



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

G.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 4056**

July 8, 2014

Bonnie Sorensen, Administrator  
Countryside Care & Rehabilitation  
1224 Eighth Street  
Rupert, ID 83350-1527

Provider #: 135064

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

Dear Ms. Sorensen:

On **June 24, 2014**, a Facility Fire Safety and Construction survey was conducted at **Countryside Care & Rehabilitation** 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 **July 21, 2014**. Failure to submit an acceptable PoC by **July 21, 2014**, may result in the imposition of civil monetary penalties by **August 10, 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 29, 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 29, 2014**. A change in the seriousness of the deficiencies on **July 29, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **July 29, 2014**, includes the following:

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Denial of payment for new admissions effective **September 24, 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 24, 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 24, 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 **July 21, 2014**. If your request for informal dispute resolution is received after **July 21, 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: 07/08/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/24/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</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  The main Extended Care Facility is a single story, type V(111) construction, with a two hour wall at the 1960 original hospital building. The short term (west unit) portion of the nursing facility occupies a wing of the Hospital building and is separated by a smoke barrier from the remaining hospital building which is type I construction. The entire facility is fully sprinklered with corridor smoke detection and manual fire alarm system. The facility is licensed for 46 SNF beds and had a census of 40 on the day of the survey. Due to a lack of separation the entire building was surveyed.  The following deficiencies were cited during the annual Life Safety Code Survey conducted on June 24, 2014. The facility was surveyed under the 2000 Life Safety Code, Existing Health Care Occupancies in accordance with 42 CFR 483.70(a).  The annual life safety survey was conducted by:  Mark Grimes, Supervisor Facility Fire Safety and Construction Program NFPA 101 LIFE SAFETY CODE STANDARD	K 000		
K 012 SS=D	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  This STANDARD is not met as evidenced by: Based upon observation the facility failed to ensure the protected construction was maintained	K 012		

**RECEIVED**  
JUL 21 2014  
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Carl Hanson</i>	TITLE CEO	(X6) DATE 7-18-14
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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.

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K 012	<p>Continued From page 1</p> <p>to prevent the passage of smoke and fire between compartments. This deficient practice allows smoke and gases to migrate between compartments during a fire event. The nursing facility is licensed for 46 beds and had a census of 40 on the day of the survey, the hospital is licensed for 25 beds with a census of four on the day of the survey. This deficient practice affected 2 of 5 smoke compartments, three hospital patients, and no SNF residents.</p> <p>Findings include:</p> <p>During the facility tour on June 24, 2014, between 1:00 PM and 4:30 PM observation revealed penetrations in construction in the following locations:</p> <ol style="list-style-type: none"> <li>1. Storage room next to medical records, eight open penetrations ranging from 3/4 inch to three inches in diameter.</li> <li>2. Electrical room near entrance to OR Suite.</li> <li>3. A four inch opening in the wall of the sprinkler riser room (new wing).</li> <li>4. Multiple penetrations in the ceiling from equipment mounting in Fluoroscopy.</li> </ol> <p>These observations were made by the surveyor and witnessed by the Maintenance Engineer.</p> <p>Actual NFPA Standard:</p> <p>NFPA 101-2000 8.2.3.2.4.2*</p> <p>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:</p> <p>(1) The space between the penetrating item and the fire barrier shall meet one of the following</p>	K 012	<p>K 012</p> <p>Corrective Action:</p> <p>The identified areas:</p> <ol style="list-style-type: none"> <li>1. The eight unsealed penetrations in the store room next to medical records have been sealed.</li> <li>2. The open penetration in the electrical room near entrance to OR Suite has been sealed.</li> <li>3. The opening in the wall of the sprinkler riser room (new wing) has been sealed.</li> <li>4. The multiple penetrations in the ceiling from the equipment mounting in fluoroscopy have been sealed.</li> </ol> <p>Maintenance Supervisor is aware of the NFPA 101 standard.</p> <p>Systemic changes – Maintenance Supervisor will do a facility walk through at least quarterly to monitor for penetrations in the smoke barriers.</p> <p>Monitor – Chief Operations Officer will review and monitor the documentation from Maintenance Supervisor proving the walk through are being completed quarterly to assure that there are not penetrations in the smoke barriers.</p> <p>Quality Assurance - Maintenance Supervisor will report to the facility's Safety Committee quarterly, beginning September 2014.</p>	7/21/14

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K 012	Continued From page 2 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 that is designed for the specific purpose. (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: 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 that is designed for the specific purpose. (3) * Insulation and coverings for pipes and ducts shall not pass through the fire barrier unless one of the following conditions is met: a. The material shall be capable of maintaining the fire resistance of the fire barrier. b. The material shall be protected by an approved device that is designed for the specific purpose. (4) Where designs take transmission of vibration into consideration, any vibration isolation shall meet one of the following conditions: a. It shall be made on either side of the fire barrier. b. It shall be made by an approved device that is designed for the specific purpose.  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: (1) The space between the penetrating item and the smoke partition shall meet one of the	K 012		

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K 012	Continued From page 3 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. (2) Where the penetrating item uses a sleeve to 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		
K 018 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ 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.	K 018		

