IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK– ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
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August 11, 2015

Shon Shuldberg, Administrator
Ashton Living Center
PO Box 838
Ashton, ID 83420-0838

Provider #: 135097

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

Dear Mr. Shuldberg:

On **August 4, 2015**, a Facility Fire Safety and Construction survey was conducted at **Ashton Living 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 Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office. If a State Form with deficiencies was issued, it should be signed, dated and returned along with the CMS-2567 Form.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **August 24, 2015**. Failure to submit an acceptable PoC by **August 24, 2015**, may result in the imposition of civil monetary penalties by **September 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 **September 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 **September 8, 2015**. A change in the seriousness of the deficiencies on **September 8, 2015**, may result in a change in the remedy.

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

Denial of payment for new admissions effective **November 4, 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 **February 4, 2016**, 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 **August 4, 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

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

BFS Letters (06/30/11)

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

This request must be received by **August 24, 2015**. If your request for informal dispute resolution is received after **August 24, 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: 08/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	135097		08/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHTON LIVING CENTER	700 NORTH SECOND STREET ASHTON, ID 83420

(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) construction. The building was completed April 4, 2002. It is fully sprinklered with Quick Response heads. Smoke detection coverage includes sleeping rooms, corridors and opens spaces to corridors. There is a propane powered generator for emergency power. Currently the Living Center is licensed for 38 SNF/NF beds. The following deficiencies were cited during the annual Fire/Life Safety survey conducted on August 4, 2015. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy and in accordance with 42 CFR, 483.70. The Survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	K 000	Preparation and/or execution of the plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in statement.	
K 012 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure the smoke and fire resistive properties of corridor walls. Failure to maintain 1-hour construction of corridor walls could allow fire and smoke to migrate between corridors affecting egress. This deficient practice affected ten residents, staff and visitors on the date of the survey. The facility is licensed for 38 SNF/NF	K 012	RECEIVED AUG 25 2015 FACILITY STANDARDS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 8/20/15

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 012	Continued From page 1 beds and had a census of 29 on the day of the survey. Findings include: During the facility tour conducted on August 4, 2015 from 11:30 AM to 3:30 PM, an above the ceiling inspection of the smoke partition separating the northeast service corridor and the resident corridor on the same side, revealed an unsealed hole which accommodated phone and cable wiring, approximately four inches in diameter above the door leading from the service corridor into the hall outside Room #1. Further observation of this area revealed an additional unsealed hole approximately two inches in diameter through the wall separating the oxygen storage room and the service corridor. Interview of the Maintenance Supervisor found he was not aware of these unsealed penetrations. Actual NFPA standard: 19.1.6.2 Health care occupancies shall be limited to the types of building construction shown in Table 19.1.6.2. (See 8.2.1.) Exception*: Any building of Type I(443), Type I(332), Type II(222), or Type II(111) construction shall be permitted to include roofing systems involving combustible supports, decking, or roofing, provided that the following criteria are met: (a) The roof covering meets Class C requirements in accordance with NFPA 256, Standard Methods of Fire Tests of Roof Coverings. (b) The roof is separated from all occupied portions of the building by a noncombustible floor	K 012	K012 Resident Specific- No Specific Residents Identified and Unsealed hole approximately four inches in diameter above the door leading from the service corridor into the hall outside Room #1also the hole approximately two inches in diameter through the wall separating the oxygen storage room and also the service corridor was filled with a material that is capable of maintaining fire resistance of the fire barrier and also limits the transfer of smoke. Other Residents - All Residents could be at risk from compromised smoke and fire barriers. All smoke and fire barriers have been inspected by maintenance supervisor to identify any that need corrected. No additional unsealed holes were found. Any new construction or cabling that is added to building in future will have the appropriate fire and smoke barriers in place. Facility Systems Maintenance supervisor and Environmental Supervisor were educated and we discussed 8.2.4.4.1 in the fire and life safety code. Maintenance Supervisor will be responsible for inspecting and educating contractors work that it meets code.	

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K 012	Continued From page 2 assembly that includes not less than 21/2 in. (6.4 cm) of concrete or gypsum fill. (c) The attic or other space is either unoccupied or protected throughout by an approved automatic sprinkler system. 8.2.1* Construction. Buildings or structures occupied or used in accordance with the individual occupancy chapters (Chapters 12 through 42) shall meet the minimum construction requirements of those chapters. NFPA 220, Standard on Types of Building Construction, shall be used to determine the requirements for the construction classification. Where the building or facility includes additions or connected structures of different construction types, the rating and classification of the structure shall be based on either of the following: (1) Separate buildings if a 2-hour or greater vertically-aligned fire barrier wall in accordance with NFPA 221, Standard for Fire Walls and Fire Barrier Walls, exists between the portions of the building Exception: The requirement of 8.2.1(1) shall not apply to previously approved separations between buildings. (2) The least fire-resistive type of construction of the connected portions, if no such separation is provided 8-2.4.4 Penetrations and Miscellaneous Openings in Smoke Partitions. 8.2.4.4.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through smoke partitions shall be protected as follows: (1) The space between the penetrating item and the smoke partition shall meet one of the	K 012	Monitors Administrator will walk building with Maintenance supervisor and review all penetrations of fire and smoke barriers and conduct an additional review of fire and smoke barriers in building. All new construction or penetrations to fire and smoke barrier will be inspected by maintenance supervisor and reported to administrator. Quarterly reviews in safety committee will be done to review any work that potentially could compromise fire and smoke barrier. Date of Compliance Sept 8, 2015	

