



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  
P.O. Box 83720  
Boise, ID 83720-0009  
PHONE 208-334-6626  
FAX 208-364-1888

**CERTIFIED MAIL: 7012 1010 0002 0836 4025**

May 16, 2014

Joseph Caroselli, Administrator  
Idaho Elks Rehab Hosp Subacute Rehab Unit  
PO Box 1100  
Boise, ID 83701-1100

Provider #: 135114

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

Dear Mr. Caroselli:

On **May 12, 2014**, a Facility Fire Safety and Construction survey was conducted at **Idaho Elks Rehab Hosp Subacute Rehab Unit** 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 tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date

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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 29, 2014**. Failure to submit an acceptable PoC by **May 29, 2014**, may result in the imposition of civil monetary penalties by **June 18, 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 16, 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 16, 2014**. A change in the seriousness of the deficiencies on **June 16, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **June 16, 2014**, includes the following:

Joseph Caroselli, Administrator  
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Denial of payment for new admissions effective **August 12, 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 **November 12, 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 **May 12, 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/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 **May 29, 2014**. If your request for informal dispute resolution is received after **May 29, 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,

A handwritten signature in black ink, appearing to read 'MPG', followed by a long horizontal line extending to the right.

Mark P. Grimes, Supervisor  
Facility Fire Safety and Construction

MPG/lj  
Enclosures

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

Printed: 05/15/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135114</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE NF FLOOR  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/12/2014</b>
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NAME OF PROVIDER OR SUPPLIER <b>ID ELKS REHAB HOSP &amp; SA REHAB UNIT</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>PO BOX 1100 BOISE, ID 83701</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

INITIAL COMMENTS

K 000

The facility is within a 4 story rehab hospital built in 1999-2000 that is fully sprinklered with Type I (443) construction. There is smoke detection in hallways, open spaces and patient rooms. Currently the SRU is located on the third floor and is licensed for 20 SNF beds.

The following deficiencies were cited during the annual life safety code survey conducted on May 12, 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

K 018  
SS=F

NFPA 101 LIFE SAFETY CODE STANDARD

K 018

Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3

Roller latches are prohibited by CMS regulations in all health care facilities.

RECEIVED

JUN - 6 2014

FACILITY STANDARDS

**K018:**

1) The hydraulic door closer to the exercise room was adjusted so the door fully latches per NFPA 101 Life Safety Code standard. The full latching of the doors will protect all patients, staff, and visitors in the exercise room and hallway of one smoke compartment from the passage of smoke and hazardous gases during a fire event. No other residents would be affected. To ensure this standard is met in the future, the Facility Engineering Staff will conduct and document monthly testing for six months to confirm the doors properly latch along with filing their findings and corrective actions. Testing will continue after six months on a quarterly basis during day shift fire drills. Testing of proper door closing and latching and corrective actions taken when needed will positively affect and protect all residents, staff, and visitors in one fire compartment in the case of a fire event.

