



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

June 8, 2018

Joe Rudd, Jr., Administrator
Life Care Center of Boise
808 North Curtis Road
Boise, ID 83706-1306

Provider #: 135038

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Mr. Rudd, Jr.:

On **May 31, 2018**, a Facility Fire Safety and Construction survey was conducted at **Life Care Center of 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

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **June 21, 2018**. Failure to submit an acceptable PoC by **June 21, 2018**, may result in the imposition of civil monetary penalties by **July 13, 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 **July 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 **July 5, 2018**. A change in the seriousness of the deficiencies on **July 5, 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 **July 5, 2018**, includes the following:

Denial of payment for new admissions effective **August 31, 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 **December 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 31, 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:

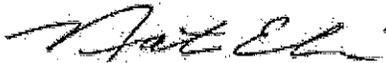
BFS Letters (06/30/11)

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

This request must be received by **June 21, 2018**. If your request for informal dispute resolution is received after **June 21, 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: 06/06/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/31/2018
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments The facility is a single story structure Type V (111) building that was built in 1967. It is fully sprinklered with smoke detection throughout, including sleeping rooms. In 1998 there was a major upgrade to the building including remodeling and a rehab addition. The facility is equipped with a diesel fired, emergency EPSS generator with automatic transfer and is supported by a municipal fire authority, including county emergency response services. Currently the facility is licensed for 153 SNF/NF beds with a census of 74 on the date of the survey. The following deficiencies were cited during the emergency preparedness survey conducted on May 30 and 31, 2018. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73. The Survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction	E 000	RECEIVED JUN 21 2018 FACILITY STANDARDS This Plan of Correction is required under Federal and State Regulations and statutes applicable to long-term care providers. This Plan of Correction does not constitute an admission of liability on part of the facility, and such liability is specifically denied. The submission of this Plan of Correction does not constitute agreement by the facility that the surveyors findings and/or conclusions constitute a deficiency, or that the scope and severity of the deficiencies cited are correctly applied. Additional Abbreviations: EP = Emergency Plan SDC = Staff Development Coordinator QA = Quality Assurance IDT = Interdisciplinary Team	
E 004 SS=D	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) [The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.] * [For hospitals at §482.15 and CAHs at §485.625(a):] The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The	E 004	Corrective Action: Facility Emergency Plan (EP) reviewed and updated as appropriate. Signatures placed on EP Manual Signature Sheet as required by policy and procedure. Identification: All residents, staff, and visitors are identified as potentially being affected by this deficiency. Continued on p. 2	

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

[Signature]

TITLE

Adm.

(X6) DATE

6-21-2018

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.

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

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E 004	<p>Continued From page 1</p> <p>[hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.</p> <p>The emergency preparedness program must include, but not be limited to, the following elements:]</p> <p>(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least annually.</p> <p>* [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least annually.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, it was determined the facility failed to develop an Emergency Preparedness program in accordance with 42 CFR 483.73 which is reviewed and updated annually. Failure to review and update emergency preparedness plan, policies and procedures annually has the potential to hinder resident continuity of care during a disaster. This deficient practice affected 74 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>On 5/30/18 from 10:00 AM - 3:00 PM, review of the provided emergency plan, policies and procedures, revealed the facility had not conducted and documented an annual review of the emergency plan in accordance with the standard. Documentation of the annual review located on page 7 of the Manual Signature sheet,</p>	E 004	<p>Systemic Changes:</p> <ol style="list-style-type: none"> 1. Facility Interdisciplinary Team (IDT) to review and update EP and related policies and procedures annually. 2. Facility IDT received inservice regarding the requirement for the annual review of the EP and related policies and procedures. <p>Monitor: Facility Administrator to ensure completion of the annual review of EP and related policies and procedures.</p>	July 5, 2018

