



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

June 29, 2016

Benjamin Roedel, Administrator  
Marquis Care at Shaw Mountain  
909 Reserve Street  
Boise, ID 83712-6508

Provider #: 135090

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

Dear Mr. Roedel:

On **June 22, 2016**, a Facility Fire Safety and Construction survey was conducted at **Marquis Care at Shaw Mountain** 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

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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 **July 12, 2016**. Failure to submit an acceptable PoC by **July 12, 2016**, may result in the imposition of civil monetary penalties by **August 1, 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. If a State Form was issued as well, it should also be signed, dated and returned.

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 **August 2, 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 **August 2, 2016**. A change in the seriousness of the deficiencies on **August 2, 2016**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **August 2, 2016**, includes the following:

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Denial of payment for new admissions effective **September 22, 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 **December 22, 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 **June 22, 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 **July 12, 2016**. If your request for informal dispute resolution is received after **July 12, 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, option 3.

Sincerely,



Nate Elkins, Supervisor  
Facility Fire Safety and Construction

NE/lj  
Enclosures

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

Printed: 06/28/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135090</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/22/2016</b>
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NAME OF PROVIDER OR SUPPLIER <b>MARQUIS CARE AT SHAW MOUNTAIN</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>909 RESERVE STREET BOISE, ID 83712</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	<p><b>INITIAL COMMENTS</b></p> <p>The facility is a Type V(111) single story building. The original building was built in 1963 with an addition in 1971. The east portion of the building was significantly re-modeled in 2007 and a special care unit set-up in the wing. The facility is fully sprinklered. There is a complete fire alarm/smoke detection system installed to include coverage in sleeping rooms. The facility is currently licensed for 98 SNF beds.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on June 23, 2016. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.</p> <p>The survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety &amp; Construction</p> <p>Nathan Elkins Supervisor Facility Fire Safety and Construction</p>	K 000	<p>This plan of correction constitutes the facility's written allegation of compliance for the deficiencies cited in the CMS 2567. However, the submission of this plan is not an admission that a deficiency exists. The Plan of Correction is prepared and executed solely because federal and state law requires it. This response and Plan of Correction does not constitute an admission or agreement by the provider of the facts alleged or set forth in the statement of deficiencies.</p> <p>Survey Definitions:</p> <p>FLS - Fire and Life Safety ESS - Environmental Services Supervisor / Maintenance Supervisor Daily - Monday through Friday IDT - Interdisciplinary Team LN - Licensed Nurse RPT - Relocatable Power Tap</p>	
K 022 SS=E	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. Doors, passages or stairways that are not a way of exit that are likely to be mistaken for an exit have a sign designating "No Exit". 7.10, 18.2.10.1, 19.2.10.1</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that exits were clearly identified. Failure to identify exits could hinder the safe.</p>	K 022		

RECEIVED  
AUG 11 2016  
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Benjamin H. Reed</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>7/12/16</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 022	<p>Continued From page 1 . evacuation of occupants during an emergency. This deficient practice affected 27 residents, staff and visitors on the date of the survey. The facility is licensed for 98 SNF/NF beds and had a census of 75 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on June 22, 2016 from approximately 10:45 AM to 2:45 PM, observation of facility corridors revealed that exit signs installed did not clearly indicate the path of travel for egress during an emergency in the following locations:</p> <p>Observation of the 300 hall revealed exit signs were not installed between the smoke compartment doors and that only one (1) exit sign was present. The lack of signs between the smoke compartment doors failed to clearly identify exits when the doors were activated. Observation of the 100 hall revealed a single exit sign installed which did not clearly identify the exits when the smoke compartment doors were activated.</p> <p>Observation of the exit sign installed above the convenience doors which separated the lobby from the main facility revealed two directional arrows for exiting, one of which directed travel into a wall.</p> <p>When asked about the signs, the Environmental Services Manager stated he had not noticed the confusing signs prior to the survey.</p> <p>Actual NFPA standard: 19.2.10 Marking of Means of Egress. 19.2.10.1 Means of egress shall have signs in accordance</p>	K 022	<p>Corrective Action:</p> <ol style="list-style-type: none"> <li>Exit Signs to be installed above each smoke compartment door in the 300 hall by July 25, 2016.</li> <li>Exit sign in the 100 hall was modified to clearly identify the exits with a single directional arrow to point toward to the exit. Completed on June 22, 2016.</li> </ol> <p>Identification: Staff, Visitors, and 27 residents are identified as possibly being affected by this deficiency.</p> <p>Systemic Changes:</p> <ol style="list-style-type: none"> <li>ESS to continue monthly audit of exit signs for compliance.</li> <li>Staff in-serviced regarding reporting of exit sign issues to ESS.</li> </ol> <p>Monitor: Administrator / IDT Designee to review monthly audits for compliance. Audits to be completed at the following frequencies.</p> <ol style="list-style-type: none"> <li>Monthly for 3 months.</li> <li>Quarterly for 6 months.</li> </ol>	