5-13-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Joseph P. Crowell*

TITLE

*Administrative*

(X6) DATE

*6/4/14*

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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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 018	<p>Continued From page 1</p> <p>This Standard is not met as evidenced by: Based on observation and operational testing, the facility failed to ensure corridor doors would remain positively latched. Failure to ensure corridor doors remain closed would allow the passage of smoke and hazardous gases during a fire event. This deficient practice affected all residents, staff and visitors in 2 of 2 smoke compartments. The facility is licensed for 20 SNF beds and had a census of 14 on the date of the survey.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1). During the facility tour conducted on May 12, 2014 at approximately 2:00 PM, observation and operational testing of the doors to the exercise room found that one of the two doors would not completely close and positively latch.</li> <li>2) During the facility tour conducted on May 12, 2014 at approximately 2:45 PM, observation and operational testing of the door to the linen storage failed to self-close and positively latch.</li> <li>3) During the facility tour conducted on May 12, 2014 at approximately 1:30 PM, observation and operational testing of the patient room door (C3130) found the door would not positively latch.</li> </ol> <p>The findings above were observed and acknowledged by the Director of Maintenance at the time of the tour and by the Administrator, CEO, Director of Maintenance at the exit conference conducted on May 12, 2014 at 4:00 PM to 4:45 PM.</p>	K 018	<ol style="list-style-type: none"> <li>2) The hydraulic door closer to the linen storage room was adjusted so the door self closes and positively latches per NFPA 101 Life Safety Code standard. The full latching of the door will protect all residents, staff, and visitors in the linen storage room and corridor of one smoke compartment from the passage of smoke and hazardous gases during a fire event. No other residents would be affected. To ensure this standard is met in the future, the facility Engineering staff will conduct and document monthly testing for six months to confirm the doors properly close and latch, along with filing their findings and corrective actions. Testing will continue after six months on a quarterly basis during day shift fire drills. Testing of proper door closing and latching and the corrective actions taken when needed will positively affect and protect all residents, staff, and visitors in one smoke compartment in case of a fire event.</li> <li>3) The worn pin in the door latch mechanism was replaced so the door to Room 314 fully closes and positively latches per NFPA 101 Life Safety Code standard. The full latching of the door will protect all patients, staff, and visitors in the SNF smoke compartment from the passage of smoke and hazardous gases in the case of a fire event. No other residents</li> </ol>	5-13-14

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K 018	Continued From page 2 Actual NFPA standard:  19.3.6.3 Corridor Doors.  19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.2. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: Existing roller latches demonstrated to keep the door closed against a force of 5 lbf (22 N) shall be permitted to be kept in service.	K 018	will be affected. To ensure this standard is met in the future, the Facility Engineering Staff will conduct and document monthly testing for six months to confirm the door properly latches, along with filing their findings and corrective actions. Testing will continue after six months on a quarterly basis during day shift fire drills. Testing of proper door closing and latching and a corrective actions taken when needed will positively affect and protect all residents, staff, and visitors in the SNF smoke compartment in the case of a fire event.	5-13-14
K 025 SS=F	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  This Standard is not met as evidenced by:	K 025	<b>K025:</b> 1) Fire pillows were repositioned and rock wool added to complete the smoke barrier in the ceiling of the electrical room off hall (C3101) to comply with NFPA 101 Life Safety Code standards. The proper smoke barrier will protect all residents, staff, and visitors in one (SNF) smoke compartment and one such smoke compartment on the 2 <sup>nd</sup> floor below and 4 <sup>th</sup> floor above from the passage of smoke and hazardous gases in the event of a fire. Occupants of all 4 floors could be affected by incomplete smoke barriers. We have checked all electrical and communications rooms	

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K 025	<p>Continued From page 3</p> <p>Based on observation the facility failed to ensure that smoke barriers would prevent the passage of smoke and hazardous gases. Failure to ensure the smoke resistance properties of a smoke barrier or compartment would allow hazardous gases and smoke to pass freely, affecting egress during a fire event. This deficient practice affected 1 of 2 smoke compartments on the 3rd floor SRU and both the 2nd floor below and 4th floor above, including all residents and approximately 6 staff on the date of the survey. The facility is licensed for 20 SNF beds and had a census of 14 on the day of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on May 12, 2014 at 2:10 PM, it was observed by the surveyor and the Director of Engineering that three conduits installed in the floor and three conduits installed in the ceiling of the electrical room located inside the (C3101) hall, had intumescent fire pillows installed that had large gaps which would allow the passage of smoke between second, third and fourth floors during a fire event.</p> <p>2) It was further observed by the surveyor and the Director of Engineering that 1 of the 2 electrical chases in the ceiling of the electrical room located inside the (C3101) hall had a fire baffle installed at the ceiling which had an opening of approximately 1-1/2 inches by approximately 4 inches which would allow the passage of smoke between third and fourth floors during a fire event.</p> <p>3) During the facility tour conducted on May 12, 2014 at 2:45 PM, a 1-1/4 inch unsealed penetration was observed by the surveyor and the Director of Engineering in the concrete floor in the communications closet across from the SRU nurses station which would allow the passage of smoke between second and third floors during a</p>	K 025	<p>on all 4 floors and completed the smoke barriers to the identified standards. To ensure this standard is met in the future, the Facility Engineering Staff will re-inspect all electrical and communication rooms on a quarterly basis and document their findings and corrective actions. Inspections and corrective actions when needed will positively affect and protect all residents, staff, and visitors in one (SNF) smoke compartment on the 3<sup>rd</sup> floor, one smoke compartment on the 2<sup>nd</sup> floor, and one smoke compartment on the 4<sup>th</sup> floor in the case of a fire event.</p> <p>2) The ceiling fire baffle above the buss duct was closed, caulked, and re-secured to eliminate the opening in the electrical room to restrict the passage of smoke per NFPA 101 Life Safety Code standard. The proper smoke barrier will protect all residents, staff and visitors in one 3<sup>rd</sup> floor (SNF) smoke compartment and one smoke compartment on 4<sup>th</sup> floor from the passage of smoke and hazardous gases in the case of a fire event. Occupants of all 4 floors could be affected by incomplete smoke barriers. We have checked all electrical and communications rooms on all 4 floors and completed the smoke barriers to the identified standard. To ensure this standard is met in the future, the Facility Engineering Staff will re-</p>	5-16-14

