



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

CERTIFIED MAIL: 7012 3050 0001 2128 2644

June 5, 2014

Shelly Henderson, Administrator
Payette Center
1019 Third Avenue South
Payette, ID 83661-2832

Provider #: 135015

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

Dear Ms. Henderson:

On **May 28, 2014**, a Facility Fire Safety and Construction survey was conducted at **Payette 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 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 **June 18, 2014**. Failure to submit an acceptable PoC by **June 18, 2014**, may result in the imposition of civil monetary penalties by **July 8, 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 **July 2, 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 **July 2, 2014**. A change in the seriousness of the deficiencies on **July 2, 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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July 2, 2014, includes the following:

Denial of payment for new admissions effective **August 28, 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 28, 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 28, 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 **June 18, 2014**. If your request for informal dispute resolution is received after **June 18, 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

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

Printed: 06/04/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135015	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 05/28/2014
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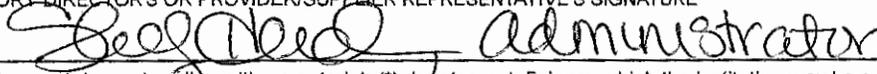
NAME OF PROVIDER OR SUPPLIER PAYETTE CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1019 3RD AVENUE SOUTH PAYETTE, ID 83661
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY 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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<p>K 000 INITIAL COMMENTS</p> <p>This facility is a single story, type V(111) construction. The facility was originally built in 1961 and is fully sprinklered. Currently it is licensed for 80 SNF/NF beds. The laundry of the facility is located in a separate, detached building.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on May 28, 2014. The facility was surveyed under the LIFE SAFETY CODE 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.</p> <p>The survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor FFS&C</p> <p>K 021 NFPA 101 LIFE SAFETY CODE STANDARD SS=F</p> <p>Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p>	<p>K 000</p> <p>“This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Genesis HealthCare, Payette Center 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.”</p> <p>K 021</p> <p>K021</p> <p>The entry door into the kitchen will be replaced by a door vendor with a solid door; held open by a magnetic mechanism that will be connected to the fire alarm system as required as per code. This will be completed by 8/1/14.</p> <p>The medical records office door will be held open by a magnetic mechanism that will be connected to</p>
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RECEIVED
JUN 18 2014

FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 6/17/14
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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.

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

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NAME OF PROVIDER OR SUPPLIER PAYETTE CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1019 3RD AVENUE SOUTH PAYETTE, ID 83661
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K 021 Continued From page 1

This Standard is not met as evidenced by:
Based on observation, interview and operational testing, the facility failed to ensure that doors to hazardous areas were held open position by an approved release device. Failure to protect hazardous areas with doors that would automatically release in a fire event would allow dangerous gases and smoke to spread into adjacent corridors. This deficient practice affected twenty residents in 2 of 4 smoke compartments, all staff and visitors on the date of the survey. The facility had a census of 31 on the day of the survey.

Findings include:

- 1) During the facility tour conducted on May 28, 2014 at 11:30 AM, observation and operational testing of the service hall access door to the main kitchen revealed that the door was held open by a shoestring secured to the adjacent jamb of the food storage area. Interview of the Kitchen staff and the Maintenance Engineer revealed that this was a common practice to keep the door open while moving stock into the kitchen storage.
- 2) During the facility tour conducted on May 28, 2014 at 11:45 AM, observation and operational testing of the door into the Medical Records room located in the business wing revealed that the door was held open by using a bungee cord. When asked, the Maintenance Engineer stated that he was unaware that this doors was being held open in this fashion.

Actual NFPA standard:

19.2.2.2.6*

K 021

the fire alarm system as required as per code. This will be completed by 8/1/14 by a professional vendor.

Other non-patient room doors will be inspected by the maintenance director by July 1, 2014 to assure that alterations are not required as mentioned above.

The results of this inspection will be reported to the Performance Improvement (PI) Committee at the next monthly meeting.

