



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

September 12, 2018

Anita Burdick, Administrator
Oak Creek Rehabilitation Center of Kimberly
500 Polk Street East
Kimberly, ID 83341-1618

Provider #: 135084

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Ms. Burdick:

On **August 28, 2018**, a Facility Fire Safety and Construction survey was conducted at **Oak Creek Rehabilitation Center Of Kimberly** 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 **September 25, 2018**. Failure to submit an acceptable PoC by **September 25, 2018**, may result in the imposition of civil monetary penalties by **October 17, 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 **October 2, 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 **October 2, 2018**. A change in the seriousness of the deficiencies on **October 2, 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 **October 2, 2018**, includes the following:

Denial of payment for new admissions effective **November 28, 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 **February 28, 2019**, 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 **August 28, 2018**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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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:

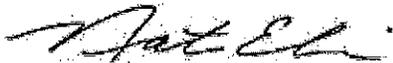
BFS Letters (06/30/11)

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

This request must be received by **September 25, 2018**. If your request for informal dispute resolution is received after **September 25, 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: 09/19/2018
FORM APPROVED
OMB NO. 0938-0391

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135084 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____ | (X3) DATE SURVEY COMPLETED 08/28/2018 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER OAK CREEK REHABILITATION CENTER OF KIMBERLY | STREET ADDRESS, CITY, STATE, ZIP CODE 500 POLK STREET EAST KIMBERLY, ID 83341 |
|--|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|--|---------------|---|----------------------|
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|---------------|---|-------|--|--|
| K 000 | INITIAL COMMENTS The facility is a single story, Type V (III) construction, with multiple exits to grade. It was originally constructed in 1963 and is fully sprinklered with a complete, electronically monitored fire alarm/smoke detection system throughout. The Essential Electrical System is supplied by a natural gas powered, on-site automatic generator installed new in 2017. Currently the facility is licensed for 57 SNF/NF beds and had a census of 29 on the date of the survey. The following deficiencies were cited during the annual life safety code survey conducted on August 28, 2018. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70, and 42 CFR 483.80. The Survey was conducted by: Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction | K 000 | | |
| K 161 SS=D | Building Construction Type and Height CFR(s): NFPA 101 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 Construction Type 1 I (442), I (332), II (222) Any number of stories | K 161 | | |

RECEIVED
OCT 01 2018
FACILITY STANDARDS

| | | |
|---|-------------------------------|-----------------------------|
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Anita Burdick</i> | TITLE <i>Administrator</i> | (X6) DATE <i>9-28-18</i> |
|---|-------------------------------|-----------------------------|

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 161 | Continued From page 1 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. 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 and ceilings, could result in fire and smoke passing between compartments during a fire event. This deficient practice affected 8 residents in the 300 | K 161 | | |

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| K 161 | Continued From page 2 hallway, staff and visitors on the date of the survey. Findings include: During the facility tour on August 28, 2018, from approximately 1:50 PM to 3:30 PM, observation revealed the following penetrations: 1.) Approximately 1" circular holes in the ceiling at each set of smoke doors in the 300 hallway. 2.) Approximately 4" x 4" hole in the wall in the medical records office. When asked, the Maintenance Manager stated the facility was not aware of the penetrations. Actual NFPA standard: NFPA 101 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. | K 161 | K 161 1. The holes in the ceiling on the 300 hall and the hole in the wall in the medical records office have been repaired. (see attachments A, B, & C) 2. All residents in the 300 hall had the potential to be affected. 3. The maintenance director or designee will complete monthly facility wide audits to ensure the smoke and fire resistive properties of the structure are maintained. 4. The results of the audits will be reviewed by the QAPI committee at least quarterly to ensure continued compliance. 5. Date of compliance: 10-2-18. | |
| K 223 SS=D | Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release | K 223 | | |

