



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSSELL S. BARRON – Director

TAMARA PRISOCK – ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
OEBRA 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 24, 2018

Darrin Radeke, Administrator
Mini-Cassia Care Center
PO Box 1224
Burley, ID 83318

Provider #: 135081

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

Dear Mr. Radeke:

On **April 17, 2018**, a Facility Fire Safety and Construction survey was conducted at **Mini-Cassia Care Center** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. Please provide **ONLY ONE**

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completion date for each federal and state tag in column (X5) Completion Date to signify when you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office. If a State Form with deficiencies was issued, it should be signed, dated and returned along with the CMS-2567 Form.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **May 7, 2018**. Failure to submit an acceptable PoC by **May 7, 2018**, may result in the imposition of civil monetary penalties by **May 27, 2018**.

Your PoC must contain the following:

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

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

Remedies may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **May 22, 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 22, 2018**. A change in the seriousness of the deficiencies on **May 22, 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 22, 2018**, includes the following:

Denial of payment for new admissions effective **July 17, 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 **October 17, 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 **April 17, 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:

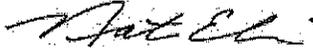
BFS Letters (06/30/11)

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

This request must be received by **May 7, 2018**. If your request for informal dispute resolution is received after **May 7, 2018**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



Nate Elkins, Supervisor
Facility Fire Safety and Construction

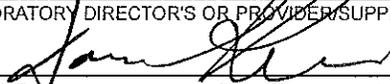
NE/lj
Enclosures

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|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135081 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE BLDG-BEHAVIOR CARE UNIT B. WING _____ | (X3) DATE SURVEY COMPLETED 04/17/2018 |
|--|--|--|--|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER MINI-CASSIA CARE CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 1729 MILLER 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 |
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|---------------|--|-------|---|-------|
| K 000 | INITIAL COMMENTS The facility is a single-story type V (000) building built in 1974, with controlled access for clinical need. The building is protected by fire alarm/smoke detection and is fully sprinklered. There is a partial basement that houses the laundry, maintenance shop, break room, central supply, and miscellaneous offices. The facility completed cosmetic upgrades to the floors and walls in 2001. It is currently licensed for 68 SNF/NF beds, and had a census of 51 on the dates of the survey. The following deficiencies were cited at the above facility during the annual fire/life safety code survey conducted on April 16 - 17, 2018. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Chapter 19, Existing Healthcare Occupancies, in accordance with 42 CFR 483.70, 42 CFR 483.80 and 42 CFR 483.65. The survey was conducted by: Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction | K 000 | <p style="text-align: center;">RECEIVED</p> <p style="text-align: center;">MAY - 8 2018</p> <p style="text-align: center;">FACILITY STANDARDS</p> | |
| K 100 SS=F | General Requirements - Other CFR(s): NFPA 101 General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by: | K 100 | | K 100 |

| | | |
|---|------------------------|---------------------|
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  | TITLE ADMINISTRATOR | (X6) DATE 5/7/18 |
|---|------------------------|---------------------|

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>Based on record review, and interview, the facility failed to develop and implement a water management plan. Failure to develop and implement a facility specific water management plan could increase risk of growth and spread of Legionella and other opportunistic pathogens in building water systems. This deficient practice could potentially affect 51 residents, staff and visitors on the dates of the survey.</p> <p>Findings include:</p> <p>During the review of facility records on April 16 -17, 2018, a water management plan, to include a facility risk assessment, control measures, and testing protocols could not be produced. When asked, the Administrator stated the facility had hired an outside contractor to develop the water management plan, but it was not complete.</p> <p>Actual Standard:</p> <p>42 CFR § 483.80 Infection control.</p> <p>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</p> <p>Additional Reference:</p> <p>Centers for Medicare/Medicaid Services S&C Letter 17-30.</p> | K 100 | <p>has been educated to the continual need for the water management plan and has assisted in the completion of the plan that was approved by the administrator on 5/3/18. Continued use of the plan will be monitored by the administrator and the findings will be brought to the quality assurance team for review Monthly X 2, then Quarterly X 1, then annually.</p> | |
| K 353 SS=D | <p>Sprinkler System - Maintenance and Testing CFR(s): NFPA 101</p> | K 353 | | |

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| K 353 | <p>Continued From page 2</p> <p>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.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</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 observation and interview, the facility failed to ensure fire suppression system pendants were maintained free of obstructions such as paint or corrosion. Failure to maintain fire sprinkler pendants free of obstructions could hinder system performance during a fire event. This deficient practice could potentially affect 31 residents in the North wing, staff and visitors on the dates of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on April 17, 2018, from approximately 10:30 AM to 1:00 PM, observation of the following areas revealed corroded sprinkler heads: 1.) Shower room between resident rooms #27 and #28 in the North Wing.</p> | K 353 | <p>K353</p> <p>The facility will ensure that the automated sprinkler system is inspected, tested and maintained by NFPA 25 standards this will be done by using a flashlight to inspect sprinkler heads for corrosion that may not be seen with the regular lighting in the room and the sprinkler heads will be exchanged in accordance with the requirements.</p> <p>Sprinkler heads in North shower room, basement laundry in front of dyers, and the basement mechanical room where the sump pump is located were replaced by Delta Fire Systems on 5/2/18. The facility maintenance manager will monitor sprinkler heads in sync with the regular schedule, using the flashlight to assist. The documentation will be brought to the quality assurance team for review Monthly X 2, then Quarterly X 1, then annually.</p> | 5/2/18 |