Compliance Date: 7/1/14

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

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K 021 Continued From page 2
Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier, or hazardous area enclosure shall be permitted to be held open only by an automatic release device that complies with 7.2.1.8.2. The automatic sprinkler system, if provided, and the fire alarm system, and the systems required by 7.2.1.8.2 shall be arranged to initiate the closing action of all such doors throughout the smoke compartment or throughout the entire facility.

K 021

K 029 NFPA 101 LIFE SAFETY CODE STANDARD SS=F

K 029

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

K029

The maintenance director will remove stored items in room 102 by 7/1/14.

The maintenance director will remove one of the two recycling containers in copy room by 7/1/14.

The maintenance director will inspect the remainder of the Center to assure that no other areas are used as cited. This will be completed by 7/1/14.

The maintenance director will inspect the entire center for the cited practice on a monthly basis for 3 months.

The results of the inspections will be reported to the PI Committee for three months.

Compliance Date: 7/1/14

This Standard is not met as evidenced by: Based on observation, interview and operational testing, the facility failed to ensure hazardous areas were protected with doors that self-close. Failure to protect hazardous areas with self-closing doors would allow an incipient fire to grow and allow the passage of smoke and dangerous gases to travel into corridors affecting egress. This deficient practice affected fourteen residents in 1 of 4 smoke compartments, all staff and visitors on the date of the survey. The facility had a census of 31 on the day of the survey.

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K 029 Continued From page 3
Findings include:

1) During the facility tour conducted on May 28, 2014 at 11:10 AM, it was observed that room 102 in the northwest corridor of the facility had been converted to storage. Operational testing of the door revealed that it would not self-close. When asked about the storage in this room, the Maintenance Engineer stated it had been converted to storage after the flooring of the physical therapy area was installed.

2) During the facility tour conducted on May 28, 2014 at 12:00 PM, the copy room in the business corridor was found to have (2) 32 gal. recycling containers inside creating a need for a hazardous area. The room was approximately 5 feet wide by 6 feet deep. Operational testing of the door revealed it would not self-close. When asked if he was aware of the standard requiring no more than 32 gal of storage in a 64 square foot area, the Maintenance Engineer stated he was not familiar with that requirement.

Actual NFPA standard:

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

K 029

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K 029	<p>Continued From page 4</p> <p>m2)</p> <p>(3) Paint shops</p> <p>(4) Repair shops</p> <p>(5) Soiled linen rooms</p> <p>(6) Trash collection rooms</p> <p>(7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction</p> <p>(8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard.</p> <p>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.</p> <p>19.7.5.5</p> <p>Soiled linen or trash collection receptacles shall not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gal/ft2 (20.4 L/m2). A capacity of 32 gal (121 L) shall not be exceeded within any 64-ft2 (5.9-m2) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) shall be located in a room protected as a hazardous area when not attended.</p> <p>Exception: Container size and density shall not be limited in hazardous areas.</p>	K 029		
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K 076 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p>	K 076		
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K 076 Continued From page 5

(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4

This Standard is not met as evidenced by:
Based on observation, the facility failed to ensure that medical gases in cylinders were secured. Failure to secure cylinders of oxygen or other medical gases would allow for accidental damage to the cylinder and injury to residents, staff or visitors. This deficient practice affected fourteen residents in 1 of 4 smoke compartments, all staff and visitors on the date of the survey. The facility had a census of 31 on the day of the survey.

Findings include:

During the facility tour conducted on May 28, 2014 at 12:00 PM, an "E" size oxygen cylinder was observed unsecured in the Oxygen Supply closet. This observation was acknowledged by the Maintenance Engineer who stated that oxygen was not normally stored in this closet.

Actual NFPA standard:
NFPA 99

4-3.1.1.1 Cylinder and Container Management. Cylinders in service and in storage shall be individually secured and located to prevent falling or being knocked over.

- (a) * Cylinders or supply containers shall be constructed, tested, and maintained in accordance with the U.S. Department of Transportation specifications and regulations.
- (b) Cylinder contents shall be identified by

K 076

K076

The Oxygen cylinder was removed by the maintenance director on 5/28/14.

