



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

May 14, 2018

Josh Smith, Administrator
Avamere Transitional Care & Rehab - Boise
1001 South Hilton Street
Boise, ID 83705-1925

Provider #: 135077

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

Dear Mr. Smith:

On **May 1, 2018**, a Facility Fire Safety and Construction survey was conducted at **Avamere Transitional Care & Rehab - Boise** 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

Josh Smith, Administrator
May 14, 2018
Page 2 of 4

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 28, 2018**. Failure to submit an acceptable PoC by **May 28, 2018**, may result in the imposition of civil monetary penalties by **June 16, 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 **June 5, 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 5, 2018**. A change in the seriousness of the deficiencies on **June 5, 2018**, may result in a change in the remedy.

Josh Smith, Administrator
May 14, 2018
Page 3 of 4

The remedy, which will be recommended if substantial compliance has not been achieved by **June 5, 2018**, includes the following:

Denial of payment for new admissions effective **August 1, 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 **November 1, 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 **May 1, 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:

Josh Smith, Administrator
May 14, 2018
Page 4 of 4

<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:

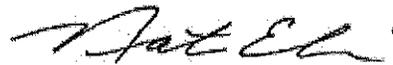
BFS Letters (06/30/11)

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

This request must be received by **May 28, 2018**. If your request for informal dispute resolution is received after **May 28, 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: 05/11/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135077	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/01/2018
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NAME OF PROVIDER OR SUPPLIER AVAMERE TRANSITIONAL CARE & REHAB - BOISE	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705
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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 000	Initial Comments The facility construction is Type V (111) and was built in 1978. It is fully sprinklered with a complete fire alarm/smoke detection system including smoke detection in sleeping rooms. The facility is currently licensed for 111 SNF/NF beds, and had a census of 68 on the dates of the survey. The following deficiencies were cited during the Emergency Preparedness Survey conducted on April 30 - May 1, 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: Linda Chaney Health Facility Surveyor Facility Fire Safety and Construction EP Training Program 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	E 000	1. Emergency Preparedness Program training provided to all staff with posttest completed to demonstrate understanding. 2. All residents, staff and visitors had the potential to be affected. Staff will not be permitted to work in facility after the date certain without passing posttest. New hires will receive this training at general orientation, and the training will be provided not less than 1x per year to ensure annual training is provided. 3. New hire general orientation updated to contain EP training information and posttest. EP training will be added to facility master training calendar no less than 1x annually. 4. 100% of current employees will receive EP training and pass posttest. Posttests will be audited against employee files to ensure all staff have received and passed training. EP training will be added to the new hire check list. Compliance with this plan of correction will be reviewed at next facility QAPI meeting and verified by Administrator or designee. 5. 5 June 2018	
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RECEIVED
MAY 25 2018
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Linda Chaney</i>	TITLE Administrator	(X6) DATE 5/25/2018
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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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NAME OF PROVIDER OR SUPPLIER AVAMERE TRANSITIONAL CARE & REHAB - BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705		
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E 037	Continued From page 1 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. *[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.	E 037			

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E 037	<p>Continued From page 2</p> <p>(ii) After initial training, provide emergency preparedness training at least annually.</p> <p>(iii) Demonstrate staff knowledge of emergency procedures.</p> <p>(iv) Maintain documentation of all emergency preparedness training.</p> <p>*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:</p> <p>(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.</p> <p>(ii) Provide emergency preparedness training at least annually.</p> <p>(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.</p> <p>(iv) Maintain documentation of all training.</p> <p>*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:</p> <p>(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.</p> <p>(ii) Provide emergency preparedness training at least annually.</p> <p>(iii) Maintain documentation of the training.</p> <p>(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</p>	E 037			

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E 037 Continued From page 3
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.
(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 implement an EP training program. Failure to implement training on the new EP plan, has the potential to hinder staff

E 037

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E 037	Continued From page 4 response during a disaster. This deficient practice affected 68 residents, staff and visitors on the dates of the survey. Findings include: On May 1, 2018, from 10:30 AM to 4:00 PM, review of the facility EP documentation revealed a written training plan, but there was no documentation that initial training for all new and existing staff, or individuals providing services under arrangement had taken place. Interview of the Administrator confirmed the facility had not implemented their training program for EP. Reference: 42 CFR 483.73 (d) (1)	E 037			
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 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	E 039	1. Facility participated in the Healthcare EEI/ WebEOC PHAR 2018 Statewide functional Exercise on 1 May 2018. 2. All residents, staff and visitors had the potential to be affected. Facility participated in the Healthcare EEI/ WebEOC PHAR 2018 Statewide functional Exercise on 1 May 2018. AAR conducted and findings utilized to analyze facilities EPP to modify identified growth areas for facility. Documentation will be provided to BFS to show the participation, analyzation and modification cycle has taken place.		

