



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 3050 0001 2128 2552

June 24, 2014

Charles Lloyd, Administrator
Oak Creek Rehabilitation Center of Kimberly
500 Polk Street East
Kimberly, ID 83341-1618

Provider #: 135084

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

Dear Mr. Lloyd, Jr.:

On **June 16, 2014**, a Facility Fire Safety and Construction survey was conducted at **Oak Creek Rehabilitation Center of Kimberly** 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 Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on

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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 **July 7, 2014**. Failure to submit an acceptable PoC by **July 7, 2014**, may result in the imposition of civil monetary penalties by **July 26, 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 21, 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 21, 2014**. A change in the seriousness of the deficiencies on **July 21, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **July 21, 2014**, includes the following:

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Denial of payment for new admissions effective **September 16, 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 **December 16, 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 **June 16, 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>

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

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following:

BFS Letters (06/30/11)

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

This request must be received by **July 7, 2014**. If your request for informal dispute resolution is received after **July 7, 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 'M. P. Grimes', with a long horizontal flourish extending to the right.

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: 135084	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 06/16/2014
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NAME OF PROVIDER OR SUPPLIER OAK CREEK REHABILITATION CENTER OF K	STREET ADDRESS, CITY, STATE, ZIP CODE 500 POLK STREET EAST KIMBERLY, ID 83341
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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 facility is a single story, Type V (III) construction, with multiple exits to grade. It was built in 1963 and is fully sprinklered with full smoke detection coverage. The long term care facility is licensed for 45 beds is attached to a 12 bed Geriatric Psychiatry Hospital. No two hour fire barrier was identified to separate the occupancies, therefore both areas were surveyed.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on June 16, 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>Dan Holbrook Health Facility Surveyor</p> <p>K 012 SS=F NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1</p> <p>This Standard is not met as evidenced by: Based on observation the facility failed to maintain compartment barriers. Failing to maintain compartment barriers can result in the products of combustion passing from one smoke compartment to another. This deficiency affected all residents, staff, and visitors. The facility is licensed for 45 beds and had a census of 43 the day of the survey.</p>	K 000	<p>The following represents the actions taken by the facility to correct and bring to complete compliance the practices in the facility, and in response to the findings as a result of the Idaho Department of Health and Welfare, Bureau of Facility Standards Annual Fire and Life Safety Recertification Survey.</p> <p>The signing of this plan of correction is not an admission or agreement by facility of the truth of the facts alleged in this statement of deficiency and plan of correction. This plan of correction is submitted exclusively to comply with state and federal law. This plan of correction serves as the facilities credible allegation of compliance.</p> <p><u>K012 NFPA 101 Life Safety Code Standard</u></p> <p>The facility will make every effort to meet and comply with the Idaho Statutes Life Safety Code regarding compartment barriers.</p>	7/2/14
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE <i>Administrator</i>	FACILITY STANDARDS (X6) DATE <i>7/7/14</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 012	Continued From page 1 Findings include 1. Observation on June 16, 2014 at 12:37 pm of resident room #209 revealed the closet sprinkler has a hole to one side of the escutcheon larger than the escutcheon can cover. This deficiency was acknowledged by the Maintenance Director and the Director of Facilities. 2. Observation of resident room #211 closet at 12:40 pm on June 16, 2014 revealed the sprinkler head had no escutcheon and had a hole around the pipe. This deficiency was acknowledged by the Maintenance Director and the Director of Facilities. 3. Observation at 2:10 on June 16, 2014 of the sprinkler riser room revealed a 2" diameter hole in the ceiling. This deficiency was acknowledged by the Maintenance Director and the Director of Facilities. Actual NFPA reference NFPA 101 8.2.3.2.4.2* Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows: (1) The space between the penetrating item and the fire barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier. b. It shall be protected by an approved device	K 012	Affected Residents All residents could be affected by this citation. Corrective Action The hole to one side of the escutcheon around sprinkler in the closet of room #209 was sealed. An escutcheon was added around the sprinkler in room #211's closet. The 2" diameter hole in the sprinkler riser room was sealed. Systematic Changes The Maintenance Director, Administrator, or their designee will conduct audits of sprinklers ensuring escutcheons are in place and that they fit around the sprinkler to ensure no holes. They will also conduct audits around the building to ensure there are no holes in any of the ceilings throughout the facility to ensure compliance with this citation. The audits will be conducted weekly x4, q2 weeks x4, then monthly x3.	

