and what corrective actions taken includes the following:

All residents have the potential to be affected by this deficient practice.

Measures that will be put into place or systematic changes you will make to ensure that the deficient practice does not recur includes the following:

To ensure the deficient practice does not recur,

- Education shall be provided to the Environmental Supervisor on the need to secure oxygen cylinders.
- Oxygen cylinders shall be secured with a chain

How the corrective actions will be monitored to ensure the deficient practice will not recur:

Monitoring will be done through:

The Administrator or Designee shall visually inspect that the oxygen cylinders are secured appropriately.

4/2/18

K 926 SS=D

**Gas Equipment-Qualifications and Training
CFR(s) NFPA 101**

The facility does ensure that staff is educated on the risks associated with the storage, handling and use of medical gases and their cylinders.

Corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice

No residents were found to be affected by this deficient practice.

Identification of other residents having the same potential to be affected by the same practice and what corrective actions taken includes the following:

All residents have the potential to be affected by this deficient practice.

Measures that will be put into place or systematic changes you will make to ensure that the deficient practice does not recur includes the following:

To ensure the deficient practice does not recur,

- Education shall be provided to all staff on the risks associated with the storage, handling and use of medical gases and their cylinders.
- All staff shall be educated upon hire on the proper use and handling of oxygen
- Annual in servicing shall be conducted.

How the corrective actions will be monitored to ensure the deficient practice will not recur:

Monitoring will be done through:

The Administrator or Designee shall conduct audits on new hire trainings to verify that new employees are being trained on the proper use and handling of oxygen

Monitoring will start on 4/2/2018

This will be done monthly x4

The Administrator or Designee will present to the quarterly QA Committee meeting any findings and/or corrective actions taken

Compliance, continuation/discontinuation of monitoring will be discussed during the QA Committee quarterly meeting.

4/2/18

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

PRINTED: 03/19/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135140	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/28/2018
NAME OF PROVIDER OR SUPPLIER MADISON CARRIAGE COVE SHORT STAY REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST 1ST NORTH REXBURG, ID 83440	
(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 Madison Carriage Cove Short Stay Rehabilitation is a single story, Type V(111) construction, approximately 35,874 square feet in size. The structure is comprised of five smoke compartments, with both fire and smoke dampers in fire-rated wall assemblies. There is a separated, protected mechanical loft on the partial second floor. Plans were approved in May of 2013 and construction completed in July of 2014. The facility is fully sprinklered, with a complete, interconnected smoke detection and fire alarm system. There is a Type 2 Essential Electrical Service and piped medical gas system. The facility is located within a municipal fire district, encompassing essential emergency services as part of a multi-jurisdictional all-hazard mitigation plan. Currently the facility is licensed for 35 SNF/NF beds with a census of 35 on the date of the survey. The following deficiencies were cited during the Emergency Preparedness survey conducted on February 28, 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 & Construction Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop	E 000		
E 006 SS=F		E 006	(Please see attached Plan of Correction)	

RECEIVED
APR 03 2018
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____
Sam Burbank Administrator 3/22/18 *Plan attached*

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 006	<p>Continued From page 1</p> <p>and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:]</p> <p>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.*</p> <p>*[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents.</p> <p>*[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients.</p> <p>(2) Include strategies for addressing emergency events identified by the risk assessment.</p> <p>* [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>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 that includes a facility based component, including missing residents, potentially hinders facility response to disasters such as elopement, and other site-specific</p>	E 006			

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E 006	Continued From page 2 emergencies, that can be identified through facility participation in the risk assessment development. This deficient practice affected 35 residents, staff and visitors on the date of the survey. Findings include: 1) On 2/28/18 from 8:30 AM - 3:00 PM, review of provided emergency plan, policies and procedures, revealed the risk assessment did not include missing residents or elopement. Further review of the plan, policies and procedures demonstrated no policy or plan for resident elopement. 2) Interview of the facility Administrator conducted on 2/28/18 from approximately 9:00 AM to 10:00 AM, revealed the facility risk assessment was provided by newly acquired corporate management and had not been evaluated internally by the facility. Reference: 42 CFR 483.73 (a) (1) - (2)	E 006			
E 007 SS=F	EP Program Patient Population CFR(s): 483.73(a)(3) [(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:] (3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession	E 007		4/2/18	

