



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

February 3, 2016

Mary Ruth Butler, Administrator
Kindred Nursing & Rehabilitation-- Mountain Valley
601 West Cameron Avenue
Kellogg, ID 83837-2004

Provider #: 135065

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

Dear Ms. Butler:

On **January 26, 2016**, a Facility Fire Safety and Construction survey was conducted at **Kindred Nursing & Rehabilitation-- Mountain Valley** 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 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 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 **February 16, 2016**. Failure to submit an acceptable PoC by **February 16, 2016**, may result in the imposition of civil monetary penalties by **March 7, 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 **March 1, 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 **March 1, 2016**. A change in the seriousness of the deficiencies on **March 1, 2016**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **March 1, 2016**, includes the following:

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Denial of payment for new admissions effective **April 26, 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 **July 26, 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 **January 26, 2016**, 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 **February 16, 2016**. If your request for informal dispute resolution is received after **February 16, 2016**, 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,

A handwritten signature in black ink, appearing to read 'M.P. Grimes', with a long horizontal line extending to the right.

Mark P. Grimes, Supervisor
Facility Fire Safety and Construction

MPG/lj
Enclosures

TIME RECEIVED February 15, 2016 10:50:36 AM MST	REMOTE CSID	DURATION 140	PAGES 6	STATUS Received
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Feb. 15. 2016 9:24AM

No. 8495

P. 1

Printed: 02/02/2016

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135065	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE NF STRUCTURE B. WING _____	(X3) DATE SURVEY COMPLETED 01/26/2016
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NAME OF PROVIDER OR SUPPLIER KINDRED NURSING & REHABILITATION - MOI	STREET ADDRESS, CITY, STATE, ZIP CODE 601 WEST CAMERON AVENUE KELLOGG, ID 83837
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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 building is a type V (111) fully sprinklered, single story structure with complete fire alarm/detection system. The building was constructed in 1971 and is licensed for 68 beds.

The following deficiencies were cited during the annual Fire/Life Safety survey conducted on January 26, 2016. 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:

Nate Elkins
Health Facility Surveyor
Facility Fire Safety & Construction

K 000

This Plan of Correction is the center's credible allegation of compliance.

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

RECEIVED
FEB 16 2016

K 018 SS=E NFPA 101 LIFE SAFETY CODE STANDARD

Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3

This Standard is not met as evidenced by:

K 018 **FACILITY STANDARDS**

I. On February 10, 2016, the door hardware on resident room 200 was removed, adjusted, and reinstalled so it would latch properly.

II. Twenty-eight residents were affected by the door hardware. The maintenance director will monitor compliance of NFPA 19.3.6.3 with daily rounds and monthly door checks.

III. On February 10, 2016, the maintenance director removed, adjusted and replaced the door hardware to room 200 to ensure positive latching of door hardware and compliance of NFPA 19.3.6.3.

IV. The Maintenance Director or designee will make preventative maintenance rounds each week for three months then monthly, document findings on the audit tool, and report findings to Executive Director ongoing. Findings will also be reported to the Safety and Performance Improvement Committee on a monthly basis.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Marybeth Butler</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>2-15-16</i>
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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 018	<p>Continued From page 1</p> <p>Based on observation, operational testing, and interview the facility failed to maintain doors that protect corridor openings. Failure to maintain corridor doors could allow smoke and dangerous gases to pass freely between compartments. This deficient practice affected one of three smoke compartments, 28 residents, staff, and visitors on the date of survey. The facility is licensed for 68 SNF/NF beds with a census of 60 on the day of survey.</p> <p>Findings include:</p> <p>During the facility tour on January 26, 2016 at approximately 11:30 AM, observation and operational testing of the door to room 200 revealed the door would not close and latch properly. When asked, the Maintenance Supervisor stated the facility was unaware the door would not close and latch properly.</p> <p>Actual NFPA standard:</p> <p>19.3.6.3 Corridor Doors. 19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1 3/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain</p>	K 018	V. Corrective action was completed 02/10/2016.	