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K 012	<p>Continued From page 2</p> <p>that is designed for the specific purpose.</p> <p>(2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(3) * Insulation and coverings for pipes and ducts shall not pass through the fire barrier unless one of the following conditions is met:</p> <p>a. The material shall be capable of maintaining the fire resistance of the fire barrier.</p> <p>b. The material shall be protected by an approved device that is designed for the specific purpose.</p> <p>(4) Where designs take transmission of vibration into consideration, any vibration isolation shall meet one of the following conditions:</p> <p>a. It shall be made on either side of the fire barrier.</p> <p>b. It shall be made by an approved device that is designed for the specific purpose.</p> <p>8.2.4.4.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through smoke partitions shall be protected as follows:</p> <p>(1) The space between the penetrating item and the smoke partition shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of limiting the transfer of smoke.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(2) Where the penetrating item uses a sleeve to</p>	K 012	<p>Monitoring</p> <p>The facility will monitor these audits through Quality Assurance Performance Improvement Committee (Q.A.P.I.) on a monthly basis. Administrator and Maintenance Director are responsible for compliance. Audits will be on 7/21/14.</p>	

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K 012	Continued From page 3 penetrate the smoke partition, the sleeve shall be solidly set in the smoke partition, and the space between the item and the sleeve shall meet one of the following conditions: a. It shall be filled with a material that is capable of limiting the transfer of smoke. b. It shall be protected by an approved device that is designed for the specific purpose. (3) Where designs take transmission of vibrations into consideration, any vibration isolation shall meet one of the following conditions: a. It shall be made on either side of the smoke partitions. b. It shall be made by an approved device that is designed for the specific purpose.	K 012	<u>K050 NFPA 101 Life Safety Code Standard</u> The facility will make every effort to meet and comply with the Idaho Statutes Life Safety Code regarding Fire Drills. Affected Residents All residents could potentially be affected by this citation.	7/2/14
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This Standard is not met as evidenced by: Based on record review the facility failed to ensure staff conduct required fire drills. Failure to train the staff to respond to emergencies will result in slower effective action and increase reaction time. This deficient practice affects all residents, staff, and visitors. The facility is licensed for 45 beds and had a census of 43 the day of the survey.	K 050	Corrective Action The facility will conduct fire drills every quarter at unexpected times at least on a quarterly basis on each shift. Systematic Changes The Maintenance Supervisor or the designee will conduct fire drills in accordance with the life safety code. Three drills each quarter will be conducted. A drill will be conducted on day shift, swing shift, and night shift. The Maintenance supervisor or designee will ensure that staff members in the facility sign the fire drill sheet and place the drill in the appropriate binder ensuring compliance. Audits will be conducted	

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K 050	Continued From page 4 Findings include Record review on June 16, 2014 between the hours of 11:00 am and 12:15 pm revealed no documentation of fire drills for the 10 pm to 6 am shift during the 2nd and 3rd qtrs of 2013 and no documentation of fire drills for the 6 am to 2 pm shift for the 1st and 4th qrtr. Actual NFPA reference 19.7.1.2* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building.	K 050	by the Administrator or designee around the first of the month to ensure compliance for the previous month. Monitoring The Maintenance Supervisor, Administrator and/or designee is responsible for compliance. The fire drill reports will be forwarded to the QAPI committee to ensure that drills are being conducted on a monthly basis to ensure compliance with this citation.	
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This Standard is not met as evidenced by: Based on observation and record review the	K 062	<u>K062 NFPA 101 Life Safety Code Standard</u> The facility will make every effort to meet and comply with the Idaho Statutes Life Safety Code regarding automatic sprinkler systems.	7/2/14