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E 039 Continued From page 5

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 RNHCs 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.

E 039

3. Facility has joined local health care emergency coalition and will participate in community wide as well as table top drills no less than annually. EP training will be added to the facility master training list calendar as the events are scheduled.
4. Training audits will be conducted and brought to QAPI committee no less than 2x annually and verified by Administrator or designee.
5. 5 June 2018

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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NAME OF PROVIDER OR SUPPLIER AVAMERE TRANSITIONAL CARE & REHAB - BOISE	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705
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E 039	<p>Continued From page 6</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, it was determined the facility failed to implement an EP testing program. Failure to test the EP plan, has the potential to hinder staff response during a disaster. This deficient practice affected 68 residents, staff and visitors on the dates of the survey.</p> <p>Findings include:</p> <p>Review of the facility EP plan on May 1, 2018, from 10:30 AM to 4:00 PM, revealed a written EP testing program, however, there was no documentation that specific testing, to include an annual exercise on the EP plan had been conducted. When asked, the Administrator stated the facility had not yet participated in a community-based full-scale exercise.</p> <p>Reference:</p> <p>42 CFR 483.73 (d) (2)</p>	E 039		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135077	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED 05/01/2018
NAME OF PROVIDER OR SUPPLIER AVAMERE TRANSITIONAL CARE & REHAB - BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705		
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K 000	INITIAL COMMENTS The facility construction is Type V (111) and was built in 1978. It is fully sprinklered with a complete fire alarm/smoke detection system including smoke detection in sleeping rooms. The facility is currently licensed for 111 SNF/NF beds, and had a census of 68 on the dates of the survey. The following deficiencies were cited during the annual fire/life safety survey conducted on April 30 - May 1, 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			
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: 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	K 100	1. Facility will implement a water management plan to mitigate potential of Legionella or other opportunistic pathogens in building water systems. 2. All residents, staff and visitors had the potential to be affected. Water management plan implemented in facility with specific controls designed to address facilities water system preventative maintenance, hazard mitigation and testing to mitigate potential of Legionella or other opportunistic pathogens in building water systems.		

RECEIVED
MAY 25 2018
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE 5/25/2018

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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NAME OF PROVIDER OR SUPPLIER AVAMERE TRANSITIONAL CARE & REHAB - BOISE	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705
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K 100

Continued From page 1
Legionella and other opportunistic pathogens in building water systems. This deficient practice could potentially affect 68 residents, staff and visitors on the dates of the survey.

Findings include:

During the review of facility records on April 30, 2018, from approximately 8:30 AM to 12:30 PM, a general document outlining the CMS water management program requirement was produced, but there was no facility specific documentation of a water management program. A facility risk assessment, with accompanying control measures, and testing protocols could not be produced. When asked, the Administrator stated the facility was still working on developing a facility specific water management plan.

Actual Standard:

42 CFR § 483.80 Infection control.

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.

Additional Reference:

Centers for Medicare/Medicaid Services S&C Letter 17-30.

K 161
SS=D

Building Construction Type and Height
CFR(s): NFPA 101

Building Construction Type and Height

K 100

3. Facility will conduct preventative maintenance of facility water systems to mitigate hazards of Legionella or other opportunistic pathogens in building water systems.
4. Implementation of water management system will be brought to QAPI committee to ensure that all systems and process are in place and occurring per schedule x3 months and verified by Administrator or designee.
5. 5 June 18

K 161

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

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FORM APPROVED
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NAME OF PROVIDER OR SUPPLIER AVAMERE TRANSITIONAL CARE & REHAB - BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705	
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K 161	Continued From page 2 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.	K 161	1. Penetration in wall of spa room repaired to remove smoke and fire hazard. 2. The deficient practice affected 4 residents, staff and visitors. It had the potential to affect any residents, staff or visitors located in the adjoining room of penetration. Penetration repaired to remove smoke and fire hazard. 3. Facility environment audit will be utilized to ensure that there are no other penetrations are present in facility. 4. Facility environment audit will be utilized 3x monthly and results will be brought to QAPI committee for review. Any deficiencies will be corrected when found. Results of audits will be verified by Administrator or designee. 5. 5 June 18	

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K 161	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the smoke and fire resistive properties of the structure were maintained. Failure to maintain the fire resistive properties of the structure by sealing penetrations in walls, could result in fire and smoke passing between compartments during a fire event. This deficient practice affected 4 residents, staff and visitors on the dates of the survey.</p> <p>Findings include:</p> <p>During the facility tour on April 30, 2018, from approximately 1:00 PM to 4:00 PM, observation revealed an approximately 4" x 1-3/4" penetration in the wall behind the tub in the 300 Hallway Shower Room. When asked, the Maintenance Director stated the facility was unaware of the penetration.</p> <p>Actual NFPA standard:</p> <p>19.1.6 Minimum Construction Requirements. 19.1.6.1 Health care occupancies shall be limited to the building construction types specified in Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7. (See 8.2.1.) 8.2 Construction and Compartmentation. 8.2.1 Construction. 8.2.1.1 Buildings or structures occupied or used in accordance with the individual occupancy chapters, Chapters 11 through 43, shall meet the minimum construction requirements of those chapters.</p>	K 161		
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101	K 211		

