November 10, 2016

Chase Gunderson, Administrator
Owyhee Health & Rehabilitation Center
PO Box A
Homedale, ID 83628-2040

Provider #: 135087

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Mr. Gunderson:

On November 2, 2016, a Facility Fire Safety and Construction survey was conducted at Owyhee 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 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 **November 23, 2016.** Failure to submit an acceptable PoC by **November 23, 2016,** may result in the imposition of civil monetary penalties by **December 12, 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 **December 7, 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 **December 7, 2016.** A change in the seriousness of the deficiencies on **December 7, 2016,** may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **December 7, 2016,** includes the following:
The remedy, which will be recommended if substantial compliance has not been achieved by **December 20, 2016**, includes the following:

Denial of payment for new admissions effective **February 15, 2017**.
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 **May 15, 2017**, 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 Nate Elkins, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, option 3; 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 **November 15, 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:
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 **November 23, 2016**. If your request for informal dispute resolution is received after **November 23, 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
INITIAL COMMENTS

The facility is a single story, type V(111) construction. The latest addition was in 1990. The facility was originally built in 1959. The facility is fully sprinklered and is equipped with smoke detection in common areas and corridors. Currently the facility is licensed for 49 SNF/NF beds.

The following deficiencies were cited during the annual fire/life safety survey conducted on November 2, 2016. The facility was surveyed under the LIFE SAFETY CODE 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.

The survey was conducted by:

Linda Chaney
Health Facility Surveyor
Facility Fire Safety and Construction
NFPA 101 Means of Egress - General

Means of Egress - General
Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1. 7.1.10.1

This STANDARD is not met as evidenced by:
Based on observation, operational testing and interview, the facility failed to maintain the means of egress. Failure to maintain the means of egress could prevent occupants ability to safely evacuate in an emergency. This deficient practice affected staff and visitors on the date of the

THE PLAN OF CORRECTION

"The plan of correction is prepared and submitted as required by law. By submitting this Plan of Correction, Owyhee Health and Rehabilitation does not admit that the deficiency listed on this form exist, nor does the center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."

K 211

Corrective Actions:
Throw bolt has been removed from the exterior of the door to the laundry room.
Identification of others affected and corrective actions:
Throw bolt has been removed. All staff using the laundry room may have been affected.
Measures to ensure the deficient practice does not happen again:
The throw bolt has been removed.
Monitor corrective actions:
Maintenance director will check door monthly for two months to ensure no throw bolt is installed.
Corrective actions will be completed
**K 211** Continued From page 1 survey. The facility is licensed for 49 SNF/NF beds and had a census of 37 on the day of the survey.

Findings include:

During the facility tour on November 2, 2016, from approximately 10:30 AM to 3:00 PM, observation and operational testing of the door to/from the laundry washing room found a throw bolt installed on the exterior side of the door. When asked, the Maintenance Supervisor stated the lock was used to secure the laundry area after hours.

Actual NFPA standard:

19.2.1 General.
Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7, unless otherwise modified by 19.2.2 through 19.2.11.

7.2.1.5.3 Locks, if provided, shall not require the use of a key, a tool, or special knowledge or effort for operation from the egress side.

**K 232**

**SS=E**

**NFPA 101 Aisle, Corridor, or Ramp Width**

Aisle, Corridor or Ramp Width
2012 EXISTING
The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5, 19.2.3.4, 19.2.3.5
K 232  Continued From page 2

This STANDARD is not met as evidenced by:
Based on observation and interview, the facility failed to maintain corridor exit access free of obstruction/storage. Failure to maintain exit access could hinder the safe evacuation of residents during a fire or other emergency. This deficient practice affected 20 residents, staff and visitors on the date of the survey. The facility is licensed for 49 SNF/NF beds and had a census of 37 on the day of the survey.

