



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
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CERTIFIED MAIL: 70121010000208363950

May 7, 2014

Dallas Clinger, Administrator
Power County Nursing Home
PO Box 420
American Falls, ID 83211-0420

Provider #: 135066

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

Dear Mr. Clinger:

On **April 29, 2014**, a Facility Fire Safety and Construction survey was conducted at **Power County Nursing Home** 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 and a similar State Form 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

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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 both Statement of Deficiencies and Plan of Correction, Form CMS-2567 and State Form, in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **May 20, 2014**. Failure to submit an acceptable PoC by **May 20, 2014**, may result in the imposition of civil monetary penalties by **June 9, 2014**.

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 **June 3, 2014**, (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 **June 3, 2014**. A change in the seriousness of the deficiencies on **June 3, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by

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June 3, 2014, includes the following:

Denial of payment for new admissions effective **July 29, 2014**.
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 **October 29, 2014**, 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 **April 29, 2014**, 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/NursingFa>

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[ilities/tabid/434/Default.aspx](#)

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

BFS Letters (06/30/11)

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

This request must be received by **May 20, 2014**. If your request for informal dispute resolution is received after **May 20, 2014**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,



Mark P. Grimes, Supervisor
Facility Fire Safety and Construction

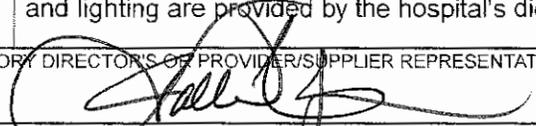
MPG/lj
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135066	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/29/2014
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NAME OF PROVIDER OR SUPPLIER POWER COUNTY NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 510 ROOSEVELT STREET AMERICAN FALLS, ID 83211
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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>INITIAL COMMENTS</p> <p>The nursing facility portion of the building occupies the east wing of both the lower and upper levels and is attached to the hospital building. The original building's construction was completed in early 1961 and consisted of the lower level east wing nursing facility and the west lower and upper level hospital portion. A two level addition was completed in early 1967 extending the upper level hospital patient wing to the east. The nursing facility was extended into the upper level east wing sleeping rooms in the fall of 1987. Both the existing and addition building construction elements are fire resistive. Wall construction varies depending upon location and is either concrete block; concrete; concrete with brick veneer; and/or 4" x 6" metal studs w/lath & plaster. Supporting beams are combination steel w/fire proofing and/or concrete. The floor/ceiling assembly between the lower and upper levels consist of steel joist with 5/8" gyp steel channel below and metal decking and poured concrete flooring above. The roof assembly is steel joists with lath/plaster attached to the underside and a metal deck with poured concrete above. There are a total of three (3) exits from the lower level nursing facility wing; two (2) directly to the exterior at grade and the third through the hospital's main entry lobby. There are two (2) exits from the upper level east nursing wing; one is an enclosed stairway at the east end of the wing and the other is accessible through the west hospital portion of the building. The building is provided with a fire alarm system with off site monitoring and system smoke detection in the exit access corridors and the open dining room on the lower level. Portable fire extinguishers are provided and are multipurpose ABC with additional K style for protection in the kitchen area. Emergency power and lighting are provided by the hospital's diesel</p>	K 000	<p style="text-align: center;">RECEIVED MAY 22 2014 FACILITY STANDARDS</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE CEO/ADMINISTRATOR	(X6) DATE 20 MAY 2014
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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 000	Continued From page 1 powered, automatic generator. The facility was retrofitted on October 4, 2010 with automatic fire sprinklers, a Halon system was also installed in the IT room, both systems are interconnected with the building fire alarm system. The facility is currently licensed for 20 SNF/NF beds. The following deficiencies were cited during the annual life safety code survey conducted on April 28th and April 29th of 2014. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70. The Survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction Dan Holbrook Health Facility Surveyor Mark Grimes Supervisor Facility Fire Safety and Construction	K 000	<i>This Plan of Correction is PCHD Skilled Nursing Facility's credible allegation of compliance.</i> <i>Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the fact 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.</i>	
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4	K 025	K025 SMOKE BARRIERS What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? On 5/02/14 the ceiling cover was placed over the access panel and all the perforations were sealed with fire caulking. The access panel in the tub room (#15) was replaced on 5/01/14. The perforations in the smoke barrier across from the medical records	20MAY14

