



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
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March 23, 2018

Jeri Herrera, Administrator
Valley Vista Care Center of Sandpoint
220 South Division
Sandpoint, ID 83864-1759

Provider #: 135055

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Ms.. Herrera:

On **March 13, 2018**, a Facility Fire Safety and Construction survey was conducted at **Valley Vista Care Center of Sandpoint** 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 **April 5, 2018**. Failure to submit an acceptable PoC by **April 5, 2018**, may result in the imposition of civil monetary penalties by **April 25, 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 17, 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 17, 2018**. A change in the seriousness of the deficiencies on **April 17, 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 17, 2018**, includes the following:

Denial of payment for new admissions effective **June 13, 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 **September 13, 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 **March 13, 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 **April 5, 2018**. If your request for informal dispute resolution is received after **April 5, 2018**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosures

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135055	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 03/13/2018
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF SANDPOINT		STREET ADDRESS, CITY, STATE, ZIP CODE 220 SOUTH DIVISION SANDPOINT, ID 83864	
(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)
	<p>K 000 INITIAL COMMENTS</p> <p>The facility is a single story, Type V(111) structure. The building is divided into three smoke compartments and is protected throughout by automatic fire extinguishing system which is interconnected to the fire alarm system. The building was originally constructed in 1959 with an addition in 1985. There have been several minor additions and remodels with a major remodel completed in 2001. The facility is currently licensed for 73 SNF/NF beds and had a census of 61 on the date of the survey.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted March 13, 2018. The facility was surveyed under the Life Safety Code 2012 Edition, Existing Health Care Occupancies in accordance with 42 CFR 483.70.</p> <p>The Survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction</p> <p>K 100 General Requirements - Other SS=F CFR(s): NFPA 101</p> <p>General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to demonstrate implementation of a water management program for waterborne pathogens such as Legionella, in accordance with 42 CFR</p>	<p>K 000</p>	<p>K 100 CORRECTIVE ACTION</p> <p>4/17/18</p> <p>On 04/02/2018 a Water Safety Services agreement was established between the facility and Naico Company LLC, with implementation of an active water management plan beginning immediately.</p>

RECEIVED
APR 05 2018
FACILITY STANDARDS

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

[Signature]

TITLE

[Signature]

(X6) DATE

4/4/18

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

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

Printed: 03/22/2018
FORM APPROVED
OMB NO. 0938-0391

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K 100	Continued From page 1 483.80. Failure to provide a water management program that includes a facility based risk assessment, active control measures and 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 61 residents, staff and visitors on the date of the survey. Findings include: During review of provided maintenance inspection and policy documentation conducted on 3/13/18 from approximately 8:30 - 10:00 AM, records 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. CFR standard: 42 CFR 483.80 § 483.80 Infection control. The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. Additional reference: Center for Medicaid/Medicare Services S & C letter 17-30	K 100	AFFECTED RESIDENTS 61 Residents, Staff and Visitors Had the potential to be affected by this citation. SYSTEMATIC CHANGES: A contracted Service agreement From Nalco Company for a water management plan that includes a Facility based risk assessment, active control measures and testing protocols was implemented on 04/02/2018. Maintenance Department was educated On the requirement for compliance on 04/04/2018. Maintenance and Administrative staff will be educated by Nalco Company on 04/30/2018 on the water management plan and their part in testing and active control measures. MONITORING Maintenance Supervisor or designee will maintain an active working relationship with Nalco Company and will report findings from water management testing and controlling to the NHA and the Safety Committee.
K 325	Alcohol Based Hand Rub Dispenser (ABHR) SS=F CFR(s): NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR)	K 325	