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E 007	Continued From page 3 plans.** *Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the facility failed to provide an emergency plan, policies and procedures, addressing the resident population, including persons at risk and the types of services the facility has the ability to provide during an emergency. Failure to address the facility's at-risk population and types of services available, has the potential to hinder continuity of care and emergency management response during an emergency. This deficient practice affected 35 residents, staff and visitors on the date of the survey. Findings include: On 2/28/18 from 8:30 AM - 3:00 PM, review of provided emergency plan, policies and procedures, failed to describe what types of services the facility had the ability to provide during an emergency, or specify as to unique vulnerabilities' of the resident population. Reference: 42 CFR 483.73 (a) (3)	E 007			
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	E 013		4/2/18	

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E 013	<p>Continued From page 4</p> <p>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.</p> <p>*Additional Requirements for PACE and ESRD Facilities:</p> <p>*[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.</p> <p>*[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area.</p>	E 013		
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E 013	<p>Continued From page 5</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, it was determined the facility failed to develop policies and procedures based on the Emergency Plan. Failure to develop policies and procedures based on the emergency plan that includes a facility and community based risk assessment, potentially limits the facility response capabilities in the protection of residents during a disaster. This deficient practice affected 35 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>On 2/28/18 from 8:30 AM to 3:00 PM, review of provided policies and procedures revealed the risk assessment did not include any evaluation for missing residents. Further review of section 7 in the Table of Contents, labeled: "Specific Facility Threat protocol", failed to demonstrate the facility provided for a plan, policy or procedure for missing resident(s) or elopement. Sections 7(a) to 7(g), located in subsection(s) 7042 to 7049, revealed no plan, policies or procedures for the event of a missing resident or elopement.</p> <p>Additionally, review of the references for utilities management located in section 3(d); disruption of utility services in section 3(e); and specific threats as listed above, revealed the plan, policies and procedures did not address 7 of 23 hazards as identified in the Hazard Vulnerability Analysis (HVA). Those areas identified as not addressed by policies and procedures are:</p> <p>Chemical Terrorism Fire Flood</p>	E 013		

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E 013	Continued From page 6 Utility Failure - Communications Utility Failure - Generator Utility Failure - HVAC Utility Failure - Telephones Reference: 42 CFR 483.73 (b) Additional Reference: E - 0006	E 013		
E 018 SS=D	Procedures for Tracking of Staff and Patients CFR(s): 483.73(b)(2) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following: (2) A system to track the location of on-duty staff 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. *[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	E 018		4/2/18

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E 018	<p>Continued From page 7 emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location.</p> <p>*[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location.</p> <p>*[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of 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</p>	E 018		
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E 018	Continued From page 8 procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the facility failed to provide a policy for tracking of staff and sheltered residents during an emergency. Lack of a tracking policy for sheltered staff and residents has the potential to hinder continuity of care and essential services during an emergency. This deficient practice affected 35 residents, staff and visitors on the date of the survey. Findings include: On 2/28/18 from 8:30 AM - 3:00 PM, review of provided emergency plan, policies and procedures, failed to demonstrate the facility had in place a system to track the location of on-duty staff and residents sheltered in the facility during an emergency. Reference: 42 CFR 483.73 (b) (2)	E 018			
E 026 SS=D	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	E 026		4/2/18	

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E 026	<p>Continued From page 9 address the following:]</p> <p>(8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.</p> <p>*[For RNHCI 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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, it was determined the facility failed to document the role it would take under an 1135 waiver as declared by the Secretary and the provisions of care as required under this action if identified by emergency management officials. Failure to plan for alternate means of care and the facility 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 35 residents, staff and visitors housed on the date of the survey, along with the available surge needs of the community during a disaster.</p> <p>Findings include:</p> <p>On 2/28/18 from 8:30 AM - 3:00 PM, review of the provided emergency plan, policies and procedures, did not demonstrate a defined role undertaken by the facility under the declaration of an 1135 waiver, should that condition be enacted</p>	E 026		