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K 025	<p>Continued From page 4 fire event. 4) During the facility tour conducted on May 12, 2014 at 2:46 PM it was observed by the surveyor and the Director of Engineering that the intumescent pillows installed in the three conduits installed in the floor and the three conduits installed in the ceiling had large gaps that would allow the passage of smoke between second, third and fourth floors during a fire event.</p> <p>The above findings were acknowledged by the Director of Engineering, CEO, Administrator at the exit conference conducted on May 12, 2014 at 4:00 PM to 4:45 PM.</p> <p>Actual NFPA standard: 101.19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour. Exception No. 1: Where an atrium is used, smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with Exception No. 2 to 8.2.5.6(1). Not less than two separate smoke compartments shall be provided on each floor. Exception No. 2*: Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.3 has been provided for smoke compartments adjacent to the smoke barrier.</p> <p>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</p>	K 025	<p>inspect all electrical and communication rooms on a quarterly basis and document their findings and corrective actions. Inspections and corrective actions when needed will positively affect and protect all residents, staff, and visitors in one 3<sup>rd</sup> floor (SNF) smoke compartment and one 4<sup>th</sup> floor smoke compartment in the case of a fire event.</p> <p>3) The 1-1/4" pipe in the floor of the communications closet was sealed, and rock wool was added as a smoke barrier to comply with NFPA 101 Life Safety Code standards. The proper smoke and fire barrier will positively affect and protect all residents, staff, and visitors in one 3<sup>rd</sup> floor smoke compartment and one 2<sup>nd</sup> floor smoke compartment from the passage of smoke and hazardous gases in the case of a fire event. Occupants of all 4 floors could be affected by incomplete smoke barriers. We have checked all electrical and communications rooms on all 4 floors and completed the smoke barriers to the identified standard. To ensure the standard is met in the future, the Facility Engineering Staff will re-inspect all electrical and communications rooms on a quarterly basis and document their findings and corrective actions. Inspections and corrective actions if needed will positive affect and protect all residents, staff, and visitors in one</p>	5-16-14

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K 025	Continued From page 5 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	3 <sup>rd</sup> floor smoke compartment and one 2 <sup>nd</sup> floor smoke compartment in case of a fire event.	5-16-14
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  This Standard is not met as evidenced by: Based on observation and operational testing, the facility failed to ensure hazardous areas were protected with self-closing doors. Failure to ensure hazardous areas are contained with self-closing doors would allow the passage of smoke and dangerous gases during a fire event. This deficient practice affected 1 of 2 smoke compartments, all residents and approximately 6 staff on the date of the survey. The facility is licensed for 20 SNF beds and had a census of 14 on the date of the survey.	K 029	4) Fire pillows were re-positioned in 3 floor and 3 ceiling conduits; rock wool was added to complete the smoke barriers per NFPA Life Safety Code standards. The proper smoke barrier will positively affect and protect all residents, staff, and visitors in one 3 <sup>rd</sup> floor smoke compartment, one 4 <sup>th</sup> floor smoke compartment, and one 2 <sup>nd</sup> floor smoke compartment in case of a fire event. Occupants of all 4 floors could be affected by incomplete smoke barriers. We have checked all electrical and communication rooms on all 4 floors and completed the smoke barriers to the identified standard. To ensure the standard is met in the future, the Facility Engineering Staff will re-inspect all electrical and communications rooms on a quarterly basis and document their findings and corrective actions. Inspections and corrective actions if needed will positively affect and protect all residents, staff and visitors in one 3 <sup>rd</sup> floor (SNF) smoke compartment, one 2 <sup>nd</sup> floor smoke compartment, and one 4 <sup>th</sup> floor smoke compartment in case of a fire event.	5-20-14

