



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

December 16, 2019

Breanna Jameson, Administrator  
Lewiston Transitional Care of Cascadia  
3315 8th Street  
Lewiston, ID 83501-4966

Provider #: 135021

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

Dear Ms. Jameson:

On **December 4, 2019**, a Facility Fire Safety and Construction survey was conducted at **Lewiston Transitional Care of Cascadia** 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 **December 30, 2019**. Failure to submit an acceptable PoC by **December 30, 2019**, may result in the imposition of civil monetary penalties by **January 20, 2020**.

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 **January 8, 2020**, (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 **March 3, 2020**. A change in the seriousness of the deficiencies on **January 18, 2020**, 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 **January 8, 2020**, includes the following:

Denial of payment for new admissions effective **March 4, 2020**.  
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 **June 4, 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 **December 4, 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:

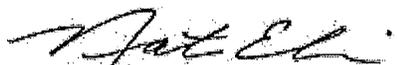
BFS Letters (06/30/11)

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

This request must be received by **December 30, 2019**. If your request for informal dispute resolution is received after **December 30, 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

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

Printed: 12/12/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135021</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - ENTIRE BUILDING</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/04/2019</b>
NAME OF PROVIDER OR SUPPLIER <b>LEWISTON TRANSITIONAL CARE OF CASCAID</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3315 8TH STREET LEWISTON, ID 83501</b>		
(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 V (111) building with a finished basement built in 1965, is fully sprinklered with an interconnected fire alarm/smoke detection system throughout. Currently the facility is licensed for 96 SNF/NF beds with a census of 67 on the date of the survey.  The following deficiencies were cited during the annual fire/life safety survey conducted on December 4, 2019. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.  The Survey was conducted by:  Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	K 000	<i>This plan of correction is submitted as required under Federal and State regulations and statutes applicable to long-term care providers. The plan of Correction does not constitute agreement by the facility that the surveyors findings constitute a deficiency and/or that the scope and severity of the deficiencies cited are correct applied.</i>  K222  1. <b>SPECIFIC ISSUE:</b> All doors in facility with magnetically controlled locking arrangements are operational in accordance with NFPA 101.  2. <b>OTHER RESIDENTS:</b> All residents have the potential to be affective by deficient practice.  3. <b>SYSTEMIC CHANGES:</b> Maintenance director installed new magnetic mechanism for locking arrangements to ensure door release from combination keypad and to meet requirements per NFPA guidelines.	
K 222 SS=D	Egress Doors CFR(s): NFPA 101  Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times.	K 222		

RECEIVED

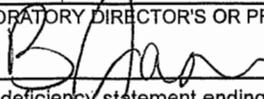
JAN - 6 2020

FACILITY STANDARDS

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

TITLE

(X6) DATE



Executive Director

12/29/19

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 222	Continued From page 1 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 <b>SPECIAL NEEDS LOCKING ARRANGEMENTS</b> Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 <b>DELAYED-EGRESS LOCKING ARRANGEMENTS</b> Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 <b>ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS</b> Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 <b>ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS</b> Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system.	K 222	4. <b>MONITOR</b> Executive director and/or designee will validate that egress doors with magnetic locking arrangements work properly per guidelines monthly for 3 months. Monitoring of this system will be added to preventive maintenance check. Additional education will be provided as necessary. Results of audit will be reviewed in PI to ensure systems being followed. Plan to be updated as indicated.  5. <b>DATE OF COMPLIANCE:</b> 01/06/20	