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K 325	<p>Continued From page 2</p> <p>ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met:</p> <ul style="list-style-type: none"> * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, observation and interview, the facility failed to ensure manual or automatically 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 61 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p>	K 325	<p>AFFECTED RESIDENTS: This deficient practice affected 61 Residents, Staff and Visitors on the date of survey.</p> <p>CORRECTIVE ACTION: The Housekeeping Supervisor completed an initial audit on all of the hand sanitizer dispensers throughout the facility on 03/30/18 to ensure that all the dispensers are operating properly in accordance with the standard.</p> <p>SYSTEMATIC CHANGES: The hand sanitizer dispenser checklist was updated to comply with NFPA dispenser criteria. The maintenance department, house-keeping supervisor and housekeepers were in-serviced on 03/30/2018 and 04/02/2018 on proper usage and maintenance procedures.</p> <p>MONITORING: Maintenance Supervisor and/or designee will be responsible for ensuring on-going compliance through monthly documented audits. Audits will be reviewed in QAPI meetings monthly x 3 to ensure proper procedures are being followed. Audits will begin on 03/30/2018.</p>	4/17/18

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K 325	<p>Continued From page 3</p> <p>1) During review of facility maintenance and inspection records conducted on 2/28/18 from approximately 8:30 - 10:00 AM, maintenance records provided for the refilling of ABHR dispensers failed to indicate what procedures were performed during the refill process. Interview of the Housekeeping staff outside the salon on 2/13/18 from 12:30 - 2:00 PM, revealed no testing was being performed during the refill process, only that the date and initials of the person replacing the refill were being documented.</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 and manually activated 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</p> <p>(b) 0.53 gal (2.0 L) for dispensers in suites of rooms</p>	K 325	

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

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K 325	Continued From page 5 (11) Operation of the dispenser shall comply with the following criteria: (a) The dispenser shall not release its contents except when the dispenser is activated, either manually or automatically by touch-free activation. (b) Any activation of the dispenser shall occur only when an object is placed within 4 in. (100 mm) of the sensing device. (c) An object placed within the activation zone and left in place shall not cause more than one activation. (d) The dispenser shall not dispense more solution than the amount required for hand hygiene consistent with label instructions. (e) The dispenser shall be designed, constructed, and operated in a manner that ensures that accidental or malicious activation of the dispensing device is minimized. (f) The dispenser shall be tested in accordance with the manufacturer's care and use instructions each time a new refill is installed.	K 325	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance 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	K 353	AFFECTED RESIDENTS: All Residents have the potential to be affected by this deficient practice. CORRECTIVE ACTION: On 03/30/2018 the maintenance Supervisor inspected the dry gauge system and removed the wasp nest that was obstructing identification of the valve's position. 4/17/18

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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K 353	<p>Continued From page 6</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on record review and observation, the facility failed to ensure that fire suppression systems were maintained in accordance with NFPA 25. Failure to inspect system components 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 61 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 2/13/18 from 8:30 AM - 10:00 AM, no records were available indicating the dry system gauges were inspected on a weekly basis.</p> <p>Interview of the Maintenance Engineer revealed he was not aware of this requirement.</p> <p>2) During the facility tour conducted on 2/13/18 from 1:00 - 3:00 PM, observation of the post indicator valve (PIV), located on the southeast side of the building, revealed the inspection window on the street side was obstructed with a wasp nest, rendering identification of the valve's position unclear.</p> <p>Actual NFPA standard: NFPA 25 5.2.4 Gauges.</p>	K 353	<p>SYSTEMATIC CHANGES:</p> <p>Maintenance will begin doing documented weekly inspections on the dry gauge to ensure that normal air and water pressures are being maintained and there are no obstructions present. Weekly checks will begin on 03/30/2018.</p> <p>MONITORING:</p> <p>Administrator or designee will do random audits to ensure that documented checks are completed weekly. Weekly audits will be reviewed monthly at the QAPI meeting x 3 months to ensure on-going compliance. Audit to begin on 03/30/2018.</p>

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K 353	Continued From page 7 5.2.4.2 Gauges on dry, preaction, and deluge systems shall be inspected weekly to ensure that normal air and water pressures are being maintained. 13.3 Control Valves in Water-Based Fire Protection Systems. 13.3.2 Inspection. 13.3.2.2* The valve inspection shall verify that the valves are in the following condition: (1) In the normal open or closed position (2)*Sealed, locked, or supervised (3) Accessible (4) Provided with correct wrenches (5) Free from external leaks (6) Provided with applicable identification	K 353	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review, 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 61	K 712	AFFECTED RESIDENTS: This deficient practice affected 61 Residents, Staff and Visitors. CORRECTIVE ACTION: Maintenance Supervisor conducted Fire Drills on all shifts on 03/30/2018. Administrator educated the maintenance department on this NFPA requirement. SYSTEMIC CHANGES: The Maintenance Department have been educated on this deficient practice. Maintenance Supervisor or Designee will ensure that fire drills are completed quarterly on each shift and document that they occurred.

