



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

April 4, 2018

Lori Bentzler, Administrator  
Twin Falls Center  
674 Eastland Drive  
Twin Falls, ID 83301-6846

Provider #: 135104

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

Dear Ms. Bentzler:

On **March 27, 2018**, a Facility Fire Safety and Construction survey was conducted at **Twin Falls Center** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

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

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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 17, 2018**. Failure to submit an acceptable PoC by **April 17, 2018**, may result in the imposition of civil monetary penalties by **May 7, 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 **May 1, 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 **May 1, 2018**. A change in the seriousness of the deficiencies on **May 1, 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 **May 1, 2018**, includes the following:

Denial of payment for new admissions effective **June 27, 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 27, 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 27, 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:

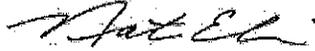
BFS Letters (06/30/11)

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

This request must be received by **April 17, 2018**. If your request for informal dispute resolution is received after **April 17, 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: 04/03/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135104</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING <b>RECEIVED</b> <b>APR 13 2018</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/27/2018</b>
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NAME OF PROVIDER OR SUPPLIER <b>TWIN FALLS CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>674 EASTLAND DRIVE FACILITY STANDARDS TWIN FALLS, ID 83301</b>
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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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K 000	<p><b>INITIAL COMMENTS</b></p> <p>The facility is a single story Type V(111) structure, comprised of six (6) smoke compartments, built in 1987. The building is protected throughout by an automatic fire extinguishing system with a fire alarm/smoke detection system installed throughout. The facility is equipped with an essential electrical system, comprised of a natural gas generator with automatic transfer. The facility is currently licensed for 116 SNF/NF beds with a census of 60 on the date of the survey.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on March 26 and 27, 2018. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.</p> <p>The Survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p> <p>K 100 SS=F 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: Based on record review, the facility failed to demonstrate implementation of a water management program for waterborne pathogens</p>	K 000	<p>“This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Genesis HealthCare Twin Falls Center, does not admit that the deficiencies listed on this form exists, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiencies. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiencies, statements, facts, and conclusions that form the basis for the deficiencies.”</p> <p><b><u>K100</u></b></p> <p><b><u>Specific Residents Identified</u></b></p> <p>The facility water management plan was reviewed and revised to accurately reflect the risk assessment and identified control measure by the Infection Control Preventionist, the Maintenance Supervisor and the Center Executive Director on or before 4/30/18. This included adding two decorative fountains and the fire suppression system to the plan, the risk for three applicable locations was revised to accurately reflect the risk for each location, controlled sources of emergency water were reviewed</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Jon Bentler</i>	TITLE <i>Center Executive Director</i>	(X6) DATE <i>4/12/18</i>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 100	<p>Continued From page 1</p> <p>such as Legionella, in accordance with 42 CFR 483.80. Failure to conduct a facility based risk assessment or defined, applicable control measures, has the potential to limit relevant facility awareness and expose residents to Legionella and other water source bacterium based on inconclusive data. This deficient practice affected 60 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During review of provided water management documentation conducted on 3/26/18 from approximately 8:30 - 10:00 AM, documentation failed to demonstrate implementation of a water management plan for the transmission of waterborne pathogens such as Legionella that included a risk assessment and identified control measures as determined by evaluation of the system.</p> <p>Further review of the provided water management plan for the control of waterborne pathogens such as Legionella revealed the following:</p> <p>The risk assessment did not identify two (2) decorative fountains. The risk assessment did not address the fire suppression system. The identified "risk" for three applicable locations in the system was "constantly wet". Controlled sources of emergency water were identified on the risk assessment that were not part of the complex water system (bottled water and water from a vendor for emergency usage). The risk assessment was not in alignment with the described water system for the facility. Control measures were not identified for stored</p>	K 100	<p>and the water management plan accurately reflects the risk and control measures for all items in the plan. The risk assessment and control measures were reviewed and accurately updated for all parts of the facility water system, stored water, point of use and inactive systems.</p> <p><b><u>Identification of Other Residents</u></b></p> <p>The facility water management plan was reviewed and revised to accurately reflect the risk assessment and identified control measure by the Infection Control Preventionist, the Maintenance Supervisor and the Center Executive Director on or before 4/30/18. This included adding two decorative fountains and the fire suppression system to the plan, the risk for three applicable locations was revised to accurately reflect the risk for each location, controlled sources of emergency water were reviewed and the water management plan accurately reflects the risk and control measures for all items in the plan. The risk assessment and control measures were reviewed and accurately updated for all parts of the facility water system, stored water, point of use and inactive systems.</p>

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K 100 Continued From page 2  
water systems, point of use, or inactive systems as applicable.