Other storage closets were inspected by the maintenance director before 7/1/14 to assure that oxygen cylinders are not being stored improperly.

All Staff were educated on the proper storage of oxygen cylinders by the maintenance director on or before 7/1/14.

The maintenance director will inspect storage areas monthly for three months to assure that oxygen cylinders are stored properly. The results of these inspections will be reported to the PI Committee.

Compliance Date: 7/1/14

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K 076 Continued From page 6
attached labels or stencils naming the components and giving their proportions. Labels and stencils shall be lettered in accordance with CGA Pamphlet C-4, Standard Method of Marking Portable Compressed Gas Containers to Identify the Material Contained.
(c) Contents of cylinders and containers shall be identified by reading the labels prior to use. Labels shall not be defaced, altered, or removed.

K 076

K 147 NFPA 101 LIFE SAFETY CODE STANDARD SS=E
Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2

K 147

This Standard is not met as evidenced by: Based on observation, the facility failed to ensure electrical connections were not used in patient care or in conflict of NFPA 70. Use of extension cords or multiple outlets with patient care equipment prevents adequate protection from electrical shock or fire. This deficient practice affected seven residents in 1 of 4 smoke compartments, all staff and visitors on the date of the survey. The facility had a census of 31 on the day of the survey.

Findings include:

- 1) During the facility tour conducted on May 28, 2014 at 10:55 AM, it was observed that an oxygen concentrator was plugged in to a relocatable power tap in resident room 119. It was further observed that an extension cord with a non-grounded plug adapter was in use in this residents room. These findings were shown to the Maintenance Engineer in the room at the time of the observation.
- 2) During the facility tour conducted on May 28,

K147

The locatable power tap and extension cord were removed from room 119 by the maintenance director by 7/1/14.

The power cord to the water fountain will be wired correctly by the maintenance director or vendor by 7/1/14.

The wifi router will be removed and/or relocated by the maintenance director or vendor by 7/1/14.

Other areas of the Center will be inspected by the maintenance director by 7/1/14 to assure no further wiring issues exist.

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K 147. Continued From page 7

K 147

2014 at 11:20 AM, it was observed that the water fountain power cord for the water fountain located in the service corridor outside the Kitchen was routed through the wall and into the Communication utility closet. Inside the closet, this cord was plugged into a relocatable power tap and then into the outlet inside the room. It was also observed that the wires controlling the Internet WiFi device located directly in the hall outside this closet had been routed through a notch cut into the door stop of the Communications closet door. These two observations were shown to the Maintenance Engineer who stated he was not aware that this practice was not allowed.

The maintenance director will inspect resident rooms and non-patient care areas of the Center for acceptable electrical wiring usage for the next three months. The results of the inspections will be reported to the PI Committee by the maintenance director.

Compliance Date: 7/1/14

Actual NFPA standard:
NFPA 70

- 400.8 Uses Not Permitted.
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 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

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135015	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/28/2014
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NAME OF PROVIDER OR SUPPLIER PAYETTE CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1019 3RD AVENUE SOUTH PAYETTE, ID 83661
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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) COMPLETE DATE
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C 000 16.03.02 INITIAL COMMENTS C 000

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.
This facility is a single story, type V(111) construction. The facility was originally built in 1961 and is fully sprinklered. Currently it is licensed for 80 SNF/NF beds. The laundry of the facility is located in a separate, detached building.

The following deficiencies were cited during the annual fire/life safety survey conducted on May 28, 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.

The survey was conducted by:

Sam Burbank
Health Facility Surveyor

"This Plan of Correction is prepared and submitted as required by law. By submitting this plan of correction Payette Center 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."

RECEIVED
JUN 18 2014

FACILITY STANDARDS

C 226 02.106 FIRE AND LIFE SAFETY C 226

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.

C 226 Refer to Federal POC K021, K029, K076, K147

This Rule is not met as evidenced by:
Refer to Federal K tags
K021
K029

Idaho form

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

TITLE

(X6) DATE

Greg Neal, Administrator 6/17/14

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135015	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/28/2014
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C 226	Continued From Page 1 K076 K147	C 226		
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