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| K 223 | <p>Continued From page 3</p> <p>device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of:</p> <ul style="list-style-type: none"> * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. <p>18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, operational testing and interview, the facility failed to ensure self-closing doors in smoke barriers were free from obstruction and able to self-close when released from magnetic hold-open devices. Obstructing smoke barrier doors from self-closing as designed could allow smoke and dangerous gases to pass between smoke compartments during a fire. This deficient practice affected 10 residents in the 200 hallway, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour on August 28, 2018, from approximately 1:50 PM to 3:30 PM, observation and operational testing of the self-closing door between the kitchen dishwashing area and the corridor revealed it would not self-close when released from the magnetic hold open device. The door was obstructed from closing by the door frame, overlapping the frame by approximately 1-1/2 inches. When asked, the Maintenance Manager stated the facility was not aware the door was obstructed and would not close.</p> <p>Actual NFPA standard:</p> | K 223 | <p>K 223</p> <ol style="list-style-type: none"> 1. The door to the kitchen dishwashing area has been repaired and now self closes when released from the magnetic hold open device. (See attachment D) 2. Ten residents on the 200 hall had the potential to be affected. 3. An inspection/audit of all doors will be completed by the maintenance director or designee at least quarterly beginning 10-1-18 to maintain compliance. Any door identified to not be in compliance will be fixed and maintained to NFPA standards. 4. The results of the inspections/audits will be reviewed by the QAPI committee at least quarterly to ensure compliance. 5. Date of Compliance 10-2-18 | | |

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| K 223 | Continued From page 4 NFPA 101 19.2.2.2.7* Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier, or hazardous area enclosure shall be permitted to be held open only by an automatic release device that complies with 7.2.1.8.2. The automatic sprinkler system, if provided, and the fire alarm system, and the systems required by 7.2.1.8.2, shall be arranged to initiate the closing action of all such doors throughout the smoke compartment or throughout the entire facility. 7.2.1.8.2 In any building of low or ordinary hazard contents, as defined in 6.2.2.2 and 6.2.2.3, or where approved by the authority having jurisdiction, door leaves shall be permitted to be automatic-closing, provided that all of the following criteria are met: (1) Upon release of the hold-open mechanism, the leaf becomes self-closing. (2) The release device is designed so that the leaf instantly releases manually and, upon release, becomes self-closing, or the leaf can be readily closed. (3) The automatic releasing mechanism or medium is activated by the operation of approved smoke detectors installed in accordance with the requirements for smoke detectors for door leaf release service in NFPA 72, National Fire Alarm and Signaling Code. (4) Upon loss of power to the hold-open device, the hold-open mechanism is released, and the door leaf becomes self-closing. | K 223 | | | |
| K 232 SS=D | Aisle, Corridor, or Ramp Width CFR(s): NFPA 101 Aisle, Corridor or Ramp Width 2012 EXISTING | K 232 | | | |

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| K 232 | <p>Continued From page 5</p> <p>The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain corridor exit access free of obstructions. Failure to maintain exit access width in the path of travel, could hinder the safe evacuation of residents during a fire or other emergency. This deficient practice affected 29 residents, staff and visitors on the dates of the survey.</p> <p>Findings include:</p> <p>During the facility tour on August 28, 2018, from approximately 1:50 PM to 3:30 PM, observation of the exit access corridor in the 300 hall and kitchen hall revealed a bug light installed in each corridor approximately 71 inches from the floor which protruded from the corridor wall approximately 6-1/2 inches. When asked, the Maintenance Manager stated the facility was unaware of the requirement for non-continuous projections.</p> <p>Actual NFPA Standard:</p> <p>19.2.3.4* Any required aisle, corridor, or ramp shall be not less than 48 in. (1220 mm) in clear width where serving as means of egress from patient sleeping rooms, unless otherwise permitted by one of the following: (1) Aisles, corridors, and ramps in adjunct areas</p> | K 232 | <p>K 232</p> <ol style="list-style-type: none"> 1. The bug lights have been removed from the facility. (see attachments E & F) 2. All residents had the potential to be affected. 3. The maintenance director or designee will complete monthly audits of all exit access corridors to ensure non-continuous projections are no greater than 6 inches from the wall. 4. The audits will be reviewed by the QAPI committee at least quarterly to ensure continued compliance. 5. Date of Compliance 10-2-18 | | |

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| K 232 | <p>Continued From page 6</p> <p>not intended for the housing, treatment, or use of inpatients shall be not less than 44 in. (1120 mm) in clear and unobstructed width.</p> <p>(2) *Where corridor width is at least 6 ft (1830 mm), non-continuous projections not more than 6 in. (150 mm) from the corridor wall, above the handrail height, shall be permitted.</p> <p>(3) Exit access within a room or suite of rooms complying with the requirements of 19.2.5 shall be permitted.</p> <p>(4) Projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met:</p> <p>(a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in. (1525 mm).</p> <p>(b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency.</p> <p>(c)*The wheeled equipment is limited to the following:</p> <p>i. Equipment in use and carts in use</p> <p>ii. Medical emergency equipment not in use</p> <p>iii. Patient lift and transport equipment</p> <p>(5) * Where the corridor width is at least 8 ft (2440 mm), projections into the required width shall be permitted for fixed furniture, provided that all of the following conditions are met:</p> <p>(a) The fixed furniture is securely attached to the floor or to the wall.</p> <p>(b) The fixed furniture does not reduce the clear unobstructed corridor width to less than 6 ft (1830 mm), except as permitted by 19.2.3.4(2).</p> <p>(c) The fixed furniture is located only on one side of the corridor.</p> <p>(d) The fixed furniture is grouped such that each grouping does not exceed an area of 50 ft² (4.6 m²).</p> | K 232 | | |

