



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK – ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

May 24, 2019

Rick Myers, Administrator
Life Care Center Of Sandpoint
1125 North Division Street
Sandpoint, ID 83864-2148

Provider #: 135127

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

Dear Mr. Myers:

On **May 9, 2019**, a Facility Fire Safety and Construction and Emergency Preparedness survey was conducted at **Life Care Center Of Sandpoint** 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 6, 2019**. Failure to submit an acceptable PoC by **June 6, 2019**, may result in the imposition of civil monetary penalties by **June 28, 2019**.

Your PoC must contain the following:

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

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

Remedies may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **June 14, 2019**, (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 **August 9, 2019**. A change in the seriousness of the deficiencies on **June 23, 2019**, 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 August 9, 2019, includes the following:

Denial of payment for new admissions effective **August 9, 2019**.
42 CFR §488.417(a)

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **November 9, 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 9, 2019**, 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:

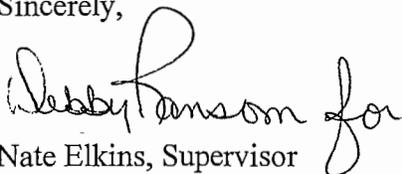
BFS Letters (06/30/11)

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

This request must be received by **June 6, 2019**. If your request for informal dispute resolution is received after **June 6, 2019**, 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,

A handwritten signature in black ink that reads "Nate Elkins for". The signature is written in a cursive, flowing style.

Nate Elkins, Supervisor
Facility Fire Safety and Construction

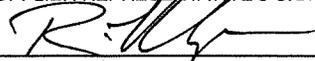
NE/dr
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 05/09/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT		STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864		
(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
K 000	<p>INITIAL COMMENTS</p> <p>The facility is a single story, Type V (111) structure that was originally completed in October of 1997. The building is protected throughout by an automatic fire suppression system in accordance with NFPA 13, along with an interconnected fire alarm/smoke detection system and piped in medical gas. Emergency backup power is equipped with a diesel powered, Emergency Power Supply System (EPSS) generator. Currently the facility is licensed for 124 SNF/NF beds, with a census of 95 on the date of the survey.</p> <p>The following deficiencies were cited during the annual Fire/Life safety survey conducted on May 9, 2019. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Chapter 19, Existing Health Care Occupancy, in accordance with 42 CFR 483.70</p> <p>The Survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	K 000	<p style="text-align: center;">RECEIVED JUN -7 2019 FACILITY STANDARDS</p>	
K 211 SS=E	<p>Means of Egress - General CFR(s): NFPA 101</p> <p>Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility</p>	K 211		<p>Corrective Action: The office furniture boxes were removed from the west corridor on or before 6-13-19.</p> <p>Identification: All residents have the potential to be affected by this deficient practice.</p>

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

TITLE

(X6) DATE



EXECUTIVE DIRECTOR

6-3-19

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 211	<p>Continued From page 1</p> <p>failed to ensure means of egress were not obstructed in accordance with NFPA 101. Blocking egress corridors with storage had the potential to hinder safe evacuation of occupants using an interconnecting egress corridor during a fire or other emergency. This deficient practice affected residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 5/9/19 from 11:00 AM - 12:00 PM, observation of the west corridor, interconnecting the north and south wings, revealed the corridor contained storage of office furniture, bed mattresses and misc. supplies. Measurements taken in this corridor established the overall clear width measured approximately 96 inches and had a remaining clear width of approximately 36 inches from the accumulated storage to the opposing wall.</p> <p>Interview of the Maintenance Director at approximately 11:30 AM, determined the office furniture was delivered the day prior and placed in this corridor to stage for office remodels.</p> <p>Actual NFPA standard:</p> <p>NFPA 101</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 not intended for the housing, treatment, or use of</p>	K 211	<p>Systematic Changes:</p> <p>Maintenance Director or designee to provide education to all staff on or before 6-13-19 on standards regarding minimal clearances in hallways.</p> <p>Monitor:</p> <p>Maintenance Director or Designee to audit hallway clearances weekly x4 then monthly x3 and report findings to QAPI Committee.</p>	6/13/2019