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

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K 211	<p>Continued From page 4</p> <p>Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure that means of egress were provided in accordance with NFPA 101. Failure to maintain means of egress free of obstructions has the potential to hinder evacuation of residents during an emergency. This deficient practice had the potential to affect 28 residents, staff and visitors in the 200 Hallway on the dates of the survey.</p> <p>Findings include: During the facility tour on April 30, 2018, from approximately 1:00 PM to 4:00 PM, observation revealed the gate from the courtyard to the public way was leaning over. Operational testing further revealed the gate was broken and required lifting to move it out of the way to exit. When asked, the Maintenance Director stated the gate was on a work order to be repaired.</p> <p>Actual NFPA standard: NFPA 101 19.2 Means of Egress Requirements. 19.2.1 General. Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7, unless</p>	K 211	<ol style="list-style-type: none"> 1. Facility will ensure that all means of egress are fully functional by affecting repair to gate so that it is operational and unimpeded. 2. The deficient practice had the potential to affect 28 residents, staff and visitors in the 200 hallway. The gate will be repaired and inspected to ensure that it can swing freely and unimpeded. 3. Facility environment audit will be utilized to ensure gate is in proper working order and any damages or issues will be remedied when identified. 4. Facility environment audit will be conducted monthly x3 and brought to the QAPI committee to ensure it is in proper working order. Results will be verified by Administrator or designee. 5. 5 June 18 		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 211	Continued From page 5 otherwise modified by 19.2.2 through 19.2.11. 7.1.10 Means of Egress Reliability. 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K 211	1. Identified hand sanitizers removed/relocated to mitigate fire hazard. 2. The deficient practice had the potential to affect all residents, staff and visitors.
K 325 SS=D	Alcohol Based Hand Rub Dispenser (ABHR) CFR(s): NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 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	K 325	a. New logs implemented to test for proper functioning on refill of the unit. b. Identified hand sanitizers removed/relocated to mitigate fire hazard. 3. Facility environment audit will be utilized to ensure that no ABHR dispensers are mounted about an ignition source in facility and any deficiencies will be corrected when identified. Inspection logs will be maintained and audited to ensure that ABHR units are inspected in accordance with manufactures guidelines. 4. Facility environment audit will be conducted monthly x3 and brought to QAPI committee to ensure no ABHR are mounted above ignition sources. Inspection logs will be brought to QAPI committee to ensure ABHR units are inspected in accordance with manufactures guidelines. 5. 5 June 18

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K 325	<p>Continued From page 6</p> <p>Interview, the facility failed to ensure Alcohol Based Hand Rub Dispensers (ABHR) were installed and maintained in accordance with NFPA 101. Failure to install, test and document the operation of ABHR dispensers in accordance with the manufacturer's care and use instructions could result in increased risk of fires. This deficient practice affected 68 residents, staff and visitors on the dates of the survey.</p> <p>Findings include:</p> <p>1.) During the review of facility records on April 30, 2018, from approximately 8:30 AM to 12:30 PM, no records were available indicating ABHR dispensers were tested in accordance with manufacturer's care and use instructions when a new refill is installed.</p> <p>2.) During the facility tour on April 30, 2018, from approximately 1:00 PM to 4:00 PM, observation of the ABHR dispenser in the Laundry room revealed it had been installed directly over an outlet. Additionally, in the office of the Director of Nursing, an ABHR dispenser had been installed directly over an in-wall light. When asked, the Maintenance Director stated the facility was not aware of the dispensers installed directly over electrical ignition sources or the requirement to test ABHR dispensers each time a new refill is installed.</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>	K 325			

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

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K 325	<p>Continued From page 7</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> <p>(3) Where aerosol containers are used, the maximum capacity of the aerosol dispenser shall be 18 oz. (0.51 kg) and shall be limited to Level 1 aerosols as defined in NFPA30B, Code for the 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</p>	K 325		

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K 325	Continued From page 8 in. (25 mm) horizontal distance from the Ignition source (c) Beneath an ignition source within a 1 in. (25 mm) vertical distance from the Ignition source (9) Dispensers installed directly over carpeted floors shall be permitted only in sprinklered smoke compartments. (10) The alcohol-based hand-rub solution shall not exceed 95 percent alcohol content by volume. (11) Operation of the dispenser shall comply with the following criteria: (a) The dispenser shall not release its contents 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 341 SS=D	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in	K 341			