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K 025	Continued From page 2 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to properly seal openings and penetrations within identified smoke barriers. Failure to ensure that smoke barriers are properly sealed allows the passage of harmful gases and smoke from one smoke compartment to another. This deficient practice affected staff and visitors in 2 of 4 smoke compartments on the date of the survey. The facility is licensed for 20 SNF/NF beds and had a census of 14 on the day of survey. Findings include: 1) During the facility tour conducted on April 28, 2014 between the hours of 3:30 PM and 4:45 PM it was observed that the Communications room in the first floor service corridor had an open access panel to the space between floors. It was further observed that communications work had recently been done in this room and that the penetrations from the addition of wiring had not been sealed. When interviewed at this location the Maintenance Engineer acknowledged that the contractor had failed to seal these openings. 2) During the facility tour conducted on April 29, 2014 between the hours of 8:15 AM and 10:30 AM it was observed that the ceiling access panel inside the utility closet of the physical therapy room (#15) in the southeast wing of the second floor was open. Further investigation of the smoke barrier door outside the medical records office on the second floor revealed multiple penetrations from communications wiring installation that were not sealed. During the exit conference on April 29, 2014, it was	K 025	room were sealed with fire caulking on 05/12/14. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken? We have made visual inspections of the walls separating the smoke compartments looking for perforations that need to be sealed with fire caulking and have sealed all perforations. What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur? Beginning 5/20/14, all contracts with outside vendors will include language requiring them to use fire caulking for any wall perforations. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Beginning 5/20/14 and for 3 months the maintenance personnel will keep a log of all contractors who perform work that requires perforations and will inspect these work areas to make sure they have been properly sealed. The maintenance personnel will require contractors to seal all perforations before they leave the job site. Any perforations not sealed will be sealed by the maintenance department and reported to the Quality Assurance Committee to determine any further action.	

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K 025	Continued From page 3 acknowledged by the Maintenance Engineer and the Nursing Supervisor that the contracted entity had failed to seal up the penetrations between smoke barriers. Actual NFPA standard: 101.8.3 Smoke Barriers 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 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1	K 029	K029 FIRE-RATED DOORS What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? On 4/30/14 the door closers of the two egress doors cited in the citations were turned up on the latch speed and tested well. They were tried 4 times and every time latched with a positive latch. The main egress door for the staff dining hall that was held open continually was	20MAY14

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K 029	<p>Continued From page 4</p> <p>This Standard is not met as evidenced by: Based on observation, operational testing and interview the facility failed to ensure that hazardous areas exiting directly to a corridor were secured with self-closing doors that would positively latch. Failure to ensure that doors included in a hazardous area are self-closing and positively latch could allow the passage of smoke, fire and dangerous gases into the egress corridor. This deficient practice affected 1 of 2 smoke compartments on the first floor, all residents, staff and visitors on the day of survey. The facility is licensed for 20 SNF/NF beds and had a census of 14 on the date of survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on April 28, 2014 from 3:30 PM to 4:45 PM it was found that two areas of the kitchen failed to secure the hazardous area.</p> <p>1) During operational testing of 2 egress doors at the southwest side of the kitchen, it was found that 1 of these doors would not positively latch.</p> <p>2) Further investigation of the kitchen path of egress found that the main door exiting the dining hall to the main entrance of the building would not positively latch.</p> <p>3) Upon interview of the Maintenance Engineer, he acknowledged that he did not know the boundary of the kitchen hazardous area. He further acknowledged that the kitchen boundary was including the staff dining hall, and that the main egress door from the staff dining hall was held open continually.</p>	K 029	<p>fitted with a magnetic door retaining device and was wired into the fire alarm panel to close automatically when the fire alarm is activated. It was also tested to make sure it positively latched.</p> <p>How you will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken? On 5/14/14, maintenance personnel tested doors throughout the facility to check to see if there were other doors that did not positively latch. Any doors that did not positively latch were adjusted to make sure they will.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur? The maintenance personnel will check doors as they do their environmental rounds.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Beginning the week of 5/11/14 the maintenance department will conduct an audit of the door closures in the facility. This audit will be performed weekly for three weeks then once per month for four months.</p>	