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| K 232 | Continued From page 7 (e) The fixed furniture groupings addressed in 19.2.3.4(5)(d) are separated from each other by a distance of at least 10 ft (3050 mm). (f)*The fixed furniture is located so as to not obstruct access to building service and fire protection equipment. (g) Corridors throughout the smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the fixed furniture spaces are arranged and located to allow direct supervision by the facility staff from a nurses' station or similar space. (h) The smoke compartment is protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.8. | K 232 | | |
| K 325 SS=F | 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 | K 325 | | |

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| K 325 | <p>Continued From page 8</p> <p>sprinklered smoke compartments</p> <p>* ABHR does not exceed 95 percent alcohol</p> <p>* Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11)</p> <p>* ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, observation and interview, the facility failed to ensure Alcohol Based Hand Rub Dispensers (ABHR) were maintained in accordance with NFPA 101. Failure to test and document the operation of ABHR dispensers in accordance with the manufacturer's care and use instructions each time a new refill is installed could result in inadvertently spilling flammable liquids, increasing the risk of fires. This deficient practice affected 29 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During the review of facility inspection records on August 28, 2018, from approximately 11:00 AM to 1:50 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. ABHR dispensers were observed throughout the facility and when asked, the Maintenance Manager stated the facility was not aware of 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.</p> | K 325 | <p>K325</p> <ol style="list-style-type: none"> 1. A process to test the ABHR dispensers each time a new refill is installed has been developed and implemented. (see attachment G) 2. All residents had the potential to be affected. 3. The maintenance director or designee will perform audits of the ABHR dispensers weekly x 4, then bimonthly x 2, then monthly to ensure compliance. 4. The results of the audits will be reported to the QAPI committee at least quarterly to ensure ongoing compliance. 5. Date of compliance: 10-2-18 | |

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| K 325 | Continued From page 9 Alcohol-based hand-rub dispensers shall be protected in accordance with 8.7.3.1, unless all of the following conditions are met: (1) Where dispensers are installed in a corridor, the corridor shall have a minimum width of 6 ft (1830 mm). (2) The maximum individual dispenser fluid capacity shall be as follows: (a) 0.32 gal (1.2 L) for dispensers in rooms, corridors, and areas open to corridors (b) 0.53 gal (2.0 L) for dispensers in suites of rooms (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. (4) Dispensers shall be separated from each other by horizontal spacing of not less than 48 in. (1220 mm). (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). (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). (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. (8) Dispensers shall not be installed in the following locations: (a) Above an ignition source within a 1 in. (25 | K 325 | | | |

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| K 325 | Continued From page 10 mm) horizontal distance from each side of the ignition source (b) To the side of an ignition source within a 1 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 345 SS=F | Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 | K 345 | | | |

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| K 345 | <p>Continued From page 11</p> <p>Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure smoke detection systems were maintained in accordance with NFPA 72. Failure to maintain smoke detection systems could result in a lack of system performance during a fire event. This deficient practice affected 29 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During review of the facility inspection records on August 28, 2018, from approximately 11:00 AM to 1:50 PM, no documentation was available to show weekly inspections of the battery powered smoke detectors. A battery powered smoke detector was observed in the laundry with the cover hanging open exposing the battery during the facility tour. When asked if the facility was aware of the battery powered smoke detector, or if there were others in the facility, their locations and whether or not they were being tested weekly, the Maintenance Manager stated the facility was not aware the battery powered smoke detectors were in the building, or the requirement for weekly testing.</p> <p>Actual NFPA standard:</p> | K 345 | <p>K 345</p> <ol style="list-style-type: none"> 1. The battery operated smoke detector was removed from the laundry room and the facility was checked for any other battery operated smoke detectors and none were found. (See attachment H) 2. All residents had the potential to be affected. 3. The maintenance director or designee will perform monthly facility wide audits to ensure there are no battery operated smoke detectors in the building. 4. The audits will be reviewed by the QAPI committee at least quarterly to ensure continued compliance. 5. Date of Compliance 10-2-18. | |