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K 341	Continued From page 9 accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure fire alarm systems were installed and maintained in accordance with NFPA 72. Failure to install smoke detection in all areas of the building, could hinder system and staff response during a fire event. This deficient practice affected 26 residents, staff and visitors on the dates of the survey. Findings include: During review of facility inspection records on April 30, 2018, from approximately 8:30 AM to 12:30 PM, review of the annual inspection documents revealed missing smoke detection/notification devices in the laundry and maintenance shop. During the facility tour later that day, from approximately 1:00 PM to 4:00 PM, observation revealed the smoke detection /notification devices had been removed in both the laundry and maintenance shop. Interview of	K 341	1. Missing smoke detection/notification devices in laundry and maintenance shop installed and integrated into facility fire/smoke monitoring system. 2. The deficient practice affected 26 residents, staff and visitors. It had the potential to affect all residents, staff and visitors. Missing smoke detection/notification devices installed in identified areas. 3. Once installed, missing equipment will be inspected in accordance with facility smoke/fire monitoring system maintenance schedule. 4. Facility fire/smoke detection and monitoring systems records will be audited quarterly x1 year to ensure that all inspections are completed per regulatory schedule. Results will be brought to the QAPI committee and results verified by Administrator or designee. 5. 5 June 18	

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K 341	Continued From page 10 the Maintenance Director revealed the facility became aware the detection/notification devices had been removed when local jurisdiction identified the deficiency. Actual NFPA standard: NFPA 101 19.3.4 Detection, Alarm, and Communications Systems. 19.3.4.1 General. Health care occupancies shall be provided with a fire alarm system in accordance with Section 9.6. 9.6.1.3 A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm and Signaling Code, unless it is an approved existing installation, which shall be permitted to be continued in use. 9.6.1.7 For the purposes of this Code, a complete fire alarm system shall provide functions for initiation, notification, and control, which shall perform as follows: (1) The initiation function provides the input signal to the system. (2) The notification function is the means by which the system advises that human action is required in response to a particular condition. (3) The control function provides outputs to control building equipment to enhance protection of life. 9.6.2.9 Where a total (complete) coverage smoke detection system is required by another section of this Code, automatic detection of smoke in accordance with NFPA 72, National Fire Alarm and Signaling Code, shall be provided in all occupiable areas in environments that are suitable for proper smoke detector operation.	K 341			

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

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K 341	Continued From page 11 9.6.3.1 Occupant notification shall be provided to alert occupants of a fire or other emergency where required by other sections of this Code. NFPA 72 14.2.1.2.2 System defects and malfunctions shall be corrected. 14.2.1.2.3 If a defect or malfunction is not corrected at the conclusion of system inspection, testing, or maintenance, the system owner or the owner's designated representative shall be informed of the impairment in writing within 24 hours.	K 341		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked b) Who provided system test c) Water system supply source Provide in REMARKS information on coverage for 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, observation and	K 353	1. Full trip test of the facility dry fire suppression system preformed to ensure proper functioning. Missing escutcheon rings replaced and checked for proper fit/function. 2. The deficient practice had the potential to affect all residents, staff and visitors. a. Missing test of dry fire suppression system conducted. b. Missing escutcheon rings replaced.	

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K 353	<p>Continued From page 12</p> <p>interview, the facility failed to inspect, test and maintain the fire suppression system in accordance with NFPA 25. Failure to maintain fire suppression systems could hinder system performance during a fire event. This deficient practice affected 68 residents, staff and visitors on the dates of the survey.</p> <p>Findings include:</p> <p>1.) During the review of facility records on April 30, 2018, from approximately 8:30 AM to 12:30 PM, last known three-year full trip test of the dry system was January 2015. No documentation could be produced for a full trip test in January 2018. When asked, the Maintenance Director stated the facility was aware the full trip test of the dry system was past due. The sprinkler company moved the full trip test from January 2018 to July 2018 to ensure the weather was warm enough to prevent freezing.</p> <p>2.) During the facility tour on April 30, 2018, from approximately 1:00 PM to 4:00 PM, observation revealed two missing escutcheon rings in the 200 hallway, one in each of the clean linen closets. When asked, the Maintenance Director stated the facility was not aware of the missing escutcheon rings.</p> <p>Actual NFPA standard:</p> <p>NFPA 25</p> <p>1.) 13.4.4.2.2.2* Every 3 years and whenever the system is altered, the dry pipe valve shall be trip tested with the control valve fully open and the quick-opening device, if provided, in service.</p> <p>2.) 5.2.1.1.4 Any sprinkler shall be replaced that has signs of leakage; is painted, other than by the</p>	K 353	<p>3. Once conducted, test logs of fire suppression system will be maintained by Maintenance Director. Tests will be conducted per regulatory guidelines. If vendor for said test is unable or unwilling to conduct test in accordance to regulator guidelines, test will be conducted early and schedule of future tests will be changed accordingly or another vendor will be utilized. Physical Environment audit will be utilized to ensure that all escutcheon rings are in place and any deficiencies will be reminded once identified.</p> <p>4. Facility fire suppression system records will be audited quarterly x1 year to ensure that all inspections are completed per regulatory schedule. Results will be brought to the QAPI committee and results verified by Administrator or designee. Physical Environment audit will be utilized and brought to QAPI committee and results verified by Administrator or designee.</p> <p>5. 5 June 18</p>	