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K 018	Continued From page 2 flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke.	K 018		
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure smoke barriers were maintained. Failure to maintain smoke barriers could allow smoke and dangerous gases to pass freely between smoke compartments affecting egress during a fire event. This deficient practice affected two of three smoke barriers, 28 residents, staff and visitors on the date of the survey. The facility is licensed for 68 SNF/NF beds with a census of 60 on the day of the survey. Findings include: During the facility tour on January 26, 2016 at approximately 11:00 AM, observation of the smoke barrier wall above the cross corridor doors near room 100 revealed multiple penetrations ranging from 1 inch to 2 inches in diameter that were unsealed. When asked, the Maintenance Supervisor stated the facility was unaware of the	K 025	K025 I. Penetrations in smoke barriers will be sealed with appropriate sealant. II. Twenty-eight residents were affected by penetrations in smoke barriers. The maintenance director will monitor compliance in sealing of penetrations in smoke barriers with NFPA 19.3.7.3. III. Penetrations in smoke barriers will be sealed with the appropriate sealant by maintenance director following compliance of NFPA 19.3.7.3. IV. The Maintenance Director or designee will make preventative maintenance rounds each week for three months then monthly, document findings on the audit tool, and report findings to Executive Director ongoing. Findings will also be reported to the Safety and Performance Improvement Committee on a monthly basis. V. Corrective action will be completed by 03/01/2016.	

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K 025	Continued From page 3 unsealed penetrations. Actual NFPA standard: 19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour. Exception No. 1: Where an atrium is used, smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with Exception No. 2 to 8.2.5.6(1). Not less than two separate smoke compartments shall be provided on each floor. Exception No. 2*: Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.3 has been provided for smoke compartments adjacent to the smoke barrier. 8.3.2* Continuity. Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces. Exception: A smoke barrier required for an occupied space below an interstitial space shall not be required to extend through the interstitial space, provided that the construction assembly forming the bottom of the interstitial space provides resistance to the passage of smoke equal to that provided by the smoke barrier.	K 025		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 062		

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K 062	<p>Continued From page 4</p> <p>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</p> <p>This Standard is not met as evidenced by: Based on record review and interview, the facility failed to ensure that the fire suppression system was tested and maintained in accordance with NFPA 25. Failure to provide proper testing of the sprinkler system could result in the system not performing properly during a fire event. This deficient practice affected staff and visitors on the date of the survey. The facility is licensed for 68 SNF/NF beds with a census of 60 on the day of the survey.</p> <p>Findings include:</p> <p>During record review on January 26, 2016 at approximately 10:00 AM, the facility sprinkler system quarterly and annual testing reports dated November 11, 2015 and January 21, 2016 stated the Propylene Glycol Antifreeze solution was tested to be at 52.7%. Upon further review of the report dated July 8, 2015 stated the Propylene Glycol Antifreeze solution was tested to be at 50.9%. The Propylene Glycol serves only the outside loop which covers the combustible overhangs. When asked, the Maintenance Supervisor stated the facility was unaware of the testing results.</p> <p>Actual NFPA standard:</p> <p>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.</p>	K 062	<p>K 062</p> <p>I. On February 9, 2016, the sprinkler system over outside covered walkway was drained and refilled with Glycerin Solution of 48%.</p> <p>II. All residents were affected by the Propylene Glycol Antifreeze Solution being at 52.7% in the sprinkler system. The maintenance director will monitor compliance using NFPA 25 Table 2-3.4 now with the 48% glycerin system installed.</p> <p>III. On February 9, 2016, Simplex Grinnell removed the Propylene Glycol Antifreeze Solution from the outside covered walkway sprinkler system and refilled it with a Glycerin Solution at 48% as per NFPA 25 Table 2-3.4.</p> <p>IV. The Maintenance Director or designee will have the Anti Freeze System tested for correct Glycerin Solution percentages each quarter for first year and then every six months to ensure compliance. All findings will be documented on the audit tool, and report findings to Executive Director ongoing. Findings will also be reported to the Safety and Performance Improvement Committee on a quarterly basis.</p> <p>V. Corrective action was completed 02/09/2016.</p>	

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K 062	Continued From page 5 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).]	K 062			