Findings include:

During the facility tour on November 2, 2016 from approximately 10:30 AM to 3:00 PM, observation of the exit access corridor at resident rooms 25 and 26 revealed non-wheeled, physical therapy steps stored in the corridor next to the exit door. When asked, the Maintenance Supervisor stated the facility was unaware that they could not be stored there.

Actual NFPA Standard:

19.2.3.4* Any required aisle, corridor, or ramp shall be not less than 48 in. (1220 mm) in clear width where serving as means of egress from patient sleeping rooms, unless otherwise permitted by one of the following:
(1) Aisles, corridors, and ramps in adjunct areas not intended for the housing, treatment, or use of inpatients shall be not less than 44 in. (1120 mm) in clear and unobstructed width.
(2)*Where corridor width is at least 6 ft (1830 mm), noncontinuous projections not more than 6 in. (150 mm) from the corridor wall, above the handrail height, shall be permitted.
(3) Exit access within a room or suite of rooms

K 232

Corrective Actions:
Physical therapy steps will be removed from the hallway.
Identification of others affected and corrective actions:
All residents, staff, and visitors may have been affected. Steps will be removed.
Measures to ensure the deficient practice does not happen again:
Steps will be removed from the hallway.
Monitor corrective actions:
Plant manager or designee will check monthly for two months to ensure steps are not brought back into the building.
Corrective actions will be completed 11/25/16.
**K 232** Continued From page 3

complying with the requirements of 19.2.5 shall be permitted.

(4) Projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met:

(a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in. (1525 mm).

(b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency.

(c)* The wheeled equipment is limited to the following:

i. Equipment in use and carts in use

ii. Medical emergency equipment not in use

iii. Patient lift and transport equipment

(5)* Where the corridor width is at least 8 ft (2440 mm), projections into the required width shall be permitted for fixed furniture, provided that all of the following conditions are met:

(a) The fixed furniture is securely attached to the floor or to the wall.

(b) The fixed furniture does not reduce the clear unobstructed corridor width to less than 6 ft (1830 mm), except as permitted by 19.2.3.4(2).

(c) The fixed furniture is located only on one side of the corridor.

(d) The fixed furniture is grouped such that each grouping does not exceed an area of 50 ft2 (4.6 m2).

(e) The fixed furniture groupings addressed in 19.2.3.4(5)(d) are separated from each other by a distance of at least 10 ft (3050 mm).

(f)* The fixed furniture is located so as to not obstruct access to building service and fire protection.
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

#### (X1) PROVIDER/SUPPLIER/Clinical Laboratory Improvement Amendments (CLIA) IDENTIFICATION NUMBER:

135087

#### (X2) MULTIPLE CONSTRUCTION

<table>
<thead>
<tr>
<th>ID</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>K232</td>
<td></td>
<td>Continued From page 4 equipment.</td>
<td>K232</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(g) Corridors throughout the smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the fixed furniture spaces are arranged and located to allow direct supervision by the facility staff from a nurses' station or similar space.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(h) The smoke compartment is protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.8.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### (X3) DATE SURVEY COMPLETED

11/02/2016

#### NAME OF PROVIDER OR SUPPLIER

OWYHEE HEALTH & REHABILITATION CENTER

#### STREET ADDRESS, CITY, STATE, ZIP CODE

108 WEST OWYHEE
HOMEDALE, ID 83628

#### (X4) ID PREFIX/TAG

<table>
<thead>
<tr>
<th>ID PREFIX/TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX/TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>K232</td>
<td>Continued From page 4 equipment. (g) Corridors throughout the smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the fixed furniture spaces are arranged and located to allow direct supervision by the facility staff from a nurses' station or similar space. (h) The smoke compartment is protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.8.</td>
<td>K353</td>
<td>Corrective Actions: Personal belongings and all other items will be moved to ensure 18 inches from the sprinkler heads. Identification of others affected and corrective actions: All residents, staff, and visitors may have been affected. All items will be removed from closets to ensure proper clearance. Measures to ensure deficient practice does not happen again: Staff will be in-serviced on the requirement to keep 18 inches of clearance from the sprinkler head. Monitor corrective actions: Housekeeping will check sprinkler heads for sufficient clearance weekly for four weeks and months for two months.</td>
</tr>
<tr>
<td>K353</td>
<td>NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked b) Who provided system test c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the sprinkler system. Failure to ensure the system was maintained properly could</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Continued From page 5

result in insufficient suppression during a fire. This deficient practice affected 1 resident, staff and visitors on the date of the survey. The facility is licensed for 49 SNF/NF beds and had a census of 37 on the day of the survey.