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K 222	<p>Continued From page 2</p> <p>18.2.2.2.4, 19.2.2.2.4</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and operational testing, the facility failed to ensure magnetically controlled locking arrangements were operational in accordance with NFPA 101. Failure to ensure locking release operations were maintained to perform in accordance with the standard, has the potential to hinder safe egress of residents during an emergency. This deficient practice affected 11 residents and staff in 1 of 5 smoke compartments on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 12/4/19 from 10:30 AM - 2:00 PM, observation of the exit door leading south from the 300 hall, revealed the door was equipped with magnetic locking arrangements and delayed egress. Operational testing of the door by the Maintenance director established the door would not release from the combination keypad operation as designed.</p> <p>Actual NFPA standard:</p> <p>NFPA 101</p> <p>19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side, unless otherwise permitted by one of the following:</p> <p>(1) Locks complying with 19.2.2.2.5 shall be permitted.</p> <p>(2)*Delayed-egress locks complying with 7.2.1.6.1 shall be permitted.</p> <p>19.2.2.2.5 Door-locking arrangements shall be</p>	K 222		

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K 222	Continued From page 3 permitted in accordance with either 19.2.2.2.5.1 or 19.2.2.2.5.2.  19.2.2.2.5.2* Door-locking arrangements shall be permitted where patient special needs require specialized protective measures for their safety, provided that all of the following are met: (1) Staff can readily unlock doors at all times in accordance with 19.2.2.2.6. (2) A total (complete) smoke detection system is provided throughout the locked space in accordance with 9.6.2.9, or locked doors can be remotely unlocked at an approved, constantly attended location within the locked space. (3)*The building is protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.1. (4) The locks are electrical locks that fail safely so as to release upon loss of power to the device. (5) The locks release by independent activation of each of the following: (a) Activation of the smoke detection system required by 19.2.2.2.5.2(2) (b) Waterflow in the automatic sprinkler system required by 19.2.2.2.5.2(3)  19.2.2.2.6 Doors that are located in the means of egress and are permitted to be locked under other provisions of 19.2.2.2.5 shall comply with all of the following: (1) Provisions shall be made for the rapid removal of occupants by means of one of the following: (a) Remote control of locks (b) Keying of all locks to keys carried by staff at all times (c) Other such reliable means available to the staff at all times	K 222		
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101	K 353		

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K 353	<p>Continued From page 4</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 observation and interview, the facility failed to ensure that fire suppression systems were maintained in accordance with NFPA 25. Failure to maintain fire suppression system pendants free of obstructions such as paint or corrosion, has the potential to hinder staff response during a fire event. This deficient practice affected staff on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 12/4/19 from 2:00 - 2:30 PM, observation of the storage space abutting the staff training room in the partial basement, revealed the sprinkler head nearest the east wall of the space was painted with non-factory applied paint.</p>	K 353	<p><i>K353</i></p> <p><b>1. SPECIFIC ISSUE</b> All sprinklers are free of paint for compliance in accordance with NFPA25.</p> <p><b>2. OTHER RESIDENTS</b> All residents have the potential to be affected by deficient practice.</p> <p><b>3. SYSTEMIC CHANGES:</b> . Facility replaced sprinkler head that had paint on them, per NFPA 25.</p> <p><b>4. MONITOR:</b> Executive director and/or designee will round to check sprinkler heads are free of paint after new paint projects monthly for 3 months. Additional education will be provided as necessary. Results of audit will be reviewed in PI to ensure systems being followed. Plan to be updated as indicated. Monitoring of this system will be added to the preventative maintenance check.</p> <p><b>5. DATE OF COMPLAINE:</b> 01/06/20</p>	

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K 353	Continued From page 5 Actual NFPA standard:  5.2* Inspection. 5.2.1 Sprinklers. 5.2.1.1* Sprinklers shall be inspected from the floor level annually. 5.2.1.1.1* Sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., upright, pendent, or sidewall). 5.2.1.1.2 Any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical damage (4) Loss of fluid in the glass bulb heat responsive element (5)*Loading (6) Painting unless painted by the sprinkler manufacturer 5.2.1.1.3* Any sprinkler that has been installed in the incorrect orientation shall be replaced.	K 353		
K 374 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101  Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors.	K 374		