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K 029	<p>Continued From page 5</p> <p>During the exit conference the Maintenance Engineer and the Administrator, both indicated they were not aware of the potential hazard of not securing the boundary of the kitchen hazardous area and that the main egress door from the dining hall was held open continually.</p> <p>Actual NFPA standard: 101.3.3.13.2 101.19.3.2.1</p> <p>3.3 GENERAL DEFINITIONS 3.3.13.2 Area, Hazardous. An area of a structure or building that poses a degree of hazard greater than that normal to the general occupancy of the building or structure, such as areas used for the storage or use of combustibles or flammables; toxic, noxious, or corrosive materials; or heat-producing appliances.</p> <p>19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft² (9.3 m²) (3) Paint shops</p>	K 029		

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K 029	Continued From page 6 (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft ² (4.6 m ²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This Standard is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to maintain doors with readily accessible means of exit access. Failure to allow rapid means of exit access has the potential to impede escape in the event of a fire or other emergency. This deficient practice affected 2 of 2 smoke compartments, all residents, staff and visitors on the date of survey. The facility is licensed for 20 SNF/NF beds and had a census of 14 on the date of survey. Findings include:	K 038	K038 Exit Access What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? On 4/30/14 all throw bolts were removed. On 5/2/14 a lever handle was installed on the kitchen door that exits to the staff dining room. The door closure was also adjusted to pull the door to a positive latch. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken? On 5/14/14 the maintenance personnel walked through the facility to check for other throw bolt locks. None were found. What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur?	20MAY14

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

Printed: 05/07/2014
FORM APPROVED
OMB NO. 0938-0391

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K 038	<p>Continued From page 7</p> <p>During the facility tour on April 28th between 2:45 PM and 4:45 PM throw bolts were found to be installed on doors leading to exit corridors. These included:</p> <ol style="list-style-type: none"> 1) The linen door located directly north of the nurses station on the first floor had a non-operational door lock. This door also had a throw bolt installed on the upper left hand corner of the door to secure it closed. 2) The Business Office door at the main first floor lobby had a throw bolt installed on the office side directly below the operational door handle in the path of egress. 3) The storage room door in the first floor service corridor adjacent to the communications room had a throw bolt installed on the upper left corner of the door facing the egress side of the corridor. 4) The Kitchen door which exits to the staff dining area had a throw bolt installed on the dining area side preventing the path of egress from the kitchen.. <p>Operational testing of these doors found that when locked they would prevent the immediate exit of residents, staff and visitors during the course of evacuation. During the exit conference the Maintenance Engineer stated he was not aware that these locks were not allowed.</p> <p>Actual NFPA standard: NFPA 101.7.2 MEANS OF EGRESS COMPONENTS 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</p>	K 038	<p>The maintenance personnel will not install throw bolt locks on any of the doors in the facility. They will also check doors for throw bolts as they do their environmental rounds.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Maintenance department will reject all work orders for throw bolt locks on doors in the facility.</p>	

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K 038	Continued From page 8 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. 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 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 038		
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to prevent an excessive lint buildup in the dryer discharge at the first floor laundry adjacent to the Maintenance Office. Failure to properly maintain the dryer discharge can result in a fire in that area. Clothes dryers have been found to be a primary cause of fires in multiple health care	K 130	K130 OTHER LSC DEFICIENCY NOT ON 2786 What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? The immediate action was that on 4/30/14 a sign was hung in the downstairs nursing home laundry room where the dryer vent exits the window to remind the nursing home staff members to not put towels or other items near or around the dryer vent. The sand bags were removed from the	20MAY14