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135077	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 05/01/2018
NAME OF PROVIDER OR SUPPLIER AVAMERE TRANSITIONAL CARE & REHAB - BOISE		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705	
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K 353	Continued From page 13 sprinkler manufacturer, corroded, damaged, or loaded; or is in the improper orientation. (See Table E.1 Examples of Classifications of Needed Corrections and Repairs)	K 353	
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.	K 363	<ol style="list-style-type: none"> 1. A. Brush guards removed from dining room doors and replaced with fire/smoke rated bulb seal to mitigate smoke inhalation risk. b. Rubber threshold removed and replaced with low profile metal transition to allow door to self-close, self-latch. c. Rehang door in resident room 115 to reduce distance between face of door and frame of door to less than 1/2". d. Move striker plate down to allow door to latch when closed. 2. The deficient practice had the potential to affect residents utilizing the dining rooms, residents in room 115 and 305, staff and visitors. The practice had the potential to affect any residents in rooms with doors that were not sealed properly, would not close or would not latch. Facility will utilize Facility Environment audit to ensure that no other doors were unsealed, un-closable or un-latch able as needed per regulations.

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K 363	Continued From page 14 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation, operational testing, and interview the facility failed to maintain doors that protect corridor openings. Failure to maintain corridor doors could allow smoke and dangerous gases to pass freely, preventing defend in place. This deficient practice has the potential to affect residents utilizing the dining rooms, residents in room #115 & #305, staff, and visitors on the dates of the survey. Findings include: During the facility tour on April 30, 2018, from approximately 1:00 PM to 4:00 PM, observation and operational testing of corridor doors throughout the facility revealed the following: 1.) The double doors at the two (2) dining rooms had damaged/missing brush guards creating gaps between the doors that would not resist the passage of smoke. At the larger dining room, the first set of doors had approximately two inches of missing brush guard at the top of the doors. The second set of doors had approximately one inch of missing brush guard. The smaller dining room had only one set of double doors with approximately three inches of missing brush guard. When asked, the Maintenance Director stated the facility was not aware of the missing brush guard.	K 363	3. Facility will utilize Facility Environment audit monthly x3 to ensure that all doors meet regulatory requirements and any deficiencies will be remedied when identified. 4. Facility Environment audit results will be brought to QAPI committee and results verified by Administrator or designee. 5. 5 June 18		

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K 363	Continued From page 15 2.) The door at the 200-hallway storage room could not self-close and latch due to a large rubber threshold on the floor. When removed from the magnetic hold open device, the door caught on the rubber threshold while closing, leaving an approximately three-inch gap. When asked, the Maintenance Director stated the facility was in the process of replacing the rubber thresholds with metal ones that would not restrict the door from closing. 3.) Resident room #115 had an approximately 5/8" gap between the face of the door and the frame of the door when fully closed. When asked, the Maintenance Director stated the facility was not aware that the maximum distance between the face of the door and frame is 1/2" when fully closed. 4.) Resident room #305 would not latch when fully closed. When asked, the Maintenance Director stated the facility was not aware the door would not latch. Actual NFPA Standards: NFPA 101 19.3.6.3* Corridor Doors. 1. - 3.) 19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be doors constructed to resist the passage of smoke and shall be constructed of materials such as the following: (1) 1-3/4 in. (44 mm) thick, solid-bonded core wood (2) Material that resists fire for a minimum of 20 minutes	K 363			

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K 363	Continued From page 16 4.) 19.3.6.3.5* Doors shall be provided with a means for keeping the door closed that is acceptable to the authority having jurisdiction, and the following requirements also shall apply: (1) The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. (2) Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.7.	K 363			
K 511 SS=F	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that electrical systems were installed, maintained and used in accordance with NFPA 70. Failure to ensure proper electrical installations and follow manufacturer recommendations for intended use could result in electrocution or fire. This deficient practice affected 68 residents, staff and visitors on the dates of the survey.	K 511	1. A. Scale in "sawtooth Dining" cord removed and scale moved to battery power. b. Cord running through wall removed and wall repaired. c. Multi-plug adapter in room 217 removed. d. Zip cord in Recreational Therapy office removed. e. Oxygen concentrator in room 213 plug moved to wall outlet. f. Zip cord in room 305 removed. g. Rooms with RPTs had RPTs moved, removed or mounted as situationally appropriate.		