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K 022	Continued From page 2 with Section 7.10. Exception: Where the path of egress travel is obvious, signs shall not be required in one-story buildings with an occupant load of fewer than 30 persons.  7.10.1.2* Exits. Exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign readily visible from any direction of exit access.	K 022		
K 056 SS=D	<b>NFPA 101 LIFE SAFETY CODE STANDARD</b>  Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13  This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that all areas were protected with automatic fire suppression systems. Failure to provide sprinkler protection to all areas, including overhangs greater than forty-eight (48) inches, could result in fires growing beyond incipient stages. This deficient practice affected staff and visitors of the 300 wing south on the date of the survey. The facility is licensed for 98 SNF/NF beds and had a census of 75 on the day of the survey.  Findings include:	K 056	Corrective Action: <b>K 056</b> Moving forward we will be compliant with the newly adopted life Safety codes from CMS, NFPA 101 edition 2012 and NFPA 13 edition 2010, Chapter 8. To be completed by July 1, 2016.  8.15.7 <b>8.15.7* Exterior Roofs, Canopies, Porte-Cocheres, Balconies, Decks, or Similar Projections.</b> <b>8.15.7.1</b> Unless the requirements of 8.15.7.2, 8.15.7.3, or 8.15.7.4 are met, sprinklers shall be installed under exterior roofs, canopies, porte-cocheres, balconies, decks, or similar projections exceeding 4 ft. (1.2 m) in width. <b>8.15.7.3</b> Sprinklers shall be permitted to be omitted from below the canopies, roofs, porte-cocheres, balconies, decks, or similar projections of combustible construction, provided the exposed finish material on the roofs, canopies, or porte-cocheres are noncombustible, limited-combustible, or fire retardant-treated wood as defined in NFPA 703, <i>Standard for Fire Retardant-Treated Wood and Fire-Retardant Coatings for Building Materials</i> , and the roofs, canopies, or porte-cocheres contain only sprinklered concealed spaces or any of the following unsprinklered combustible concealed spaces:	

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K 056	<p>Continued From page 3</p> <p>During the facility tour conducted on June 22, 2016 from approximately 2:00 PM to 3:00 PM, observation of the exit overhang located at the 300 wing south corridor revealed the overhang was of combustible construction, measuring approximately fifty (50) inches deep by ninety-six (96) inches wide and not equipped with fire sprinkler protection.</p> <p>Interview of the Environmental Services Manager revealed he was not aware of the requirement for this overhang to be protected with automatic sprinklers.</p> <p>Actual NFPA standard: NFPA 13</p> <p>5-1* Basic Requirements. 5-1.1* The requirements for spacing, location, and position of sprinklers shall be based on the following principles: (1) Sprinklers installed throughout the premises (2) Sprinklers located so as not to exceed maximum protection area per sprinkler (3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution Exception No. 1: For locations permitting omission of sprinklers, see 5-13.1, 5-13.2, and 5-13.9. Exception No. 2: When sprinklers are specifically tested and test results demonstrate that deviations from clearance requirements to structural members do not impair the ability of the sprinkler to control or suppress a fire, their positioning and locating in accordance with the test results shall be permitted. Exception No. 3: Clearance between sprinklers</p>	K 056	<p>(1) Combustible concealed spaces filled entirely with noncombustible insulation (2) Light or ordinary hazard occupancies where noncombustible or limited-combustible ceilings are directly attached to the bottom of solid wood joists so as to create enclosed joist spaces 160 ft<sup>3</sup> (4.5 m<sup>3</sup>) or less in volume, including space below insulation that is laid directly on top or within the ceiling joists in an otherwise sprinklered attic [see 11.2.3.1.4(4)(d)] (3) Concealed spaces over isolated small roofs, canopies, or porte-cocheres not exceeding 55 ft<sup>2</sup> (5.1 m<sup>2</sup>) in area"</p> <p>Identification: Staff, Visitors, and 75 residents identified as possibly being affected by this deficiency.</p> <p>Systemic Changes: We will comply with the newly adopted regulations by CMS.</p> <p>Monitor: Administrator / IDT Designee to review monthly audits for compliance. Audits to be completed at the following frequencies. 1. Monthly for 3 months 2. Quarterly for 6 months</p>	