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E 004	Continued From page 2 did not contain any signatures of those persons listed as required for review. Further review of the provided plan, policies and procedures revealed the facility HVA (Hazard Vulnerability Analysis) provided information of the impact of Hurricanes, which are not geographically relevant to the facility location. Reference: 42 CFR 483.73 (a)	E 004		
E 006 SS=F	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* *[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. *[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the	E 006	Corrective Action: 1. Hurricanes have been removed from Hazard Vulnerability Assessment (HVA) as hazard for the facility. 2. HVA has been reviewed and updated to reflect pertinent hazards for the facility geographic location and that the facility may encounter or be vulnerable to. 3. The hazard presented by the fossil fuel depot, located to the south of the facility has been included in the HVA. Identification: All residents, staff, and visitors are identified as possibly being affected by this deficiency. Systemic Changes: 1. Facility IDT to receive inservice regarding the HVA and the requirement to review and update it annually. 2. Facility IDT to review and update the HVA annually. Monitor: Administrator / Designee to ensure EP and HVA are reviewed and updated annually.	July 5, 2018

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E 006	<p>Continued From page 3</p> <p>management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care.</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 develop an Emergency Preparedness program that included a relevant facility based and community based risk assessment. Failure to provide a relevant facility and community based risk assessment, has the potential to focus staff training and resources on hazards that are not site specific. This deficient practice affected 74 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>1) On 5/30/18 from 2:00 - 2:30 PM, review of the provided emergency plan, policies and procedures, revealed the facility HVA (Hazard Vulnerability Analysis) provided information of the impact of Hurricanes, which are not geographically relevant to the facility. Review of the county all-hazard mitigation plan for the area found no indication Hurricanes were a likely occurrence.</p> <p>2) On 5/30/18 from 2:00 - 2:30 PM, comparison of the county hazard mitigation plan found hazmat was regarded as a substantial risk to the community, yet the facility found the risk of external hazmat exposure as low. Further observation of the facility location revealed two (2) fully operational fossil fuel depots, one across the street and one less than one-half mile from the facility. Interview of 3 of 3 staff members identified this risk as substantial to the facility's potential for disasters.</p>	E 006		

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E 006	Continued From page 4 3) On 5/30/18 from 2:00 - 2:30 PM, comparison of the provided HVA to one provided from the EP plan dated 2004, revealed the information contained on external hazmat risk was the same and had not been reviewed or recently updated. Reference: 42 CFR 483.73 (a) (1) - (2)	E 006		
E 026 SS=E	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) [[b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the facility failed to document their role under an 1135	E 026	<p>Corrective Action: Document defining role of facility in the event of 1135 waiver, as declared by the Secretary, and provisions of care as required if identified by emergency management officials has been included in the facility EP.</p> <p>Identification: All residents, staff, and visitors are identified as possibly being affected by this deficiency.</p> <p>Systemic Changes: Review of this document to be included in the annual IDT review of the facility EP.</p> <p>Monitor: Administrator / Designee to ensure EP and HVA are reviewed and updated annually.</p>	July 5, 2018

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E 026	Continued From page 5 waiver as declared by the Secretary and the provisions of care as required under this action if identified by emergency management officials. Failure to plan for alternate means of care and the role under an 1135 waiver has the potential to limit facility options during an emergency. This deficient practice potentially affects reimbursement and continuity of care for the 74 residents, staff and visitors housed on the date of the survey along with the available surge needs of the community during a disaster. Findings include: On 5/30/18 from 10:30 AM - 3:00 PM, review of the provided emergency plan, policies and procedures, did not demonstrate the role of the facility under the declaration of an 1135 waiver, should that condition be enacted by the Secretary. Reference: 42 CFR 483.73 (b) (8)	E 026		
E 030 SS=F	Names and Contact Information CFR(s): 483.73(c)(1) [(c) The [facility, except RNHCs, hospices, transplant centers, and HHAs] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities].	E 030	Corrective Action: 1. Communication Plan portion of EP reviewed and updated to include other LTC facilities and volunteers. 2. Communication Plan to be reviewed and updated annually. Identification: All residents, staff, and visitors are identified as possibly being affected by this deficiency. Systemic Changes: 1. Communication Plan to be reviewed and updated annually. 2. Facility staff to receive inservice regarding Communication Plan and the availability of names and contact information of parties that may be of assistance in the facility's response to an emergency or disaster. Continued on p. 7	