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K 511	Continued From page 17 Findings include: During the facility tour on April 30, 2018, from approximately 1:00 PM to 4:00 PM, observation of the facility revealed the following: 1.) The scale in the "Sawtooth Dining" was plugged into an outlet inside of an adjacent closet. The power cord was running underneath the closed closet door. 2.) A power cord was plugged into the bathroom outlet and running into the wall at the storage room in the 200 hallway. 3.) A multi-plug adapter was in use in resident room #217. 4.) A microwave was plugged in to a "zip" extension cord at the Recreational Therapy Office. 5.) An oxygen concentrator was plugged into a relocatable power tap in resident room #213. 6.) A "zip" extension cord was in use, and secured around the top of the bathroom doorway with thumb tacks in resident room #305. 7.) A wall outlet approximately eight inches from the ceiling had a relocatable power tap (RPT) dangling from it, supported only by the power cord or cords plugged into the RPT. This was observed in multiple resident rooms in multiple areas of the facility, and appeared to be typical. When asked, the Maintenance Director stated the facility was unaware of the electrical deficiencies in the building. Actual NFPA standard: NFPA 70 400.8 Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the	K 511	2. All residents, staff and visitors had the potential to be affected. Facility will conduct full building audit for these deficiencies and any issues will be remedied when identified. Education will be provided to staff regarding plugging DME into wall outlets and never into RPTs. 3. Facility will utilize Facility Environment audit to ensure that all power cords are used in accordance with regulatory requirements and any deficiencies identified will be remedied when identified. 4. Facility Environment audit results will be brought to QAPI committee and results verified by Administrator or designee. 5. 5 June 18	

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K 511	Continued From page 18 following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of 388.8. (5) Where concealed by walls, floors, or ceilings or located above suspended or dropped ceilings (6) Where installed in raceways, except as otherwise permitted in this Code	K 511		
K 781 SS=D	Portable Space Heaters CFR(s): NFPA 101 Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to prohibit portable space heaters in sleeping areas of the facility. Portable space heaters are considered a significant risk due to the history of fires they have caused. This deficient practice had the potential to affect 4 residents, staff, and visitors on the dates of the survey. Findings include:	K 781	1. Portable space heater removed from Business Managers office. 2. 4 residents, staff and visitors had the potential to be affected by deficient practice. Any residents in rooms within the resident sleep area had the potential to be affected. All office areas will be inspected to ensure that portable space heaters are not present. 3. Facility will utilize Facility Environment audit to ensure that all office areas are free from portable space heaters and any deficiencies identified will be remedied when identified. 4. Facility Environment audit results will be brought to QAPI committee and results verified by Administrator or designee. 5. 5 June 18	

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K 781	Continued From page 19 During the facility tour on April 30, 2018, from approximately 1:00 PM to 4:00 PM, observation revealed a portable space heater located in the Business Manager's office. The office is part of a resident sleeping area. When asked, the Maintenance Director stated facility staff were aware portable space heaters were not allowed in the facility, and it would be removed immediately. Actual NFPA standard: 19.7.8 Portable Space-Heating Devices. Portable space heating devices shall be prohibited in all health care occupancies, unless both of the following criteria are met: (1) Such devices are used only in non-sleeping staff and employee areas. (2) The heating elements of such devices do not exceed 212°F (100°C).	K 781		
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 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	K 911	1. Remote manual stop station installed on facility grounds and labeled accordingly. 2. The deficient practice had the potential to affect all residents, staff and visitors. Remote manual stop station installed and labeled to mitigate the risk associated with deficiency. 3. Facility shall add remote manual stop station to generator inspection log to ensure placement, operation and labeling of remote manual stop station is in place and functional in accordance with regulations and any deficiencies identified will be remedied when identified. 4. Generator inspection logs will be brought to QAPI committee quarterly x1 year and results verified by Administrator or designee. 5. 5 June 18	

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K 911	Continued From page 20 stop, potentially hinders the ability of staff to shut down the generator if required. This deficient practice affected 68 residents, staff and visitors on the dates of the survey. Findings include: During the facility tour on April 30, 2018, from approximately 1:00 PM to 4:00 PM, a remote manual stop station for the EES generator could not be located. When asked, the Maintenance Director stated the facility 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			
K 918 SS=F	Electrical Systems - Essential Electric System CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source	K 918			

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K 918	Continued From page 21 and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure the generator for the EES (Essential Electrical System) was maintained in accordance with NFPA 110. Failure to inspect and test EES generators could result in a lack of system reliability during a power loss. This	K 918	1. Load bank test performed and any identified deficiencies remedied. 2. The deficient practice had the potential to affect all residents, staff and visitors. Load bank test performed and any identified issues remedied. 3. Facility shall add load bank test timing and results of generator inspection log to ensure generator tests are conducted in accordance with regulatory timelines and any deficiencies identified will be remedied when identified. 4. Generator inspection logs will be brought to QAPI committee quarterly x1 year and results verified by Administrator or designee. 5. 5 June 18	