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E 026	Continued From page 10 by the Secretary.	E 026		
E 030 SS=C	<p>Reference: 42 CFR 483.73 (b) (8)</p> <p>Names and Contact Information CFR(s): 483.73(c)(1)</p> <p>[(c) The [facility, except RNHCIs, hospices, transplant centers, and HHAs] 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:]</p> <p>(1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers.</p> <p>*[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers.</p> <p>*[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following:</p>	E 030		4/2/18

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E 030	<p>Continued From page 11</p> <p>(i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers.</p> <p>*[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices.</p> <p>*[For OPOs at §486.360(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the facility failed to document a communication plan which included contact information for staff, resident physicians, other facilities and volunteers. Failure to have a communication plan which includes contact information for those parties assisting in the facility's response and recovery during a disaster, has the potential to hinder both internal and external emergency response efforts. This deficient practice affected 35 residents, staff and visitors on the date of the survey.</p>	E 030		
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E 030	Continued From page 12 Findings include: On 2/28/18 from 8:30 AM - 3:00 PM, review of provided emergency plan, policies and procedures revealed the communication plan did not include contact information for resident physicians. Reference: 42 CFR 483.73 (c) (1)	E 030			
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 information for the following: (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. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local	E 031		4/2/18	

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E 031	Continued From page 13 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 35 residents in the facility on the date of the survey. Findings include: On 2/28/18 from 8:30 AM - 3:00 PM, review of the emergency plan, policies and procedures, revealed the plan did not include contact information for the Ombudsman and State Licensing Agency, however in the section identified as 7019, "Disruption of services", the fourth bullet point refers to the notification of "Department of Health, Office of Emergency Services, Licensing Bureau and accrediting organization, etc." as referenced by the rule.	E 031		
E 036 SS=F	Reference: 42 CFR 483.73 (c) (2) 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		4/2/18

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E 036	<p>Continued From page 14</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</p>	E 036			

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E 036	Continued From page 15 program focused on the emergency preparedness plan, policies and procedures, has the potential to hinder staff response during a disaster. This deficient practice affected 35 residents, staff and visitors on the date of the survey. Findings include: On 2/28/18 from 8:30 AM - 3:00 PM, review of provided emergency plan, policies and procedures, found no documentation demonstrating the facility had a current testing program for staff based on training conducted on the emergency plan. Interview of 4 of 4 staff conducted on 2/28/18 from :00 AM - 12:30 PM, established staff had not participated in any specific testing program on the emergency plan contents, only an inservice of the initial overview of the upcoming implementation of a new emergency plan. Reference: 42 CFR 483.73 (d)	E 036		
E 039 SS=F	EP Testing Requirements CFR(s): 483.73(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency	E 039		4/2/18

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E 039	Continued From page 16 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 discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or	E 039		

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E 039	<p>Continued From page 17</p> <p>prepared questions designed to challenge an emergency plan.</p> <p>(ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, it was determined the facility failed to participate in any exercises which tested the emergency preparedness readiness of the facility. Failure to participate in full-scale 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 35 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>On 2/28/18 from 8:30 AM - 3:00 PM, review of provided emergency plan documents revealed no documentation demonstrating the facility had participated in at least two (2) exercises of the emergency preparedness policies and procedures.</p> <p>Interview of the Administrator on 2/28/18 from 10:00 - 11:00 AM substantiated the facility had not participated in any full-scale exercises, or tabletop events to test the emergency plan.</p> <p>Reference:</p> <p>42 CFR 483.73 (d) (1)</p>	E 039			

EMERGENCY PREPAREDNESS PLAN OF CORRECTION

February 28th 2018

Preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the accuracy or truthfulness of any facts alleged or any conclusions set forth in this allegation of deficiencies by the State Licensing Authority. Accordingly, the facility has drafted this Plan of Correction in accordance with Federal and State Laws which mandate the submission of a Plan of Correction as a condition for participating in the Medicare and Medicaid program. This Plan of Correction shall constitute this facility's credible allegation compliance with this section.