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K 056	Continued From page 4 and ceilings exceeding the maximum specified in 5-6.4.1, 5-7.4.1, 5-8.4.1, 5-9.4.1, 5-10.4.1, and 5-11.4.1 shall be permitted provided that tests or calculations demonstrate comparable sensitivity and performance of the sprinklers to those installed in conformance with these sections.  5-13.8* Exterior Roofs or Canopies. 5-13.8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 ft (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction	K 056		
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10, 18.3.5.6, 19.3.5.6 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that portable fire extinguishers were accessible and not blocked by obstructions. Failure to ensure access to portable fire extinguishers could hinder staff response during a fire event. This deficient practice affected staff and vendors to the Kitchen on the date of the survey. The facility is licensed for 98 SNF/NF beds and had a census of 75 on the day of the survey.  Findings include:  During the facility tour conducted on June 22, 2016 from approximately 10:45 AM to 2:45 PM, observation of the K-style fire extinguisher in the Kitchen revealed access to the extinguisher was blocked by two (2) dietary carts. When asked	K 064	Corrective Action: <ol style="list-style-type: none"><li>1. Red tape to be installed clearly indicating on where staff can and cannot store/park dietary carts in the kitchen hall. To be completed by July 25, 2016.</li><li>2. All staff will be educated on the purpose of the red tape to ensure all fire extinguishers are accessible at all times with the facility. To be completed by July 25, 2016.</li></ol> Identification: Kitchen staff and Food Vendors are identified as possibly being affected by this deficiency.  Systemic Changes: Dietary Manager to continue monthly audits for compliance.  Monitor: Administrator / IDT Designee to review monthly audits for compliance. Audits to be completed at the following frequencies. <ol style="list-style-type: none"><li>3. Monthly for 3 months.</li><li>4. Quarterly for 6 months.</li></ol>	

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K 064	Continued From page 5 about the lack of access to the extinguisher, the Environmental Services Manager stated he was not sure why the carts were there as staff in the Kitchen had been directed to keep the area clear on multiple occasions.  Actual NFPA standard:  NFPA-10 1-6.3 Fire extinguishers shall be conspicuously located where they will be readily accessible and immediately available in the event of fire. Preferably they shall be located along normal paths of travel, including exits from areas.	K 064		
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10, 18.2.1, 19.2.1 This Standard is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure that means of egress were maintained free of impediments and available for immediate use in a fire event or other emergency. Failure to provide instant use of doors could hinder safe evacuation during an emergency. This deficient practice affected staff and visitors on the date of the survey. The facility is licensed for 98 SNF/NF beds and had a census of 75 on the day of the survey.  Findings include:  During the facility tour conducted on June 22, 2016 from approximately 10:45 AM to 2:45 PM,	K 072	Corrective Action:  1. Door lock to the Activities Office as well as the Bathroom within that office to be changed to single operational door locks. This was completed on July 15, 2016.  Identification: Two staff members that work in the Activities office are identified as possibly being affected by this deficiency.  Systemic Changes:  1. ESS to continue monthly audits of doors and door handles for compliance.  Monitor: Administrator / IDT Designee to review monthly audits for compliance. Audits to be completed at the following frequencies.  1. Monthly for 3 months. 2. Quarterly for 6 months.	

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K 072	<p>Continued From page 6</p> <p>observation and operational testing of door locks to the Activities Office and the bathroom inside the office, revealed the locks were non-single operational from the egress side and required a key, tool or special knowledge to release. When asked about this locking arrangement, the Enviromental Services Manager stated he was not aware these locks were not acceptable in this location.</p> <p>Actual NFPA standard:</p> <p>NFPA 101</p> <p>7.1.10 Means of Egress Reliability. 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.</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.</p> <p><i>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 floor. Existing security devices shall be permitted</i></p>	K 072		

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K 072	Continued From page 7 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 072		
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code, 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This Standard is not met as evidenced by: Based on observation, the facility failed to ensure safe electrical installations in accordance with NFPA 70 and state regulations. Failure to provide safe electrical installations could result in fires by arcing or electrocution. This deficient practice affected all residents, staff and visitors on the date of the survey. The facility is licensed for 98 SNF/NF beds and had a census of 75 on the day of the survey.  Findings include:  During the facility tour conducted on June 22, 2016 from approximately 10:30 AM to 3:00 PM, observation of electrical installations revealed the following:  1) Observation of the electrical panel located at the 100 - 200 - 300 halls intersection revealed breaker #24 was not labeled as to the circuit it energized.  2) Observation of the electrical panel labeled "P" revealed the breakers numbering 13 to 16 did not	K 147	<b>Corrective Action:</b> <ol style="list-style-type: none"><li>Each Breaker including #24 to be clearly labeled as to the circuit it energizes by July 25, 2016.</li><li>Electrical panel "P" to clearly identify all breakers the circuits they energize by July 25, 2016.</li><li>Electrical panel "A" to clearly identify all breakers the circuits they energize by July 25, 2016.</li><li>The server room electrical box panel cover placed and secured over exposed wires. Completed July 12, 2016.</li><li>Food Store Room electrical box panel cover placed and secured over exposed wires. Completed July 12, 2016.</li><li>The three-to-one multiple plug adapter in room 304 was removed from facility. Completed July 12, 2016.</li></ol> <b>Identification:</b> All residents and Staff are identified as possibly being affected by this deficiency.	