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K 918	Continued From page 22 deficient practice affected 68 residents, staff and visitors on the dates of the survey. Findings include: During review of the facility generator inspection and testing records on April 30, 2018, from approximately 8:30 AM to 12:30 PM, the facility failed to provide a three-year, four-hour load test. When asked, the Maintenance Director stated the facility was unaware of the required three-year inspection and load test. Actual NFPA standard: NFPA 110 8.4 Operational Inspection and Testing. 8.4.9* Level 1 EPSS shall be tested at least once within every 36 months. 8.4.9.1 Level 1 EPSS shall be tested continuously for the duration of its assigned class (see Section 4.2). 8.4.9.2 Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 continuous hours. 8.4.9.3 The test shall be initiated by operating at least one transfer switch test function and then by operating the test function of all remaining ATSS, or initiated by opening all switches or breakers supplying normal power to all ATSS that are part of the EPSS being tested. 8.4.9.4 A power interruption to non-EPSS loads shall not be required. 8.4.9.5 The minimum load for this test shall be as specified in 8.4.9.5.1, 8.4.9.5.2, or 8.4.9.5.3. 8.4.9.5.1 For a diesel-powered EPS, loading shall be not less than 30 percent of the nameplate kW rating of the EPS. A supplemental load bank shall be permitted to be used to meet or	K 918			

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K 918	Continued From page 23 exceed the 30 percent requirement. 8.4.9.5.2 For a diesel-powered EPS, loading shall be that which maintains the minimum exhaust gas temperatures as recommended by the manufacturer. 8.4.9.5.3 For spark-ignited EPSs, loading shall be the available EPSS load. 8.4.9.6 The test required in 8.4.9 shall be permitted to be combined with one of the monthly tests required by 8.4.2 and one of the annual tests required by 8.4.2.3 as a single test. 8.4.9.7 Where the test required in 8.4.9 is combined with the annual load bank test, the first 3 hours shall be at not less than the minimum loading required by 8.4.9.5 and the remaining hour shall be at not less than 75 percent of the nameplate kW rating of the EPS.	K 918		
K 922 SS=F	Gas Equipment - Other CFR(s): NFPA 101 Gas Equipment - Other List in the REMARKS section any NFPA 99 Chapter 11 Gas Equipment 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 11 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based upon observation and interview the facility failed to ensure required signage was present where supplemental oxygen was in use. Failure to alert that supplemental oxygen is in use, could lead to ignition of an oxygen rich environment. This deficient practice affected 68 residents, staff and visitors on the dates of the survey.	K 922	K922 S/S F 1. Required O2 signage placed in areas where supplemental oxygen in use. 2. The deficient practice had the potential to affect all residents, staff and visitors. O2 signage placed in all appropriate areas. 3. Facility will utilize Facility Environment audit to ensure that all O2 in use signage is in place and any deficiencies identified will be remedied when identified. 4. Facility Environment audit results will be brought to QAPI committee and results verified by Administrator or designee. 5. 5 June 18	

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

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K 922	Continued From page 24 Findings include: During the facility tour on April 30, 2018, from approximately 1:00 PM to 4:00 PM, observation of corridors and resident room doors revealed none of the residents using supplemental oxygen had the required signage on or near their room door. This determination was based on a list of residents currently using supplemental oxygen supplied by the Director of Nursing. When asked, the Maintenance Director stated the facility was unaware signage was required. Actual NFPA standard: NFPA 99 11.5.3.2* Signs. 11.5.3.2.1 In health care facilities where smoking is not prohibited, precautionary signs readable from a distance of 1.5 m (5 ft) shall be conspicuously displayed wherever supplemental oxygen is in use and in aisles and walkways leading to such an area. 11.5.3.2.2 The signs shall be attached to adjacent doorways or to building walls or be supported by other appropriate means.	K 922		
K 923 SS=D	Gas Equipment - Cylinder and Container Storage CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or	K 923		

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K 923 Continued From page 25
limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating.
Less than or equal to 300 cubic feet
In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING."
Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather.
11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)
This REQUIREMENT is not met as evidenced by:
Based upon observation and interview the facility failed to ensure oxygen cylinders were secured and stored in a safe manner. Failure to secure and maintain cylinders can result in physical damage to the cylinder and could create an oxygen enriched atmosphere. This deficient practice affected 28 residents in the 200 hallway, staff and visitors on the dates of the survey.