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K 712	Continued From page 8 residents, staff and visitors on the date of the survey. Findings include: During review of provided facility fire drills conducted on 2/13/18 from approximately 8:30 - 10:00 AM, fire drill documentation revealed the facility failed to conduct fire drills on the Evening and Graveyard shift during the fourth 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	MONITORING: The Administrator or designee will perform random audits to ensure the maintenance department is conducting fire drills quarterly per NFPA standards and they are documented. Audits will be reviewed at QAPI to ensure on-going compliance.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual	K 918	AFFECTED RESIDENTS: This deficient practice affected 61 Residents, Staff and Visitors on the date of survey. CORRECTIVE ACTION: On 03/21/2018 the EES generator test for load and the weekly inspection was completed per NFPA standard by the maintenance Supervisor. The Administrator educated the maintenance Supervisor on the monthly load and weekly inspection requirement.	4/17/18

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135055	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 03/13/2018
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF SANDPOINT		STREET ADDRESS, CITY, STATE, ZIP CODE 220 SOUTH DIVISION SANDPOINT, ID 83864	
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K 918	<p>Continued From page 9</p> <p>transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.</p> <p>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure the EES (Essential Electrical System) generator was maintained in accordance with NFPA 110. Failure to test for load monthly has the potential of hindering system performance during a power loss or other emergency. This deficient practice affected 61 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 2/13/18 from approximately 8:30 - 10:00 AM, records provided for the monthly generator testing revealed monthly testing had not been conducted from December 2017 to date.</p> <p>When asked, the Maintenance Engineer stated he was not aware of the missing documentation</p>	K 918	<p>SYSTEMATIC CHANGES:</p> <p>The maintenance supervisor or designee will ensure that the weekly and monthly generator inspections and testing are performed. All documentation of the inspections will be filed promptly where they are accessible to the Administrator for random auditing.</p> <p>MONITORING:</p> <p>Administrator or designee will perform Audits x 3 months to ensure compliance is maintained. Results of audits will be reviewed in QAPI x 3 months.</p>

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K 918	Continued From page 10 for monthly load testing. Actual NFPA standard: NFPA 110 8.4 Operational Inspection and Testing. 8.4.1* EPSSs, including all appurtenant components, shall be inspected weekly and exercised under load at least monthly.	K 918		

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E 000 Initial Comments

E 000

The facility is a single story, type V (111) fire resistive structure with multiple exits to grade, originally constructed in 1959 with subsequent renovations. The facility has an on-site, diesel powered generator system, is fully sprinklered and equipped with an interconnected fire alarm system. The facility is located in a municipal fire district and is currently licensed for 73 SNF/NF beds, with a census of 61 on the date of the survey.

The following deficiencies were cited during the Emergency Preparedness survey conducted on March 13, 2018. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.

The Survey was conducted by:

Sam Burbank
Health Facility Surveyor
Facility Fire Safety and Construction

E 004 Develop EP Plan, Review and Update Annually
SS=F CFR(s): 483 73(a)

E 004

[The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.]

* [For hospitals at §482.15 and CAHs at §485.625(a):] The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this

Preparation and execution of this POC does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusions set forth in the statement of deficiencies rendered by the reviewing agency. The plan of correction is prepared and executed solely because the provisions of federal and state law require it.

AFFECTED RESIDENTS:

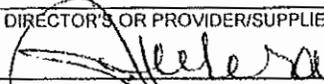
This deficient practice had the Potential to affect 61 Residents, Staff and Visitors on the date of survey.