Findings include:

During the facility tour on November 2, 2016, from approximately 10:30 AM to 3:00 PM, inspection of the closet in resident room #14 revealed the sprinkler head was blocked by personal belongings stored closer than 18 inches from the sprinkler head. When asked, the Maintenance Supervisor stated the facility was not aware that the sprinkler was blocked.

Actual NFPA standard:

NFPA 101
19.3.5.1 Buildings containing nursing homes shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7; unless otherwise permitted by 19.3.5.5.

9.7.1.1.1 Each automatic sprinkler system required by another section of this Code shall be in accordance with one of the following:

(1) NFPA 13, Standard for the Installation of Sprinkler Systems
(2) NFPA 13D, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes
(3) NFPA 13R, Standard for the Installation of...
K 353 Continued from page 6
Sprinkler Systems in Residential Occupancies up to and Including Four Stories in Height

NFPA 13
8.5.6.1* Unless the requirements of 8.5.6.2, 8.5.6.3, 8.5.6.4, or 8.5.6.5 are met, the clearance between the deflector and the top of storage shall be 18 in. (457 mm) or greater.

K 363 NFPA 101 Corridor - Doors

K 363

Corrective actions:
Molding installed on room #1 door to create proper seal.

Identification of others affected and corrective actions:
Anyone in room #1, other residents, staff, and visitors may have been affected. Molding has been installed to create proper seal.

Measures to ensure the deficient practice does not happen again:
Door has been fixed to create proper seal.

Monitor corrective actions:
Maintenance will check door weekly for 2 weeks and monthly for one month to ensure proper seal is intact.

Corrective actions will be completed 11/20/16
K 363  Continued From page 7
sprinklered compartments there are no restrictions in area or fire resistance of glass or
frames in window assemblies.
19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483,
and 485
Show in REMARKS details of doors such as fire protection ratings, automatics closing devices,
etc.
This STANDARD is not met as evidenced by:
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, preventing defend in place.
This deficient practice has affected 1 resident,
staff, and visitors on the date of survey. The
facility is licensed for 48 SNF/NF beds with a
census of 37 on the day of survey.

Findings include:

During the facility tour on October 20, 2016 from
approximately 10:30 AM to 3:00 PM, observation
and operational testing of resident room #1 door
revealed the door did not close and seal properly
leaving an approximately 1/2" gap between the
doors and the door frame at the top of the door
large enough to feel positive airflow through the
gap. When asked, the Maintenance Supervisor
stated the facility was unaware there was a gap at
the top of the door.

Actual NFPA standard:

NFPA 101
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
<table>
<thead>
<tr>
<th>ID</th>
<th>Summary Statement of Deficiencies</th>
<th>ID</th>
<th>Provider's Plan of Correction</th>
</tr>
</thead>
<tbody>
<tr>
<td>K 363</td>
<td>Continued From page 8 hazardous areas shall be doors constructed to resist the passage of smoke and shall be constructed of materials such as the following: (1) 13/4 in. (44 mm) thick, solid-bonded core wood (2) Material that resists fire for a minimum of 20 minutes</td>
<td>K 363</td>
<td>Corrective actions: Gap in smoke partition will be fixed. Metal collar installed around the hot water vent pipe to cover the hole in the ceiling. Identification of others and corrective actions: All residents, staff, and visitors may have been affected. Smoke partitions were fixed to ensure smoke partition integrity. Metal collar was installed to cover the hole in the ceiling. Measures to ensure deficient practice does not happen again: Smoke partitions have been fixed. Metal collar installed to cover the hole in the ceiling. Monitor corrective actions: Plant manager or designee will check partitions weekly for four weeks and monthly for two months. Plant manager will also check metal collar weekly for two weeks and monthly for one month.</td>
</tr>
<tr>
<td>K 372</td>
<td>NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that smoke partitions were maintained. Failure to maintain smoke partitions could allow smoke and dangerous gases to pass freely between compartments affecting egress during a fire event. This deficient practice affected staff and visitors on the date of the survey. The facility is licensed for 49 SNF/NF beds and had a census of 37 on the day of the survey.</td>
<td>K 372</td>
<td></td>
</tr>
</tbody>
</table>