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E 030	<p>Continued From page 6</p> <p>(v) Volunteers.</p> <p>*[For RNHCl's at §403.748(c):] The communication plan must include all of the following:</p> <p>(1) Names and contact information for the following:</p> <p>(i) Staff.</p> <p>(ii) Entities providing services under arrangement.</p> <p>(iii) Next of kin, guardian, or custodian.</p> <p>(iv) Other RNHCIs.</p> <p>(v) Volunteers.</p> <p>*[For ASCs at §416.45(c):] The communication plan must include all of the following:</p> <p>(1) Names and contact information for the following:</p> <p>(i) Staff.</p> <p>(ii) Entities providing services under arrangement.</p> <p>(iii) Patients' physicians.</p> <p>(iv) Volunteers.</p> <p>*[For Hospices at §418.113(c):] The communication plan must include all of the following:</p> <p>(1) Names and contact information for the following:</p> <p>(i) Hospice employees,</p> <p>(ii) Entities providing services under arrangement.</p> <p>(iii) Patients' physicians.</p> <p>(iv) Other hospices.</p> <p>*[For OPOs at §486.360(c):] The communication plan must include all of the following:</p> <p>(1) Names and contact information for the following:</p> <p>(i) Staff.</p> <p>(ii) Entities providing services under arrangement.</p> <p>(iii) Volunteers.</p> <p>(iv) Other OPOs.</p>	E 030	<p>Monitor: Facility Administrator / Designee to ensure Communication Plan is reviewed and updated annually.</p>	July 5, 2018

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E 030	Continued From page 7 (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the facility failed to document a communication plan which included contact information for staff, resident physicians, other facilities and volunteers. Failure to have a communication plan which includes contact information for those parties assisting in the facility's response and recovery during a disaster, has the potential to hinder both internal and external emergency response efforts. This deficient practice affected 74 residents, staff and visitors on the date of the survey. Findings include: On 5/30/18 from 11:30 AM - 3:00 PM, review of provided emergency plan, policies and procedures, failed to reveal a communication plan that included contact information for volunteers and other LTC (Long Term Care Facilities). Reference: 42 CFR 483.73 (c) (1)	E 030		
E 036 SS=F	EP Training and Testing CFR(s): 483.73(d) (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must	E 036	Corrective Action: <ol style="list-style-type: none">1. The facility Emergency Preparedness Training and Testing plan, based on the facility EP, has been reviewed, updated, and implemented per facility policy and procedure.2. The facility Emergency Preparedness Training and Testing plan to be reviewed and updated annually. Identification: All residents, staff, and visitors are identified as possibly being affected by this deficiency. Continued on p. 9	

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E 036	<p>Continued From page 8 be reviewed and updated at least annually.</p> <p>*[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h).</p> <p>*[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to provide an emergency prep training and testing program. Lack of a facility emergency training and testing program covering the emergency preparedness plan, policies and procedures, has the potential to hinder staff response during a disaster. This deficient practice affected 74 residents, staff and visitors on the date of the survey.</p>	E 036	<p>Systemic Changes:</p> <ol style="list-style-type: none"> 1. Facility SDC to update schedule of Emergency Preparedness Training and Testing and place schedule on calendar annually. 2. Facility staff inserviced regarding facility Emergency Preparedness Training and Testing and policy and procedures. 3. Facility SDC to manage the documentation of Emergency Preparedness Training and Testing. <p>Monitor: Facility Administrator / Designee to review Emergency Preparedness Training and Testing Schedule and documentation to ensure compliance.</p>	July 5, 2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/31/2018
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BOISE		STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 036	Continued From page 9 Findings include: On 5/30/18 from 2:00 - 2:30 PM, review of provided emergency plan, policies and procedures, found no documentation demonstrating the facility had a current testing program for staff based on training conducted of the emergency plan. Interview of 4 of 4 staff conducted on 5/31/18 from 10:00 AM - 2:00 PM, established staff had not participated in any specific training or testing program on the emergency plan contents. Reference: 42 CFR 483.73 (d)	E 036		
E 037 SS=F	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 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	E 037	Corrective Action: 1. As noted in Corrective Action for E 036, facility EP Training Program related to EP policy and procedures has been reviewed and implemented as per policy and procedure. EP Training Program includes: a. Initial training of newly hired staff regarding EP and related policies and procedures. b. Ongoing training for existing staff on an annual basis c. Testing of staff knowledge of EP policies and procedures presented. Identification: All residents, staff, and visitors are identified as possibly being affected by this deficiency. Continued on p. 11	