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 291 Emergency Lighting  
SS=D CFR(s): NFPA 101

Emergency Lighting  
Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9.18.2.9.1, 19.2.9.1  
This REQUIREMENT is not met as evidenced by:  
Based on record review and observation, the facility failed to provide emergency lighting in accordance with NFPA 101. Failure to provide emergency lighting for doors equipped with delayed egress potentially hinders identification of exits affecting resident 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 March 27, 2018 from 1:00 - 3:00 PM, observation of the exit door in the rear service corridor, revealed the exit door was equipped with a Wanderguard system

K 100 **Systematic Changes**

The Maintenance Supervisor was educated on or before 4/30/18 by the Center Executive Director regarding the requirement that the facility water management plan must include an accurate risk assessment and accurate evaluation of the identified control measures of all potential sources of Legionella and other water source bacterium.

K 291 **Monitoring**

Starting the week of 5/1/18, the Maintenance Supervisor or designee will complete a review/audit of the facility water management plan and implementation of control measures per the water management plan weekly x 4 weeks and then monthly for two months to ensure that it includes an accurate risk assessment, an accurate evaluation of the identified control measures of all potential sources of Legionella and other water source bacterium and that control measures are implemented per the water management plan. Audits will be reviewed by the Safety Committee monthly for compliance. A report will be submitted to the Performance

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K 291	<p>Continued From page 3</p> <p>and delayed egress component for the magnetic locking arrangements. Further observation established the facility was not providing battery backup emergency lighting for this exit.</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	<p>Improvement Committee monthly for three months. The Maintenance Supervisor is responsible for monitoring and follow up.</p> <p><b><u>Date of Compliance</u></b></p> <p>4/30/18</p> <p><b><u>K291</u></b></p> <p><b><u>Specific Residents Identified</u></b></p> <p>A battery backup emergency light was purchased and put in place at the exit door in the rear service corridor with a delayed egress/Wander Guard system by the Maintenance Supervisor on or before 4/30/18.</p> <p><b><u>Identification of Other Residents</u></b></p> <p>Any additional doors in the facility that are equipped with a delayed egress/Wander guard system have been inspected by the Maintenance Supervisor on or before 4/30/18 to ensure that they have a battery backup emergency light. Any findings were corrected.</p>
K 325 SS=F	<p>Alcohol Based Hand Rub Dispenser (ABHR) CFR(s): NFPA 101</p> <p>Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1,</p>	K 325	

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K 325 Continued From page 4  
unless all conditions are met:  
\* Corridor is at least 6 feet wide  
\* Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols  
\* Dispensers shall have a minimum of 4-foot horizontal spacing  
\* Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room  
\* Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30  
\* Dispensers are not installed within 1 inch of an ignition source  
\* Dispensers over carpeted floors are in sprinklered smoke compartments  
\* ABHR does not exceed 95 percent alcohol  
\* Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11)  
\* ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485  
This REQUIREMENT is not met as evidenced by:  
Based on record review, observation and 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 60 residents, staff and visitors on the date of the survey.

Findings include:

- 1) During review of facility maintenance and

K 325

**Systematic Changes**

The Maintenance Supervisor was educated on or before 4/30/18 by the Center Executive Director regarding the requirement that doors that are equipped with a delayed egress/Wander guard system are required to have a battery backup emergency light.

**Monitoring**

Starting the week of 5/1/18, environmental rounds will be completed weekly x 4 weeks and then monthly for 2 months by the Maintenance Supervisor or designee to ensure that the battery operated backup emergency lighting is in place and working properly at the doors with a delayed egress/Wander Guard systems. Audits will be reviewed monthly for three months by the Safety Committee for compliance. A report will be submitted to the Performance Improvement Committee monthly for three months. The Maintenance Supervisor is responsible for monitoring and follow up.

**Date of Compliance**

4/30/18

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K 325	<p>Continued From page 5</p> <p>inspection records conducted on 3/26/18 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 Maintenance Director revealed he was only documenting the date a refill was replaced and was not aware he needed to document any testing performed during the refill process.</p> <p>2) During the facility tour conducted on 3/27/18 from 9:00 AM - 2:00 PM, observation of installed ABHR dispensers revealed manually activated dispensers had been installed throughout the facility, along with three (3) automatically activated dispensers.</p> <p>Actual NFPA standard: 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</p>	K 325	<p><b><u>K325</u></b></p> <p><b><u>Specific Residents Identified</u></b></p> <p>The alcohol based hand rub dispensers in the facility were inspected and tested based on the manufacturer's recommendations and NFPA guidelines by the Maintenance Supervisor or designee on or before 4/30/18. The inspections and testing were documented as required.</p> <p><b><u>Identification of Other Residents</u></b></p> <p>The alcohol based hand rub dispensers in the facility were inspected and tested based on the manufacturer's recommendations and NFPA guidelines by the Maintenance Supervisor or designee on or before 4/30/18. The inspections and testing were documented as required.</p>

