



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

August 13, 2019

Corwin Lewis, Jr., Administrator
Parke View Rehabilitation & Care Center
2303 Parke Avenue
Burley, ID 83318-2106

Provider #: 135068

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Mr. Lewis, Jr.:

On **July 31, 2019**, a Facility Fire Safety and Construction survey was conducted at **Parke View Rehabilitation & Care Center** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. Please provide **ONLY ONE** 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 **August 26, 2019**. Failure to submit an acceptable PoC by **August 26, 2019**, may result in the imposition of civil monetary penalties by **September 17, 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 **September 4, 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 **October 29, 2019**. A change in the seriousness of the deficiencies on **September 14, 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 **September 4, 2019**, includes the following:

Denial of payment for new admissions effective **October 31, 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 **January 31, 2020**, 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 **July 31, 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:

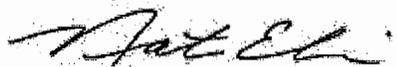
BFS Letters (06/30/11)

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

This request must be received by **August 26, 2019**. If your request for informal dispute resolution is received after **August 26, 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,



Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135068	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 07/31/2019
NAME OF PROVIDER OR SUPPLIER PARKE VIEW REHABILITATION & CARE CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 2303 PARKE AVENUE BURLEY, ID 83318		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The facility is a single story, Type II (111) structure originally constructed in 1963, with a subsequent addition completed in 1998, along with cosmetic upgrades to common areas and administration offices completed as late as 2018. It is fully sprinklered with an interconnected fire alarm/smoke detection system. There is piped in medical gas and an on-site diesel-fired generator. The building has a partial basement with storage, classrooms and maintenance shop. with both county and state EMS services available. The facility is currently licensed for 86 SNF/NF beds and had a census of 71 on the date of the survey. The following deficiencies were cited during the annual Fire/Life Safety survey conducted on July 31, 2019. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy and 42 CFR 483.70. The survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction	K 000	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Parke View Rehabilitation & Care Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.	
K 161 SS=F	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 non-sprinklered and	K 161	1. Fire protective coating to be installed on steel support floor trusses and conduit at 500 break room penetration is sealed. 2. All residents have the potential to be affected by this practice 3. Inservice to be done with maintenance staff regarding fire wall penetrations and fire protective coating.	9/4/19

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

TITLE

(X6) DATE

[Signature]
ADMINISTRATOR

8/23/19

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.

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

Printed: 08/09/2019
FORM APPROVED
OMB NO. 0938-0391

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K 161	<p>Continued From page 1 sprinklered</p> <p>2 II (111) One story non-sprinklered Maximum 3 stories sprinklered</p> <p>3 II (000) Not allowed non-sprinklered</p> <p>4 III (211) Maximum 2 stories sprinklered</p> <p>5 IV (2HH) 6 V (111)</p> <p>7 III (200) Not allowed non-sprinklered</p> <p>8 V (000) Maximum 1 story sprinklered</p> <p>Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5)</p> <p>Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure the fire and smoke resistive properties of the structure were maintained. Failure to maintain penetrations from data sources and the required fire coatings on steel support structures, has the potential to allow smoke, fire and dangerous gases to pass between compartments, as well as decrease the rated assembly load bearing capabilities and cause premature structural failure. This deficient practice affected 71</p>	K 161	4. Maintenance Director or designee will audit steel support structures to have fire protective coating and barrier penetrations are sealed after all work. This will be done monthly for 3 months and reviewed by the QA committee to determine if further audits are necessary.	

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K 161	<p>Continued From page 2 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on 7/31/19 from 1:30 - 3:00 PM, observation of the steel floor support trusses in the riser room on the basement level that supported the upper floor of the facility, found the trusses had the following estimated surface area of missing fire protective coating(s):</p> <p>A section approximately three (3) inches wide by twenty-four (24) inches in length on one truss. A section approximately three (3) inches wide by ten (10) inches in length on one truss. A section approximately three (3) inches wide by forty-eight (48) inches in length on one truss. A section approximately one (1) inch wide by six (6) inches in length on one truss. A section approximately three (3) inches wide by ten (10) inches in length on one truss. A section approximately one (1) inch wide by eight (8) inches in length on one truss. A section approximately one (1) inch wide by four (4) inches in length on one truss.</p> <p>2) During the facility tour conducted on 7/31/19 from 1:30 - 3:00 PM, an above the ceiling observation of the 500 hall nurse's station and abutting breakroom, revealed an approximately 2-1/2 inch diameter plastic data conduit penetration that was not sealed on either side of the wall.</p> <p>Actual NFPA standard:</p> <p>Finding 1</p>	K 161		