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K 374	<p>Continued From page 6 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and operational testing, the facility failed to ensure smoke barrier doors were maintained to resist the passage of smoke. Failure to ensure smoke barrier doors fully self-close and resist the passage of smoke, has the potential to allow fire, smoke and dangerous gases to pass between smoke compartments, affecting the safe egress of residents. This deficient practice affected 25 residents and staff in 2 of 5 smoke compartments on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 12/4/19 from 11:30 AM - 3:30 PM, observation and operational testing of the smoke barrier doors located outside room 200, revealed the doors would not fully self-close, leaving a gap of approximately 8 inches from top to bottom. Further observation revealed these doors were obstructed from full closure by the installed regulator at the header of the door frame.</p> <p>Actual NFPA standard:</p> <p>19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.5 and shall have a minimum 1.2-hour fire resistance rating, unless otherwise permitted by one of the following: (1) This requirement shall not apply where an atrium is used, and both of the following criteria also shall apply: (a) Smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with 8.6.7(1)(c).</p>	K 374	<p><i>K374</i></p> <ol style="list-style-type: none"> <li><b>SPECIFIC ISSUE</b> All smoke barrier doors will fully self-close ensuring no gap greater than eight inches from top to bottom to be in accordance with 101.</li> <li><b>OTHER RESIDENTS</b> All residents have the potential to be affected by deficient practice.</li> <li><b>SYSTEMIC CHANGES:</b> Maintenance Director inspected and updated the installed regulated at the header of the door frame. To ensure compliance with NFPA101</li> <li><b>MONITOR:</b> Executive director and/or designee will validate smoke barrier doors self-close properly by the installed regulator, monthly for 3 months. Additional education will be provided as necessary. Results of audit will be reviewed in PI to ensure systems being followed. Plan to be updated as indicated. Monitoring of this system will be added to the preventative maintenance check.</li> <li><b>DATE OF COMPLAINE:</b> 01/06/20</li> </ol>	

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K 374	Continued From page 7 (b) Not less than two separate smoke compartments shall be provided on each floor. (2)*Smoke dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air-conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.8 has been provided for smoke compartments adjacent to the smoke barrier.	K 374		
K 511 SS=D	8.5 Smoke Barriers. 8.5.1* General. Where required by Chapters 11 through 43, smoke barriers shall be provided to subdivide building spaces for the purpose of restricting the movement of smoke.  Utilities - Gas and Electric CFR(s): NFPA 101  Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2  This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure safe electrical installations in accordance with NFPA 70. Failure to enclose electrical boxes with exposed, live parts, has the potential to increase the risks associated with arc fires and electrical shock. This deficient practice affected staff on the date of the survey.	K 511		

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K 511	Continued From page 8 Findings include:  During the facility tour conducted on 12/4/19 from 1:00 - 2:00 PM, an above the ceiling inspection conducted in the partial basement outside of the staff training room, revealed an open, four inch by four inch electrical junction box with exposed wiring.  Actual NFPA standard:  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 platform elevated and arranged so as to exclude unqualified persons. (4) By elevation of 2.5 m (8 ft) or more above the floor or other working surface. (B) Prevent Physical Damage. In locations where electrical equipment is likely to be exposed to physical damage, enclosures or guards shall be so arranged and of such strength as to prevent such damage. (C) Warning Signs. Entrances to rooms and other	K 511	<i>K511</i>  <b>1. SPECIFIC ISSUE</b> Facility is free of open electrical junction boxes.  <b>2. OTHER RESIDENTS</b> All residents have potential to be affected by deficient practice.  <b>3. SYSTEMATIC CHANGES:</b> Maintenance Director updated electrical junction box to ensure no open wiring was exposed.  <b>MONITOR</b>  Executive Director and / or designee will audit electrical junction boxes to ensure there are no open wiring that is exposed. Additional education will be provided as necessary. Results of audit will be reviewed in PI to ensure systems being followed. Plan to be updated as indicated.  <b>4. DATE OF COMPLIANCE:</b>  1/06/2020	

