



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 23, 2015

Shelly Henderson, Administrator
Payette Center
1019 Third Avenue South
Payette, ID 83661-2832

Provider #: 135015

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

Dear Ms. Henderson:

On **June 15, 2015**, a Facility Fire Safety and Construction survey was conducted at **Payette 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 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

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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 **July 6, 2015**. Failure to submit an acceptable PoC by **July 6, 2015**, may result in the imposition of civil monetary penalties by **July 26, 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 20, 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 20, 2015**. A change in the seriousness of the deficiencies on **July 20, 2015**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **July 20, 2015**, includes the following:

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Denial of payment for new admissions effective **September 15, 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 15, 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 15, 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>

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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 **July 6, 2015**. If your request for informal dispute resolution is received after **July 6, 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: 06/23/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135015	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 06/15/2015
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NAME OF PROVIDER OR SUPPLIER PAYETTE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1019 THIRD AVENUE SOUTH PAYETTE, ID 83661
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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	INITIAL COMMENTS The facility is a single story, type V(111) construction. The facility was originally built in 1961 and is fully sprinklered. Currently it is licensed for 80 SNF/NF beds. The laundry is located in a separately detached building. The following deficiencies were cited during the annual life safety code survey conducted on June 15, 2015. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Chapter 19, Existing Health Care Occupancy, in accordance with 42 CFR 483.70. The Survey was conducted by: Nathan Elkins Health Facility Surveyor Facility Fire Safety & Construction	K 000	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Genesis HealthCarè, Payette 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."</p>	
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		

RECEIVED
JUL 02 2015
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Keef Deed</i>	TITLE Administrator	(X6) DATE 7/1/15
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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 025	Continued From page 1 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 residents, staff and visitors on the day of survey. The facility has a capacity for 80 SNF/NF beds with a census of 35 on the date of survey. Findings include: During the facility tour on June 15, 2015 at approximately 2:00 PM, observation of the Cart Storage room revealed a half-inch pipe penetrating through a two inch unsealed hole in the ceiling. When asked, the maintenance supervisor stated the facility was unaware of the open penetration. Actual NFPA reference: NFPA 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	K025 The open ceiling penetration caused by the 1/2 inch pipe in the Cart Storage will be sealed as required by the Maintenance Director on or before 7/9/15. Other non-patient rooms will be inspected by the maintenance director by 7/9/15 to assure that smoke barrier alterations are not required as mentioned above. The results of this inspection will be reported to the Performance Improvement (PI) Committee's monthly meeting for the next three months. Compliance Date: 7/10/15	
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with 3/4 hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1	K 029		

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K 029	<p>Continued From page 2</p> <p>This Standard is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure that hazardous areas were protected with self-closing doors that would resist the passage of smoke. Failure to provide self-closing doors to hazardous areas would allow smoke and dangerous gases to pass freely between compartments affecting egress. This deficient practice affected 18 residents, staff and visitors on the date of the survey. The facility is licensed for 80 SNF/NF beds and had a census of 35 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour on June 15, 2015 at approximately 2:00 PM, observation and operational testing of the door to the Medical Records room would not close and latch upon release of the magnetic hold-open device. Upon further investigation it was observed that the door was impeded by the floor. When asked, the Maintenance Supervisor stated the facility was aware the door would not close and latch due to a recent water leak that warped the floor.</p> <p>Actual NFPA standard: NFPA 101 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the</p>	K 029	<p>K029</p> <p>The warped flooring impeding the door in Medical Records office from closing when the magnetic door is released will be repaired by Westma. This will be completed by 7/10/15.</p> <p>The maintenance director will inspect the entire center on or before 7/9/15 for other potential door closure issues.</p> <p>The maintenance director will inspect the facility monthly for potential door closure issues monthly.</p> <p>The results of the inspections will be reported to the PI Committee for three months.</p> <p>Compliance Date: 7/10/15</p>

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K 029	Continued From page 3 sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard	K 029		
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This Standard is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure doors provided a readily accessible means of exit access. Failure to allow rapid means of exit access would prevent occupants ability to safely evacuate in an emergency. This deficient practice affected staff and visitors in one of four smoke compartments on the date of the survey. The	K 038		

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K 038	<p>Continued From page 4</p> <p>facility is licensed for 80 SNF/NF beds and had a census of 35 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour on January 15, 2015 at approximately 2:00 PM, observation of the Cart Storage room revealed the door was equipped with a throw bolt that was installed on the upper portion of the door. When asked, the Maintenance Supervisor stated the facility was unaware of the lock requirements.</p> <p>Actual NFPA standard: NFPA 101 19.2.1 General. Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7. Exception: As modified by 19.2.2 through 19.2.11.</p> <p>7.2.1.5.4* A latch or other fastening device on a door shall be provided with a releasing device having an obvious method of operation and that is readily operated under all lighting conditions. The releasing mechanism for any latch shall be located not less than 34 in. (86 cm), and not more than 48 in. (122 cm), above the finished floor. Doors shall be operable with not more than one releasing operation. Exception No. 1*: Egress doors from individual living units and guest rooms of residential occupancies shall be permitted to be provided with devices that require not more than one additional releasing operation, provided that such device is operable from the inside without the use of a key or tool and is mounted at a height not exceeding 48 in. (122 cm) above the finished</p>	K 038	<p>K038</p> <p>The maintenance director removed the throw bolt from the door in the Cart Storage room by on or before 7/9/15.</p> <p>Other storage areas will be inspected by the Maintenance Director to ensure that no throw bolts are being used, by 7/9/15.</p> <p>The maintenance director will inspect the facility for this issue monthly.</p> <p>The results of these inspections will be reported to the PI Committee for the next three months.</p> <p>Compliance Date: 7/10/15</p>	