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K 211	Continued From page 2 inpatients shall be not less than 44 in. (1120 mm) in clear and unobstructed width. (2)*Where corridor width is at least 6 ft (1830 mm), noncontinuous projections not more than 6 in. (150 mm) from the corridor wall, above the handrail height, shall be permitted. (3) Exit access within a room or suite of rooms complying with the requirements of 19.2.5 shall be permitted. (4) Projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in.(1525 mm). (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c)*The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment	K 211		
K 354 SS=F	Sprinkler System - Out of Service CFR(s): NFPA 101 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the	K 354	Corrective Action: The impaired fire suppression system had been repaired prior to the time of survey. Identification: All resident have the potential to be affected by this deficient practice.	6/13/2019

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K 354	<p>Continued From page 3 sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure resident protections during the course of unplanned fire suppression system impairments. Failure to conduct fire watch procedures as required during fire suppression system outages, has the potential for fires to develop and spread beyond incipient stages. This deficient practice affected 95 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During review of maintenance and inspection records conducted on 5/9/19 from 8:30 - 11:00AM, records indicated the dry section of the fire suppression system had been under repair from 2/13/19 to 3/27/19. Further review of documentation provided failed to determine any fire watch was documented during this period. When asked about the missing documentation, the Maintenance Director stated he was informed by corporate no fire watch documentation was needed for a dry system outage as it was not a "below the ceiling" impairment.</p> <p>Actual NFPA standard:</p> <p>NFPA 25 15.6 Emergency Impairments. 15.6.1 Emergency impairments shall include, but are not limited to, system leakage, interruption of water supply, frozen or ruptured piping, and equipment failure. 15.6.2 When emergency impairments occur, emergency action shall be taken to minimize potential injury and damage.</p>	K 354	<p>Systematic Changes: Executive Director or designee to provide education to all maintenance staff on or before 6-13-19, regarding proper fire watch procedures in the instance of an impaired fire suppression system.</p> <p>Monitor: Maintenance Director or designee conduct fire watch drills with maintenance staff weekly x4 and then monthly x3 and report findings to QAPI Committee.</p>	6/13/2019

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K 354	Continued From page 4 15.6.3 The coordinator shall implement the steps outlined in Section 15.5. 15.5.2 Before authorization is given, the impairment coordinator shall be responsible for verifying that the following procedures have been implemented: (1) The extent and expected duration of the impairment have been determined. (2) The areas or buildings involved have been inspected and the increased risks determined. (3) Recommendations have been submitted to management or the property owner or designated representative. (4) Where a required fire protection system is out of service for more than 10 hours in a 24-hour period, the impairment coordinator shall arrange for one of the following: (a) Evacuation of the building or portion of the building affected by the system out of service (b)*An approved fire watch (c)*Establishment of a temporary water supply (d)*Establishment and implementation of an approved program to eliminate potential ignition sources and limit the amount of fuel available to the fire (5) The fire department has been notified. (6) The insurance carrier, the alarm company, property owner or designated representative, and other authorities having jurisdiction have been notified. (7) The supervisors in the areas to be affected have been notified. (8) A tag impairment system has been implemented. (See Section 15.3.) (9) All necessary tools and materials have been assembled on the impairment site.	K 354		
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101	K 511	Corrective Action: An audit of the entire facility for "daisy chain" cords and/or power	6/13/19

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K 511	<p>Continued From page 5</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, the facility failed to ensure safe electrical installation in accordance with NFPA 70 and their approved, listed assemblies. Use of relocatable power taps (RPTs) outside of their listing and when connected in series (daisy-chained), has been historically linked to potential electrical shocks and arc fires. This deficient practice affected staff of the administrative wing on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 5/9/19 from 1:00 - 3:00 PM, observation of the Social Services office at the front of the facility, revealed the use of a RPT, daisy-chained into an extension cord, to supply power to office equipment.</p> <p>Actual NFPA standard: NFPA 70</p> <p>110.2 Approval. The conductors and equipment required or permitted by this Code shall be acceptable only if approved. Informational Note: See 90.7, Examination of</p>	K 511	<p>strips was conducted on or before 6-13-19.</p> <p>Identification:</p> <p>All residents have the potential to be affected by this deficient practice.</p> <p>Systematic Changes:</p> <p>Maintenance Director or designee to provide education to all staff on or before 6-13-19, regarding the proper use of extension cords and power strips within the facility.</p> <p>Monitor:</p> <p>Maintenance Director or designee will audit extension cord/power strip usage in 10 rooms/offices weekly x4 then monthly x3 and report findings to QAPI Committee.</p>	6/13/2019

