



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 208-334-5826
FAX 208-364-1888

April 4, 2018

Corwin Lewis, Jr., Administrator
Parke View Rehabilitation & Care Center
2303 Parke Avenue
Burley, ID 83318-2106

Provider #: 135068

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Mr. Lewis, Jr.:

On **March 28, 2018**, a Facility Fire Safety and Construction survey was conducted at **Parke View Rehabilitation & Care Center** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. Please provide **ONLY ONE completion date** for each federal and state tag in column (X5) Completion Date to signify when you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator

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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 **April 27, 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 **June 21, 2018**. A change in the seriousness of the deficiencies on **May 7, 2018**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **June 23, 2018**, includes the following:

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Denial of payment for new admissions effective **June 23, 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 23, 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 28, 2018**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

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

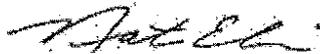
BFS Letters (06/30/11)

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

APR 06 2018

Printed: 04/04/2018
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135068	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 03/28/2018
NAME OF PROVIDER OR SUPPLIER PARKE VIEW REHABILITATION & CARE CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 2303 PARKE AVENUE BURLEY, ID 83318		
(X4) ID PREFIX TAG K 000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG K 000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>INITIAL COMMENTS</p> <p>The facility is a single story, protected non-combustible building originally constructed in 1983. A new addition was completed in 1998, with cosmetic upgrades to the lobby and administration offices completed in 2015. The facility is fully sprinklered with interconnected smoke/fire alarm system. There is a partial basement with storage, classrooms and maintenance shop and is equipped with an emergency generator. Currently, the facility is licensed for 86 SNF/NF beds with a census of 67 on the date of the survey.</p> <p>The following deficiencies were cited during the annual Fire/Life Safety survey conducted on March 28, 2018. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy and 42 CFR 483.70.</p> <p>The survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction</p>		<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Parke View Rehabilitation & Care Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.</p> <p style="text-align: center;">RECEIVED APR 17 2018 FACILITY STANDARDS</p>	
K 100 SS=F	<p>General Requirements - Other CFR(s): NFPA 101</p> <p>General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, the facility failed to demonstrate implementation of a water management program for waterborne pathogens</p>	K 100	<p>1. The water management program was updated to include the water fountain, the fire suppression system, and the boiler. Control measures were also added</p> <p>2. All residents have potential to be impacted by this practice.</p> <p>3. Inservice to be provided regarding the water management program risk assessment and control measures.</p> <p>4. At the annual review of the water management program, a checklist will be used to monitor risk assessment and control measures.</p>	5/3/18 5/1/18 W/Bombardier

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE ADMINISTRATOR (X6) DATE 4/24/18

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

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K 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 67 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 3/28/18 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 the inside fountain located in the atrium. The risk assessment did not address the fire suppression system. The risk assessment did not identify the installed boiler.</p> <p>The risk assessment was not in alignment with the described water system for the facility. Control measures were not identified for stored water systems, point of use, or inactive systems as applicable.</p>	K 100		

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K 100	Continued From page 2 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		
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9.18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on record review and 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 67 residents, staff and visitors on the date of the survey. Findings include: During the facility tour conducted on March 28, 2018 from 10:00 AM - 3:00 PM, observation of the facility exit doors, revealed 7 of 7 exit doors documented throughout the facility were equipped with Wanderguard and a delayed egress component for the magnetic locking	K 291	1. Emergency lighting installed at delayed egress doors. 2. All residents have potential to be impacted by this practice. 3. Inservice to be provided to maintenance staff that emergency lighting must be at delayed egress doors. 4. Administrator or designee will conduct an audit of all delayed egress doors that will be done with the annual 90 minute emergency lighting test.	5/3/18 5/1/18 837 w/now

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K 291	Continued From page 3 arrangements. Further observation established the facility was not providing battery backup emergency lighting for these exits. Actual NFPA standard: 19.2.9 Emergency Lighting. 19.2.9.1 Emergency lighting shall be provided in accordance with Section 7.9. 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: (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.	K 291		
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in	K 521	1. Fire dampers to be tested 2. All residents have potential to be impacted by this practice. 3. Fire dampers to be added to schedule of equipment testing (Continued)	5/3/18 5/1/18 85 WITH ADMIN

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K 521	<p>Continued From page 4 accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure HVAC (Heating Vacuum and Air Conditioning) systems were maintained in accordance with NFPA 101. Failure to maintain HVAC fire dampers has the potential to allow fires and dangerous gases the ability to communicate between smoke compartments. This deficient practice affected 67 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During review of facility maintenance and inspection records conducted on 3/28/18 from 8:30 - 10:00 AM, No records were available for the testing of installed fire dampers.</p> <p>Interview of the Environmental Services Director revealed the facility HVAC system was equipped with fire dampers, but she was not aware of the requirement to test these, or the last time the testing had been conducted.</p> <p>Actual NFPA standard:</p> <p>19.5.2 Heating, Ventilating, and Air-Conditioning.</p> <p>19.5.2.1 Heating, ventilating, and air-conditioning shall comply with the provisions of Section 9.2 and shall be installed in accordance with the manufacturer's specifications, unless otherwise</p>	K 521	4. Fire damper testing is to be done every 4 years. TELS recurring task initiated to schedule inspection within 4 years of previous inspection.	