FORM CMS-2567(02-90) Previous Versions Obsolete Event ID:L1L021 Facility ID: MDS001660 If continuation sheet Page 9 of 19
K 372 Continued From page 9

Findings include:

During the facility tour on November 2, 2016 from approximately 10:30 AM to 3:00 PM, observation of the Laundry washer room revealed an approximate 1-1/2" inch hole in the ceiling around the hot water vent pipe. When asked, the Maintenance Supervisor stated the facility was unaware that it needed to be sealed.

Actual NFPA standard:

19.1.1.4.1.1 Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.)

8.3.5.1* Firestop Systems and Devices Required. Penetrations for cables, cable trays, conduits, pipes, tubes, combustion vents and exhaust vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a fire barrier shall be protected by a firestop system or device. The firestop system or device shall be tested in accordance with ASTM E 814, Standard Test Method for Fire Tests of Through Penetration Fire Stops, or ANSI/UL 1479, Standard for Fire Tests of Through-Penetration Firestops, at a minimum positive pressure differential of 0.01 in. water
**OWYHEE HEALTH & REHABILITATION CENTER**

**K 372**
Continued From page 10
column (2.5 N/m2) between the exposed and the unexposed surface of the test assembly

**K 511**
NFPA 101 Utilities - Gas and Electric
Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life.
18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2

This STANDARD is not met as evidenced by:
Based on observation and interview, the facility failed to ensure that electrical systems were installed in accordance with NFPA 70. Failure to ensure proper electrical installations could result in electrocution or fire. This deficient practice affected 17 residents, staff and visitors on the date of the survey. The facility is licensed for 49 SNF/NF beds and had a census of 37 on the day of the survey.

Findings include:
1.) During the facility tour on November 2, 2016 from approximately 10:30 AM to 3:00 PM, observation of the main medical storage room revealed boxes stacked in front of the electrical panel making it inaccessible. When asked, the Maintenance Supervisor stated the facility was unaware of the blocked panel.
2.) During the facility tour on November 2, 2016...
K 511 Continued From page 11
from approximately 10:30 AM to 3:00 PM, observation of the electrical panel in the dry storage room in the kitchen area revealed black duct tape had been used to cover a hole where there was a missing breaker/blank. When asked, the Maintenance Supervisor stated the facility was unaware that duct tape could not be used to cover the opening in the electrical panel.

3.) During the facility tour on November 2, 2016 from approximately 10:30 AM to 3:00 PM, observation of the main office revealed a small refrigerator plugged in to an RPT (Relocatable Power Tap) being used as fixed wiring. When asked, the Maintenance Supervisor stated the facility was unaware that small appliances could not be plugged in to RPTs.

4.) During the facility tour on November 2, 2016 from approximately 10:30 AM to 3:00 PM, observation of the electrical outlet in the main entry to the facility revealed that it was cracked. When asked, the Maintenance Supervisor stated the facility was unaware the outlet was cracked.

Actual NFPA standard:

NFPA 70

1.) 110.26 Spaces About Electrical Equipment. Sufficient access and working space shall be provided and maintained about all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons.
   (A) Working Space. Working space for equipment operating at 600 volts, nominal, or less
K 511 Continued From page 12

To ground and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A)(1), (2), and (3) as required or permitted elsewhere in this Code.