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K 029	Continued From page 6 Findings include:  During the facility tour conducted on May 12, 2014 at 1:15 PM, observation and operational testing of the door from the hospital dining area into the Acute Rehab Nourishment Kitchen revealed it did not have a self-closing device installed.  During the exit conference conducted on May 12, 2014 from 4:00 PM to 4:45 PM, the Director of Engineering, the Administrator and the CEO acknowledged when questioned that the Acute Rehab Nourishment Kitchen is a fully-functional operating kitchen and consistently maintained despite it now being used primarily as a storage area.  Actual NFPA standard:  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.	K 029	<b>K029:</b> A self closing hydraulic door closer was installed, adjusted, and tested on the door located between the hospital dining area and the 3 <sup>rd</sup> floor Nourishment Kitchen per NFPA 101 Life Safety Code standards. This creates a barrier between heat producing equipment and residents, staff, and visitors in one 3 <sup>rd</sup> floor smoke compartment to prevent the passage of smoke and hazardous gases in case of a fire event. The 2 <sup>nd</sup> floor serve-out kitchen poses a similar risk, so a new door closer was also installed on the 2 <sup>nd</sup> floor to prevent the passage of smoke and dangerous gases in case of a fire event. This secures one smoke compartment positively affecting all residents, staff and visitors in that one compartment. To ensure the standard is met in the future, the Facility Engineering Staff will re-test the door self closing and latching functions quarterly on both floors to positively affect and protect all residents, staff, and visitors in one smoke compartment each on the 3 <sup>rd</sup> and 2 <sup>nd</sup> floors in case of a fire event.	
K 147 SS=F	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 on observation and interview the facility failed to ensure electrical wiring and equipment usage was done in accordance with NFPA 70 and NFPA 99. Failure to ensure electrical installations are used appropriately can lead to overloaded	K 147	<b>K147:</b> 1) The small refrigerator was plugged directly into a wall receptacle and the re-locatable power tap was removed to comply with NFPA 101 Life Safety Code standards. Removing the fire hazard will	5-15-14

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K 147	<p>Continued From page 7</p> <p>wiring and create a fire hazard. This deficient practice affected 2 of 2 smoke barriers, all residents and 6 staff on the date of the survey. The facility is licensed for 20 SNF beds and had a census of 14 on the date of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on May 12, 2014 at 1:39 PM, a relocatable power tap was observed in use by the surveyor and the Director of Engineering with a refrigerator plugged into it in the SNF/Assisted dining room.</p> <p>2) During the facility tour conducted on May 12, 2014 at 2:32 PM, a relocatable power tap was observed in use by the surveyor and the Director of Engineering in the Clean linen room with a large appliance plugged into it. When interviewed about the appliance, the Director of Maintenance stated it was a linen sanitizer.</p> <p>The above findings were acknowledged by the CEO, Administrator, the Director of Engineering and the attending nursing staff during the exit conference conducted on May 12, 2014 between 4:00 PM and 4:45 PM.</p> <p>Actual NFPA standard: NFPA 99 3-3.2.1.1 Electrical Installation. Installation shall be in accordance with NFPA 70, National Electrical Code.</p> <p>NFPA 70 400.8 Uses Not Permitted.</p> <p>Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a</p>	K 147	<p>positively affect and protect all residents, staff and visitors to one 3<sup>rd</sup> floor smoke compartment in case of a fire event. To ensure this standard is met in the future, Facility Engineering Staff will conduct quarterly inspections and document their findings and corrective actions. Staff will be counseled about the use of re-locatable power taps. Residents, staff and visitors may be affected on all 4 floors, so all spaces will be inspected, devices removed if found, and staff education supplied.</p> <p>2) The large appliance is safely hard-wired into a dedicated circuit. The small monitor has been plugged into a wall receptacle and the re-locatable power tap has been removed per NFPA 101 Life Safety Code standards. Removing the fire hazard will positively affect and protect all residents, staff and visitors in one smoke compartment on the 3<sup>rd</sup> floor in case of a fire event. No other residents would be affected on this floor. To ensure this standard is met in the future, Facility Engineering Staff will conduct quarterly inspections of all spaces; staff will be counseled on the use of re-locatable power taps, and corrective actions documented.</p>	<p>5-20-14</p> <p>5-20-14</p>