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E 037	<p>Continued From page 10 their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures.</p> <p>*[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.</p> <p>*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training.</p> <p>*[For PACE at §460.84(d):] (1) The PACE</p>	E 037	<p>Systemic Changes:</p> <ol style="list-style-type: none"> 1. Facility SDC to update schedule of Emergency Preparedness Training and Testing and place schedule on calendar annually. 2. Facility staff inserviced regarding facility Emergency Preparedness Training and Testing and policy and procedures. 3. Facility SDC to manage the documentation of Emergency Preparedness Training and Testing. <p>Monitor: Facility Administrator / Designee to review Emergency Preparedness Training and Testing Schedule and documentation to ensure compliance.</p>	July 5, 2018

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E 037	<p>Continued From page 11</p> <p>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 alarm systems and signals and firefighting equipment.</p> <p>*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:</p> <p>(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</p>	E 037		

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E 037	<p>Continued From page 12</p> <p>cooperation with firefighting and disaster authorities, 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.</p> <p>*[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.</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 provide an emergency prep training program. Lack of a training program on the emergency preparedness plan and policies for the facility, has the potential to hinder staff response during a disaster. This deficient practice affected 74 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>On 5/30/18 from 2:00 - 2:30 PM, review of provided emergency plan, policy and procedures, revealed no substantiating documentation demonstrating the facility had conducted a training program on the emergency preparedness</p>	E 037		

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E 037	Continued From page 13 plan, policies and procedures for existing staff and newly hired staff. Interview of the interim staff development coordinator on 5/30/18 from approximately 2:00 - 2:30 PM revealed the facility had not yet conducted a training for both existing and newly hired staff. Further interview of 2 of 2 staff on 5/31/18 from 8:30 - 10:00 AM revealed neither had gone through any training on the emergency plan. Reference: 42 CFR 483.73 (d) (1) Additional Reference: E-0036	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 actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a	E 039	Corrective Action: 1. Facility to conduct a table top exercise. 2. Facility to conduct a full-scale community-based exercise. 3. Facility team to conduct analysis of exercises and review the documentation of those exercise and revise EP as needed Identification: All residents, staff, and visitors are identified as possibly being affected by this deficiency. Systemic Changes: 1. Facility to review and update EP annually and plan two (2) exercises (table top and full-scale community based) to test the EP each year. 2. Facility staff to be inserviced regarding the regulation to conduct testing exercises and training for respective exercises. Continued on p. 15	

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E 039	<p>Continued From page 14 community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event.</p> <p>(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.</p> <p>(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.</p> <p>*[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the facility failed to complete the required full-scale exercises which tested the emergency</p>	E 039	<p>Monitor: Facility Administrator / Designee to review Emergency Preparedness Training and Testing Exercises and documentation related to those exercises to ensure compliance</p>	July 5, 2018

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

Printed: 06/06/2018
FORM APPROVED
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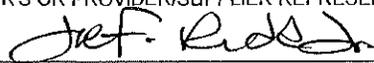
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E 039	<p>Continued From page 15</p> <p>preparedness readiness of the facility. Failure to participate in a full-scale or tabletop exercise event has the potential to reduce the facility's effectiveness to provide continuation of care to residents during an emergency. This deficient practice affected 74 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>On 5/30/18 from 10:30 AM - 1:30 PM, review of provided emergency plan documents, revealed the facility failed to document completion of two (2) full-scale exercises, testing the effectiveness of the emergency preparedness plan, policies and procedures.</p> <p>Reference:</p> <p>42 CFR 483.73 (d) (1).</p>	E 039		