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K 325	<p>Continued From page 6</p> <p>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.</p> <p>(4) Dispensers shall be separated from each other by horizontal spacing of not less than 48 in. (1220 mm).</p> <p>(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).</p> <p>(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).</p> <p>(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.</p> <p>(8) Dispensers shall not be installed in the following locations:</p> <p>(a) Above an ignition source within a 1 in. (25 mm) horizontal distance from each side of the ignition source</p> <p>(b) To the side of an ignition source within a 1 in. (25mm) horizontal distance from the ignition source</p> <p>(c) Beneath an ignition source within a 1 in. (25 mm) vertical distance from the ignition source</p> <p>(9) Dispensers installed directly over carpeted floors shall be permitted only in sprinklered smoke compartments.</p> <p>(10) The alcohol-based hand-rub solution shall not exceed 95 percent alcohol content by volume.</p> <p>(11) Operation of the dispenser shall comply with</p>	K 325	<p><b><u>Systematic Changes</u></b></p> <p>The Maintenance Supervisor was educated by the Center Executive Director on or before 4/30/18 on the NFPA and manufacturer's requirements for testing the ABHR dispensers when they are refilled and documentation requirements when the ABHR dispensers are refilled.</p> <p><b><u>Monitoring</u></b></p> <p>Starting the week of 5/1/18, audits of the ABHR refill/testing logs will be completed weekly x 4 weeks and then monthly for two months by the Center Executive Director to ensure that refill requirements including testing are being completed as required. Audits will be reviewed monthly by the Safety Committee for compliance. A report will be submitted to the Performance Improvement Committee monthly for three months. The Maintenance Supervisor is responsible for monitoring and follow up.</p> <p><b><u>Date of Compliance</u></b></p> <p>4/30/18</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135104</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/27/2018</b>
NAME OF PROVIDER OR SUPPLIER <b>TWIN FALLS CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>674 EASTLAND DRIVE TWIN FALLS, ID 83301</b>		
(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 325	Continued From page 7 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 _____ Provide in REMARKS information on coverage	K 353	<b><u>K353</u></b>  <b><u>Specific Residents Identified</u></b>  The dry system gauges were inspected by the Maintenance Supervisor or designee on or before 4/30/18. Additional pendants for the sprinkler system were purchased by the facility from Delta Fire Systems on or before 4/30/18 to ensure that there are at least 24 spare pendants for the sprinkler system in the facility.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135104</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/27/2018</b>
NAME OF PROVIDER OR SUPPLIER <b>TWIN FALLS CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>674 EASTLAND DRIVE TWIN FALLS, ID 83301</b>	
(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)
K 353	<p>Continued From page 8 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 60 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 3/26/18 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 Supervisor revealed he was not aware of this requirement.</p> <p>2) During the facility tour conducted on 3/27/18 from 1:00 - 3:00 PM, observation of the spare sprinkler pendants at the main riser revealed only ten (10) spare pendants. Subsequent review of facility sprinkler plans on file revealed the facility is equipped with 1,098 installed sprinklers.</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 systems shall be inspected weekly to ensure that</p>	K 353	<p><b><u>Identification of Other Residents</u></b></p> <p>The dry system gauges were inspected by the Maintenance Supervisor or designee on or before 4/30/18. Any findings were corrected. The Maintenance Supervisor has a copy of this inspection. Additional pendants for the sprinkler system were purchased by the facility from Delta Fire Systems on or before 4/30/18 to ensure that there are at least 24 spare pendants for the sprinkler system in the facility.</p> <p><b><u>Systematic Changes</u></b></p> <p>The Maintenance Supervisor was educated on or before 4/30/18 by the Center Executive Director regarding the requirement that the gauges on the dry system need to be inspected weekly and the required number of spare pendants for the sprinkler system that need to be kept in the facility.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135104</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/27/2018</b>
NAME OF PROVIDER OR SUPPLIER <b>TWIN FALLS CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>674 EASTLAND DRIVE TWIN FALLS, ID 83301</b>	
(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)
K 353	Continued From page 9 normal air and water pressures are being maintained.  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	K 353	<p><b><u>Monitoring</u></b></p> <p>Starting the week of 5/1/18, inspections of the gauges on the dry system will be completed weekly by the Maintenance Supervisor or designee. Audits of the inspections will be completed weekly for 4 weeks and then monthly for 2 months by the Maintenance Supervisor or designee to ensure that the inspections were completed and any findings addressed.</p> <p>Starting the week of 5/1/18, audits will be completed weekly x 4 weeks and monthly for 2 months by the Maintenance Supervisor or designee to ensure that the required number of spare pendants are kept in the facility.</p> <p>Audits will be reviewed monthly for three months by the Safety Committee for compliance. A report will be submitted to the Performance Improvement Committee monthly for three months. The Maintenance Supervisor is responsible for monitoring and follow up.</p> <p><b><u>Date of Compliance</u></b></p> <p>4/30/18</p>