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K 147	Continued From page 8 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	K 147		

Bureau of Facility Standards

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C 000	<p><b>16.03.02 INITIAL COMMENTS</b></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 facility is within a 4 story rehab hospital built in 1999-2000 that is fully sprinklered with Type I (443) construction. There is smoke detection in hallways, open spaces and patient rooms. Currently the SRU is located on the third floor and is licensed for 20 SNF beds.</p> <p>The following deficiencies were cited during the annual life safety code survey conducted on May 12, 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 and Intermediate Care Facilities.</p> <p>The Survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	C 000	<p><b>K018:</b></p> <p>1) Hydraulic door closer to the exercise room was adjusted so the door will latch. Testing will occur with each active fire drill. <b>5-13-14</b></p> <p>2) Hydraulic door closer to the linen storage room was adjusted so the door will latch. Testing will occur with each active fire drill. <b>5-13-14</b></p> <p>3) The worn pin in the door latch mechanism (on patient room) was replaced. Testing will occur on all patient rooms doors with each active fire drill. <b>5-13-14</b></p> <p><b>K025:</b></p> <p>1) Fire pillows were repositioned and rock wool added to complete the smoke barrier in the ceiling of the electrical room inside the hall. <b>5-16-14</b></p> <p>2) Fire baffle was closed, caulked and re-secured to eliminate the opening at the ceiling of the electrical room inside the hall. <b>5-16-14</b></p> <p>3) The hole in the concrete floor of the communications closet was sealed. Rock wool was added as a smoke barrier. <b>5-16-14</b></p> <p>4) Fire pillows were repositioned and rock wool added to complete the smoke barrier in the floor and ceiling. <b>5-20-14</b></p> <p>All Electrical and communication rooms will be inspected during semi-annual safety rounds.</p>	
C 226	<p><b>02.106 FIRE AND LIFE SAFETY</b></p> <p>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 life safety standards that are applicable to health care facilities.</p> <p>This Rule is not met as evidenced by: Refer to the following "K" tags on Federal Form</p>	C 226		

**RECEIVED**  
MAY 29 2014  
FACILITY STANDARDS

Idaho form  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Joseph P. Bouchard*

TITLE

*Administrative*

(X6) DATE

*5/29/14*

Bureau of Facility Standards

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C 226	Continued From Page 1  2567:  K 018 Corridor doors K 025 Smoke Barriers K 029 Hazardous Areas K 147 Electrical and Emergency Power	C 226	<p><b>K029:</b></p> <p>A self-closing hydraulic door closer was installed, adjusted and tested on the door located between the hospital dining area into the Acute Rehab Nourishment Kitchen.</p> <p><b>K147:</b></p> <p>1) Small refrigerator was plugged into a wall receptacle and plug strip (re-locatable power tap) was removed.</p> <p>2) The large appliance is hard wired into a dedicated circuit. The small monitor was plugged into a wall receptacle and plug strip (re-locatable power tap) was removed.</p> <p>Unnecessary plug strips (re-locatable power taps) will be watched for during semi-annual safety inspections.</p>	<p>S-15-14</p> <p>S-20-14</p> <p>S-20-14</p>