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K 012	Continued From page 3 following conditions: a. It shall be filled with a material that is capable of limiting the transfer of smoke. b. It shall be protected by an approved device that is designed for the specific purpose. (2) Where the penetrating item uses a sleeve to penetrate the smoke partition, the sleeve shall be solidly set in the smoke partition, and the space between the item and the sleeve shall meet one of the following conditions: a. It shall be filled with a material that is capable of limiting the transfer of smoke. b. It shall be protected by an approved device that is designed for the specific purpose. (3) Where designs take transmission of vibrations into consideration, any vibration isolation shall meet one of the following conditions: a. It shall be made on either side of the smoke partitions. b. It shall be made by an approved device that is designed for the specific purpose.	K 012		
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This Standard is not met as evidenced by: Based on observation, the facility failed to ensure that fire extinguishers were installed in accordance with NFPA 10. Failure to mount extinguishers properly could hinder their use during a fire event. This deficient practice affected staff and visitors of the service wing of the facility. The facility is licensed for 38 SNF/NF	K 064		

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K 064	Continued From page 4 beds and had a census of 29 on the day of the survey. Findings include: During the facility tour conducted on August 4, 2015 from 11:30 AM to 3:30 PM, observation of extinguishers installed in the facility, revealed the following extinguishers were not mounted in accordance with NFPA 10: 1) The extinguisher in the Maintenance shop was placed on the floor. 2) The extinguisher in the Mechanical room was mounted at 61-1/2 inches from the floor to the top of the extinguisher. 3) The K-style fire extinguisher in the Kitchen was mounted at 62 inches from the floor to the top of the extinguisher. Actual NFPA standard: NFPA 10 1-6.10 Fire extinguishers having a gross weight not exceeding 40 lb (18.14 kg) shall be installed so that the top of the fire extinguisher is not more than 5 ft (1.53 m) above the floor. Fire extinguishers having a gross weight greater than 40 lb (18.14 kg) (except wheeled types) shall be so installed that the top of the fire extinguisher is not more than 31/2 ft (1.07 m) above the floor. In no case shall the clearance between the bottom of the fire extinguisher and the floor be less than 4 in. (10.2 cm).	K 064	K 064 Specific Residents - None Identified Other Residents - All Residents could be affected. 1) Extinguisher was removed from maintenance shop. No other extinguishers were found to be on the floor or unsecured. 2) Extinguisher in mechanical room was lowered by Maintenance supervisor so the top of the extinguisher was not higher than 5 ft or 60 inches above the floor 3) K-Style fire extinguisher in the kitchen was lowered so that the top of the extinguisher was not higher than 5 ft or 60 inches above the floor. Facility Systems Maintenance Supervisor and Environmental Supervisor reviewed and discussed compliance K 064 also NFPA 10 1-6.10 and reviewed compliance. All extinguishers were measured and reviewed for proper height in building by maintenance supervisor. All others were found to be in compliance. Monitor Monthly inspections of fire extinguishers will be conducted and review correct height. Inspections will be reported to Quality Assurance committee quarterly by Maintenance Supervisor. For the next 2 quarters this year.	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144		

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K 144	Continued From page 5 This Standard is not met as evidenced by: Based on record review and interview, the facility failed to document a load test for the Emergency Power Supply System in accordance with NFPA 99 and NFPA 110. Failure to exercise EPSS generators under load could result in a lack of system performance during a power failure. This deficient practice affected 29 residents, staff and visitors on the date of the survey. The facility is licensed for 38 SNF/NF beds and had a census of 29 on the day of the survey. Findings include: During review of the facility generator inspection and testing reports conducted on August 4, 2015 from 10:30 AM to 11:30 AM, generator records did not indicate a monthly load test was being conducted. When asked regarding the method used to document a monthly load test, the Maintenance Supervisor stated that he took readings from the generator display when the generator was running during an automatic transfer. He further stated he was not aware of how to, or the requirement for, documenting thirty (30) percent load capacity of generators. Actual NFPA standard: NFPA 99 Standard for Healthcare Facilities 1999 Edition	K 144	No Specific Residents affected. Other Residents - All residents have potential to be affected. Maintenance supervisor had been conducting weekly 30 min load tests but was not documenting results to justify a 30% load capacity of generator with a cold start. Maintenance Supervisor will conduct appropriate monthly test of generator to comply with regulation. Facility Systems - Maintenance Supervisor will conduct a monthly cold start for a minimum of 30 minutes to test under at minimum a 30% load of generator capacity to meet the requirement in NGPA 99 and NFPA 110 K 144 3-4.4.1.1. Redi Services and Intermountain Power Supply will train Maintenance Supervisor to conduct an appropriate reading and test to meet minimum standard. Monthly tests will be documented by Maintenance Supervisor on a log sheet. Monitor - Maintenance Supervisor will report results of monthly generator test to Safety Committee monthly for 3 months. Then will report to QA committee quarterly for 6 months. Date of Compliance Sept 8, 2015	