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| K 353 | Continued From page 3 2.) Basement Laundry in front of dryers. 3.) Basement Mechanical room where sump pump is located. When asked, the Maintenance Director stated the facility was not aware of the corroded heads. Actual NFPA standard: NFPA 25 5.2.1 Sprinklers. 5.2.1.1* Sprinklers shall be inspected from the floor level annually. 5.2.1.1.1* Sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., upright, pendent, or sidewall). 5.2.1.1.2 Any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical damage (4) Loss of fluid in the glass bulb heat responsive element (5)*Loading (6) Painting unless painted by the sprinkler manufacturer | K 353 | | | |
| K 355 SS=D | Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 | K 355 | K355 The facility will ensure that the portable fire extinguishers will be maintained in accordance with NFPA 10 standards. The facility maintenance manager has been educated to ensure, during his | 4/20/18 | |

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| K 355 | <p>Continued From page 4</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure portable fire extinguishers were maintained in accordance with NFPA 10. Failure to maintain fire extinguishers could result in reduced or failed performance in the event of a fire. This deficient practice could potentially affect staff and visitors on the dates of the survey.</p> <p>Findings include:</p> <p>During the facility tour on April 17, 2018, from approximately 10:30 AM to 1:00 PM, observation of the Class K fire extinguisher in the kitchen, and the ABC extinguisher outside of the laundry revealed both pressure gauge indicators were outside of the operable range. When asked, the Maintenance Director stated he was unaware pressure gauge indicators could not be in the red section above the green on the pressure gauge. He thought an overcharged extinguisher would still operate as intended.</p> <p>Actual NFPA standard:</p> <p>NFPA 101</p> <p>19.3.5.12 Portable fire extinguishers shall be provided in all health care occupancies in accordance with 9.7.4.1.</p> <p>9.7.4.1* Where required by the provisions of another section of this Code, portable fire extinguishers shall be selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers.</p> <p>NFPA 10</p> | K 355 | <p>monthly rounds, that all portable fire extinguishers are not only to be fully charged, but are not to be overcharged. The facility has also educated the contracting fire extinguisher company and the company recharged the deficient extinguishers on 4/20/18.</p> <p>The facility maintenance manager will complete the extinguisher checks on a monthly basis and the documentation will be brought to the quality assurance team for review Monthly X 2, then Quarterly X 1, then annually.</p> | |

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| K 355 | Continued From page 5 7.2 Inspection. 7.2.2 Procedures. Periodic inspection or electronic monitoring of fire extinguishers shall include a check of at least the following items: (1) Location in designated place (2) No obstruction to access or visibility (3) Pressure gauge reading or indicator in the operable range or position (4) Fullness determined by weighing or hefting for self-expelling type extinguishers, cartridge-operated extinguishers, and pump tanks (5) Condition of tires, wheels, carriage, hose, and nozzle for wheeled extinguishers (6) Indicator for non-rechargeable extinguishers using push-to-test pressure indicators 7.2.3 Corrective Action. When an inspection of any fire extinguisher reveals a deficiency in any of the conditions listed in 7.2.2, immediate corrective action shall be taken. 7.2.3.1 Rechargeable Fire Extinguishers. When an inspection of any rechargeable fire extinguisher reveals a deficiency in any of the conditions listed in 7.2.2(3) or 7.2.2(4), the extinguisher shall be subjected to applicable maintenance procedures. | K 355 | | | |
| K 911 SS=F | Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems 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. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced | K 911 | K911 The facility will ensure compliance with NFPA 99 standards by installing a remote emergency shutoff switch for the emergency generator. This was accomplished on 4/25/18 by Gietzen Electric, Inc.. The switch was in stalled and fully functional on that date. | 4/25/18 | |

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| K 911 | Continued From page 6 by: Based on observation and interview, the facility failed to ensure the Essential Electrical System (EES) generator was equipped with a remote manual stop station. Failure to provide a remote stop, potentially hinders the ability of staff to shut down the generator if required. This deficient practice could potentially affect 51 residents, staff and visitors on the date of the survey. Findings include: During the facility tour conducted on April 17, 2018 from approximately 10:30 AM to 1:00 PM, a remote manual stop station for the EES generator could not be located. When asked, both the Maintenance Director and the Administrator stated the facility generator was not equipped with a remote stop station. Actual NFPA standard: NFPA 99 6.4.1.1.16.2 Safety indications and shutdowns shall be in accordance with Table 6.4.1.1.16.2. (SEE TABLE) NFPA 110 5.6.5.6* All installations shall have a remote manual stop station of a type to prevent inadvertent or unintentional operation located outside the room housing the prime mover, where so installed, or elsewhere on the premises where the prime mover is located outside the building. 5.6.5.6.1 The remote manual stop station shall be labeled. | K 911 | The facility maintenance manager will test the operation on the appropriate schedule and the documentation will be brought to the quality assurance team for review Monthly X 2, then Quarterly X 1, then annually. | |