



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

C.L. "BUTCH" OTTER – Governor  
RICHARD M. ARMSTRONG – Director

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

June 10, 2015

Dallas Clinger, Administrator  
Power County Nursing Home  
PO Box 420  
American Falls, ID 83211-0420

Provider #: 135066

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

Dear Mr. Clinger:

On **June 3, 2015**, a Facility Fire Safety and Construction survey was conducted at **Power County Nursing Home** 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 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

Dallas Clinger, Administrator  
June 10, 2015  
Page 2 of 4

Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign both Statement of Deficiencies and Plan of Correction, Form CMS-2567 and State Form, in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **June 23, 2015**. Failure to submit an acceptable PoC by **June 23, 2015**, may result in the imposition of civil monetary penalties by **July 13, 2015**.

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 and the state licensure survey report, State Form.

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **July 8, 2015**, (Opportunity to Correct). Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **July 8, 2015**. A change in the seriousness of the deficiencies on **July 8, 2015**, may result in a change in the remedy:

The remedy, which will be recommended if substantial compliance has not been achieved by **July 8, 2015**, includes the following:

Dallas Clinger, Administrator  
June 10, 2015  
Page 3 of 4

Denial of payment for new admissions effective **September 3, 2015**.  
42 CFR §488.417(a)

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **December 3, 2015**, 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 Mark P. Grimes, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, 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 **June 3, 2015**, 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>

Dallas Clinger, Administrator  
June 10, 2015  
Page 4 of 4

Go to the middle of the page to Information Letters section and click on State and select the following:

BFS Letters (06/30/11)

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

This request must be received by **June 23, 2015**. If your request for informal dispute resolution is received after **June 23, 2015**, 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.

Sincerely,



Mark P. Grimes, Supervisor  
Facility Fire Safety and Construction

MPG/lj  
Enclosures

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

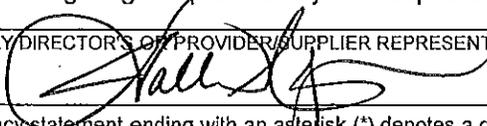
Printed: 06/10/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135066</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/03/2015</b>
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NAME OF PROVIDER OR SUPPLIER <b>POWER COUNTY NURSING HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>510 ROOSEVELT STREET (83211-1362) AMERICAN FALLS, ID 83211</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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K 000	<p><b>INITIAL COMMENTS</b></p> <p>The nursing facility portion of the building occupies the east wing of both the lower and upper levels and is attached to the hospital building. The original building's construction was completed in early 1961 and consisted of the lower level east wing nursing facility and the west lower and upper level hospital portion. A two level addition was completed in early 1967 extending the upper level hospital patient wing to the east. The nursing facility was extended into the upper level east wing sleeping rooms in the fall of 1987. Both the existing and addition building construction elements are fire resistive. Wall construction varies depending upon location and is either concrete block; concrete; concrete with brick veneer; and/or 4" x 6" metal studs w/lath &amp; plaster. Supporting beams are combination steel w/fire proofing and/or concrete. The floor/ceiling assembly between the lower and upper levels consist of steel joist with 5/8" gyp steel channel below and metal decking and poured concrete flooring above. The roof assembly is steel joists with lath/plaster attached to the underside and a metal deck with poured concrete above. There are a total of three (3) exits from the lower level nursing facility wing; two (2) directly to the exterior at grade and the third through the hospital's main entry lobby. There are two (2) exits from the upper level east nursing wing; one is an enclosed stairway at the east end of the wing and the other is accessible through the west hospital portion of the building. The building is provided with a fire alarm system with off site monitoring and system smoke detection in the exit access corridors and the open dining room on the lower level. Portable fire extinguishers are provided and are multipurpose ABC with additional K style for protection in the kitchen area. Emergency power and lighting are provided by the hospital's diesel</p>	K 000	<p>RECEIVED</p> <p>JUN 25 2015</p> <p>FACILITY STANDARDS</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>CEO / ADMINISTRATOR</b>	(X6) DATE <b>23 JUNE 2015</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.

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K 000	Continued From page 1 powered, automatic generator. The facility was retrofitted on October 4, 2010 with automatic fire sprinklers, a Halon system was also installed in the IT room, both systems are interconnected with the building fire alarm system. The facility is currently licensed for 20 SNF/NF beds.  The following deficiencies were cited during the annual life safety code survey conducted on June 3, 2015. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.  The survey was conducted by:  Nathan Elkins Health Facility Surveyor Fire Life Safety & Construction	K 000	<b>K025 NFPA 101</b>  What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice?  The three unsealed holes in the first floor janitor's closet ceiling were sealed with fire caulking on June 3, 2015, following the inspection.  How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?  All residents, staff, and visitors have the potential to be affected by this deficiency.	23JUNE15
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4  This Standard is not met as evidenced by: Based on observation and interview the facility failed to assure that all smoke barriers would provide protection against passage of smoke.	K 025	What measure will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur?  The Maintenance staff will inspect all outside contractor work upon completion to ensure that the contractor has sealed all areas worked on sufficiently or they will complete the seal work to ensure compliance with the smoke barrier requirements.  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?  The Professional Services Director will begin an audit on June 23, 2015 to monitor all new maintenance wall work done by outside contractors or maintenance staff that could affect smoke barriers for the next six	