4/17/18

RECEIVED
APR 05 2018

FACILITY STANDARDS

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



TITLE

NHA

(X6) DATE

4/4/18

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

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E 004	<p>Continued From page 1 section, utilizing an all-hazards approach.</p> <p>The emergency preparedness program must include, but not be limited to, the following elements:] (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least annually.</p> <p>* [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least annually.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to develop an Emergency Preparedness program in accordance with 42 CFR 483.73 which is reviewed and updated annually. Failure to review and update emergency preparedness plan, policies and procedures annually has the potential to hinder resident continuity of care during a disaster. This deficient practice affected 61 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>1) On 3/13/18 from 2:00 - 2:30 PM, review of the provided emergency plan, policies and procedures, revealed the facility had not conducted and documented an annual review of the emergency plan in accordance with the standard. Further review of the provided plan, policies and procedures revealed the facility HVA (Hazard Vulnerability Analysis) provided information of the probability and impact of</p>	E 004	<p>CORRECTIVE ACTION: The IDT reviewed and updated the Facility risk assessment. The potential for Hurricane was removed from the assessment as it was not geographically relevant to the Facility location. Annual review of the emergency disaster plan by the Administrator was completed and updated on 04/02/2018.</p> <p>SYSTEMATIC CHANGES: IDT will review the Emergency Preparedness plan quarterly at QAPI to ensure that any changes or updates are addressed promptly. There will be documentation of the review and any findings.</p> <p>MONITORING: Any findings and or revisions needed will be brought to QAPI monthly for a minimum of 3 months to ensure on-going compliance. NHA will be responsible for compliance.</p>	

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E 004 Continued From page 2 E 004

Hurricanes, which are not geographically relevant to the facility location.

When asked, about the inclusion of the risk in the plan, the Administrator stated the facility plan was provided by corporate and she was not aware this information had been included in the plan.

2) On 3/13/18 from 2:00 - 2:30 PM, review of Section IV, page 18: Emergency Preparedness and Planning, revealed the reference for the "Florida Health Care Association Disaster Planning Guide 2005".

Reference:
42 CFR 483.73 (a)

E 006 Plan Based on All Hazards Risk Assessment SS=D CFR(s): 483.73(a)(1)-(2)

[(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:]

(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.*

*[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents.

*[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.

E 006 AFFECTED RESIDENTS: 4/17/18

This deficient practice had the potential to affect 61 Residents, Staff and Residents on the date of survey.

CORRECTIVE ACTION:
The Facility HVA analysis was reviewed and updated on 3/29/18. The probability of hurricanes was removed. The county all-hazard mitigation plan was reviewed and compared to Facility HVA to ensure localized risks that are addressed is site specific.

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E 006 Continued From page 3

(2) Include strategies for addressing emergency events identified by the risk assessment.

* [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.

This REQUIREMENT is not met as evidenced by:

Based on record review and interview, it was determined the facility failed to develop an Emergency Preparedness program that included a facility based and community based risk assessment. Failure to review and update emergency preparedness plan, policies and procedures that considers localized risks has the potential to hinder resident continuity of care during a disaster. This deficient practice affected 61 residents, staff and visitors on the date of the survey.

Findings include:

1) On 3/13/18 from 2:00 - 2:30 PM, review of the provided emergency plan, policies and procedures, revealed the facility HVA (Hazard Vulnerability Analysis) provided information of the probability and impact of Hurricanes, which are not geographically relevant to the facility. Review of the county all-hazard mitigation plan for the area found no indication Hurricanes were a likely occurrence.

2) On 3/13/18 from 10:30 AM to 2:00 PM, interview of 4 of 4 staff members failed to demonstrate staff considered Hurricanes to be a

E 006

SYSTEMATIC CHANGES:

Staff were educated on 04/3/2018 and 04/04/2018 on the updated all-hazard assessment.

MONITORING:

Upon completion of initial staff in-services, Maintenance Supervisor will provide on-going Education with written tests at each Quarterly in-service to ensure on-going Compliance.