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K 000	INITIAL COMMENTS The facility is a single story structure Type V (111) building that was built in 1967. It is fully sprinklered with smoke detection throughout, including sleeping rooms. In 1998 there was a major upgrade to the building including remodeling and a rehab addition. The facility is currently licensed for 153 SNF/NF beds, with a census of 74 on the date of the survey. The following deficiencies were cited during the annual life safety code survey conducted on May 30 and 31, 2018. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70. The Survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction	K 000	RECEIVED JUN 21 2018 FACILITY STANDARDS This Plan of Correction is required under Federal and State Regulations and statutes applicable to long-term care providers. This Plan of Correction does not constitute an admission of liability on part of the facility, and such liability is specifically denied. The submission of this Plan of Correction does not constitute agreement by the facility that the surveyors findings and/or conclusions constitute a deficiency, or that the scope and severity of the deficiencies cited are correctly applied. Additional Abbreviations: EP = Emergency Plan SDC = Staff Development Coordinator QA = Quality Assurance	
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 demonstrate implementation of a water management program for waterborne pathogens such as Legionella, in accordance with 42 CFR 483.80. Failure to conduct a facility based risk assessment, provide appropriate control	K 100	Corrective Action: <ol style="list-style-type: none">1. The facility has a Water Management Program and has an ongoing testing schedule for Legionella as directed. The results of each of those tests have been negative for Legionella.2. Water Management Program has been reviewed and updated.3. Facility-based Risk Assessment for water borne pathogens has been updated and completed.4. Control Measures and Testing Protocols, based on the Risk Assessment, have been reviewed, updated, and implemented as necessary. Identification: All residents, staff, and visitors are identified as potentially being affected by this deficiency. Continued on p. 2	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Adm.	(X6) DATE 6-21-2018
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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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K 100	<p>Continued From page 1</p> <p>measures based on that assessment and determine necessary testing protocols, limits the facility's ability to prevent transmission of waterborne pathogens. This deficient practice affected 74 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During review of provided water management documentation conducted on 5/30/18 from approximately 9:30 - 10:00 AM, documentation failed to identify the facility had conducted a risk assessment, identified appropriate control measures and determine what, if any, testing protocols would be established.</p> <p>Interview of the Maintenance Director established that the water management plan had been initiated by the former maintenance director, but he did not have any documentation of and was unable to substantiate if any further development of the plan had been completed.</p> <p>CFR standard: 42 CFR 483.80</p> <p>§ 483.80 Infection control. The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>Additional reference: Center for Medicaid/Medicare Services S & C letter 17-30</p>	K 100	<p>Systemic Changes:</p> <ol style="list-style-type: none"> 1. Water Management Program reviewed and updated as noted in Corrective Action. 2. Maintenance Supervisor to conduct testing and implement control measures as prescribed in Water Management Program and according to facility policy and procedure. <p>Monitor:</p> <ol style="list-style-type: none"> 1. Facility Administrator to review documentation related to testing and control measures on a monthly basis ongoing 2. Findings to be reviewed in facility QA and Infection Control meetings. 	July 5, 2018
K 161 SS=D	Building Construction Type and Height CFR(s): NFPA 101	K 161	POC on p. 3	