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K 161	<p>Continued From page 3 NFPA 101</p> <p>19.1.6 Minimum Construction Requirements. 19.1.6.1 Health care occupancies shall be limited to the building construction types specified in Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7. (See 8.2.1.)</p> <p>8.2.1.2* NFPA 220, Standard on Types of Building Construction, shall be used to determine the requirements for the construction classification.</p> <p>NFPA 220</p> <p>5.1.4 Structural elements, other than those specified in 5.1.3, required to have a fire resistance rating shall be protected by individual encasement, or by membrane or ceiling protection in accordance with NFPA 5000, Building Construction and Safety Code, Section 8.6, or a combination of both. [5000:7.2.7.4]</p> <p>Finding 2</p> <p>NFPA 101</p> <p>8.3.5 Penetrations. The provisions of 8.3.5 shall govern the materials and methods of construction used to protect through-penetrations and membrane penetrations in fire walls, fire barrier walls, and fire resistance-rated horizontal assemblies. The provisions of 8.3.5 shall not apply to approved existing materials and methods of construction used to protect existing through-penetrations and existing membrane penetrations in fire walls, fire barrier walls, or fire resistance-rated horizontal assemblies, unless otherwise required by Chapters 11 through 43. 8.3.5.1* Firestop Systems and Devices Required. Penetrations for cables, cable trays, conduits,</p>	K 161		

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K 161	Continued From page 4 pipes, tubes, combustion vents and exhaust vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a fire barrier shall be protected by a firestop system or device. The firestop system or device shall be tested in accordance with ASTM E 814, Standard Test Method for Fire Tests of Through Penetration Fire Stops, or ANSI/UL 1479, Standard for Fire Tests of Through-Penetration Firestops, at a minimum positive pressure differential of 0.01 in. water column (2.5 N/m ²) between the exposed and the unexposed surface of the test assembly.	K 161		
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 sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with	K 325	1. Inspections of ABHR dispensers being done 2. All residents have the potential to be affected by this practice. 3. Inservice to be done with housekeeping and maintenance staff regarding ABHR dispenser inspections. 4. Maintenance Director or designee will audit inspection forms monthly for 3 months and reviewed by the QA committee to determine if further audits are necessary.	9/4/19

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K 325	<p>Continued From page 5</p> <p>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 (ABHR) dispensers were maintained in accordance with NFPA 101. Failure to test and document operation of ABHR dispensers under manufacturer's recommendations and in accordance with the standard, has the potential of increasing the risk of fires from flammable liquids. This deficient practice affected 71 residents and staff on the date of the survey.</p> <p>Findings include:</p> <p>1) During review of provided maintenance and inspection records conducted on 7/31/19 from 9:30 - 11:00 AM, no records were available for the inspection and testing of ABHR dispensers during the refill process.</p> <p>2) During the facility tour conducted on 7/31/19 from 11:00 AM - 4:00 PM, observation of installed ABHR dispensers revealed both manual and automatic dispensers were installed throughout the facility.</p> <p>Prior to the exit conference at approximately 4:30 PM, Interview with the Environmental Services Manager revealed the Housekeeping department had changed forms for the documentation process, but had yet to implement it during refilling procedures.</p> <p>Actual NFPA standard:</p>	K 325		