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| K 345 | Continued From page 12 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. NFPA 72 29.6.6 Primary Power Source (Non-rechargeable Battery). If smoke alarms are powered by a primary battery, the battery shall be monitored to ensure the following conditions are met: (1) All power requirements are met for at least 1 year of battery life, including weekly testing. (2) A distinctive audible trouble signal before the battery is incapable of operating (from causes such as aging or terminal corrosion) the device(s) for alarm purposes. (3) For a unit employing a lock-in alarm feature, automatic transfer is provided from alarm to a trouble condition. (4) At the battery voltage at which a trouble signal is obtained, the unit is capable of producing an alarm signal for at least 4 minutes, followed by not less than 7 days of trouble signal operation. (5) The audible trouble signal is produced at least once every minute for 7 consecutive days. (6) Acceptable replacement batteries are clearly identified by the manufacturer ' s name and model number on the unit near the battery compartment. | K 345 | | | |

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| K 345 | Continued From page 13 | K 345 | | |
| K 353 SS=F | <p>(7) A noticeable, visible indication is displayed when a primary battery is removed from the unit.</p> <p>Sprinkler System - Maintenance and Testing CFR(s): NFPA 101</p> <p>Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on record review, observation and 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 29 residents, staff and visitors on the dates of the survey.</p> <p>Findings include: During the review of facility records on August 28,</p> | K 353 | | |

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| K 353 | Continued From page 14 2018, from approximately 11:00 AM to 1:50 PM, documentation for a three-year full trip test of the dry system was last recorded in 2014. No documentation could be produced for a full trip test in 2017. Further review of the sprinkler inspection records revealed dry sprinkler heads had been identified on the annual sprinkler inspections in 2016 and 2017 as being in service for more than 10 years. When asked, the Maintenance Manager stated the facility was not aware the full trip test of the dry system was past due or dry sprinkler heads were in service longer than 10 years. Actual NFPA standard: NFPA 25 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. 5.3.1.1.1.6* Dry sprinklers that have been in service for 10 years shall be replaced or representative samples shall be tested and then retested at 10-year intervals. | K 353 | K353 1. The full trip test was completed on 6-22-17 (see attachment I). The sprinkler heads will be measured on 10-1-18 and replacements will be ordered. (see attachment J). 2. All residents had the potential to be affected. 3. The maintenance director or designee will audit the trip test schedules and the replacement of sprinkler heads to ensure compliance. 4. The results of the audits will be reviewed by the QAPI committee at least quarterly to ensure continued compliance 5. Date of compliance: 10-2-18 | | |
| K 355 SS=F | Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure portable fire extinguishers were | K 355 | | | |

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| K 355 | <p>Continued From page 15</p> <p>installed, inspected and maintained in accordance with NFPA 10. Failure to install, inspect and maintain portable fire extinguishers could result in a lack of availability and performance during a fire event. This deficient practice affected 29 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour on August 28, 2018, from approximately 1:50 PM to 3:30 PM, observation of the fire extinguishers throughout the facility revealed the 6-year internal inspections were past due. Fire extinguishers were dated either 2009, 2010 or 2011, which all exceeded the six-year requirement. Observation also revealed the kitchen was equipped with a Class K extinguisher, but not an ABC extinguisher as required. When asked, the Maintenance Manager stated the facility was unaware of these extinguisher requirements.</p> <p>Actual NFPA standard:</p> <p>NFPA 10 5.4.2* Selection by Occupancy. Fire extinguishers shall be provided for the protection of both the building structure and the occupancy hazards contained therein regardless of the presence of any fixed fire suppression systems. 7.3.1.1.2 Fire extinguishers shall be internally examined at intervals not exceeding those specified in Table 7.3.1.1.2. (see Table 7.3.1.1.2) 7.3.1.2.1 Six-Year Internal Examination. Every 6 years, stored-pressure fire extinguishers that require a 12-year hydrostatic test shall be emptied and subjected to the applicable internal examination procedures as detailed in the</p> | K 355 | <p>K 355</p> <ol style="list-style-type: none"> 1. All fire extinguishers in the building will be replaced on 10-1-18. An ABC extinguisher will be added to the kitchen on 10-1-18. 2. All residents had the potential to be affected. 3. The maintenance director or designee will audit/inspect the fire extinguishers on a monthly basis to ensure compliance. 4. The results of the audits/inspections will be reviewed by the QAPI committee at least quarterly to ensure continued compliance. 5. Date of Compliance: 10-2-18 | | |