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K 062	<p>Continued From page 5</p> <p>facility failed to maintain the fire sprinkler system. Failing to maintain the fire sprinkler system can result in uncontrolled fire. This deficiency affected all residents, staff, and visitors. The facility is licensed for 45 beds and had a census of 43 the day of the survey.</p> <p>Findings include</p> <p>1. Record review on June 16, 2016 between the hours of 110 am and 12:15 pm revealed no evidence of ongoing quarterly sprinkler maintenance. Quarterly sprinkler maintenance was last documented on April 29, 2013. Maintenance Director stated he was not aware of the requirement.</p> <p>1. Observation at 12:38 pm on June 16, 2014 revealed the corridor sprinkler head near resident room #211 was missing an escutcheon. This deficiency was acknowledged by the Maintenance Director and the Director of Facilities.</p> <p>2. Observation on June 16, 2014 at 1:40 pm revealed the closet sprinkler in resident room #304 had no escutcheon leaving a hole around the pipe. This deficiency was acknowledged by the Maintenance Director and the Director of Facilities.</p> <p>3. Observation at 1:54 pm June 16, 2014 of resident room #212 revealed the sprinkler head in the closet and the sprinkler head in the bathroom were missing escutcheons and the space around the pipes were sealed with drywall mud. This deficiency was acknowledged by the Maintenance Director and the Director of Facilities.</p>	K 062	<p>Affected Residents All residents could be affected by this citation.</p> <p>Corrective Action Quarterly sprinkler maintenance will be performed on a quarterly basis by vendor DELTA FIRE SYSTEMS.</p> <p>The escutcheon was installed near resident room #211.</p> <p>An escutcheon was installed for the closet sprinkler in room #304 ensuring there was no hold around the pipe.</p> <p>Escutcheons' were installed in room #212's closet and the bathroom. DELTA FIRE SYSTEMS replaced and repaired the recessed sprinkler in the psychiatric hospital seclusion room.</p> <p>Systematic Changes The Maintenance Director will ensure that quarterly sprinkler checks are conducted by DELTA FIRE SYSTEMS.</p>		

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K 062	Continued From page 6 4. Observation on June 16, 2014 at 2:50 pm of the psychiatric wing seclusion room revealed the concealment cover for the recessed sprinkler head was held in place by caulk. This deficiency was acknowledged by the Maintenance Director and the Director of Facilities. NFPA Chapter 13 Standard for the Installation of Sprinkler Systems 13.3.3-2.7.2* Escutcheon plates used with a recessed or flush-type sprinkler shall be part of a listed sprinkler assembly. NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. Exception No. 1*: Sprinklers installed in concealed spaces such as above suspended ceilings shall not require inspection. Exception No. 2: Sprinklers installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown..	K 062	The Maintenance Director, Administrator, or their designee will conduct audits of sprinklers ensuring escutcheons are in place and that they fit around the sprinkler to ensure no holes to ensure compliance with this citation. The audits will be conducted weekly x4, q2 weeks x4, then monthly x 3. Monitoring The Maintenance Supervisor, Administrator and/or designee is responsible for compliance. The quarterly fire sprinkler reports will be forwarded to the QAPI committee to ensure that sprinklers audits are being conducted on a quarterly basis to ensure compliance with this citation. Audits surrounding escutcheons will be forwarded to the Q.A.P.I. committee to ensure ongoing compliance. Audits begin 7/21/14. Maintenance Director and Administrator are responsible for compliance.	
K 074 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for	K 074		