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K 325	<p>Continued From page 6</p> <p>NFPA 101</p> <p>19.3.2.6* Alcohol-Based Hand-Rub Dispensers. Alcohol-based hand-rub dispensers shall be protected in accordance with 8.7.3.1, unless all of the following conditions are met:</p> <p>(1) Where dispensers are installed in a corridor, the corridor shall have a minimum width of 6 ft (1830 mm).</p> <p>(2) The maximum individual dispenser fluid capacity shall be as follows:</p> <p>(a) 0.32 gal (1.2 L) for dispensers in rooms, corridors, and areas open to corridors (b) 0.53 gal (2.0 L) for dispensers in suites of rooms</p> <p>(3) Where aerosol containers are used, the maximum capacity of the aerosol dispenser shall be 18 oz. (0.51 kg) and shall be limited to Level 1 aerosols as defined in NFPA30B, Code for the Manufacture and Storage of Aerosol Products.</p> <p>(4) Dispensers shall be separated from each other by horizontal spacing of not less than 48 in. (1220 mm).</p> <p>(5) Not more than an aggregate 10 gal (37.8 L) of alcohol-based hand-rub solution or 1135 oz (32.2 kg) of Level 1 aerosols, or a combination of liquids and Level 1 aerosols not to exceed, in total, the equivalent of 10 gal (37.8 L) or 1135 oz (32.2 kg), shall be in use outside of a storage cabinet in a single smoke compartment, except as otherwise provided in 19.3.2.6(6).</p> <p>(6) One dispenser complying with 19.3.2.6 (2) or (3) per room and located in that room shall not be included in the aggregated quantity addressed in</p>	K 325		

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K 325	<p>Continued From page 7</p> <p>19.3.2.6(5).</p> <p>(7) Storage of quantities greater than 5 gal (18.9 L) in a single smoke compartment shall meet the requirements of NFPA 30, Flammable and Combustible Liquids Code.</p> <p>(8) Dispensers shall not be installed in the following locations:</p> <p>(a) Above an ignition source within a 1 in. (25 mm) horizontal distance from each side of the ignition source</p> <p>(b) To the side of an ignition source within a 1 in. (25mm) horizontal distance from the ignition source</p> <p>(c) Beneath an ignition source within a 1 in. (25 mm) vertical distance from the ignition source</p> <p>(9) Dispensers installed directly over carpeted floors shall be permitted only in sprinklered smoke compartments.</p> <p>(10) The alcohol-based hand-rub solution shall not exceed 95 percent alcohol content by volume.</p> <p>(11) Operation of the dispenser shall comply with the following criteria:</p> <p>(a) The dispenser shall not release its contents except when the dispenser is activated, either manually or automatically by touch-free activation.</p> <p>(b) Any activation of the dispenser shall occur only when an object is placed within 4 in. (100 mm) of the sensing device.</p> <p>(c) An object placed within the activation zone and left in place shall not cause more than one activation.</p> <p>(d) The dispenser shall not dispense more solution than the amount required for hand hygiene consistent with label instructions.</p> <p>(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.</p> <p>(f) The dispenser shall be tested in accordance</p>	K 325		

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K 325 K 345 SS=F	<p>Continued From page 8 with the manufacturer 's care and use instructions each time a new refill is installed.</p> <p>Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101</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 and interview, the facility failed to ensure fire alarm systems were maintained in accordance with NFPA 72. Failure to conduct sensitivity testing on fire alarm systems has the potential to hinder system response during a fire event. This deficient practice affected 71 residents and staff on the date of the survey.</p> <p>Findings include:</p> <p>During review of facility fire alarm inspection records conducted on 7/31/19 from approximately 1:30 PM to 4:00 PM, no documentation was provided indicating a sensitivity testing of the smoke detectors was conducted within the last five years. Interview of the Environmental Services Manager revealed he was not aware any sensitivity test was required as the system was addressable.</p> <p>Actual NFPA standard: NFPA 72</p>	K 325 K 345	<p>1. Sensitivity test was done</p> <p>2. All residents have the potential to be affected by this practice</p> <p>3. Inservice to be done with maintenance staff regarding sensitivity testing requirement</p> <p>4. Administrator or designee to audit that sensitivity test is done and TELS task added to review annually</p>	9/4/19

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K 345	Continued From page 9 Chapter 14 Inspection, Testing, and Maintenance 14.4.5.3.1 Sensitivity shall be checked within 1 year after installation. 14.4.5.3.2 Sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with 14.4.5.3.3. 14.4.5.3.3 After the second required calibration test, if sensitivity tests indicate that the device has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years.	K 345		
K 364 SS=E	Corridor - Openings CFR(s): NFPA 101 Corridor - Openings Transfer grilles are not used in corridor walls or doors. Auxiliary spaces that do not contain flammable or combustible materials are permitted to have louvers or be undercut. In other than smoke compartments containing patient sleeping rooms, miscellaneous openings are permitted in vision panels or doors, provided the openings per room do not exceed 20 square inches and are at or below half the distance from floor to ceiling. In sprinklered rooms, the openings per room do not exceed 80 square inches. Vision panels in corridor walls or doors shall be fixed window assemblies in approved frames. (In fully sprinklered smoke compartments, there are no restrictions in the area and fire resistance of glass and frames.) 18.3.6.5.1, 19.3.6.5.2, 8.3 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure corridor walls were absent of	K 364	1. Doors with grilles to be replaced 2. Residents and staff using the main front door have the potential to be affected by this practice. 3. Inservice to be done with Maintenance staff regarding corridor openings 4. Maintenance Director or designee to audit all corridor doors to verify no transfer grilles.	9/4/19