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| K 355 | Continued From page 16 manufacturer's service manual and this standard. 7.3.1.2.1.1 When the applicable maintenance procedures are performed during periodic recharging or hydrostatic testing, the 6-year requirement shall begin from that date. NFPA 96 10.10 Portable Fire Extinguishers. 10.10.1* Portable fire extinguishers shall be installed in kitchen cooking areas in accordance with NFPA 10 and shall be specifically listed for such use. 10.10.2 Portable extinguishers shall use agents that saponify upon contact with hot grease in accordance with NFPA 10 (Class K extinguishers). 10.10.3 Other fire extinguishers in the kitchen area shall be installed in accordance with NFPA 10. 10.10.4 Portable fire extinguishers shall be maintained in accordance with NFPA 10. | K 355 | | | |
| K 363 SS=D | 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 | K 363 | | | |

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| K 363 | <p>Continued From page 17</p> <p>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.</p> <p>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 between smoke compartments, preventing defend in place. This deficient practice has the potential to affect 2 residents, staff, and visitors on the date of survey.</p> <p>Findings include:</p> <p>During the facility tour on August 28, 2018, from approximately 1:50 PM to 3:30 PM, observation and operational testing of the corridor doors revealed resident room #302 would not latch, and</p> | K 363 | <p>K 363</p> <ol style="list-style-type: none"> 1. The latch for door #302 has been repaired and the door to room # 105 has been replaced. (see attachments M & N) 2. Two residents had the potential to be affected. 3. An inspection of all doors will be completed by the maintenance director or designee at least quarterly beginning 9-28-18. Any door identified to not be in compliance will be fixed and maintained to NFPA standards. 4. The door inspection results will be reviewed at least quarterly by the QAPI committee to ensure continued compliance. 5. Date of Compliance 10-2-18. | |

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| K 363 | Continued From page 18 resident room #105 had an approximately 5/8" gap between the face of the door and the door frame. When asked, the Maintenance Manager stated the facility was unaware of the door issues. Actual NFPA Standards: 19.3.6.3* Corridor Doors. 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 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. Additional Reference: Centers for Medicare/Medicaid Services S&C Letter 07-18. | K 363 | | | |
| K 511 SS=D | Utilities - Gas and Electric CFR(s): NFPA 101 | K 511 | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135084 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____ | | (X3) DATE SURVEY COMPLETED 08/28/2018 |
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| K 511 | <p>Continued From page 19</p> <p>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</p> <p>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 staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour on August 28, 2018 from approximately 1:50 PM to 3:30 PM, observation of the facility revealed the following: 1.) The Administrator's office and Director of Nursing's office had extension cords being used as permanent wiring for window air conditioners. 2.) Staff break room had a microwave, full-sized refrigerator, and coffee pot plugged in to an RPT. 4.) The electrical panel in the janitorial closet of the 200 hallway had a blank missing. When asked, the Maintenance Manager stated the facility was unaware of the extension cords,</p> | K 511 | <p>K 511</p> <ol style="list-style-type: none"> The window air conditioners and extension cords in the Administrator's and DNS's offices have been removed. (see attachments O, P) The refrigerator in the staff break room has been moved and RPT has been removed. (see attachments Q, R) The blank in the electrical panel in the janitorial closet have been replaced (see attachment S) No residents were affected by this practice. The maintenance director or designee will audit all areas of the building on a monthly basis to ensure no extension cords or RPT's are being used and the electrical panels do not have any blanks missing. The audits will be reviewed by the QAPI committee on a quarterly basis to ensure ongoing compliance. Date of compliance 10-2-18 | | |

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| K 511 | <p>Continued From page 20 appliances plugged into a relocatable power tap in the break room and missing blank at the electrical panel in the janitorial closet.</p> <p>Actual NFPA standard:</p> <p>NFPA 70 400.8 Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following:</p> <ul style="list-style-type: none"> (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 <p>Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of 368.8.</p> <ul style="list-style-type: none"> (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 <p>110.12 Mechanical Execution of Work. Electrical equipment shall be installed in a neat and workmanlike manner.</p> <p>(A) Unused Openings. Unused cable or raceway openings in boxes, raceways, auxiliary gutters, cabinets, cutout boxes, meter socket enclosures, equipment cases, or housings shall be effectively closed to afford protection substantially equivalent to the wall of the equipment. Where metallic plugs or plates are used with nonmetallic enclosures, they shall be recessed at least 6 mm (¼ in.) from the outer surface of the enclosure.</p> | K 511 | | |