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K 511	<p>Continued From page 6</p> <p>Equipment for Safety, and 110.3, Examination, Identification, Installation, and Use of Equipment. See definitions of Approved, Identified, Labeled, and Listed.</p> <p>110.3 Examination, Identification, Installation, and Use of Equipment.</p> <p>(A) Examination. In judging equipment, considerations such as the following shall be evaluated:</p> <p>(1) Suitability for installation and use in conformity with the provisions of this Code</p> <p>Informational Note: Suitability of equipment use may be identified by a description marked on or provided with a product to identify the suitability of the product for a specific purpose, environment, or application. Special conditions of use or other limitations and other pertinent information may be marked on the equipment, included in the product instructions, or included in the appropriate listing and labeling information. Suitability of equipment may be evidenced by listing or labeling.</p> <p>(2) Mechanical strength and durability, including, for parts designed to enclose and protect other equipment, the adequacy of the protection thus provided</p> <p>(3) Wire-bending and connection space</p> <p>(4) Electrical insulation</p> <p>(5) Heating effects under normal conditions of use and also under abnormal conditions likely to arise in service</p> <p>(6) Arcing effects</p> <p>(7) Classification by type, size, voltage, current capacity, and specific use</p> <p>(8) Other factors that contribute to the practical safeguarding of persons using or likely to come in contact with the equipment</p> <p>(B) Installation and Use. Listed or labeled equipment</p>	K 511		

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K 511	Continued From page 7 shall be installed and used in accordance with any instructions included in the listing or labeling. Additional reference: UL 1363 Standard for Relocatable Power Taps	K 511		
K 923 SS=D	Gas Equipment - Cylinder and Container Storage CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full	K 923	Corrective Action: All oxygen cylinders were put in their proper locations on or before 6-13-19. Identification: All residents have the potential to be affected by this deficient practice. Systematic Changes: Maintenance Director or designee to provide education to all staff on or before 6-13-19, regarding the proper storage of oxygen cylinders. Monitor: Maintenance Director or Designee to audit oxygen cylinder storage weekly x4 then monthly x3 and report findings to QAPI Committee.	6/13/19

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K 923	<p>Continued From page 8</p> <p>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)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, the facility failed to ensure oxygen cylinders were maintained in accordance with NFPA 99. Failure to segregate oxygen cylinders in storage has the potential to inadvertently use the incorrect cylinder during an emergency requiring supplemental oxygen. This deficient practice affected those residents requiring supplemental oxygen treatment and staff on the date of the survey.</p> <p>During the facility tour conducted on 5/9/19 from 1:00 - 3:00 PM, observation of the oxygen storage room in the east 200 hall at approximately 1:45 PM, revealed four (4) "A" cylinders stored on the side marked "Empty". Asked at the time of this observation if these cylinders were full or empty, the Maintenance Director identified them as "full".</p> <p>Actual NFPA standard:</p> <p>NFPA 99</p> <p>11.6.5 Special Precautions - Storage of Cylinders and Containers.</p> <p>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.</p> <p>11.6.5.2 If empty and full cylinders are stored within the same enclosure, empty cylinders shall be segregated from full cylinders.</p>	K 923		

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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864		
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K 923	Continued From page 9 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			

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C 000	<p>INITIAL COMMENTS</p> <p>The facility is a single story, Type V (111) structure that was originally completed in October of 1997. The building is protected throughout by an automatic fire suppression system in accordance with NFPA 13, along with an interconnected fire alarm/smoke detection system and piped in medical gas. Emergency backup power is equipped with a diesel powered, Emergency Power Supply System (EPSS) generator. Currently the facility is licensed for 124 SNF/NF beds and had a census of 95 on the date of the survey.</p> <p>The following deficiency was cited during the annual fire/life safety survey conducted on May 9, 2019. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Chapter 19, Existing Health Care Occupancy, in accordance with 42 CFR 483.70 and IDAPA 16.03.02, Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities.</p> <p>The Survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	C 000	<p>RECEIVED</p> <p>JUN - 7 2019</p> <p>FACILITY STANDARDS</p>	
C 260	<p>02.106,07,h Weekly Cleaning of Range Hoods/Filters</p> <p>h. All range hoods and filters shall be cleaned at least weekly. This RULE: is not met as evidenced by: Based on record review and interview, the facility failed to ensure UL 300 kitchen exhaust hood system filters were cleaned on a weekly basis. Failure to clean exhaust hood filters that capture grease-laden vapors weekly, potentially increases</p>	C 260	<p>Corrective Action: All range hood filters were cleaned on or before 6-13-19.</p> <p>Identification: All residents have the potential to be affected by this deficient practice.</p>	6/13/2019