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 05/31/2018
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K 161	<p>Continued From page 2</p> <p>Building Construction Type and Height 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</p> <p>Construction Type</p> <p>1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered</p> <p>2 II (111) One story non-sprinklered Maximum 3 stories sprinklered</p> <p>3 II (000) Not allowed non-sprinklered</p> <p>4 III (211) Maximum 2 stories sprinklered</p> <p>5 IV (2HH)</p> <p>6 V (111)</p> <p>7 III (200) Not allowed non-sprinklered</p> <p>8 V (000) Maximum 1 story sprinklered</p> <p>Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5)</p> <p>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.</p>	K 161	<p>Corrective Action:</p> <ol style="list-style-type: none"> Area identified in 2567 as #1 has been sealed as needed. Area identified in 2567 as #2 has been sealed as needed. <p>Identification: All residents, staff, and visitors are identified as possibly being affected by this deficiency.</p> <p>Systemic Changes:</p> <ol style="list-style-type: none"> Facility Maintenance Supervisor to inspect work by outside contractors, that may have necessitated penetration of any facility structure, to ensure that penetrations are sealed to maintain the smoke resistive properties of the structure. Facility Maintenance Supervisor to conduct monthly inspections of facility to ensure no penetrations are unsealed. <p>Monitor:</p> <ol style="list-style-type: none"> Administrator / IDT Designee to review monthly inspections for compliance. Reviews to occur on a monthly basis ongoing. 	July 5, 2018
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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 that the fire and smoke resistive properties of the structure were maintained. Failure to maintain rated construction assemblies, has the potential to allow fire, smoke and dangerous gases to pass into unprotected concealed spaces and between compartments. This deficient practice potentially affected 22 residents staff and visitors in 1 of 5 smoke compartments on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on May 30, 2018 from approximately 11:00 AM to 12:30 PM, the following unsealed penetrations were revealed:</p> <p>1) One (1) unsealed penetration approximately two inches in diameter, which contained seven (7) data cables, which passed through the wall of the server room into the suspended ceiling area of the corridor.</p> <p>2) One (1) unsealed hole approximately two inches by three inches in the northwest wall of the Medical records storage in the 300 hall, which exposed the interior wall cavity.</p> <p>When asked, the Maintenance Director stated he had not been aware of these penetrations prior to the survey.</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</p>	K 161		

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K 161	Continued From page 4 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. 8.2.2.2 Fire compartments shall be formed with fire barriers that comply with Section 8.3. 8.3.5.6 Membrane Penetrations. 8.3.5.6.1 Membrane penetrations for cables, cable trays, conduits, pipes, tubes, combustion vents and exhaust vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a membrane of a wall, floor, or floor/ceiling assembly constructed as a fire barrier shall be protected by a firestop system or device and shall comply with 8.3.5.1 through 8.3.5.5.2.	K 161		
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9.18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to provide emergency lighting in accordance with NFPA 101. Failure to provide emergency lighting for doors equipped with delayed egress potentially hinders identification of exits affecting resident egress during an emergency. This deficient practice	K 291	<p>Corrective Action: Battery Back-Up Emergency Lighting has been installed at each exit of the facility.</p> <p>Identification: All residents, staff, and visitors are identified as possibly being affected by this deficiency.</p> <p>Systemic Changes: Facility Maintenance Supervisor to conduct monthly inspections of the emergency lighting to ensure they are operating properly.</p> <p>Continued on p. 6</p>	

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K 291	<p>Continued From page 5 affected 74 residents staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on May 30, 2018 from 10:30 AM to 3:00 PM, observation of exit doors revealed all exits were equipped with magnetic locking arrangements, which included a delayed egress component. Further observation established the facility was not providing battery backup emergency lighting for illumination of the means of egress to any of these exits.</p> <p>Actual NFPA standard:</p> <p>19.2.9 Emergency Lighting. 19.2.9.1 Emergency lighting shall be provided in accordance with Section 7.9.</p> <p>7.9 Emergency Lighting. 7.9.1 General. 7.9.1.1* Emergency lighting facilities for means of egress shall be provided in accordance with Section 7.9 for the following: (1) Buildings or structures where required in Chapters 11 through 43 (2) Underground and limited access structures as addressed in Section 11.7 (3) High-rise buildings as required by other sections of this Code (4) Doors equipped with delayed-egress locks (5) Stair shafts and vestibules of smokeproof enclosures, for which the following also apply: (a) The stair shaft and vestibule shall be permitted to include a standby generator that is installed for the smokeproof enclosure mechanical ventilation equipment. (b) The standby generator shall be permitted to</p>	K 291	<p>Monitor:</p> <ol style="list-style-type: none"> 1. Administrator / IDT Designee to review monthly inspections for compliance. 2. Reviews to occur on a monthly basis ongoing. 	July 5, 2018