2.) 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.

3.) 400.8 Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following:
<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>K 511</td>
<td>Continued From page 13 (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of 368.8. (5) Where concealed by walls, floors, or ceilings or located above suspended or dropped ceilings (6) Where installed in raceways, except as otherwise permitted in this Code 4.) 406.5 Receptacle Faceplates (Cover Plates). Receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. K 781 Corrective actions: Portable heater has been removed. Electric fireplace has been hardwired into the wall and bracketed against the wall. Identification of others affected and corrective actions: Residents, staff, and visitors may have been affected. Measures to ensure that the deficient practice does not happen again: In-service staff on portable heaters and tell them they are not allowed in the facility. Monitor corrective actions: Housekeeping will check for portable heaters weekly for four weeks and monthly for 2 months.</td>
<td>11/02/2016</td>
</tr>
<tr>
<td>K 781</td>
<td>K 781 Portable Space Heaters NFPA 101 Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to prohibit portable space heaters in sleeping areas. Portable space heaters in sleeping areas is considered a significant risk due to the history of fires caused by space heaters. This deficient practice affected 17 residents, staff, and visitors on the day of survey. The facility is licensed for 49 SNF/NF beds with a census of 37</td>
<td>11/02/2016</td>
</tr>
<tr>
<td>K 781</td>
<td>Continued From page 14 on the date of survey. Findings include: During the facility tour on November 2, 2016 from approximately 10:30 AM to 3:00 PM, observation revealed a portable electric fireplace located in the main lobby of the facility. It was observed that the main lobby was open to resident sleeping rooms. When asked, the Maintenance Supervisor stated the facility was unaware the fireplace was considered a portable space heater. Actual NFPA standard: 19.7.8 Portable Space-Heating Devices. Portable spaceheating devices shall be prohibited in all health care occupancies, unless both of the following criteria are met: (1) Such devices are used only in nonsleeping staff and employee areas. (2) The heating elements of such devices do not exceed 212°F (100°C).</td>
<td>K 781</td>
</tr>
<tr>
<td>K 916</td>
<td>NFPA 101 Electrical Systems - Essential Electric System Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. Corrective actions: Building will be getting a new generator with the new building being constructed on the adjacent lot and will have an annunciator panel. If the new building is not built an annunciator panel will be installed. Identification of others affected and corrective actions: Residents, staff, and visitors have the potential to be affected. A new generator will be installed with the new building being constructed. Measures to ensure the deficient practice does not happen again: A new generator with an annunciator panel will be installed. Monitor corrective actions: Will update state on the status of the new building and date of new generator installation.</td>
<td>K 916</td>
</tr>
</tbody>
</table>
**K 916** Continued From page 15
6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99)
This STANDARD is not met as evidenced by:
Based on observation and interview, the facility failed to ensure the EES (Essential Electrical System) was installed in accordance with NFPA 99. Failure to provide an alarm annunciator for the EES could hinder early notification of equipment failures, leaving the facility without emergency power during an outage. This deficient practice affected 37 residents, staff and visitors on the date of the survey. The facility is licensed for 49 SNF/NF beds and had a census of 37 on the date of the survey.

Findings include:
During the facility tour conducted on November 2, 2016 from approximately 10:30 AM to 3:00 PM, observation of all of the work stations inside the facility, did not reveal an alarm annunciator for the EES. When asked, the Maintenance Supervisor stated that he was not aware of an alarm panel, or other device which would indicate the facility was under auxiliary power (generator) during a power outage.