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| K 511 | Continued From page 21 (B) Subsurface Enclosures. Conductors shall be racked to provide ready and safe access in underground and subsurface enclosures into which persons enter for installation and maintenance. (C) Integrity of Electrical Equipment and Connections. Internal parts of electrical equipment, including busbars, wiring terminals, insulators, and other surfaces, shall not be damaged or contaminated by foreign materials such as paint, plaster, cleaners, abrasives, or corrosive residues. There shall be no damaged parts that may adversely affect safe operation or mechanical strength of the equipment such as parts that are broken; bent; cut; or deteriorated by corrosion, chemical action, or overheating. | K 511 | | | |
| 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 stop, potentially hinders the ability of staff to shut down the generator if required. This deficient practice affected 29 residents, staff and visitors on the date of the survey. | K 911 | K 911 1. A remote manual stop station was installed on the generator on 9-25-18. (see attachment T) 2. All residents had the potential to be affected. 3. The maintenance director or designee will inspect and ensure label is intact to the remote manual stop station on a monthly basis to ensure compliance. 4. The inspection results will be reviewed at least quarterly by the QAPI committee to ensure compliance. 5. Date of compliance: 10-2-18 | | |

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| K 911 | Continued From page 22 Findings include: During the facility tour conducted on August 28, 2018 from approximately 1:50 PM to 3:30 PM, a remote manual stop station for the EES generator could not be located. When asked, the Maintenance Manager stated the facility was not equipped with a remote stop station, or aware of the requirement. 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 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 | K 918 | | | |

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| K 918 | <p>Continued From page 23</p> <p>transfer switches are performed in accordance with NFPA 110.</p> <p>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.</p> <p>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>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 deficient practice affected 29 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During review of the facility generator inspection</p> | K 918 | <p>K 918</p> <ol style="list-style-type: none"> 1. The monthly generator load test was completed on 9-26-18 and the weekly generator inspection log was completed on 9-26-18 (see attachments U & V) 2. All residents had the potential to be affected. 3. The maintenance director or designee will perform monthly generator load tests and weekly generator inspections/audits. 4. The load tests and inspections/audits will be reviewed at least quarterly by the QAPI committee to ensure ongoing compliance. 5. Date of Compliance: 10-2-18 | | |

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| K 918 | Continued From page 24 and testing records on August 28, 2018, from approximately 11:00 AM to 1:50 PM, the facility failed to provide a monthly load test for March 2018 and the following weekly generator inspection logs: a.) Week of 9/24/17 - 9/30/17 b.) Week of 7/1/18 - 7/7/18 When asked, the Maintenance Manager stated the facility was unaware of the missing inspections and monthly load test. Actual NFPA standard: NFPA 110 8.4 Operational Inspection and Testing. 8.4.1* EPSSs, including all appurtenant components, shall be inspected weekly and exercised under load at least monthly. | K 918 | | | |



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

September 12, 2018

Anita Burdick, Administrator
Oak Creek Rehabilitation Center of Kimberly
500 Polk Street East
Kimberly, ID 83341-1618

Provider #: 135084

RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER

Dear Ms. Burdick:

On **August 28, 2018**, an Emergency Preparedness survey was conducted at **Oak Creek Rehabilitation Center of Kimberly** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with 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. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. Please provide **ONLY ONE** completion date for each federal and state tag in column (X5) Completion Date to signify when you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **September 25, 2018**. Failure to submit an acceptable PoC by **September 25, 2018**, may result in the imposition of civil monetary penalties by **October 17, 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 **October 2, 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 **October 2, 2018**. A change in the seriousness of the deficiencies on **October 2, 2018**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **October 2, 2018**, includes the following:

Denial of payment for new admissions effective **November 28, 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 **February 28, 2019**, 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 **August 28, 2018**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

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

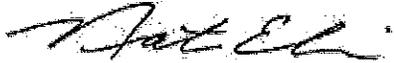
This request must be received by **September 25, 2018**. If your request for informal dispute resolution is received after **September 25, 2018**, the request will not be granted.