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K 147	<p>Continued From page 8 identify the circuits they energized.</p> <p>3) Observation of the electrical panel labeled "A" revealed the breakers numbering 35 to 37 did not identify the circuits they energized.</p> <p>4) Observation of the Server room revealed an open electrical box approximately four (4) inches by ten (10) inches with exposed wiring.</p> <p>5) Observation of the Food Store Room revealed an open electrical box approximately six (6) inches by ten (10) inches with exposed wiring.</p> <p>6) Room 304 had a three-to-one multiple plug adapter in use.</p> <p>Actual NFPA standard:  NFPA 70  110.2 Approval. The conductors and equipment required or permitted by this Code shall be acceptable only if approved. FPN: See 90.7, Examination of Equipment for Safety, and 110.3, Examination, Identification, Installation, and Use of Equipment. See definitions of Approved, Identified, Labeled, and Listed.</p> <p>Finding 1-3 and Finding 6</p> <p>110.3 Examination, Identification, Installation, and Use of Equipment. (A) Examination. In judging equipment, considerations such as the following shall be evaluated: (1) Suitability for installation and use in conformity with the provisions of this Code</p>	K 147	<p>Systemic Changes:</p> <ol style="list-style-type: none"> <li>1. ESS to continue audit monthly for electrical boxes for compliance with labeling and panel covers.</li> <li>2. ESS to continue audit monthly for electrical receptacles for compliance with labeling and panel covers.</li> <li>3. Staff in serviced regarding reporting issues with electrical receptacles to ESS. Completed by July 25, 2016.</li> <li>4. Staff in serviced regarding policy pertaining to use of RPT in the facility. Completed by July 25, 2016.</li> </ol> <p>Monitor: Administrator / IDT Designee to review monthly audits for compliance. Audits to be completed at the following frequencies.</p> <ol style="list-style-type: none"> <li>1. Monthly for 3 months.</li> <li>2. Quarterly for 6 months.</li> </ol>	

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K 147	<p>Continued From page 9</p> <p>FPN: Suitability of equipment use may be identified by a description marked on or provided with a product to identify the suitability of the product for a specific purpose, environment, or application. Suitability of equipment may be evidenced by listing or labeling.</p> <p>(2) Mechanical strength and durability, including, for parts designed to enclose and protect other equipment, the adequacy of the protection thus provided</p> <p>(3) Wire-bending and connection space</p> <p>(4) Electrical insulation</p> <p>(5) Heating effects under normal conditions of use and also under abnormal conditions likely to arise in service</p> <p>(6) Arcing effects</p> <p>(7) Classification by type, size, voltage, current capacity, and specific use</p> <p>(8) Other factors that contribute to the practical safeguarding of persons using or likely to come in contact with the equipment</p> <p>110.22 Identification of Disconnecting Means. Each disconnecting means shall be legibly marked to indicate its purpose unless located and arranged so the purpose is evident. The marking shall be of sufficient durability to withstand the environment involved. Where circuit breakers or fuses are applied in compliance with the series combination ratings marked on the equipment by the manufacturer, the equipment enclosure(s) shall be legibly marked in the field to indicate the equipment has been applied with a series combination rating. The marking shall be readily visible and state the following: CAUTION - SERIES COMBINATION SYSTEM RATED _____ AMPERES. IDENTIFIED REPLACEMENT COMPONENTS REQUIRED. FPN: See Section 240.86(A) for interrupting</p>	K 147		

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K 147	<p>Continued From page 10 rating marking for end-use equipment.</p> <p>Finding 4 and 5</p> <p>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, 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.</p> <p>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</p>	K 147		

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K 147	Continued From page 11 closed.....  Finding 6  IDAPA 16.03.02.120.10 (c)  120.EXISTING BUILDINGS. These standards shall be applied to all currently licensed health care facilities. Any minor alterations, repairs, and maintenance shall meet these standards. In the event of a change in ownership of a facility, the entire facility shall meet these standards prior to issuance of a new license.  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.	K 147		