Actual NFPA standard:
NFPA 99
Chapter 3 Electrical Systems
3-4 Essential Electrical System Requirements - Type 1.
3-4.1.1.15 + Alarm Annunciator.
A remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station (see NFPA 70, National Electrical Code, Section

Plant manager will conduct visual inspection of generator daily Monday-Friday until new generator is installed.
| K 916 Continued From page 16 700-12.) The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows: (a) Individual visual signals shall indicate the following: 1. When the emergency or auxiliary power source is operating to supply power to load 2. When the battery charger is malfunctioning (b) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate the following: 1. Low lubricating oil pressure 2. Low water temperature (below those required in 3-4.1.1.9) 3. Excessive water temperature 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply 5. Overcrank (failed to start) 6. Overspeed Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.16(a) and (b) occur, but need not display these conditions individually. [110: 3-6.5.2] | K 916 |
| K 920 NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of | K 920 |

Corrective actions:

Power strips for PCREE will meet UL 1363 A or UL 60601-1.

Identification of others affected and corrective actions:

All residents needing additional outlets may have been affected. Rooms needing additional outlets will have power strips meeting UL 1363 A or UL 60601-1.

Measures to ensure the deficient practice does not happen again:

Power strips meeting UL 1363 A or UL 60601-1 will be provided.

Monitor corrective actions:

Maintenance or designee will check rooms weekly for four weeks and monthly for two months to ensure proper use of power strips meeting UL 1363 A or UL 60601-1 in resident rooms.
<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR IGC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
</table>
| K 920        | Continued From page 17  
10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms outside of vicinity meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4.  
10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5.  
This STANDARD is not met as evidenced by:  
Based on observation and interview, the facility failed to ensure electrical wiring was in accordance with the National Electrical Code.  
Exposure of open electrical connections, wiring, or improper use of flexible cords, could result in fires by arcing or electrocution. The deficient practice was wide spread throughout the facility and affected 37 residents, staff, and visitors on the date of survey. The facility is licensed for 49 SNF/NF beds and had a census of 37 the day of survey.  
Findings include:  
During the facility tour on November 2, 2016 from 10:30 AM to 3:00 PM, observation revealed medical equipment plugged in to Relocatable Power Taps (RPTs) being used as a substitute to permanent wiring in the following areas:  
- Resident Room #10, two medical beds and two oxygen concentrators | K 920 | | | |
<table>
<thead>
<tr>
<th>K 920</th>
<th>Continued From page 18</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- Resident Room #12, one medical bed</td>
</tr>
<tr>
<td></td>
<td>- Resident Room #14, one medical bed</td>
</tr>
<tr>
<td></td>
<td>- Resident Room #21, one medical bed</td>
</tr>
<tr>
<td></td>
<td>- Resident Room #22, one oxygen concentrator</td>
</tr>
<tr>
<td></td>
<td>When asked, the Maintenance Supervisor stated the facility was unaware that medical</td>
</tr>
<tr>
<td></td>
<td>beds and oxygen concentrators could not be plugged in to RPTs.</td>
</tr>
<tr>
<td></td>
<td>Actual NFPA standard:</td>
</tr>
<tr>
<td></td>
<td>NFPA 70, 400-8. Uses Not Permitted</td>
</tr>
<tr>
<td></td>
<td>Unless specifically permitted in Section 400-7, flexible cords and cables shall not</td>
</tr>
<tr>
<td></td>
<td>be used for the following:</td>
</tr>
<tr>
<td></td>
<td>1. As a substitute for the fixed wiring of a structure</td>
</tr>
<tr>
<td></td>
<td>2. Where run through holes in walls, structural ceilings suspended ceilings, dropped</td>
</tr>
<tr>
<td></td>
<td>ceilings, or floors</td>
</tr>
<tr>
<td></td>
<td>3. Where run through doorways, windows, or similar openings</td>
</tr>
<tr>
<td></td>
<td>4. Where attached to building surfaces</td>
</tr>
<tr>
<td></td>
<td>Exception: Flexible cord and cable shall be permitted to be attached to building</td>
</tr>
<tr>
<td></td>
<td>surfaces in accordance with the provisions of Section 364-8.</td>
</tr>
<tr>
<td></td>
<td>5. Where concealed behind building walls, structural ceilings, suspended ceilings,</td>
</tr>
<tr>
<td></td>
<td>dropped ceilings, or floors</td>
</tr>
<tr>
<td></td>
<td>6. Where installed in raceways, except as otherwise permitted in this Code</td>
</tr>
<tr>
<td></td>
<td>Also refer to UL Online Certifications Directory</td>
</tr>
<tr>
<td></td>
<td>XBYS.GuideInfo Relocatable Power Taps</td>
</tr>
</tbody>
</table>