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K 025	Continued From page 2 Openings in smoke barriers can allow smoke and fire gasses to enter other smoke compartments in the event of a fire. This deficient practice could potentially affect all patients, staff and visitors on the day of survey. The facility has a capacity for 20 SNF/NF beds with a census of 14 on the date of survey.  Findings include:  During the facility tour on June 3, 2015 at approximately 9:30 AM, observation of the Janitor's Closet located on the first floor across from the Nurse's station revealed three unsealed circular holes approximately 2" x 2" penetrating through the ceiling. When asked, the maintenance supervisor stated he was unaware of the open penetrations.  Actual NFPA reference: LSC 101, 19.3.7.3. Smoke barriers shall provide at least a one half hour fire resistance rating. 8.3.1* General. Where required by Chapters 12 through 42, smoke barriers shall be provided to subdivide building spaces for the purpose of restricting the movement of smoke.	K 025	months to ensure compliance with fire sealing standards.	
K 046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.  This Standard is not met as evidenced by: Based on operational testing and interview the facility failed to ensure emergency lighting with battery back-up was maintained. Failure to ensure that battery powered emergency egress lighting operated under battery load could inhibit	K 046	What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice?  The emergency lighting system test button at the front entrance was checked again by the maintenance staff on the afternoon of June 3, 2015 and was found to need some additional cleaning and lubrication with an electrical spray on the button. The batteries were also checked	23JUNE15

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K 046	Continued From page 3 egress of residents during an emergency. This deficient practice could potentially affect all residents, staff and visitors on the date of the survey. The facility is licensed for 20 SNF/NF residents with a census of 14 on the day of the survey.  Findings include:  During the facility tour conducted on June 3, 2015 at approximately 12:00 PM, operational testing of the emergency lighting system near the front entrance of the facility found the lights failed to operate when the test button was pushed. When asked, the maintenance supervisor stated he was unaware of the inoperable batteries.  Actual NFPA standard: NFPA 19.2.9.1 Emergency lighting shall be provided in accordance with Section 7.9. 7.9.2.1* Emergency illumination shall be provided for not less than 1 1/2 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10 lux) and, at any point, not less than 0.1 ft-candle (1 lux), measured along the path of egress at floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (6 lux) and, at any point, not less than 0.06 ft-candle (0.6 lux) at the end of the 1 1/2 hours. A maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded.	K 046	and are in working order. The lighting test button is compliant and in working order. All residents, staff and visitors have the potential to be affected by this deficiency. All other emergency light test buttons were also checked for any additional cleaning needed.  How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?  All residents, staff, and visitors have the potential to be affected by this deficiency.  What measure will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur?  The maintenance department will continue to check the lights on the regularly scheduled testing cycle.  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?  The Maintenance staff will continue to monitor the test buttons on the emergency lighting systems to test for compliance.	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	K 147	<b>K147 NFPA 101</b>	<b>23JUNE15</b>

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K 147	<p>Continued From page 4</p> <p>This Standard is not met as evidenced by: Based on observation and interview the facility did not ensure that electrical wiring with NFPA 70. Utilizing relocatable power taps and extension cords improperly can lead to overload wiring and start a fire. The deficient practice affected staff members and visitors on the date of survey. The facility is licensed for 20 SNF/NF with a census of 14 on day of survey.</p> <p>Findings include:</p> <p>During the facility tour on June 3, 2015 at approximately 10:30 AM, observation of the Collections Office revealed a Relocatable Power Tap (RPT) series connected (daisy chained) to another Relocatable Power Tap (RPT) and being used as permanent wiring. When asked, the Maintenance Supervisor stated he was unaware of the usage of the wiring.</p> <p>Actual NFPA reference: NFPA 70 National Electrical Code 1999 Edition 400-8. Uses Not Permitted Unless specifically permitted in Section 400-7, flexible cords and cables shall not be used for the following:</p> <ol style="list-style-type: none"> <li>1. As a substitute for the fixed wiring of a structure</li> <li>2. Where run through holes in walls, structural ceilings suspended ceilings, dropped ceilings, or floors</li> <li>3. Where run through doorways, windows, or similar openings</li> <li>4. Where attached to building surfaces</li> </ol> <p>Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of Section 364-8.</p>	K 147	<p>What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice?</p> <p>The Maintenance staff removed the Relocatable Power Tap series located in the Collections office on June 3, 2015. The Maintenance staff will continue to look for unauthorized RPT connections or series connected to equipment on their daily Monday through Friday walk-throughs of the plant facility.</p> <p>How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?</p> <p>All residents, staff and visitors have the potential to be affected by this deficiency.</p> <p>What measure will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>All managers were warned in the Administrative Council meeting of the dangers of the RPTs and were reminded about the prohibited use of RPTs unless for computers. They were asked to contact the Maintenance staff if any are found for removal.</p> <p>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?</p> <p>The Professional Services Director will begin an audit walk-through of all facility areas to also check for unauthorized RPT connections or series beginning June 23,</p>	

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K 147	Continued From page 5 5. Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors 6. Where installed in raceways, except as otherwise permitted in this Code See UL listings: XBYS Guide information XBZN2 Guide information	K 147	2015. This will be done once a week for one month, then once a month for three months.	