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K 144	Continued From page 6 3-4.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches. (a) Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-4.3.1. Maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6. (b) Inspection and Testing. 1. * Test Criteria. Generator sets shall be tested twelve (12) times a year with testing intervals between not less than 20 days or exceeding 40 days. Generator sets serving emergency and equipment systems shall be in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6. 2. Test Conditions. The scheduled test under load conditions shall include a complete simulated cold start and appropriate automatic and manual transfer of all essential electrical system loads. 3. Test Personnel. The scheduled tests shall be conducted by competent personnel. The tests are needed to keep the machines ready to function and, in addition, serve to detect causes of malfunction and to train personnel in operating procedures. 3-4.4.2 Recordkeeping. A written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. NFPA 110, Standard for Emergency and Standby	K 144		

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K 144	Continued From page 7 Power Systems, Chapter 6 6-3 Maintenance and Operational Testing. 6-3.1* The EPSS shall be maintained to ensure to a reasonable degree that the system is capable of supplying service within the time specified for the type and for the time duration specified for the class. 6-3.3 A written schedule for routine maintenance and operational testing of the EPSS shall be established. 6-3.4 A written record of the EPSS inspections, tests, exercising, operation, and repairs shall be maintained on the premises. The written record shall include the following: (a) The date of the maintenance report (b) Identification of the servicing personnel (c) Notation of any unsatisfactory condition and the corrective action taken, including parts replaced (d) Testing of any repair for the appropriate time as recommended by the manufacturer	K 144		
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 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that electrical installations were in accordance with NFPA 70. Failure to ensure electrical systems are installed properly could result in fire by arcing or electrocution. This deficient practice affected staff and visitors of the	K 147		

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K 147	Continued From page 8 northeast service corridor on the date of the survey. The facility is licensed for 38 SNF/NF beds and had a census of 29 on the day of the survey. Findings include: During the facility tour conducted on August 4, 2015 from 11:30 AM to 3:30 PM, an above the ceiling inspection at the service corridor outside the oxygen storage area revealed an open four inch by four inch electrical junction box with exposed wiring. When asked, Maintenance Supervisor stated he was not aware this junction box was missing a cover. Actual NFPA standard: NFPA 70 110.12 Mechanical Execution of Work. Electrical equipment shall be installed in a neat and workmanlike manner. (A) Unused Openings. Unused cable or raceway openings in boxes, raceways, auxiliary gutters, cabinets, cutout boxes, meter socket enclosures, equipment cases, or housings shall be effectively closed to afford protection substantially equivalent to the wall of the equipment. Where metallic plugs or plates are used with nonmetallic enclosures, they shall be recessed at least 6 mm (¼ in.) from the outer surface of the enclosure. (B) Subsurface Enclosures. Conductors shall be racked to provide ready and safe access in underground and subsurface enclosures into which persons enter for installation and maintenance. (C) Integrity of Electrical Equipment and Connections. Internal parts of electrical equipment, including busbars, wiring terminals,	K 147	Specfic Residents - No Specific Residents Other residents - All Residents could be affected. In the service corridor outside the oxygen storage the electrical junction box was found to be uncovered and a appropriate cover was placed on electrical junction box. Facility systems - The building was inspected by Maintenance Supervisor and Environmental supervisor for any uncovered electrical junction boxes. One junction box was identified in the dining room area 10 feet up from floor near wall hanging clock. The appropriate cover was put on junction box. Maintenance Supervisor and Environmental Supervisor reviewed K 147 NFPA 70 314.17 & 110.12 with administrator and discussion to maintain compliance. Monitoring - Maintenance supervisor and Environmental supervisor will conduct a monthly walk through in building looking for maintenance issues specifically any missing or damaged covers will be replaced and all findings will be reported to QA committee and monitored for the next 6 months. Date of Completion Sept 8th, 2015	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	135097		08/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHTON LIVING CENTER	700 NORTH SECOND STREET ASHTON, ID 83420

(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 147	Continued From page 9 Insulators, and other surfaces, shall not be damaged or contaminated by foreign materials such as paint, plaster, cleaners, abrasives, or corrosive residues. There shall be no damaged parts that may adversely affect safe operation or mechanical strength of the equipment such as parts that are broken; bent; cut; or deteriorated by corrosion, chemical action, or overheating. 314.17 Conductors Entering Boxes, Conduit Bodies, or Fittings. Conductors entering boxes, conduit bodies, or fittings shall be protected from abrasion and shall comply with 314.17(A) through (D). (A) Openings to Be Closed. Openings through which conductors enter shall be adequately closed.....	K 147		