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K 074	<p>Continued From page 7</p> <p>the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701.</p> <p>Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13</p> <p>Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3</p> <p>This Standard is not met as evidenced by: Based on observation and interview the facility failed to maintain the flame resistive characteristics of draperies and curtains. Failure to maintain flame resistive characteristics of draperies and curtains can result in rapid combustion growth. This deficiency affected all residents, staff, and visitors. The facility is licensed for 45 beds and had a census of 43 the day of the survey.</p> <p>Findings include:</p> <p>Based on record review and observation on June 16, 2014 between the hours of 12:15 pm and 2:55 pm the building survey revealed no NFPA 701 tags affixed to resident room divider curtains nor was there any evidence the curtains received flame resistance treatment by the facility after laundry. Interview of Maintenance Director revealed he was not aware of the requirement.</p>	K 074	<p><u>K074 NFPA 101 Life Safety Code Standard</u></p> <p>The facility will make every effort to meet and comply with the Idaho Statutes Life Safety Code regarding Draperies.</p> <p>Affected Residents All residents may be affected by this citation.</p> <p>Corrective Action All privacy curtains in resident rooms were sprayed with a flame resistant spray to ensure compliance with this citation.</p> <p>Systematic Changes All draperies, resident room privacy curtains, and furniture that do not have a NFPA 701 tag affixed will be sprayed with an approved flame resistance spray on an annual basis. The Maintenance Director and/or Housekeeping Supervisor will document the room number, curtain location, date and time that the item was sprayed on an annual basis.</p>	7/24/14

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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
K 144	Continued From page 9 stated he was unaware of the requirement. Actual NFPA reference NFPA 110, 6.4.1* and 6.4.2*. Level 1 and level 2 Emergency Power Supply Sources (EPS'S), including all appurtenant components, shall be inspected weekly and shall be exercised under load monthly for a minimum of 30 minutes.	K 144	Systematic Changes The Maintenance Director will inspect the generator on a weekly basis. They will also put the generator under load for at least 30 minutes on a monthly basis to ensure compliance with this citation.	
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 the facility failed to ensure National Electrical Code was followed. Not following the electrical code may result in electric shock or fire. These deficiencies affected all residents, staff and visitors. The facility is licensed for 45 beds and had a census of 43 the day of the survey. Findings include 1. Observation on June 16, 2014 at 12:40 pm revealed resident room #211 had an oxygen concentrator plugged into a power strip. This deficiency was acknowledged by the Maintenance Director and the Director of Facilities. 2. Observation of the nurses room at 12:50 pm June 16, 2014 revealed one six outlet power strip plugged into another. An extension cord was plugged into one power strip and was used to power the copier. This deficiency was acknowledged by the Maintenance Director and	K 147	Monitoring The Maintenance Director will forward weekly and monthly checks to the Q.A.P.I. Committee to ensure compliance with this citation. The Maintenance Director and Administrator are responsible for compliance for this citation. <u>K147 NFPA 101 Life Safety Code Standard</u> The facility will make every effort to meet and comply with the Idaho Statutes Life Safety Code regarding electrical wiring.	8/30/14

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K 147	<p>Continued From page 10 the Director of Facilities.</p> <p>3. Observation of the laundry room on June 16, 2014 at 1:25 pm revealed a flexible cord hardwired in an electrical junction box and routed through a closet wall to an affixed electrical box with two outlets and a cover, powering a vacuum and a water softener. This deficiency was acknowledged by the Maintenance Director and the Director of Facilities.</p> <p>4. Observation on June 16, 2014 at 1:45 pm of resident room #302 revealed a GFCI equipped multiplug adapter powering an oxygen concentrator, food infusing pump, and a lamp. This deficiency was acknowledged by the Maintenance Director and the Director of Facilities.</p> <p>5. Observation on June 16, 2014 at 1:50 pm of the resident dining room revealed the ice machine was powered by a shortened extension cord hardwired to the ice machine as a replacement for the factory power cord. This deficiency was acknowledged by the Maintenance Director and the Director of Facilities.</p> <p>6. Observation at 2:15 pm on June 16, 2014 of the water heater room revealed the air compressor for the dry portion of the fire sprinkler system was positioned directly in front of and less than one foot from an electrical panel marked "main breaker" and partially blocking a three breaker sub panel. It is also inside the clear area of other electrical control panels. This deficiency was acknowledged by the Maintenance Director and the Director of Facilities.</p> <p>Actual NFPA reference</p>	K 147	<p>Affected Residents All residents could be affected by this citation.</p> <p>Corrective Action The power strips in resident room #211 and nurse room were removed.</p> <p>The laundry room flexible cord was replaced by a Certified Electrical Contractor (Bond Electric).</p> <p>The multiplug adapter in resident room #302 was removed.</p> <p>An Certified Electrical Contractor (Bond Electric) certified that the cord on the ice machine met specifications of electrical standards.</p> <p>The compressor located in the water heater room will be relocated outside the water heater room on the side of the facility. This work will be completed by DELTA FIRE SYSTEMS and Bond Electric.</p> <p>Systematic Changes The facility in-serviced all staff members that medical equipment (i.e. oxygen concentrator or food infusing</p>	<p>7/2/14</p> <p>7/2/14</p> <p>7/2/14</p> <p>7/2/14</p> <p>8/30/14</p>	