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E 006	Continued From page 4 likely hazardous event for the area. 2) When asked, about the inclusion of the risk in the plan, the Administrator stated the facility plan was provided by corporate and she was not aware this information had been included in the plan. Reference: 42 CFR 483.73 (a) (1) - (2)	E 006		
E 013 SS=D	Development of EP Policies and Procedures CFR(s): 483.73(b) (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this 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	E 013	AFFECTED RESIDENTS: This deficient practice had the potential to affect 61 Residents, Staff and Visitors on the date of survey. CORRECTIVE ACTION: The Facility risk assessment has been updated and Hurricane has been removed on the assessment and the table of contents. SYSTEMATIC CHANGES: The Disaster Plan and risk Assessment was reviewed by the IDT and updated 04/02/2018. The Disaster Plan will be reviewed by the IDT no less than annually and the signature page will be Signed following each review. MONITORING: The annual IDT Disaster Plan review will be scheduled by the NHA to coincide with the QAPI meeting. The NHA will be Responsible for ensuring the Annual review is scheduled.	4/17/18

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E 013 Continued From page 5 E 013

policies and procedures must be reviewed and updated at least annually.

*[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.

This REQUIREMENT is not met as evidenced by:

Based on record review and interview, it was determined the facility failed to develop policies and procedures based on the Emergency Plan that aligned with a facility and community based risk assessment. Development of policies and procedures based on non-geographically relevant hazards, creates purposeless facility training of non-localized events. This deficient practice potentially affected 61 residents, staff and visitors on the date of the survey.

Findings include:

On 3/13/18 from 2:00 - 3:00 PM, review of provided policies and procedures revealed the risk assessment included probability and outcome for the risk of a Hurricane, yet the facility is landlocked and the closest ocean is approximately 500 miles away. Further review of section VIII, Resource X and BB listed in the Table of Contents, revealed procedures for

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E 018 Continued From page 7

Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location.

*[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.

*[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.

*[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

E 018 MONITORING:
The Administrator and/or designee will monitor the effectiveness of staff trainings through written exams and random staff inter-views and provide outcomes to the QAPI committee x 3 months. Additional staff training will occur between quarterly trainings if testing and staff interviews indicate additional training is necessary.

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E 018 Continued From page 8
secures and maintains the availability of records.

E 018

*(For ESRD at § 494.62(b):) Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. 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 has the potential to affect the 61 residents, staff and visitors in the facility on the date of the survey.

Findings include:

On 3/13/18 from 2:00 - 2:30 PM, review of provided emergency plan, policies and procedures, failed to demonstrate the facility had in place a system to track the location of on-duty staff and residents sheltered in the facility during an emergency.

Reference:
42 CFR 483.73 (b) (2)

E 024 Policies/Procedures-Volunteers and Staffing
SS=D CFR(s): 483.73(b)(6)

E 024 AFFECTED RESIDENTS:
This deficient practice had
The potential to affect 61
Residents, Staff and Visitors
on the date of survey.

4/17/18

[(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

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E 024 Continued From page 9
least annually. At a minimum, the policies and procedures must address the following:]

(6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.

*[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency.
This REQUIREMENT is not met as evidenced by:
Based on record review, it was determined the facility failed to develop emergency plan, policies and procedures addressing the use of volunteers during an emergency. Lack of a plan, policy and procedure specific to the use of volunteers, potentially hinders the facility's ability to provide continuity of care during a disaster. This deficient practice had the potential to affect the 61 residents, staff and visitors in the facility on the date of the survey.

Findings include:

Review of provided emergency plan, policies and procedures conducted on 3/13/18 from 2:00 - 2:30 PM, failed to demonstrate a plan, policy or procedure on the use of volunteers.

Reference:
42 CFR 483.73 (b) (6)

E 026 Roles Under a Waiver Declared by Secretary
SS=D CFR(s): 483.73(b)(8)

E 024 CORRECTIVE ACTION:
The Facility included a Policy and Procedure in our disaster plan that specifically addresses the use of Volunteers that may be in the Facility during a disaster on 04/02/2018. A tracking sheet specific to volunteers was included in the plan.