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K 038	Continued From page 5 floor. Existing security devices shall be permitted to have two additional releasing operations. Existing security devices other than automatic latching devices shall not be located more than 60 in. (152 cm) above the finished floor. Automatic latching devices shall not be located more than 48 in. (122 cm) above the finished floor. Exception No. 2: The minimum mounting height for the releasing mechanism shall not be applicable to existing installations.	K 038		
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 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 80 SNF/NF residents with a census of 35 on the day of the survey. Findings include: During the facility tour on June 15, 2015 at approximately 3:00 PM, operational testing of the emergency lighting system in the central hallway near the nurses station found the light failed to operate when the test button was pushed. When asked, the maintenance supervisor stated he was unaware of the inoperable batteries.	K 046	K046 The emergency lighting system in the central hallway will be repaired by Burke Electric on or before 7/9/15. All emergency lighting will be tested for 30 seconds by the maintenance director by 7/9/15. Additionally, 90 minute annual tests will be performed by the maintenance director by 7/9/15. All tests will be logged in the Life Safety Binder by the maintenance director. The 30 second tests and 90 minute tests will be added to the facilities TELS program for future notifications that need to be completed. The results of the inspections and TELS work completed will be reported to the PI Committee by the maintenance director. Compliance Date: 7/10/15	

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K 046	Continued From page 6 Actual NFPA standard: NFPA 101 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		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This Standard is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that fire suppression systems were tested and maintained in accordance with NFPA 25. Failure to provide proper testing, inspection and maintenance of sprinkler systems could result in these systems not performing as designed during a fire event. This deficient practice affected all residents, staff	K 062		

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K 062	<p>Continued From page 7 and visitors on the date of the survey. The facility is licensed for 80 SNF/NF beds and had a census of 35 on the day of the survey.</p> <p>Findings Include:</p> <p>1.) During record review on June 15, 2015 at approximately 10:30 AM, observation of the inspection report for the water based fire protection systems revealed that the antifreeze percentage was not recorded on the report. When asked, the maintenance supervisor stated he was unaware the antifreeze percentage was not being documented.</p> <p>2.) During the facility tour on June 15, 2015 at approximately 1:30 PM, observation of room 214 "B" side revealed the sprinkler escutcheon missing. When asked, the maintenance supervisor stated he was unaware of the missing escutcheon.</p> <p>Actual NFPA standards:</p> <p>Item #1 NFPA 25. 2-3.4* Antifreeze Systems. The freezing point of solutions in antifreeze shall be tested annually by measuring the specific gravity with a hydrometer or refractometer and adjusting the solutions if necessary. Solutions shall be in accordance with Tables 2-3.4(a) and (b). The use of antifreeze solutions shall be in accordance with any state or local health regulations. [See Table 2-3.4(b).]</p> <p>Item #2 19.7.6 Maintenance and Testing. (See 4.6.12.) 4.6.12.1</p>	K 062	<p>K062</p> <p>Antifreeze percentages in the water based fire protection system will be obtained by Viking Fire Sprinkler on or before 7/9/15.</p> <p>The Maintenance Director will require the fire sprinkler inspection company to record antifreeze percentages on their quarterly inspection report.</p> <p>The water sprinkler escutcheon in room 214-B will be replaced on or before 7/9/15 by the maintenance director.</p> <p>All water sprinklers in the center will be checked by the Maintenance Director for missing escutcheons on or before 7/9/15.</p> <p>The results of the inspections will be reported to the PI Committee by the maintenance director for three months.</p> <p>Compliance Date: 7/10/15</p>	

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K 062	Continued From page 8 Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be continuously maintained in accordance with applicable NFPA requirements or as directed by the authority having jurisdiction.	K 062		
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure electrical wiring was in accordance with the National Electrical Code. The deficient practice affected 18 residents, staff, and visitors on the date of survey. The facility is licensed for 80 SNF/NF beds with a census of 35 the day of survey. Findings include: During the facility tour on June 15, 2015 at approximately 1:30 PM, observation revealed a refrigerator plugged into a relocatable power tap in the Activities office. When asked, the maintenance supervisor stated the facility was unaware the refrigerator was plugged in a relocatable power tap. 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	K 147	K147 The refrigerator in the Activities office was plugged into an outlet by the maintenance director on or before 7/9/15. The Maintenance Director will inspect the remainder of the facility to assure that only approved equipment is plugged into a relocatable power tap. The maintenance director will inspect the facility monthly to identify any potential misuse of relocatable power taps. The results of the inspections will be reported to the PI Committee by the maintenance director for three months. Compliance Date: 7/10/15	

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135015	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 06/15/2015	
NAME OF PROVIDER OR SUPPLIER PAYETTE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1019 THIRD AVENUE SOUTH PAYETTE, ID 83661		
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K 147	Continued From page 9 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: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of Section 364-8. 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		