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K 147	Continued From page 11 Citations # 1, 2, 3, 4: NFPA 70, ARTICLE 400 Flexible Cords and Cables 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 NFPA 70, 110-3. Examination, Identification, Installation, and Use of Equipment. (A) Examination. In judging equipment, considerations such as the following shall be evaluated: (1) Suitability for installation and use in conformity with the provisions of this Code 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. (2) Mechanical strength and durability, including, for parts designed to enclose and protect other	K 147	pumps) cannot be plugged into a power strip or a multiplug adapter. The Certified Electrical Contractor (Bond Electric) added more service locations to the rooms identified (Resident room #211, nurse room, and Resident room #302). The Maintenance Director, Administrator, and/or their designee will conduct audits to ensure that no medical equipment is plugged into non-approved devices (power strips and multiplug adapters). Audits will also be conduct to ensure that extension cords are not used in the facility. Audits will be conducted weekly x4, q2 weeks x4, then monthly x 3. Monitoring Audits will be forwarded to the Q.A.P.I. Committee to ensure compliance with this citation. The Maintenance Director and Administrator are responsible for compliance for this citation. Audits will begin on 7/21/14.	

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K 147	<p>Continued From page 12</p> <p>equipment, the adequacy of the protection thus provided</p> <p>(3) Wire-bending and connection space</p> <p>(4) Electrical insulation</p> <p>(5) Heating effects under normal conditions of use and also under abnormal conditions likely to arise in service</p> <p>(6) Arcing effects</p> <p>(7) Classification by type, size, voltage, current capacity, and specific use</p> <p>(8) Other factors that contribute to the practical safeguarding of persons using or likely to come in contact with the equipment</p> <p>(B) Installation and Use. Listed or labeled equipment shall be installed and used in accordance with any instructions included in the listing or labeling.</p> <p>NFPA 70,400-8. Uses Not Permitted Unless specifically permitted in Section 400-7, flexible cords and cables shall not be used for the following:</p> <ol style="list-style-type: none"> 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 Section 364-8. 5. Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors 6. Where installed in raceways, except as otherwise permitted in this Code <p>Citation #5:</p>	K 147		