| K 920  | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO |
|        |   THE APPROPRIATE DEFICIENCY)                                                        |
|        |                                                                                      |
|        |                                                                                      |
**Statement of Deficiencies and Plan of Correction**

<table>
<thead>
<tr>
<th>(X1) Provider/Supplier/Clinic Identification Number:</th>
<th>(X2) Multiple Construction</th>
</tr>
</thead>
<tbody>
<tr>
<td>MDS001660</td>
<td>A. Building: 03 - Entire NF Structure</td>
</tr>
<tr>
<td></td>
<td>B. Wing ____________________</td>
</tr>
</tbody>
</table>

**Name of Provider or Supplier:**

OWYHEE HEALTH & REHABILITATION CENTER

**Street Address, City, State, Zip Code:**

108 WEST OWYHEE

HOMEDALE, ID 83628

**Date Survey Completed:**

11/02/2016

**(X4) ID Prefix Tag**

<table>
<thead>
<tr>
<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</th>
</tr>
</thead>
<tbody>
<tr>
<td>C 000 16.03.02 Initial Comments</td>
</tr>
<tr>
<td>The facility is a single story, type V(111) construction. The latest addition was in 1990. The facility was originally built in 1959. The facility is fully sprinklered and is equipped with smoke detection in common areas and corridors. Currently the facility is licensed for 49 SNF/NF beds. The following deficiencies were cited during the annual fire/life safety survey conducted on November 2, 2016. The facility was surveyed under the LIFE SAFETY CODE 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70 and IDAPA 16.03.02 Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities. The survey was conducted by: Linda Chaney Health Facility Surveyor Facility Fire Safety and Construction</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ID Prefix Tag</th>
<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency)</th>
</tr>
</thead>
<tbody>
<tr>
<td>C 000</td>
<td></td>
</tr>
</tbody>
</table>

**Corrective Actions:**

C 237

Corrective Actions:

- Will place metal containers with self-closing, tight-fitting lids in all designated smoking areas.
- Identification of others affected and corrective actions:
  - Anyone using the smoking areas may have been affected. New containers will be placed in designated smoking areas.
  - Measures to ensure the deficient practice does not happen again: Containers will be placed at each designated smoking area.
  - Monitor corrective actions:
    - Plant manager or designee will check weekly for two weeks that designated smoking areas have metal containers with self-closing, tight-fitting lids and are placed in each designated smoking area.

**Date:**

11/25/16

**Laboratory Director or Provider/Supplier Representative's Signature:**

[Signature]

**Title:**

Administrator

**Date:**

11/27/16

**State Form:**

6800

**L1L021**

If continuation sheet 1 of 2
C 237 Continued From page 1

Findings include:

During the facility tour on November 2, 2016 from approximately 10:30 AM to 3:00 PM, observation revealed the residents designated smoking area outside the Dining Room was not equipped with a metal container with a self-closing, tight-fitting cover. Further investigation of the trash receptacle revealed cigarette butts thrown into the trash that contained combustible materials. There was also no metal container with a self-closing, tight-fitting lid at the designated staff smoking area outside of the dryer building. When asked, the Maintenance Supervisor stated the facility was not aware the smoking areas required a self-closing metal container with a tight-fitting lid.

Actual standard:

IDAPA 106.03f
That metal containers with self-closing, tight-fitting lids, or their equivalent, shall be provided in all areas where smoking is permitted.