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K 364	<p>Continued From page 10</p> <p>transfer grilles and would resist the passage of smoke. Installation of transfer grilles which expose interior wall cavities, has the potential to allow smoke, fire and dangerous gases to pass between compartments. This deficient practice affected residents and staff using the main front door exit on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 7/31/19 from approximately 3:00 - 4:00 PM, observation of the front office area by the main front door exit, revealed a transfer grille had been cut into both doors from the corridor entering the Human Resource (HR) office and the copy room. Further observation revealed the grille cut into the HR door measured approximately six inches by six inches and the grille cut into the copy room door measured approximately twelve inches by twenty-four inches.</p> <p>Interview of the Environmental Services Manager at approximately 3:30 PM established he was not aware transfer grilles were not allowed in corridor doors.</p> <p>Actual NFPA standard:</p> <p>19.3.6.4 Transfer Grilles. 19.3.6.4.1 Transfer grilles, regardless of whether they are protected by fusible link-operated dampers, shall not be used in corridor walls or doors.</p>	K 364		
K 511 SS=D	<p>Utilities - Gas and Electric CFR(s): NFPA 101</p> <p>Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code,</p>	K 511	<p>1. Laundry room extension cord daisy chain removed, boiler room electrical panel replaced, boiler conduit junction box installed, ambulance bay junction boxes installed (cont.)</p>	9/4/19

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K 511	<p>Continued From page 11</p> <p>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 safe electrical installations in accordance with NFPA 70 and approved, listed assemblies. Failure to ensure electrical installations are protected from accidental contact and used in accordance with approved, listed assemblies, has the potential to increase the risk of arc fires and exposing residents and staff to electrical shock. This deficient practice affected staff on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 7/31/19 from 2:00 - 4:30 PM, observation of installed electrical systems revealed the following:</p> <ul style="list-style-type: none"> - Laundry room in the basement using an extension cord plugged in series (daisy-chained) to a relocatable power tap to supply power to a fan. - Basement boiler room electrical panel PB had the cover off, exposing all live connections to the breaker panel. When asked about the exposed wiring at the breaker panel, the Environmental Services Manager stated at approximately 3:00 PM that he had been working on an electrical connection within the panel prior to the survey. 	K 511	<p>(cont.)</p> <ol style="list-style-type: none"> 2. All residents have the potential to be affected by this practice 3. Inservice to be done with Maintenance Staff regarding electrical wires and equipment 4. Audit to be done for three months of electrical wires and equipment and reviewed by the QA Committee to determine if further audits are required 	

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K 511	<p>Continued From page 12</p> <ul style="list-style-type: none"> - Basement Boiler room had a 1-1/2 inch conduit hanging from the ceiling with three wires not terminated in an appropriate, approved enclosure such as a junction box. - Basement riser room had an open 4 inch by 4 inch electrical box at the ceiling with exposed wiring. Interview of the Environmental Services Manager at approximately 3:15 PM established he believed these wires were a live connection. - Outside storage area(s) (old ambulance bay(s)) had open electrical junction boxes with exposed wiring in the following sizes: <ol style="list-style-type: none"> 1) Three (3) four inch by four inch junction boxes 2) One (1) twelve inch by twelve inch junction box 3) One (1) two inch by three inch junction box <p>Actual NFPA standard:</p> <p>NFPA 70</p> <p>110.27 Guarding of Live Parts. (A) Live Parts Guarded Against Accidental Contact. Except as elsewhere required or permitted by this Code, live parts of electrical equipment operating at 50 volts or more shall be guarded against accidental contact by approved enclosures or by any of the following means: (1) By location in a room, vault, or similar enclosure that is accessible only to qualified persons. (2) By suitable permanent, substantial partitions or screens arranged so that only qualified persons have access to the space within reach of the live parts. Any openings in such partitions or screens shall be sized and located so that persons are not likely to come into accidental contact with the live parts or to bring conducting objects into contact with them. (3) By location on a suitable balcony, gallery, or</p>	K 511		