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

TITLE

EXECUTIVE DIRECTOR 6-3-19

(X6) DATE

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C 260	Continued From Page 1 the facility exposure to the risks of grease fires. This deficient practice affected staff of the main Kitchen on the date of the survey. Findings include: During the facility tour conducted on 5/9/19 from 10:30 AM to 2:00 PM, kitchen weekly cleaning and maintenance records were presented by Kitchen staff in the main Kitchen at approximately 1:00 PM. During review of these records, no documentation was available that indicated a weekly cleaning of exhaust filters of the main hood was being conducted. At approximately 1:15 PM, interview of the Kitchen staff on duty revealed the facility had formerly documented hood filter cleaning, but the documentation of procedures had been updated and the hood filter cleaning was not currently being documented. Actual standard: 07. Maintenance of Equipment. The facility shall establish routine test, check and maintenance procedures for all equipment. h. All range hoods and filters shall be cleaned at least weekly.	C 260	Systematic Changes: Dietary Services Manager (DSM) or designee to provide training to all dietary staff on or before 6-13-19 regarding proper cleaning of range hood filters. Monitor: DSM or designee will audit range hood filter cleaning log weekly x4 then monthly x3 and report findings to QAPI Committee.	6/13/2019

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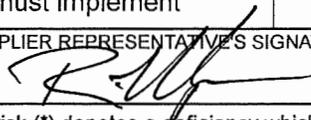
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E 000	Initial Comments The facility is a single story, Type V (111) structure that was originally completed in October of 1997. The building is protected throughout by an automatic fire suppression system in accordance with NFPA 13, along with an interconnected fire alarm/smoke detection system and piped in medical gas. Emergency backup power is equipped with a diesel powered, Emergency Power Supply System (EPSS) generator. The facility is located within a municipal fire district, with county and state EMS support. Currently the facility is licensed for 124 SNF/NF beds, with a census of 95 on the date of the survey. The following deficiency was cited during the emergency preparedness survey conducted on May 9, 2019. 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 and Construction	E 000	RECEIVED JUN -7 2019 FACILITY STANDARDS	
E 041 SS=F	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	E 041	Corrective Action: Generator 36 month/4 hour load test scheduled before 6-13-19. Identification: All residents have the potential to be affected by this deficient practice.	6/13/2019

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EXECUTIVE DIRECTOR 6-3-19

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 041	<p>Continued From page 1</p> <p>emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section.</p> <p>§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.</p> <p>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.</p> <p>482.15(e)(3), §483.73(e)(3), §485.625(e)(3) 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.</p> <p>*[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</p>	E 041	<p>Systematic Changes:</p> <p>Executive Director or designee to provide training to all maintenance staff on or before 6-13-19 regarding proper frequency of generator load tests.</p> <p>Monitor: Generator 36 month/4 hour load test added to TELS System to ensure compliance and findings reported to QAPI Committee.</p>	6/13/2019

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E 041	Continued From page 2 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. (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	E 041		

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E 041	<p>Continued From page 3</p> <p>failed to ensure the EPSS generator was maintained in accordance with NFPA 110. Failure to conducted required load testing for the backup Emergency Electrical System (EES), has the potential to render the facility without necessary electrical support during a power loss or other disaster. This deficient practice affected 95 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During review of provided EPSS generator records conducted on 5/9/19 from 8:30 - 11:00 AM, load test records did not identify a four-hour load test was conducted on the Level 1, Class X EES within the last three years. Interview of the Maintenance Director during record review conducted from 8:30 - 11:00 AM, established he was not aware of the required load test.</p> <p>Actual NFPA standard:</p> <p>8.3 Maintenance and Operational Testing. 8.3.1* The EPSS shall be maintained to ensure to a reasonable degree that the system is capable of supplying service within the time specified for the type and for the time duration specified for the class. 8.4.9.1 Level 1 EPSS shall be tested continuously for the duration of its assigned class (see Section 4.2). 8.4.9.2 Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 continuous hours.</p>	E 041		