SYSTEMATIC CHANGES:
As of 04/02/2018 this Policy and Procedure will remain a permanent procedure in The Disaster Preparedness Plan.

MONITORING:
The NHA will be responsible for ensuring that the Policy and Procedure for utilizing Volunteers during an emergency remains current and in the Disaster Plan and is reviewed no less than annually during the annual Disaster Plan Review.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 026	<p>Continued From page 10</p> <p>[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:]</p> <p>(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: 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 61 residents, staff and visitors housed on the date of the survey, along with the available surge needs of the community during a disaster.</p>	E 026	<p>AFFECTED RESIDENTS: This deficient practice had the potential to affect 61 Residents, Staff and Visitors on the date of survey.</p> <p>CORRECTIVE ACTION: The Policy and Procedure for a 1135 waiver for the provision of care at an alternate site and the role of this Facility was included in this Facilities Disaster Plan on 04/02/2018.</p> <p>SYSTEMATIC CHANGES: The 1135 waiver will remain a permanent part of the Facility Disaster Plan detailing this Facilities Role in the event that the Secretary enacts that declaration.</p> <p>MONITORING: The NHA will be responsible for ensuring that the 1135 waiver remains a permanent part of the disaster plan and is reviewed no less than on an annual basis.</p>	4/17/18

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E 026 Continued From page 11

E 026

Findings include:

On 3/13/18 from 2:00 - 2:30 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 by the Secretary.

Reference:
42 CFR 483.73 (b) (8)

E 029 Development of Communication Plan
SS=D CFR(s): 483.73(c)

E 029

AFFECTED RESIDENTS:

4/17/18

This deficient practice had the potential to affect 61 Residents, Staff and Visitors on the date of survey.

(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.
This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to develop and update annually a communication plan, to provide coordination of care for the residents during a disaster. Failure to implement, review and update annually a communication plan for internal and external communications during a disaster, has the potential to hinder emergency response and the coordinated efforts of care for the 61 residents, staff and visitors in the facility on the date of the survey.

CORRECTIVE ACTION:

The Emergency Disaster Plan was reviewed by the IDT on 04/02/2018. It was updated to include a Policy and Procedure that includes a site specific plan on communication. The signature page for the Approval of the Disaster Plan Manual was signed by the NHA and will be reviewed no less than annually with a updated NHA signature that review was Completed.

Findings include:

During review of provided facility emergency plan, policies and procedures conducted on 3/13/18 from 2:00 - 2:30 PM, documentation did not reveal the annual review of the communication

SYSTEMATIC CHANGE:

Staff were educated on site specific communication plan on 04/03/18 and 04/04/18.

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E 029 Continued From page 12 plan had been conducted.

Interview of 4 of 4 staff members conducted on 3/13/18 from 10:30 AM to 2:00 PM established staff were unaware of any communication plan to be implemented by the facility during the course of a disaster.

Reference:
42 CFR 483.73 (c)

Additional references:
E-0004

E 029 MONITORING:
After initial staff educations on 4/3/18 and 04/04/18, quarterly mandatory staff trainings will be scheduled. Additional staff trainings will be held as needed. Maintenance Supervisor will provide the training.

E 036 EP Training and Testing
SS=F 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 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.

*[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).

E 036 AFFECTED RESIDENTS: 4/17/18
This deficient practice had the potential to affect 61 Residents, Staff and Visitors on the date of survey.

CORRECTIVE ACTION:
All-Staff mandatory trainings were held on the site specific Disaster Plan on 04/03/2018 and 04/04/2018. Also implemented in the training was a written exam.

SYSTEMATIC CHANGES:
The training will now be included in the new employee orientation to ensure all staff receive training on the Facilities Disaster Plan upon hire. The training, testing and orientation program will be reviewed annually and updated as needed.

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E 036 Continued From page 13

*[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.

This REQUIREMENT is not met as evidenced by:

Based on record review and interview, it was determined the facility failed to provide a emergency prep training and testing program. Lack of a facility emergency training and testing program covering the emergency preparedness plan, policies and procedures, has the potential to hinder staff response during a disaster. This deficient practice affected 61 residents, staff and visitors on the date of the survey.