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K 521	<p>Continued From page 5 modified by 19.5.2.2.</p> <p>19.5.2.2* Any heating device, other than a central heating plant, shall be designed and installed so that combustible material cannot be ignited by the device or its appurtenances, and the following requirements also shall apply: (1) If fuel-fired, such heating devices shall comply with the following: (a) They shall be chimney connected or vent connected. (b) They shall take air for combustion directly from the outside. (c) They shall be designed and installed to provide for complete separation of the combustion system from the atmosphere of the occupied area. (2) Any heating device shall have safety features to immediately stop the flow of fuel and shut down the equipment in case of either excessive temperature or ignition failure.</p> <p>9.2 Heating, Ventilating, and Air-Conditioning. 9.2.1 Air-Conditioning, Heating, Ventilating Ductwork, and Related Equipment. Air-conditioning, heating, ventilating ductwork, and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems, or NFPA 90B, Standard for the Installation of Warm Air Heating and Air-Conditioning Systems, as applicable, unless such installations are approved existing installations, which shall be permitted to be continued in service.</p> <p>NFPA 90A 4.3.9 Fire Dampers. 4.3.9.1 Approved fire dampers shall be provided as required in Chapter 5.</p>	K 521		

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K 521	Continued From page 6 5.4.8 Maintenance. 5.4.8.1 Fire dampers and ceiling dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80 Chapter 19 Installation, Testing, and Maintenance of Fire Dampers 19.4* Periodic Inspection and Testing. 19.4.1 Each damper shall be tested and inspected 1 year after installation. 19.4.1.1 The test and inspection frequency shall then be every 4 years, except in hospitals, where the frequency shall be every 6 years.	K 521		
K 926 SS=E	Gas Equipment - Qualifications and Training CFR(s): NFPA 101 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on record review, and interview, the facility failed to ensure continuing education and staff training was provided on the risks associated with the storage, handling and use of medical gases and their cylinders. Failure to provide training of safety and the risks associated with medical gases, potentially increases risks associated and	K 926	1. Inservice for staff involved with application, maintenance, and handling of medical gases to be provided on risks associated with the storage, handling and use of medical gases and their cylinders. 2. All residents have potential to be impacted by this practice. 3. Annual Inservice on medical gas safety to be changed to include risks associated with the storage, handling and use of medical gases in their cylinders. 4. Administrator or designee will audit that staff involved with application, maintenance, and handling of medical gases has been completed.	5/1/18

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K 926	<p>Continued From page 7</p> <p>hinders staff response with the use and handling of oxygen. This deficient practice potentially affected oxygen dependent residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During review of provided training records on 3/28/18 from 8:30 - 10:00 AM, no records were provided for annual oxygen training. Interview of 3 of 3 staff members on 3/28/18 from 10:00 - 11:30 AM, revealed none had participated in any continuing education program on the risks associated with the storage, handling or use of medical gases.</p> <p>Actual NFPA standard:</p> <p>NFPA 99 11.5.2 Gases in Cylinders and Liquefied Gases In Containers. 11.5.2.1 Qualification and Training of Personnel. 11.5.2.1.1* Personnel concerned with the application and maintenance of medical gases and others who handle medical gases and the cylinders that contain the medical gases shall be trained on the risks associated with their handling and use. 11.5.2.1.2 Health care facilities shall provide programs of continuing education for their personnel. 11.5.2.1.3 Continuing education programs shall include periodic review of safety guidelines and usage requirements for medical gases and their cylinders.</p>	K 926		

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APR 06 2018

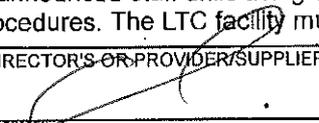
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E 000	Initial Comments The facility is a single story, protected non-combustible building originally constructed in 1963, with a subsequent addition completed in 1998, along with cosmetic upgrades to the lobby and administration offices completed in 2015. It is fully sprinklered with an interconnected fire alarm/smoke detection system. The building has a partial basement with storage, classrooms and maintenance shop. The facility is equipped with an emergency generator and is located in a municipal fire district. The facility is currently licensed for 86 SNF/NF beds and had a census of 67 on the day of the survey. The following deficiencies were cited during the Emergency Preparedness survey conducted on March 28, 2018. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73. The survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction	E 000	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Parke View Rehabilitation & Care Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency. RECEIVED APR 17 2018 FACILITY STANDARDS	
E 039 SS=F	EP Testing Requirements 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	E 039	1. A community-based exercise has been planned for 4/30/18 with the District 5 Healthcare Coalition and a Tabletop exercise for 4/27/18. 2. All residents have potential to be impacted by this practice. 3. Inservice to be provided regarding documentation requirements and what qualifies for emergency plan exercises. 4. At the annual review of the emergency plan, a checklist will be used to monitor exercises completion.	5/3/18 5/17/18 83 (with Annex)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE ADMINISTRATOR	(X8) DATE 4/16/18
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

Printed: 04/04/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/28/2018
NAME OF PROVIDER OR SUPPLIER PARKE VIEW REHABILITATION & CARE CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 2303 PARKE AVENUE BURLEY, ID 83318		
(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 039	Continued From page 1 following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response	E 039		

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E 039	<p>Continued From page 2</p> <p>to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHC]'s and OPO's] emergency plan, as needed.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>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 67 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>On 3/28/18 from 8:30 - 10:30 AM, review of provided emergency plan documents, documentation revealed the facility failed to document required full-scale exercises of the emergency preparedness policies and procedures.</p> <p>Reference:</p> <p>42 CFR 483.73 (d) (1)</p>	E 039		