



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – 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 9, 2015

James Burt, Administrator
Grangeville Health & Rehabilitation Center
410 East North Second Street
Grangeville, ID 83530-2258

Provider #: 135080

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

Dear Mr. Burt:

On **December 2, 2015**, a Facility Fire Safety and Construction survey was conducted at **Grangeville Health & Rehabilitation 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 one that comprises a pattern 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 22, 2015**. Failure to submit an acceptable PoC by **December 22, 2015**, may result in the imposition of civil monetary penalties by **January 11, 2016**.

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 **January 6, 2016**, (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 **January 6, 2016**. A change in the seriousness of the deficiencies on **January 6, 2016**, 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 6, 2016**, includes the following:

Denial of payment for new admissions effective **March 2, 2016**.
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 2, 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 **December 2, 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:

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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 22, 2015**. If your request for informal dispute resolution is received after **December 22, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135080	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 12/02/2015
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NAME OF PROVIDER OR SUPPLIER GRANGEVILLE HEALTH & REHABILITATION C	STREET ADDRESS, CITY, STATE, ZIP CODE 410 EAST NORTH SECOND STREET GRANGEVILLE, ID 83530
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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) fully sprinklered structure built in 1967. It has smoke detection throughout corridors and open spaces. Currently the facility is licensed for 60 SNF/NF beds. The following deficiencies were cited during the annual fire/life safety survey conducted on December 02, 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: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	K 000	"This plan of Correction is submitted as required under Federal and State regulations and statutes applicable to skilled nursing facilities. This plan of correction does not constitute an admission of liability, and such liability is hereby specifically denied. The submission of this plan does not constitute agreement by the facility that the surveyor's conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied." Please accept this plan of correction as our credible allegation of compliance	
K 012 SS=E	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 fire and smoke resistive properties of the structure were maintained. Failure to ensure that holes created in walls of the structure are sealed could allow smoke and fire to communicate into concealed, unprotected spaces undetected. This deficient practice affected residents, staff and visitors utilizing the entrance into the main dining room from the entrance corridor on the date of the survey. The facility is licensed for 60 SNF/NF beds and had a census	K 012	Resident Specific: Please see systemic changes. Other Residents: Please see systemic changes. Systemic Changes: The two inch by four inch hole has been repaired in the water heater closet. Monitors: The administrator or designee will perform monthly rounds times four to ensure there are no holes exposing the interiors of any wall in the facility. The administrator will report findings at the QA meeting and make changes to the above plan of correction as needed. Date of Compliance: December 22, 2015	

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

GPB

Administrator

12/22/15

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	<p>Continued From page 1 of 42 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on December 2, 2015 from 10:00 AM to 12:00 PM, observation of the water heater closet located directly outside the entrance to the main dining room revealed the wall inside had an approximately two inch by four inch hole exposing the interior of the wall cavity. Asked about the unsealed opening cut into the wall, the Maintenance technician stated he was not aware of the unsealed opening.</p> <p>Actual NFPA standard:</p> <p>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 assembly that includes not less than 2 1/2 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.</p> <p>8.2.1* Construction. Buildings or structures occupied or used in</p>	K 012		

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

Printed: 12/08/2015
FORM APPROVED
OMB NO. 0938-0391

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K 012	Continued From page 2 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.	K 012		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ 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 This Standard is not met as evidenced by:	K 029	K 029 Resident Specific: Please see systemic changes. Other Residents: Please see systemic changes. Systemic Changes: Please see attached extension waiver. The facility will ensure that all hazardous areas have self-closing mechanisms. Monitors: The administrator or designee will perform monthly rounds times four to ensure that all hazardous areas have self-closing mechanisms and are in place and functioning. The administrator will report findings at the QA meeting and make changes to the above plan of correction as needed. Date of Compliance: JUNE 15, 2016 December 22, 2015 PTW/INK WITH JR BURT SB 12/29/15	

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K 029	<p>Continued From page 3.</p> <p>Based on observation and operational testing, the facility failed to ensure hazardous areas were provided with self-closing doors. Failure to provide self-closing doors to hazardous areas could expose the facility to products of combustion during a fire event. This deficient practice affected residents, staff and visitors utilizing the main dining hall on the date of the survey. The facility is licensed for 60 SNF/NF beds and had a census of 42 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on December 2, 2015 from 10:00 AM to 12:00 PM, observation and operational testing of the pass through serving door from the kitchen to the main dining room revealed this door was a wood sliding type which was not equipped to self-close.</p> <p>Actual NFPA standard:</p> <p>3.3.13.2 Area, Hazardous. An area of a structure or building that poses a degree of hazard greater than that normal to the general occupancy of the building or structure, such as areas used for the storage or use of combustibles or flammables; toxic, noxious, or corrosive materials; or heat-producing appliances.</p> <p>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 sprinkler option is used, the areas shall be</p>	K 029		