Findings include:

On 3/13/18 from 2:00 - 2:30 PM, review of provided emergency plan, policies and procedures, found no documentation demonstrating the facility had a current testing program for staff based on training conducted of the emergency plan.

Interview of 4 of 4 staff conducted on 3/13/18 from 10:00 AM - 2:00 PM, established staff had not participated in any specific training or testing program on the emergency plan contents, and that the plan had not been implemented to the facility as of the date of the survey.

E 036

MONITORING:

The effectiveness of the trainings will be evaluated by the Maintenance Supervisor through disaster drills and documented outcomes of the drills. Trainings will be modified as needed from information gathered from the drills. Information from drills will be reviewed at QAPI meetings x 3 months.

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E 036

Additional interview of the Administrator established the emergency plan was recently updated by corporate and staff had not yet undergone training or testing over the contents of the plan.

Reference:
42 CFR 483.73 (d)

E 037 EP Training Program
SS=F CFR(s): 483.73(d)(1)

(1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following:

- (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.
 - (ii) Provide emergency preparedness training at least annually.
 - (iii) Maintain documentation of the training.
 - (iv) Demonstrate staff knowledge of emergency procedures.
- *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following:
- (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles.
 - (ii) Provide emergency preparedness training at least annually.
 - (iii) Maintain documentation of the training.
 - (iv) Demonstrate staff knowledge of emergency procedures.

E 037 AFFECTED RESIDENTS:
All Residents, Staff and Visitors have the potential to be affected by this citation.

4/17/18

CORRECTIVE ACTION:
The Facility began Disaster Training on 04/03/2018 and 04/04/2018 for existing staff. New staff will be trained and tested upon hire at orientation. On-going trainings will be held quarterly.

SYSTEMATIC CHANGES:
Maintenance Supervisor will Monitor effectiveness of staff Training through disaster drills and documented staff responses. Training needs will be updated accordingly and the training will be offered quarterly.

MONITORING:
Outcomes of disaster drills will be reviewed by the IDT at QAPI X 3 months and additional training will be offered as necessary.

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E 037	Continued From page 15 *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least annually. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at	E 037	

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least annually.
(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.
(iv) Maintain documentation of all training.

*[For CORFs at §485.68(d):] (1) Training. The CORF must do all of the following:
(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.

*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:
(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least annually.

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E 037 Continued From page 17 E 037

- (iii) Maintain documentation of the training.
- (iv) Demonstrate staff knowledge of emergency procedures.

*(For CMHCs at §485.920(d):) (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually.

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, it was determined the facility failed to provide an emergency prep training program. Lack of a training program on the emergency preparedness plan and policies for the facility, has the potential to hinder staff response during a disaster. This deficient practice affected 61 residents, staff and visitors on the date of the survey.

Findings include:

On 3/13/18 from 2:00 - 2:30 PM, review of provided emergency plan, policy and procedures, revealed no substantiating documentation demonstrating the facility had a training program for staff based on the plan.

Interview of 4 of 4 staff members on 3/13/18 from 10:00 AM - 2:00 PM revealed no specific training was conducted on the emergency plan or its contents.

Reference:

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E 037 Continued From page 18
42 CFR 483.73 (d) (1)

Additional Reference:
E-0036

E 039 EP Testing Requirements
SS=F CFR(s): 483.73(d)(2)

(2) Testing. The [facility, except for LTC facilities, RNHCs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCs and OPOs] must do all of the following:

*[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:]

(i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event.

(ii) Conduct an additional exercise that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or individual, facility-based.

(B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

E 037

E 039 AFFECTED RESIDENTS: 4/17/18
This deficient practice had the potential to affect 61 Residents, Staff and Visitors on the date of survey.

CORRECTIVE ACTION:
On or before 04/17/2018, the facility will Participate in a facility-based, full-scale Exercise as a community based exercise Is not available prior to compliance date. On 04/12/2018, the facility Maintenance Supervisor and Corporate Compliance Director will attend the Bonner County Disaster Planning Committee meeting to collaborate with Agencies within our area to plan for Participation in the next scheduled Community based event.