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K 291 K 293 SS=F	<p>Continued From page 6 be used for the stair shaft and vestibule emergency lighting power supply. (6) New access-controlled egress doors in accordance with 7.2.1.6.2.</p> <p>Exit Signage CFR(s): NFPA 101</p> <p>Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure means of egress signage was provided in accordance with NFPA 101. Failure to provide exit signs which are clear and identifiable has the potential to confuse residents and hinder egress during an emergency. This deficient practice affected 69 residents in 2 of 5 smoke compartments on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on May 30, 2018 from approximately 11:30 AM - 3:00 PM, observation of installed exit signs, revealed the following locations were not equipped with exit signs identifying the path of egress during a fire or other emergency:</p> <p>1) The bulkhead above the east/west path of travel in the 100 corridor located at rooms 116/111, exit signs were missing on both sides of the solid smoke doors, rendering continued path</p>	K 291 K 293	<p>Corrective Action: Exit / Directional signs have been installed at locations noted in 2567.</p> <p>Identification: All residents, staff, and visitors are identified as possibly being affected by this deficiency.</p> <p>Systemic Changes: Facility Maintenance Supervisor to conduct monthly inspections of the exit / directional signs to ensure they are operating properly.</p> <p>Monitor:</p> <ol style="list-style-type: none"> 1. Administrator / IDT Designee to review monthly inspections for compliance. 2. Reviews to occur monthly ongoing 	July 5, 2018

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K 293	Continued From page 7 of travel unclear when these doors closed under activation of the fire alarm. 2) The bulkhead above the east path of travel in the 200 corridor located at rooms 207/208, the exit sign was missing on one side of the solid smoke doors, rendering continued path of travel unclear when these doors closed under activation of the fire alarm. Actual NFPA standard: 7.10.1.2 Exits. 7.10.1.2.1* Exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign that is readily visible from any direction of exit access.	K 293		
K 923 SS=E	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 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	K 923	<p>Corrective Action: Oxygen storage room has been re-arranged and labeling affixed to the wall to more clearly define "FULL" and "EMPTY" storage spaces</p> <p>Identification: All residents are identified as possibly being affected by this deficiency.</p> <p>Systemic Changes:</p> <ol style="list-style-type: none"> 1. Inservice education provided to facility staff regarding proper storage of oxygen tanks. 2. Facility Maintenance Supervisor to conduct monthly inspections of the oxygen storage to ensure compliance. <p>Monitor:</p> <ol style="list-style-type: none"> 1. Administrator / IDT Designee to review monthly inspections for compliance. 2. Reviews to occur on a monthly basis ongoing. 	July 5, 2018

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K 923	<p>Continued From page 8</p> <p>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."</p> <p>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.</p> <p>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:</p> <p>Based on observation and interview, the facility failed to ensure medical gases were stored in accordance with NFPA 99. Failure to segregate empty oxygen cylinders from full has the potential of using incorrect cylinders during an emergency requiring supplemental oxygen. This deficient practice affected 45 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on May 30, 2018 from approximately 11:00 AM - 12:00 PM, observation of the oxygen storage area in the 200 hall patio access breezeway, revealed three (3) "E" size oxygen cylinders and three (3) "A" size oxygen cylinders in a rack on the "Full" side of the room. When asked if these cylinders were empty or full, the Maintenance Director stated they were empty, but that the facility didn't use these types of cylinders any longer and was not sure why they</p>	K 923		