E 006 SS=F

**Plan Based on All Hazards Risk Assessment
CFR(s) 483.73(a)(1)-(2)**

RECEIVED
MAR 26 2018
FACILITY STANDARDS

The facility does ensure that a risk assessment includes missing residents or elopement and is evaluated internally by the facility.

Corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice

No residents were found to be affected by this deficient practice.

Identification of other residents having the same potential to be affected by the same practice and what corrective actions taken includes the following:

All residents have the potential to be affected by this deficient practice.

Measures that will be put into place or systematic changes you will make to ensure that the deficient practice does not recur includes the following:

To ensure the deficient practice does not recur,

- Assessment shall be revised to include missing residents or elopement
- An all staff meeting shall be arranged that discusses the emergency risk assessment

How the corrective actions will be monitored to ensure the deficient practice will not recur:

Monitoring will be done through:

The Administrator or designee shall visually inspect that the risk assessment includes missing resident or elopement.

4/2/18

E 007 SS=F

EP Program Patient Population

CFR(s) 483.73(a)(3)

The facility does ensure that the emergency plan does address how to deal with persons at risk and the types of services the facility can provide during an emergency.

Corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice

No residents were found to be affected by this deficient practice.

Identification of other residents having the same potential to be affected by the same practice and what corrective actions taken includes the following:

All residents have the potential to be affected by this deficient practice.

Measures that will be put into place or systematic changes you will make to ensure that the deficient practice does not recur includes the following:

To ensure the deficient practice does not recur,

- Emergency Plan shall be revised to indicate what types of services the facility can provide during an emergency and identify unique vulnerabilities of the resident population.

How the corrective actions will be monitored to ensure the deficient practice will not recur:

Monitoring will be done through:

The Administrator or designee shall visually inspect that the emergency plan includes the types of services provided in an emergency as well as the unique vulnerabilities of the resident population.

4/2/18

E 013 SS=F

**Development of EP Policies and Procedures
CFR(s) 483.73(b)**

The facility does ensure that a risk assessment includes missing residents and addresses all 23 hazards in the Hazard Vulnerability Analysis

Corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice

No residents were found to be affected by this deficient practice.

Identification of other residents having the same potential to be affected by the same practice and what corrective actions taken includes the following:

All residents have the potential to be affected by this deficient practice.

Measures that will be put into place or systematic changes you will make to ensure that the deficient practice does not recur includes the following:

To ensure the deficient practice does not recur,

- Assessment shall be revised to include missing residents or elopement
- The Hazard Vulnerability Analysis shall be revised to add the 7 missing hazards.

How the corrective actions will be monitored to ensure the deficient practice will not recur:

Monitoring will be done through:

The Administrator or designee shall visually inspect that the risk assessment includes missing resident or elopement and the HVA analysis includes all 23 hazards.

4/2/18

E 018 SS=D

**Procedures for Tracking of Staff and Patients
CFR(s) 483.73(b)(2)**

The facility does ensure that the emergency plan includes a policy for tracking on-duty staff and sheltered residents during an emergency.

Corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice

No residents were found to be affected by this deficient practice.

Identification of other residents having the same potential to be affected by the same practice and what corrective actions taken includes the following:

All residents have the potential to be affected by this deficient practice.

Measures that will be put into place or systematic changes you will make to ensure that the deficient practice does not recur includes the following:

To ensure the deficient practice does not recur,

- The emergency plan shall be revised to include a policy that tracks on-duty staff and residents sheltered during an emergency.

How the corrective actions will be monitored to ensure the deficient practice will not recur:

Monitoring will be done through:

The Administrator or designee shall visually inspect that the emergency plan has a tracking policy of on-duty staff and residents

4/2/18

E 026 SS=D

**Roles Under a Waiver Declared by Secretary
CFR(s) 483.73(b)(8)**

The facility does ensure that a documented role that the facility would take under an 1135 waiver

Corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice

No residents were found to be affected by this deficient practice.

Identification of other residents having the same potential to be affected by the same practice and what corrective actions taken includes the following:

All residents have the potential to be affected by this deficient practice.