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(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 prepared questions designed to challenge an emergency plan.

(ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.

This REQUIREMENT is not met as evidenced by:

Based on record review, 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 61 residents, staff and visitors on the date of the survey.

Findings include:

On 3/13/18 from 2:00 - 2:30 PM, review of provided emergency plan documents, documentation revealed the facility had participated in 1 of 2 required full-scale exercises

E 039 SYSTEMATIC CHANGES:

The facility Maintenance Supervisor and/or Administrator (or designees) will continue participation in County and Regional Coalition meetings to increase coordination of services and participation in community based disaster Planning. The facility will hold a minimum of One tabletop exercise and one full-scale Community-based and/or individual facility based full-scale exercise to test the validity of our Emergency Preparedness Plan. Documentation of the outcomes of each exercise will be maintained by the Maintenance Supervisor and additional education provided as needed based on the findings.

MONITORING

The Administrator and/or designee will monitor the effectiveness of the Emergency Preparedness Plan and training through review and evaluation of each exercise. The administrator will also monitor the facility's participation in community and regional planning meetings and progress toward event planning. These findings will be shared monthly X3 months at the facility's QAPI meetings. At the conclusion of three months, the QAPI committee will determine the need for, and frequency of ongoing monitoring, based on the outcome of the disaster drills.

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E 039 Continued From page 20 of the emergency preparedness policies and procedures.

E 039

Reference:

42 CFR 483.73 (d) (1)

E 041 Hospital CAH and LTC Emergency Power SS=F CFR(s): 483.73(e)

E 041

AFFECTED RESIDENTS:
All Residents, Staff and Visitors have the potential to be affected by this citation.

4/17/18

(e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section.

CORRECTIVE ACTION:
Maintenance Supervisor Performed the Monthly generator Load test on 03/21/3018 and documented the findings.

§483.73(e), §485.625(e)

(e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section.

SYSTEMATIC CHANGES:
On 03/30/2018 the NHA and Corporate Compliance Director provided education to the Maintenance Department on the regulation for weekly and monthly testing for emergency generators. Maintenance department was Provided with weekly and monthly checklists.

§482.15(e)(1), §483.73(e)(1), §485.625(e)(1)
Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated.

MONITORING:
The NHA will perform weekly audits X 4 weeks and monthly x 3 to ensure on-going compliance with the monthly load testing and documentation.

482.15(e)(2), §483.73(e)(2), §485.625(e)(2)
Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and maintenance requirements found in the

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135055	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/13/2018
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NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF SANDPOINT	STREET ADDRESS, CITY, STATE, ZIP CODE 220 SOUTH DIVISION SANDPOINT, ID 83864
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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E 041	Continued From page 21 Health Care Facilities Code, NFPA 110, and Life Safety Code.	E 041		
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482.15(e)(3), §483.73(e)(3), §485.625(e)(3)
Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates.

*[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):]

The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to:

http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes.

(1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org. 1.617.770.3000.

(i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011.

(ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011.

(iii) TIA 12-3 to NFPA 99, issued August 9, 2012.

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

Printed: 03/22/2018
FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF SANDPOINT		STREET ADDRESS, CITY, STATE, ZIP CODE 220 SOUTH DIVISION SANDPOINT, ID 83864	

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E 041	<p>Continued From page 22</p> <p>(iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009. This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to ensure the emergency and standby power systems were maintained and provided subsistence as required under the rule. Failure to ensure emergency generators are maintained and tested in accordance with NFPA 99 and NFPA 110, hinders the facility ability to provide continuity of care during an emergency to the 61 residents housed in the facility on the date of the survey.</p> <p>Findings include:</p> <p>During review of the facility maintenance and inspection records and facility emergency plan, policies and procedures on 3/13/18 from 2:00 - 2:30 PM, records provided for the emergency generators revealed missing documentation for monthly load testing in accordance with NFPA 110 (Reference K-918 on CMS 2567).</p> <p>Reference:</p>	E 041		

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E 041	Continued From page 23 42 CFR 483.73 (e) (1)	E 041		
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