Anita Burdick, Administrator
September 12, 2018
Page 4 of 4

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,

A handwritten signature in black ink, appearing to read "Nate Elkins".

Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosures

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

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| E 000 | Initial Comments The facility is a single story, Type V (III) construction, with multiple exits to grade. It was originally constructed in 1963 and is fully sprinklered with a complete, electronically monitored fire alarm/smoke detection system throughout. The Essential Electrical System is supplied by a natural gas powered, on-site automatic generator installed new in 2017. Currently the facility is licensed for 57 SNF/NF beds and had a census of 29 on the date of the survey. The following deficiencies were cited during the emergency preparedness survey conducted on August 28, 2018. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73. The Survey was conducted by: Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction | E 000 |  | |
| E 009 SS=D | Local, State, Tribal Collaboration Process CFR(s): 483.73(a)(4) [(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:] (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the facility's efforts to contact | E 009 | | |

| | | |
|---|-------------------------------|-----------------------------|
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Anita Burdick</i> | TITLE <i>Administrator</i> | (X6) DATE <i>9-28-18</i> |
|---|-------------------------------|-----------------------------|

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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| E 009 | <p>Continued From page 1</p> <p>such officials and, when applicable, of its participation in collaborative and cooperative planning efforts.</p> <p>* [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the dialysis facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility had not implemented a method for collaboration with local, tribal, regional, State and Federal emergency response officials to promote an integrated response to emergency events. This deficient practice has the potential to affect 29 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>Review of the facility emergency plan on August 28, 2018, from approximately 8:45 AM to 11:00 AM, revealed the facility failed to collaborate with local, tribal, regional, State, and Federal officials to maintain an integrated response in the event of a disaster. When asked, the Administrator stated the facility had not yet reached out to any of these organizations or participated in any of the</p> | E 009 | <p>E 009</p> <ol style="list-style-type: none"> 1. Page eight (8) of the Emergency Preparedness Program was updated on 9-27-18 to require the plan be sent to local, regional, State and Federal Officials after each annual or significant update (see bolded in attachment AA). 2. All residents had the potential to be affected. 3. The Administrator and or designees will attend and document local, regional, State and Federally sponsored emergency preparedness meetings, trainings, etc. to ensure collaborative efforts are practiced and include such documentation in Appendix H, which title has been broadened to include those training documentations (see bolded in attachment AB) 4. Collaborative efforts to maintain and integrated response in the event of a disaster will be reported to and reviewed by the QAPI committee at least quarterly to ensure ongoing compliance. 5. Date of Compliance: 10-2-18 | | |

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| E 009 | Continued From page 2 planning or training they provide. | E 009 | E 034 1. The Emergency Preparedness Plan was updated on 9-27-18 to update the facility's critical functions & needs to utilize occupancy and surge occupancy criteria should the facility be able provide assistance in the event of an emergency. (see attachments AC) 2. All residents had the potential to be affected. 3. The Incident Command team will review the facility needs, occupancy and assistance we can provide on an annual basis to ensure 96 hours of critical functions and inventory are available and communicated to emergency personnel with each annual update. Central supply, housekeeping and dietary will inventory supplies quarterly to the surge capacity levels identified. 4. The current plan to provide information to emergency personnel on the facility's needs, occupancy and assistance the facility could provide will be reviewed by the QAPI committee at least quarterly to | | |
| E 034 SS=E | Reference: 42 CFR 483.73 (a) (4) Information on Occupancy/Needs CFR(s): 483.73(c)(7) [(c) The [facility] 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: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For Inpatient Hospice at §418.113:] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to document a current plan for sharing information on facility needs, occupancy and its ability to provide | E 034 | | | |

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| E 034 | Continued From page 3 assistance with emergency management officials. Lack of a current plan for providing information to emergency personnel on the facility's needs and abilities to provide assistance during an emergency has the potential to hinder response assistance and continuation of care of residents. This deficient practice could potentially affect 29 residents, staff and visitors on the date of the survey. Findings include: On August 28, 2018, from approximately 8:45 AM to 11:00 AM, review of the facility emergency plan revealed no indication facility had documented facility needs, occupancy and assistance facility could provide in the event of an emergency. When asked, Administrator stated facility had not yet reached out to emergency management officials to share information on the facility. Reference: 42 CFR 483.73 (c) (7) | E 034 | ensure compliance. 5. Date of Compliance: 10-2-18 | | |
| E 035 SS=D | LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) [(c) The [LTC facility and ICF/IID] 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: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. | E 035 | | | |