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K 029	Continued From page 4 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. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		
K 062 SS=E	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 and interview, the facility failed to ensure fire suppression sprinkler pendants were maintained free of corrosion. Corroded fire suppression pendants could inhibit	K 062	K 062 Resident Specific: Please see systemic changes. Other Residents: Please see systemic changes. Systemic Changes: A contractor has been hired and will replace the three sprinkler heads that were found to be corroded on 12/23/2015. Additionally, all sprinkler heads will be checked and replaced if need be. Monitors: Administrator or designee will perform monthly rounds times four to ensure that all sprinkler heads are without signs of corrosion. Administrator will reports findings at QA and make changes to the above plan of correction as needed. Date of Compliance: 12/22/2015	

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K 062	<p>Continued From page 5</p> <p>system capabilities, allowing fires to grow beyond incipient stages. This deficient practice affected staff and vendors of the main Kitchen on the date of the survey. The facility is licensed for 60 SNF/NF beds and had a census of 42 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on December 2, 2015 from 1:00 PM to 3:30 PM, observation of the facility fire suppression system revealed three (3) corroded sprinkler pendants in the main Kitchen. When asked, the Maintenance technician stated he was not aware of this condition prior to the survey.</p> <p>Actual NFPA standard:</p> <p>NFPA 25 2-2 Inspection. 2-2.1 Sprinklers.</p> <p>2-2.1.1*</p> <p>Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.</p> <p>Exception No. 1*: Sprinklers installed in concealed spaces such as above suspended ceilings shall not require inspection.</p> <p>Exception No. 2: Sprinklers installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown.</p>	K 062		
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD	K 147		

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K 147	<p>Continued From page 6</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure electrical installations were in accordance with NFPA 70. Failure to ensure the proper installation of electrical systems could result in fires by arcing or electrocution. This deficient practice affected residents, staff and visitors utilizing the main entrance corridor entering into the dining hall. The facility is licensed for 60 SNF/NF beds and had a census of 42 on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on December 2, 2015 from 10:00 AM to 12:00 PM, observation of the water heater closet adjacent to the main dining room revealed the water heater recirculation pump was connected to non-grounded, multiple plug, light socket adapter. Further observation revealed the wiring of the pump was a makeshift non-grounded electrical cord. Interview of the Maintenance technician revealed he was not aware of this installation.</p> <p>Actual NFPA standard:</p> <p>NFPA 70</p> <p>400.8 Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure</p>	K 147	<p>K 147</p> <p>Resident Specific:</p> <p>Please see systemic changes.</p> <p>Other Residents:</p> <p>Please see systemic changes.</p> <p>Systemic Changes:</p> <p>Water heater has been connected to a grounded electrical outlet. The extension cord and multiple p lug have been removed from the facility.</p> <p>Monitors:</p> <p>Administrator or designee will perform monthly rounds times four to ensure that no extension cords or multiple plugs are being used in the facility. They will also check all water heaters to make sure they are connected to a grounded electrical outlet. Administrator will reports findings at QA and make changes to the above plan of correction as needed.</p> <p>Date of Compliance: 12/22/2015</p>	

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K 147	<p>Continued From page 7</p> <p>(2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors</p> <p>(3) Where run through doorways, windows, or similar openings</p> <p>(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 388.8.</p> <p>(5) Where concealed by walls, floors, or ceilings or located above suspended or dropped ceilings</p> <p>(6) Where installed in raceways, except as otherwise permitted in this Code</p> <p>200.3 Connection to Grounded System. Premises wiring shall not be electrically connected to a supply system unless the latter contains, for any grounded conductor of the interior system, a corresponding conductor that is grounded. For the purpose of this section, electrically connected shall mean connected so as to be capable of carrying current, as distinguished from connection through electromagnetic induction.</p> <p>IDAPA 16.03.02.120 10. Electrical and Lighting. All electrical and lighting installation shall be in accordance with the National Electrical Code (1984 ed.) and as follows: c. Plug adaptors and multiple outlets are prohibited.</p>	K 147		