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K 511	<p>Continued From page 13</p> <p>platform elevated and arranged so as to exclude unqualified persons.</p> <p>(4) By elevation of 2.5 m (8 ft) or more above the floor or other working surface.</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 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 shall be installed and used in</p>	K 511		

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K 511	Continued From page 14 accordance with any instructions included in the listing or labeling 400.8 Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces Exception to (4): Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of 368.56(B) (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 (7) Where subject to physical damage Additional reference: UL 1363 XBYS	K 511			
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced	K 712	1. Fire drill to be done one drill per shift per quarter 2. All residents have the potential to affected by this practice 3. Inservice to be done with Maintenance Staff regarding fire drills 4. Administrator or designee will audit fire drill compliance for three months and reviewed by the QA committee to determine if further audits are necessary	9/4/19	

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K 712	Continued From page 15 by: Based on record review and interview, the facility failed to ensure fire drills were conducted in accordance with NFPA 101. Failure to perform fire drills quarterly for each shift has the potential to hinder staff response in the event of a fire. This deficient practice affected 71 residents and staff on the date of the survey. Findings include: During review of provided facility fire drill records conducted on 7/31/19 from 9:30 - 11:00 AM, records revealed the facility had missed the fire drill for the noc shift during the first quarter of 2019. Interview of the Environmental Services Manager conducted at approximately 10:30 AM, revealed he was unaware the facility had a missed fire drill. Actual NFPA standard: 19.7* Operating Features. 19.7.1 Evacuation and Relocation Plan and Fire Drills. 19.7.1.6 Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions.	K 712			
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial	K 914	1. Outlets are being tested on a monthly basis 2. All residents have the potential to be affected by this practice (Cont.)	9/4/19	

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K 914	<p>Continued From page 16</p> <p>installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results.</p> <p>6.3.4 (NFPA 99)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure resident room electrical receptacles were maintained in accordance with NFPA 99. Failure to test resident room electrical receptacles annually has the potential to hinder system response during an emergency that encompasses a loss of power. This deficient practice affected 74 residents and staff on the date of the survey.</p> <p>Findings include:</p> <p>During review of provided maintenance documents conducted on 7/31/19 from 8:30 - 10:30 AM, no documentation was available demonstrating an annual test conducted on resident room outlets.</p> <p>Interview of the Environmental Services Manager on 7/31/19 at approximately 1:30 PM established</p>	K 914	(Cont.) 3. Inservice to be done with maintenance staff regarding outlet testing 4. Administrator or designee will audit outlet testing each month for three months and review with the QA committee to determine if further audits are necessary		

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K 914	<p>Continued From page 17 he had not yet completed an annual test on resident room outlets.</p> <p>Actual NFPA standard:</p> <p>NFPA 99 Chapter 6 Electrical Systems</p> <p>6.3.3.2 Receptacle Testing in Patient Care Rooms. 6.3.3.2.1 The physical integrity of each receptacle shall be confirmed by visual inspection. 6.3.3.2.2 The continuity of the grounding circuit in each electrical receptacle shall be verified. 6.3.3.2.3 Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed. 6.3.3.2.4 The retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 g (4 oz).</p> <p>6.3.4.1 Maintenance and Testing of Electrical System.</p> <p>6.3.4.1.1 Where hospital-grade receptacles are required at patient bed locations and in locations where deep sedation or general anesthesia is administered, testing shall be performed after initial installation, replacement, or servicing of the device. 6.3.4.1.2 Additional testing of receptacles in patient care rooms shall be performed at intervals defined by documented performance data. 6.3.4.1.3 Receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months.</p>	K 914		

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K 918 K 918 SS=F	Continued From page 18 Electrical Systems - Essential Electric Syste 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 transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to	K 918 K 918	1. Generator fuel test was done 2. All residents have the potential to be affected by this practice 3. Inservice to be done with maintenance staff regarding fuel tests 4. Administrator or designee will audit that generator fuel test was done. TELS task to be created to trigger verification that fuel test is completed annually	9/4/19