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K 511	Continued From page 9 guarded locations that contain exposed live parts shall be marked with conspicuous warning signs forbidding unqualified persons to enter. Informational Note: For motors, see 430.232 and 430.233. For over 600 volts, see 110.34.	K 511	<i>K741</i>	
K 741 SS=D	Smoking Regulations CFR(s): NFPA 101  Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4  This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure smoking was conducted in accordance with NFPA 101 and facility policy.	K 741	<ol style="list-style-type: none"> <li>1. <b>SPECIFIC ISSUE</b> Facility has provided safe smoking practices by ensuring proper ash trays and separate trash cans, labeled as such, are located in designated smoking area, per NFPA 101 standards.</li> <li>2. <b>OTHER RESIDENTS</b> All residents have potential to be affected by deficient practice.</li> <li>3. <b>SYSTEMIC CHANGES</b> Maintenance director ensured proper smoking materials, labeled, are provided in the designated smoking areas.</li> <li>4. <b>MONITOR:</b> Executive director and/ or designee will audit weekly x4 and monthly x3 to validate proper smoking materials are present in designated smoking areas per NFPA guidelines. Monitoring of this system will be added to the preventive maintenance check. Additional education will be provided as necessary. Results of audit will be reviewed in PI to ensure systems being followed. Plan to be updated as indication.</li> <li>5. <b>DATE OF COMPLIANCE:</b> 1/06/20</li> </ol>	

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K 741	<p>Continued From page 10</p> <p>Failure to ensure smoking procedures are in accordance with safe practices as defined in NFPA 101 and as supported by facility policy, has the potential to increase the risk of exposing residents to fires from unextinguished smoking materials. This deficient practice affected residents and staff using designated smoking areas on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 12/4/19 from 10:30 AM - 2:00 PM, observation of the resident smoking area revealed provided trash cans were being used for both combustible trash, i.e. empty cigarette cartons and mixed paper trash, and the disposal of cigarette ashes and ashtray contents. Further observation of the staff smoking area revealed the provided trash can for the disposal of trash such as paper, was being used for the disposal of ashes and the contents of ashtrays.</p> <p>Additionally, neither area trash cans were labeled as to the use or purpose of what materials would be disposed in them.</p> <p>Review of the provided smoking policy conducted on 12/4/19 from 3:00 - 3:30 PM revealed the policy stated in sections 10 (d), that smoking areas would be provided with "waste receptacles made of non-combustible material with self-closing covers and labeled 'For Smoking Materials Only'".</p> <p>Actual NFPA standard:</p> <p>19.7.4* Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room,</p>	K 741		

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K 741	Continued From page 11 ward, or individual enclosed space where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 19.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.	K 741		
K 918 SS=F	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	K 918	<p>K 918</p> <ol style="list-style-type: none"> <li><b>SPECIFIC ISSUE:</b> Facility has performed the required 4 hour load generator test</li> <li><b>OTHER RESIDENTS:</b> All residents at risk to be affected by deficient practice.</li> <li><b>SYSTEMIC CHANGES:</b> Maintenance Director ensured vendor returned to the facility to perform 4 hour generator load test. Facility Maintenance Director educated by Executive Director related to requirement of 4 hour load test for generator.</li> <li><b>MONITOR:</b> Executive Director or designee will audit facility testing monthly for 3 months. Results to be reviewed and addressed in QAPI meetings.</li> <li><b>Date of Compliance:</b> 01/06/20</li> </ol>	

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K 918	<p>Continued From page 12</p> <p>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 EPSS generator was maintained in accordance with NFPA 110. Failure to perform required maintenance and testing of emergency generators has the potential to hinder system performance during emergencies such as a loss of power. This deficient practice affected 67 residents and staff on the date of the survey.</p> <p>Findings include:</p> <p>During the review of provided EPSS generator maintenance and inspection records conducted on 12/4/19 from 8:45 - 10:00 AM, no records were available indicating the facility had performed a four-hour load test on the EPSS generator set. When asked at approximately 10:30 AM about the missing load test documentation, the Maintenance Director stated he was not aware of the missing documentation</p>	K 918		