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K 147	<p>Continued From page 13</p> <p>NFPA 70 Chapter 1 Table 110.26(A)(1) Working Spaces Nominal Voltage to Ground Minimum Clear Distance</p> <table border="0"> <tr> <td>Condition 1</td> <td>Condition 2</td> <td>Condition 3</td> </tr> <tr> <td>0-150 900 mm (3 ft)</td> <td>900 mm (3 ft)</td> <td>900 mm (3 ft)</td> </tr> <tr> <td>151-600 900 mm (3 ft)</td> <td>1 m (3½ ft)</td> <td>1.2 m (4 ft)</td> </tr> </table> <p>Note: Where the conditions are as follows: Condition 1 - Exposed live parts on one side and no live or grounded parts on the other side of the working space, or exposed live parts on both sides effectively guarded by suitable wood or other insulating materials. Insulated wire or insulated busbars operating at not over 300 volts to ground shall not be considered live parts. Condition 2 - Exposed live parts on one side and grounded parts on the other side. Concrete, brick, or tile walls shall be considered as grounded. Condition 3 - Exposed live parts on both sides of the work space (not guarded as provided in Condition 1) with the operator between.</p>	Condition 1	Condition 2	Condition 3	0-150 900 mm (3 ft)	900 mm (3 ft)	900 mm (3 ft)	151-600 900 mm (3 ft)	1 m (3½ ft)	1.2 m (4 ft)	K 147			
Condition 1	Condition 2	Condition 3												
0-150 900 mm (3 ft)	900 mm (3 ft)	900 mm (3 ft)												
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C 000	16.03.02 INITIAL COMMENTS 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. The following deficiencies were cited during the annual fire/life safety survey conducted on June 16, 2014. The facility was surveyed under IDAPA 16.03.02, Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities. The surveyor conducting the survey was: Dan Holbrook Health Facility Surveyor	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 life safety standards that are applicable to health care facilities. This RULE: is not met as evidenced by: Refer to 2567 K 12 Penetrations K 50 Fire Drills K 62 Sprinkler Maintenance K 74 Draperies K 144 Generator Maintenance K 147 Electrical	C 226	C226 Please see the plans of corrections for the Federal Fire and Life Safety Code citations (K 12, K50, K62, K74, K144, and K147).	7/21/14 K147 8/30/14
C 443	02.120,13,a 13. Plumbing. Plumbing at the facility shall be as follows:	C 443		7/21/14

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JUL - 8 2014

FACILITY STANDARDS

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

[Signature] MBA/Hem

TITLE

Administrative

(X6) DATE

7/7/14

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C 443	<p>Continued From Page 1</p> <p>a. All plumbing shall comply with applicable local and state codes. This RULE: is not met as evidenced by: Based on observation and interview the facility failed to maintain the plumbing and drainage systems. Failure to maintain the plumbing and drainage systems will result in formation of mold and mildew, foul odors, and loss of structural integrity. This deficiency affected no residents, staff, or visitors. The facility is licensed for 45 beds and had a census of 43 the day of the survey.</p> <p>Findings include</p> <p>Observation of the sprinkler riser room on June 16, 2014 at 2:10 pm revealed an approximately 3 by 4 foot area of wet carpeting around the base of the water softener. Investigation and interview with the Maintenance Director revealed the source of the water leak is an improperly plumbed waste pipe. Maintenance stated he observed the leak when the water softener was cycling but had not had time to make repairs.</p> <p>Actual IDAPA reference</p> <p>16.03.02 120</p> <p>13. Plumbing. Plumbing at the facility shall be as follows: (1-1-88)</p> <p>a. All plumbing shall comply with applicable local and state codes. (1-1-88)</p> <p>b. Vacuum breakers shall be installed where necessary to prevent backsiphonage. (1-1-88)</p> <p>c. The temperature of hot water at plumbing fixtures used by patients/residents shall be between one hundred five degrees (105F) and one hundred twenty degrees (120F) Fahrenheit. (1-1-88)</p>	C 443	<p>C443 02.120,13,a Plumbing.</p> <p>The facility will make every effort to meet and comply with the Idaho Statutes Life Safety Code regarding plumbing.</p> <p>Affected Residents No residents are affected by this citation.</p> <p>Corrective Action The facility had a licensed plumber fix the improper plumbing of the waste pipe from the water softener.</p> <p>Systematic Changes The Maintenance Director will conduct audits of the water softener to ensure that there is no leak causing the floor to become wet. The audits will be conducted weekly x4, q2 weeks x4, then monthly x 3.</p> <p>Monitoring The audits will be forwarded to the Q.A.P.I. Committee to ensure compliance with this citation. The Maintenance Supervisor is responsible for compliance. Audits begin on 7/21/14.</p>	

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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