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K 130	Continued From page 9 facilities. This deficient practice affected staff and visitors on the date of the survey. The facility is licensed for 20 SNF/NF beds and had a census of 14 on the date of the survey. Findings include: During the facility tour on April 28, 2014 between the hours of 3:30 PM and 4:15 PM it was observed that the dryer hose of the dryer in the laundry room directly adjacent to the Maintenance Office had towels on top of the hose while the dryer was in operation. When the dryer exhaust was viewed on the exterior of the building, it was found to be blocked by sandbags and that an excessive amount of lint from the dryer discharge had not been cleared. During the exit conference the Maintenance Engineer stated he was not aware of this problem being present. Actual NFPA standard: NFPA 101.4.5.7 Maintenance Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be maintained unless the Code exempts such maintenance.	K 130	discharge area and the lint was cleaned up outside of the building. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken? All residents, staff members and visitors have potential to be affected by this deficient practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur? The dryer vent will be rerouted so that it will exit through the wall rather than through the window. This will shorten the flex tube vent and will also shorten the path to the exterior. By rerouting, the dryer vent will no longer run over the counter and the window sill thus giving room for towels and linens without being near to the venting system. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Starting the week of 05/19/14 an audit of the dryer discharge area will be conducted by the maintenance personnel to ensure that the lint is being cleaned from the area and that items are not being put around the discharge. This audit will be done weekly for 7 weeks and then monthly for 6 months.	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This Standard is not met as evidenced by: Based upon observation interview, the facility failed to ensure adequate electrical safety in	K 147	K147 ELECTRICAL WIRING AND EQUIPMENT What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?	20MAY14

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K 147	<p>Continued From page 10 accordance with NFPA 70. Failure to provide adequate electrical safety can create a potential electrical shock or fire hazard. This deficient practice affected twelve staff and visitors on the date of the survey. The facility is licensed for 20 SNF/NF beds and had a census of 14 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on April 28th between the hours of 3:10 PM and 4:45 PM and on April 29th between the hours of 10:30 AM and 11:00 AM, it was observed that electrical hazards were found in multiple locations. These locations included:</p> <p>1) 2 relocatable power taps and a 6-2 multiple outlet powering a compressor and a 12-volt battery charger were found in use in the Maintenance Office/Mechanical room.</p> <p>2) A relocatable power tap was found in use plugged into an outlet without an approved outlet cover in the file records office located on the second floor south.</p> <p>3) A home made extension cord was found in use at the southern wall of the gift shop directly adjacent to the main doors to the nursing home. This cord was spliced from a non-grounded wire to a grounded wire and covered with electrical tape.</p> <p>4) The wiring of the light fixture directly above the dishwashing sink in the kitchen was found to have been modified from a direct-wire fixture. An extension cord had been installed and plugged into a plug adapter with the ground wire hanging loose.</p>	K 147	<ol style="list-style-type: none"> All re-locatable power taps were removed from the Maintenance Office/Mechanical room. On 5/08/14 new outlets were installed along the west wall by a contracted local licensed electrician. This will provide electrical outlets for all equipment that was previously being provided by the re-locatable power taps. In the file records office located on the second floor, the re-locatable power tap was removed from service and a new outlet cover was placed on the outlet. The homemade extension cord found on the southern wall of the gift shop was removed and the glass case was moved closer to the outlet and a new male plug was installed to the cord. On 5/09/14 a contracted local licensed electrician rewired the light in the kitchen. It is now wired direct according to code. The missing cover for the electrical boxes in the Mechanical room was replaced and tightened. The outlet in the communications room was removed and covered with a plate and fire caulked. <p>How you will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken? All residents, visitors and employees have the potential to be affected by this deficient practice. The maintenance personnel will check for unauthorized power strips and</p>	

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K 147	<p>Continued From page 11</p> <p>5) Open 4-gang electrical boxes were found in the Mechanical room and the Communications room on the first floor.</p> <p>During the exit conference the Maintenance Engineer acknowledged he was not aware of these electrical hazards being present.</p> <p>Actual NFPA reference:</p> <p>NFPA 101 the Life Safety Code 9.1.2 Electric. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction. NFPA 70, National Electrical Code, 1999 Edition</p> <p>NFPA 70 - 110.3 Examination, Identification, Installation, and Use of Equipment. (A) Examination. In judging equipment, considerations such as the following shall be evaluated:</p> <p>(1) Suitability for installation and use in conformity with the provisions of this Code 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</p>	K 147	<p>other wiring deficiencies as they do their weekly rounds.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur? The maintenance personnel will track all re-locatable power taps that are authorized (those attached to computers or audio-visual). Any unauthorized re-locatable power taps will be removed. The maintenance personnel will check for missing outlet covers during their weekly rounds.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Maintenance personnel will check on their weekly walk through inspections for any unauthorized re-locatable power taps. When an unauthorized re-locatable power tap is discovered in use in the facility, the maintenance personnel will remove it and bring it up for discussion in our Quality Assurance Committee to determine if further actions are needed.</p>	