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K 918	Continued From page 13 and had thought the test was completed by the vendor prior to the survey date.  Actual NFPA standard:  NFPA 110  Chapter 8 Routine Maintenance and Operational Testing  8.4.9* Level 1 EPSS shall be tested at least once within every 36 months. 8.4.9.1 Level 1 EPSS shall be tested continuously for the duration of its assigned class (see Section 4.2). 8.4.9.2 Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 continuous hours.	K 918		
K 923 SS=E	Gas Equipment - Cylinder and Container Storage CFR(s): NFPA 101  Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than	K 923		

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K 923	<p>Continued From page 14</p> <p>or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING."</p> <p>Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, the facility failed to ensure medical gas storage such as oxygen, was performed in accordance with NFPA 99. Failure to segregate stored empty oxygen cylinders from full cylinders, 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>Findings include:</p> <p>During the facility tour conducted on 12/4/19 from 10:30 AM - 2:00 PM, observation of the oxygen storage room on the southwest side of the facility, revealed the room was used for storage and transfilling of oxygen. Further observation revealed five (5) oxygen cylinders identified by nursing staff as "Empty" on the right side of the space as seen from the door.</p>	K 923	<p>K 923</p> <ol style="list-style-type: none"> <li><b>SPECIFIC ISSUE:</b> Facility specified in oxygen room between full and empty part of the room.</li> <li><b>OTHER RESIDENTS:</b> All residents are potentially affected by deficient practice</li> <li><b>SYSTEMIC CHANGES:</b> Facility staff educated by Executive Director and/or designee to ensure the understanding of full side and empty side of the oxygen room, and properly labeled, per NFPA regulations.</li> <li><b>MONITOR:</b> Executive Director and/or designee will audit designated oxygen holding area and other potential areas weekly x 3 then monthly x 3 to ensure ongoing compliance. Additional education will be provided as necessary. Results of audit will be reviewed in PI to ensure systems being followed. Plan to be updated as indicated.</li> <li><b>Date of Compliance:</b> 1/06/20</li> </ol>	

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K 923	Continued From page 15  When asked at the time of the observation how the facility identified the differentiation of full from empty storage in the space, the Maintenance Director stated the right side was considered "Full" and the left side was "Empty", however no signs indicating the method of segregation in this space.  Actual NFPA standard:  NFPA 99  11.6.5 Special Precautions - Storage of Cylinders and Containers. 11.6.5.1 Storage shall be planned so that cylinders can be used in the order in which they are received from the supplier. 11.6.5.2 If empty and full cylinders are stored within the same enclosure, empty cylinders shall be segregated from full cylinders. 11.6.5.3 Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed in a rapid manner.	K 923		



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**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

December 16, 2019

Breanna Jameson, Administrator  
Lewiston Transitional Care of Cascadia  
3315 8th Street  
Lewiston, ID 83501-4966

Provider #: 135021

**RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER**

Dear Ms. Jameson:

On **December 4, 2019**, an Emergency Preparedness survey was conducted at **Lewiston Transitional Care Of Cascadia** 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 **December 30, 2019**. Failure to submit an acceptable PoC by **December 30, 2019**, may result in the imposition of civil monetary penalties by **January 20, 2020**.

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 **January 8, 2020**, (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 . A change in the seriousness of the deficiencies on **January 30, 2020**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **January 8, 2020**, includes the following:

Denial of payment for new admissions effective **March 4, 2020**.  
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.