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K 918	Continued From page 19 ensure that the diesel-fired Emergency Power Supply System (EPSS) generator set fuel was tested annually in accordance with ASTM standards. Failure to test diesel fuel for EPSS generators annually has the potential to hinder system response during a power outage or other emergency requiring generator power supply. This deficient practice affected 71 residents and staff on the date of the survey. Findings include: During review of provided facility maintenance and testing records conducted on 7/31/19 from 8:30 - 10:30 AM, no documentation was available for an annual fuel test conducted on the diesel fuel supply for the generator in accordance with ASTM standards. Further review established the vendor completing the annual inspection for the EPSS generator, had documented the fuel tank was locked and inaccessible during the annual service conducted. Actual NFPA standard: NFPA 110 8.3 Maintenance and Operational Testing. 8.3.8 A fuel quality test shall be performed at least annually using tests approved by ASTM standards.	K 918			
K 927 SS=D	Gas Equipment - Transfilling Cylinders CFR(s): NFPA 101 Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen	K 927	1. Exhaust fan in oxygen room was fixed 2. All residents have the potential to be affected by this practice 3. Inservice to be done with maintenance staff regarding oxygen fill area ventilation (Cont.)	9/4/19	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135068	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED 07/31/2019
NAME OF PROVIDER OR SUPPLIER PARKE VIEW REHABILITATION & CARE CENT			STREET ADDRESS, CITY, STATE, ZIP CODE 2303 PARKE AVENUE BURLEY, ID 83318		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 927	<p>Continued From page 20</p> <p>containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99)</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and operational testing, the facility failed to ensure transfilling of medical gases such as oxygen, were performed properly. Failure to ensure mechanical ventilation in transfilling locations was operational as designed, has the potential to create an oxygen-rich environment which increases the risk for fires and explosions. This deficient practice affected 10 residents and staff on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 7/31/19 from 2:00 - 4:00 PM, observation and operational testing by the Environmental Services Manager of the mechanical ventilation in the oxygen transfill location by the 400 hall, established the fan was operational, but lacked exhaust airflow when tested with a single sheet of note paper placed on the grille.</p> <p>Actual NFPA standard:</p> <p>NFPA 99</p> <p>9.3.7.5.3.2 Mechanical exhaust shall be at a rate of 1 L/sec of airflow for each 300 L (1 cfm per 5 ft³ of fluid) designed to be stored in the space and not less than 24 L/sec (50 cfm) nor more than 235 L/sec (500 cfm).</p>	K 927	<p>4. Administrator or designee to verify oxygen room exhaust fan function. Audits to be done monthly of exhaust fans functioning for 3 months and reviewed with QA Committee to determine if further audits are needed.</p>		



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

August 13, 2019

Corwin Lewis, Jr., Administrator
Parke View Rehabilitation & Care Center
2303 Parke Avenue
Burley, ID 83318-2106

Provider #: 135068

RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER

Dear Mr. Lewis, Jr.:

On **July 31, 2019**, an Emergency Preparedness survey was conducted at Parke View Rehabilitation & Care Center by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. Your facility was found to be in substantial compliance with Federal regulations during this survey.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, which states that the facility complies with the requirements of CFR 42, 483.70(a) of the federal requirements. This form is for your records only and does not need to be returned.

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

Sincerely,

Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosure

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

Printed: 08/09/2019
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NAME OF PROVIDER OR SUPPLIER PARKE VIEW REHABILITATION & CARE CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 2303 PARKE AVENUE BURLEY, ID 83318		
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E 000	<p>Initial Comments</p> <p>The facility is a single story, Type II (111) structure originally constructed in 1963, with a subsequent addition completed in 1998, along with cosmetic upgrades to common areas and administration offices completed as late as 2018. It is fully sprinklered with an interconnected fire alarm/smoke detection system. The building has a partial basement with storage, classrooms and maintenance shop. There is on-site, piped in medical gases and the facility is equipped with a diesel-fired Emergency Power Supply System (EPSS) generator. The building is located within a rural fire district, with both county and state EMS services available. The facility is currently licensed for 86 SNF/NF beds and had a census of 71 on the date of the survey.</p> <p>The facility was found to be in substantial compliance during the Emergency Preparedness Survey conducted on July 31, 2019. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.</p> <p>The survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	E 000	<p style="text-align: center;">RECEIVED</p> <p style="text-align: center;">AUG 27 2019</p> <p style="text-align: center;">FACILITY STANDARDS</p>	

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

TITLE

(X8) DATE

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.