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K 923	Continued From page 9 were stored in this space. Actual NFPA standard: NFPA 99 11.6.5 Special Precautions - Storage of Cylinders and Containers. 11.6.5.1 Storage shall be planned so that cylinders can be used in the order in which they are received from the supplier. 11.6.5.2 If empty and full cylinders are stored within the same enclosure, empty cylinders shall be segregated from full cylinders. 11.6.5.3 Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed in a rapid manner.	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 continuing education and staff training was provided on the risks associated with the storage, handling and use of medical gases and their cylinders. Failure to provide training of safety and the risks associated with medical gases, potentially increases risks associated and hinders staff response with the use and handling	K 926	Corrective Action: Facility staff have received in-service education regarding the risks associated with oxygen storage, handling, or use. Identification: All residents, staff, and visitors are identified as possibly being affected by this deficiency. Systemic Changes: 1. In-service education provided to facility staff regarding the risks associated with oxygen storage, handling, or use. 2. Annual continuing education to be provided to facility staff regarding the risks associated with oxygen storage, handling, or use.	

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K 926	<p>Continued From page 10 of oxygen. This deficient practice potentially affected oxygen dependent residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During review of provided training records on May 30 and 31, 2018, records provided did not demonstrate continuing training was performed for the risks associated with oxygen and its use, only initial training conducted at orientation. Interview of 4 of 4 staff members on May 30, 2018, revealed none had participated in any continuing education program on the risks associated with the storage, handling or use of medical gases such as oxygen.</p> <p>Actual NFPA standard:</p> <p>NFPA 99 11.5.2 Gases in Cylinders and Liquefied Gases in Containers. 11.5.2.1 Qualification and Training of Personnel. 11.5.2.1.1* Personnel concerned with the application and maintenance of medical gases and others who handle medical gases and the cylinders that contain the medical gases shall be trained on the risks associated with their handling and use. 11.5.2.1.2 Health care facilities shall provide programs of continuing education for their personnel. 11.5.2.1.3 Continuing education programs shall include periodic review of safety guidelines and usage requirements for medical gases and their cylinders.</p>	K 926	<p>Monitor:</p> <ol style="list-style-type: none"> 1. Facility SDC to monitor in-service records to ensure oxygen education and training is completed annually and as otherwise prescribed by policy. 2. Administrator / IDT Designee to review in-service records for compliance. 3. Record review to occur on a monthly basis for three (3) months and annually thereafter. 	July 5, 2018
K 927 SS=E	<p>Gas Equipment - Transfilling Cylinders CFR(s): NFPA 101</p> <p>Gas Equipment - Transfilling Cylinders</p>	K 927	POC on p. 12	

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K 927	<p>Continued From page 11</p> <p>Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99)</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and operational testing, the facility failed to ensure liquid oxygen transfilling was conducted in accordance with NFPA 99. Transfilling liquid oxygen without sufficient mechanical ventilation has the potential to increase the risks of combustion and explosions. This deficient practice affected 45 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on May 30, 2018 from approximately 10:00 AM - 12:00 PM, observation and operational testing by the Maintenance Director of the fan for the oxygen storage/transfill area at the nurse's station, revealed the fan was operational, but lacked exhaust airflow when tested with a sheet of standard note paper placed against the exhaust vent.</p> <p>Actual NFPA standard:</p> <p>NFPA 99</p> <p>9.3.7.5.3.2 Mechanical exhaust shall be at a rate</p>	K 927	<p>Corrective Action: Fan identified in 2567 has been repaired and is fully functional.</p> <p>Identification: All residents, staff, and visitors are identified as possibly being affected by this deficiency.</p> <p>Systemic Changes: Facility maintenance Supervisor to conduct monthly inspection of fan identified in 2567 to ensure it is operating properly.</p> <p>Monitor:</p> <ol style="list-style-type: none"> 1. Administrator / IDT Designee to review monthly inspection for compliance. 2. Reviews to occur on a monthly basis ongoing. 	July 5, 2018

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

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K 927	Continued From page 12 of 1 L/sec of airflow for each 300 L (1 cfm per 5 ft3 of fluid) designed to be stored in the space and not less than 24 L/sec (50 cfm) nor more than 235 L/sec (500 cfm).	K 927		