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| E 035 | Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to provide current information on the facility emergency preparedness plan with residents, families and representatives. Not sharing information with residents, families and representatives on the EP plan, has the potential to create confusion and lack of understanding of the facility's response during a disaster. This deficient practice could potentially affect 29 residents, staff and visitors on the date of the survey. Findings include: On August 28, 2018, from approximately 8:45 AM to 11:00 AM, review of the facility Emergency Preparedness (EP) Plan and related documents revealed the facility did not have a plan to share information with residents, families and representatives on the emergency preparedness plan. When asked, the Administrator stated the facility was unaware of this requirement. Reference: 42 CFR 483.73 (c) (8) | E 035 | E 035 1. A letter was written and sent to all current residents, families, and/or responsible parties on 9-24-18 with Appendix Q "Emergency Preparedness Guide" from the resident handbook. (see Attachment AD). New residents will be given the handbook on admission with information as to where the entire EPP is located if they wish to review it. 2. All residents had the potential to be affected. 3. The administrator or designee will audit new admission charts monthly to ensure compliance. 4. The results of the audits will be reviewed by the QAPI committee at least quarterly to ensure ongoing compliance. 5. Date of Compliance: 10-2-18 | | |
| E 039 SS=F | EP Testing Requirements CFR(s): 483.73(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. | E 039 | | | |

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| E 039 | <p>Continued From page 5</p> <p>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:]</p> <p>(i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event.</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</p> | E 039 | <p>E 039</p> <ol style="list-style-type: none"> 1. The facility will conduct a full-scale community based exercise on 10-2-18 by conducting an evacuation to a nearby staging area and inviting local emergency responders to participate. 2. All residents had the potential to be affected. 3. The incident command team (Administrator, DNS and Maintenance Director) will complete an After Action Report and Improvement Plan for the full-scale community exercise. The Administrator and/or designees have also registered to attend "Operation Special Pathogens – A coordinated Community Response" workshop on Oct. 17th, 2018 in Twin Falls, Idaho. 4. The After Action Report and Improvement Plan from the full scale community based exercise will be reviewed by the QAPI committee to ensure compliance. 5. Date of Compliance: 10-2-18 | | |

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| E 039 | <p>Continued From page 6</p> <p>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>(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.</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 test the emergency preparedness plan annually. Failure to test the emergency preparedness plan annually, has the potential to hinder staff response during a disaster. This deficient practice affected 29 residents, staff and visitors on the date of the survey.</p> <p>Findings Include:</p> <p>Review of the facility EP plan on August 28, 2018, from approximately 8:45 AM to 11:00 AM, revealed a written EP testing program, and both a full-scale, community-based exercise and a facility-based exercise. However, there had not been a full-scale, community-based exercise in the last 12 months. The last known full-scale exercise was July 2017. When asked, the Administrator stated the facility had not yet planned or participated in a community-based full-scale exercise this year.</p> <p>Reference:</p> <p>42 CFR 483.73 (d) (2)</p> | E 039 | | |

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| E 041 E 041 SS=F | Continued From page 7 Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) | E 041 E 041 | | | |

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| E 041 | Continued From page 8 Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html . If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. | E 041 | | | |

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| E 041 | <p>Continued From page 9</p> <p>(vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009. 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 deficient practice affected 29 residents, staff and visitors on the dates of the survey.</p> <p>Findings Include:</p> <p>During review of the facility generator inspection and testing records on August 28, 2018, from approximately 11:00 AM to 1:50 PM, the facility failed to provide a monthly load test for March 2018 and the following weekly generator inspection logs:</p> <p>a.) Week of 9/24/17 - 9/30/17 b.) Week of 7/1/18 - 7/7/18</p> <p>When asked, the Maintenance Manager stated the facility was unaware of the missing inspections and monthly load test.</p> | E 041 | <p>E 041</p> <ol style="list-style-type: none"> 1. The monthly generator load test was completed on 9-26-18 and the weekly generator inspection log was completed on 9-26-18 (see attachments U, V) 2. All residents had the potential to be affected. 3. The maintenance director or designee will perform monthly generator load tests and weekly generator inspections/audits. 4. The load tests and inspections/audits will be reviewed at least quarterly by the QAPI committee to ensure ongoing compliance. 5. Date of Compliance: 10-2-18 | |

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| E 041 | Continued From page 10 Reference: 42 CFR 483.73 (e) (2) | E 041 | | |