Measures that will be put into place or systematic changes you will make to ensure that the deficient practice does not recur includes the following:

To ensure the deficient practice does not recur,

- Documentation shall be provided to determine the role the facility would take in the event of an 1135 waiver.

How the corrective actions will be monitored to ensure the deficient practice will not recur:

Monitoring will be done through:

The Administrator or designee shall visually inspect that the role in the event of an 1135 waiver is documented within the emergency plan.

4/2/18

E 030 SS=C

Name and Contact Information

CFR(s) 483.73(c)(1)

The facility does ensure that contact information for staff, resident physicians, other facilities and volunteers are contained within the emergency plan.

Corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice

No residents were found to be affected by this deficient practice.

Identification of other residents having the same potential to be affected by the same practice and what corrective actions taken includes the following:

All residents have the potential to be affected by this deficient practice.

Measures that will be put into place or systematic changes you will make to ensure that the deficient practice does not recur includes the following:

To ensure the deficient practice does not recur,

- Emergency plan will be revised to include contact information for staff, physicians, other facilities and volunteers.

How the corrective actions will be monitored to ensure the deficient practice will not recur:

Monitoring will be done through:

The Administrator or designee shall visually inspect that the emergency plan to ensure that all needful contact numbers are represented.

4/2/18

E 031 SS=F

**Emergency Officials Contact Information
CFR(s) 483.73(c)(2)**

The facility does ensure that current contact information for the ombudsmen and state licensing agency is contained in the emergency plan

Corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice

No residents were found to be affected by this deficient practice.

Identification of other residents having the same potential to be affected by the same practice and what corrective actions taken includes the following:

All residents have the potential to be affected by this deficient practice.

Measures that will be put into place or systematic changes you will make to ensure that the deficient practice does not recur includes the following:

To ensure the deficient practice does not recur,

- Emergency plan will be revised to include ombudsmen and state licensing agency contact information

How the corrective actions will be monitored to ensure the deficient practice will not recur:

Monitoring will be done through:

The Administrator or designee shall visually inspect that the emergency plan contains contact information for the ombudsmen and state licensing agency.

4/2/18

E 036 SS=F

EP Training and Testing

CFR(s) 483.73(d)

The facility does ensure that an emergency prep training and testing program is implemented.

Corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice

No residents were found to be affected by this deficient practice.

Identification of other residents having the same potential to be affected by the same practice and what corrective actions taken includes the following:

All residents have the potential to be affected by this deficient practice.

Measures that will be put into place or systematic changes you will make to ensure that the deficient practice does not recur includes the following:

To ensure the deficient practice does not recur,

- All staff shall be educated upon hire in regards to emergency preparedness
- Mock emergency shall be staged at the facility
- Annual In servicing shall be conducted

How the corrective actions will be monitored to ensure the deficient practice will not recur:

Monitoring will be done through:

The Administrator or Designee shall conduct audits on new hire trainings to verify that new employees are being trained on emergency preparedness

Monitoring will start on 4/2/2018

This will be done monthly x4

The Administrator or Designee will present to the quarterly QA Committee meeting any findings and/or corrective actions taken

Compliance, continuation/discontinuation of monitoring will be discussed during the QA Committee quarterly meeting.

4/2/18

E 039 SS=F

EP Testing Requirements

CFR(s) 483.73(d)(2)

The facility does ensure that it tests the emergency preparedness readiness of the facility

Corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice

No residents were found to be affected by this deficient practice.

Identification of other residents having the same potential to be affected by the same practice and what corrective actions taken includes the following:

All residents have the potential to be affected by this deficient practice.

Measures that will be put into place or systematic changes you will make to ensure that the deficient practice does not recur includes the following:

To ensure the deficient practice does not recur,

- Mock emergency shall be staged at the facility at least twice per year
- Environmental director shall be educated on need to perform mock emergencies

How the corrective actions will be monitored to ensure the deficient practice will not recur:

Monitoring will be done through:

The Administrator or Designee shall ensure that a mock emergency is performed 4/2/18

4/2/18