Breanna Jameson, Administrator

December 16, 2019

Page 3 of 4

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **June 4, 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 **December 4, 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:

<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

Breanna Jameson, Administrator

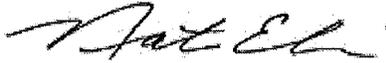
December 16, 2019

Page 4 of 4

This request must be received by **December 30, 2019**. If your request for informal dispute resolution is received after **December 30, 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, 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

Printed: 12/12/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135021</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/04/2019</b>
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NAME OF PROVIDER OR SUPPLIER <b>LEWISTON TRANSITIONAL CARE OF CASCAID</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3315 8TH STREET LEWISTON, ID 83501</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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E 000	Initial Comments  The facility is a single story Type V (111) building with a finished basement built in 1965, is fully sprinklered with an interconnected fire alarm/smoke detection system throughout. The facility is equipped with an Emergency Power Supply System (EPSS), diesel-fired generator and is situated in a municipal fire district with both county and state EMS services available. Currently the facility is licensed for 96 SNF/NF beds with a census of 67 on the date of the survey.  The following deficiency was cited during the Emergency Preparedness survey conducted on December 4, 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		
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 emergency and standby power systems based on the emergency plan set forth in paragraph (a) of	E 041	<p style="text-align: right;"><b>RECEIVED</b> JAN - 6 2020 FACILITY STANDARDS</p> <p>E 041</p> <ol style="list-style-type: none"> <li><b>SPECIFIC ISSUE:</b> Facility has performed the required 4 hour load generator test</li> <li><b>OTHER RESIDENTS:</b> All residents at risk to be affected by deficient practice.</li> <li><b>SYSTEMIC CHANGES:</b> Maintenance Director ensured vendor returned to the facility to perform 4 hour generator load test. Facility Maintenance Director educated by Executive Director related to requirement of 4 hour load test for generator.</li> <li><b>MONITOR:</b> Executive Director or designee will audit facility testing monthly for 3 months. Results to be reviewed and addressed in QAPI meetings.</li> <li><b>Date of Compliance:</b> 01/06/20</li> </ol>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>Executive Director</b>	(X6) DATE <b>12/29/19</b>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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NAME OF PROVIDER OR SUPPLIER <b>LEWISTON TRANSITIONAL CARE OF CASCAI</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3315 8TH STREET LEWISTON, ID 83501</b>		
(X4) ID. PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
E 041	<p>Continued From page 1 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 inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD</p>	E 041			

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

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E 041	<p>Continued From page 2 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: <a href="http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html">http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html</a>. 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.</p> <p>(1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000.</p> <p>(i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011.</p> <p>(ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011.</p> <p>(iii) TIA 12-3 to NFPA 99, issued August 9, 2012.</p> <p>(iv) TIA 12-4 to NFPA 99, issued March 7, 2013.</p> <p>(v) TIA 12-5 to NFPA 99, issued August 1, 2013.</p> <p>(vi) TIA 12-6 to NFPA 99, issued March 3, 2014.</p> <p>(vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011.</p> <p>(viii) TIA 12-1 to NFPA 101, issued August 11, 2011.</p> <p>(ix) TIA 12-2 to NFPA 101, issued October 30, 2012.</p> <p>(x) TIA 12-3 to NFPA 101, issued October 22, 2013.</p> <p>(xi) TIA 12-4 to NFPA 101, issued October 22, 2013.</p> <p>(xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Emergency Power Supply System (EPSS) generator was maintained in</p>	E 041			

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E 041	<p>Continued From page 3</p> <p>accordance with NFPA 110. Failure to conduct load testing as required in the standard, has the potential to hinder system response during an emergency such as a loss of power. This deficient practice affected 67 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During review of provided EPSS generator inspection and testing records conducted on 12/4/19 from 8:45 - 10:00 AM, records did not indicate a four-hour load test had been conducted within the past three years. Interview of the Maintenance Director at approximately 12:30 PM on 12/4/19, established he was not aware of when the last four hour load test had been conducted.</p> <p>Reference 42 CFR 483.73 (e) (1)</p>	E 041			