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

Printed: 05/07/2014
FORM APPROVED
OMB NO. 0938-0391

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K 147	Continued From page 12 use and also under abnormal conditions likely to arise in service (6) Arcing effects (7) Classification by type, size, voltage, current capacity, and specific use (8) Other factors that contribute to the practical safeguarding of persons using or likely to come in contact with the equipment (B) Installation and Use. Listed or labeled equipment shall be installed and used in accordance with any instructions included in the listing or labeling. See UL listing 1363 and UL XBYS.GuidelInfo Relocatable Power Taps	K 147		

Bureau of Facility Standards

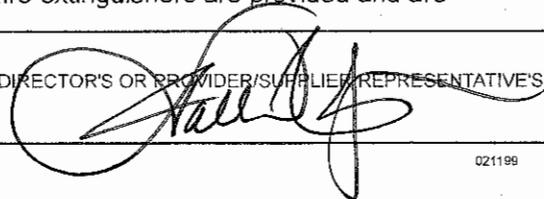
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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2.</p> <p>The nursing facility portion of the building occupies the east wing of both the lower and upper levels and is attached to the hospital building. The original building's construction was completed in early 1961 and consisted of the lower level east wing nursing facility and the west lower and upper level hospital portion. A two level addition was completed in early 1967 extending the upper level hospital patient wing to the east. The nursing facility was extended into the upper level east wing sleeping rooms in the fall of 1987. Both the existing and addition building construction elements are fire resistive. Wall construction varies depending upon location and is either concrete block; concrete; concrete with brick veneer; and/or 4"/6" metal studs w/lath & plaster. Supporting beams are combination steel w/fire proofing and/or concrete. The floor/ceiling assembly between the lower and upper levels consist of steel joist with 5/8" gyp steel channel below and metal decking and poured concrete flooring above. The roof assembly is steel joists with lath/plaster attached to the underside and a metal deck with poured concrete above. There are a total of three (3) exits from the lower level nursing facility wing; two (2) directly to the exterior at grade and the third through the hospital's main entry lobby. There are two (2) exits from the upper level east nursing wing; one is an enclosed stairway at the east end of the wing and the other is accessible through the west hospital portion of the building. The building is provided with a fire alarm system with off site monitoring and system smoke detection in the exit access corridors and the open dining room on the lower level. Portable fire extinguishers are provided and are</p>	C 000	<p style="text-align: center;">RECEIVED MAY 22 2014 FACILITY STANDARDS</p>	
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Idaho form
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE

CEO/ADMINISTRATOR **20 MAY 2014**

(X6) DATE

Bureau of Facility Standards

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C 000	Continued From Page 1 multipurpose ABC with additional K style for protection in the kitchen area. Emergency power and lighting are provided by the hospital's diesel powered, automatic generator. The facility was retrofitted on October 4, 2010 with automatic fire sprinklers, a Halon system was also installed in the IT room, both systems are interconnected with the building fire alarm system. The facility is currently licensed for 20 SNF/NF beds. The following deficiencies were cited during the annual life safety code survey conducted on April 28th and April 29th of 2014. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70 and IDAPA 16.03.02; Rules And Minimum Standards for Skilled Nursing Facilities and Intermediate Care Facilities. The Survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction Dan Holbrook Health Facility Surveyor Mark Grimes Supervisor Facility Fire Safety and Construction	C 000		
C 226	02.106 FIRE AND LIFE SAFETY 106. FIRE AND LIFE SAFETY. Buildings on the premises used as facilities shall meet all the requirements of local, state and national codes concerning fire and	C 226	C226 Please refer to the corrective action for federal citations K025, K029, K038, K130 and K147 on the form CMS-2567.	20MAY14

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C 226	Continued From Page 2 life safety standards that are applicable to health care facilities. This Rule is not met as evidenced by: Refer to K 025 of CMS 2567 Refer to K029 of CMS 2567 Refer to K038 of CMS 2567 Refer to K130 of CMS 2567 Refer to K147 of CMS 2567	C 226		