- K 923
1. Unsecured O2 "E" tank secured appropriately in identified room.
 2. The deficient practice had the potential to affect 28 residents, staff and visitors. Medical gas in-service provided to all staff who handle medical gas on hire and annually thereafter. Staff in-service held and education provided to all staff who handle medical gas regarding proper use and storage of O2 gas and cylinders. Facility inspected to ensure no other "E" tanks were unsecured.
 3. Facility will utilize Facility Environment audit to ensure that all tanks are stored appropriately and any deficiencies identified will be remedied when identified.
 4. Facility Environment audit results will be brought to QAPI committee and results verified by Administrator or designee.
 5. 5 June 18

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K 923	Continued From page 26 Findings include: During the facility tour on April 30, 2018, from approximately 1:00 PM to 4:00 PM, observation of resident room #213 revealed an unsecured "E" style oxygen tank sitting unsecured on the floor of the room. When asked, the Maintenance Director stated the facility was unaware of the unsecured gas cylinder. Actual NFPA standard: NFPA 99 11.3 Cylinder and Container Storage Requirements. 11.3.2.6 Cylinder or container restraints shall comply with 11.6.2.3. 11.6.2.3 Cylinders shall be protected from damage by means of the following specific procedures: (1) Oxygen cylinders shall be protected from abnormal mechanical shock, which is liable to damage the cylinder, valve, or safety device. (2) Oxygen cylinders shall not be stored near elevators or gangways or in locations where heavy moving objects will strike them or fall on them. (3) Cylinders shall be protected from tampering by unauthorized individuals. (4) Cylinders or cylinder valves shall not be repaired, painted, or altered. (5) Safety relief devices in valves or cylinders shall not be tampered with. (6) Valve outlets clogged with ice shall be thawed with warm - not boiling - water. (7) A torch flame shall not be permitted, under any circumstances, to come in contact with a cylinder, cylinder valve, or safety device.	K 923			

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K 923	Continued From page 27 (8) Sparks and flame shall be kept away from cylinders. (9) Even if they are considered to be empty, cylinders shall not be used as rollers, supports, or for any purpose other than that for which the supplier intended them. (10) Large cylinders (exceeding size E) and containers larger than 45 kg (100 lb) weight shall be transported on a proper hand truck or cart complying with 11.4.3.1. (11) Freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. (12) Cylinders shall not be supported by radiators, steam pipes, or heat ducts.	K 923		
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 staff were properly trained on the risks associated with the use and handling of medical gases. Failure to provide an education program which includes periodic review of safety guidelines and usage requirements for medical	K 926	1. Medical Gas use and handling education provided to all staff who handle medical gas. Medical Gas use and handling education added to new hire orientation material. Medical Gas use and handling education added to facility master education calendar no less than annually.	

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K 926	<p>Continued From page 28</p> <p>gases and their cylinders, could result in a life threatening or catastrophic accident. This deficient practice could potentially affect 20 oxygen dependent residents, staff and visitors on the dates of the survey.</p> <p>Findings include:</p> <p>During the review of facility records on April 30, 2018, from approximately 8:30 AM to 12:30 PM, no records were available indicating that the facility maintained an ongoing continuing education program for staff which includes periodic review of safety guidelines and usage requirements for medical gases and their cylinders. When asked, the Facility Administrator stated, the facility was not aware of the requirement for medical gas training and did not currently have a documented training program for the use and handling of oxygen.</p> <p>Actual NFPA Standard:</p> <p>NFPA 101 19.3.2.4 Medical Gas. Medical gas storage and administration areas shall be in accordance with Section 8.7 and the provisions of NFPA 99, Health Care Facilities Code, applicable to administration, maintenance, and testing.</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</p>	K 926	<p>2. The deficient practice had the potential to affect 20 oxygen dependent residents, staff and visitors. Medical Gas use and handling education provided to all staff who handle medical gas to ensure Medical Gas use in accordance with regulatory guidelines. No staff shall be permitted to work without receiving education and having a passing posttest on file by past 5 June 18.</p> <p>3. Facility will utilize passing posttests to track staff on master staff list to ensure that all staff who handle medical gas receive education. Education will then be provided for appropriate staff upon hire and annually thereafter. New hires will receive training as part of general orientation and have passing posttest in file upon completion of training. Education will be added to facility master training calendar no less than annually thereafter.</p>		

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K 926	Continued From page 29 and use. 11.5.2.1.2 Health care facilities shall provide programs of continuing education for their personnel. 11.5.2.1.3 Continuing education programs shall include periodic review of safety guidelines and usage requirements for medical gases and their cylinders.	K 926	4. Master staff log which has been matched against passing posttest shall be brought to QAPI committee to ensure that all staff have received this training. New hire paperwork will be audited by sample quarter x 4 to ensure that all staff receive education upon hire. Master training calendar will be brought to QAPI and checked against in services provided quarterly x4 to ensure Medical Gas training is provided no less than annually. Administrator or designee will verify results and any deficiencies will be corrected once identified. 5. 5 June 18		