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K 018	Continued From page 4  This STANDARD is not met as evidenced by: Based upon observation and operational testing on 6/24/14 the facility failed to ensure that corridor doors closed and latched securely. This deficient practice allows products of combustion to move freely between rooms and the exit access corridor compromising egress. The facility is licensed for 46 beds and had a census of 40 on the day of the survey. This deficiency affected 14 Residents and one of five smoke compartments.  Findings include:  During the facility tour on 6/24/14 between 1:15 PM and 4:00 PM corridor doors were tested and the following were observed to not close and latch securely; 1. Physical therapy (rehab) would not self close and latch 2. Storage next to rehab had a door wedge propping the smoke barrier door open, 3. Electrical closet near the OR suite entrance would not latch. 4. Hospital Airborne Infection Isolation room perimeter door was propped open with a door wedge. Infectious Isolation room doors must self close. Testing was conducted by the surveyor and witnessed by the Maintenance Engineer.	K 018	K 018 Corrective Action: The identified areas:  1. The Physical therapy (rehab) corridor door latch has been fixed. 2. The wedge was removed from the Storage door next to rehab. 3. The latch on the Electrical closet near the OR suite entrance has been fixed. 4. The wedge was removed from the Hospital Airborne Infection Isolation room perimeter door.  Systemic Change: Staff were inserviced about wedges not permitted to prop doors.  Monitor: Maintenance Supervisor will routinely monitor corridor areas to assure that doors are latching properly and are not propped.  Quality: Maintenance Supervisor will report to the facility's Safety Committee quarterly, beginning in September 2014.	7/21/14	

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K 018	Continued From page 5  Actual NFPA standard: LSC 2000 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. Roller latches are prohibited by 42 CFR 482.41	K 018		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1	K 029		

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K 029	Continued From page 6  This STANDARD is not met as evidenced by: Based upon observation and interview the facility failed to ensure safe storage of flammable materials in a defined and protected hazardous area. Failure to ensure proper storage would allow dense amounts of smoke and gases to propagate throughout the suite during a fire. This practice affected no residents, one patient and four staff in the radiology suite.  Findings include:  During the facility tour on 6/24/14 between 2:30 and 4:00 PM observation revealed an open storage area in the radiology suite, greater than 100 square feet, containing 36 open shelving units, approximately 18" by 26" by 14" each holding PET (Polyethylene Terephthalate) X-ray film sheets in heavy duty paper sleeves, an additional 12 shelves were 50% full of the same film and paper products. This storage area created a hazardous area which was open to the waiting area, reception and the circulation space of the suite. When asked about storage, radiology staff indicated that these records will be maintained there for at least several more years. This deficient practice was observed by the surveyor and acknowledged by the maintenance engineer.  Actual NFPA standard: NFPA 101-2000 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.	K 029	K 029  Corrective Action: The Identified Area: The open storage area in the radiology suite containing X-ray film sheets in heavy duty paper sleeves is being cleared.  Other individuals: All hospital staff, patients, visitors have the ability to be affected by this.  Systemic Changes: The X-ray film sheets in heavy duty paper sleeve will be stored off-site.  X-ray staff were trained on procedures for storing X-ray film sheets in heavy duty paper sleeves.  Monitor: The X-ray Director will monitor monthly to ensure no storing X-ray film sheets in heavy duty paper sleeves are stored in the open storage area.  Quality: The Radiology Director, or designee, will report monitor results at the quarterly Safety Committee meeting beginning September 2014.	7-22-14 <i>Per phone call ML6</i> <u>8/29/14</u> <u>9/01/14</u>

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K 029	<p>Continued From page 7</p> <p>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:</p> <ol style="list-style-type: none"> <li>(1) Boiler and fuel-fired heater rooms</li> <li>(2) Central/bulk laundries larger than 100 ft2 (9.3 m2)</li> <li>(3) Paint shops</li> <li>(4) Repair shops</li> <li>(5) Soiled linen rooms</li> <li>(6) Trash collection rooms</li> <li>(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</li> <li>(8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard.</li> </ol> <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>Definitions: 3.3.13.2 Area, Hazardous. An area of a structure or building that poses a degree of hazard greater than that normal to the general occupancy of the building or structure, such as areas used for the storage or use of combustibles or flammables; toxic, noxious, or corrosive materials; or heat-producing appliances.</p>	K 029		
K 070	NFPA 101 LIFE SAFETY CODE STANDARD	K 070		

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NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(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 070 SS=D	<p>Continued From page 8</p> <p>Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8</p> <p>This STANDARD is not met as evidenced by: Based upon observation and interview conducted on 6/24/14, the facility failed to prohibit portable space heating devices with elements that exceed 212 degrees Fahrenheit. This deficient practice is considered a significant risk due to the history of fires caused by space heaters. The nursing facility is licensed for 46 beds and had a census of 40 on the day of the survey, the hospital is licensed for 25 beds with a census of four on the day of the survey. This deficient practice affected staff, one hospital patient and no SNF residents.</p> <p>Findings include:</p> <p>During the facility tour conducted on 6/24/14 between 1:00 PM and 4:00 PM, observation revealed portable space heating devices located in the reception office of Radiology and the reception office of the Emergency Department. Interview with the Maintenance Engineer indicated the facility had an ongoing effort to prohibit portable space heaters and he was unaware of these.</p> <p>Actual NFPA Standard:</p> <p>NFPA 101, the Life Safety Code, 2000 Edition</p>	K 070	<p>K 070 Corrective Action: The Identified Area: Portable space heaters were removed.</p> <p>Other individuals: All hospital staff, patients, visitors have the ability to be affected by this.</p> <p>Systemic Change: Staff was inserviced on portable space heaters being prohibited.</p> <p>Monitor: Maintenance Supervisor will routinely monitor areas to assure that space heaters are not in use.</p> <p>Quality: Maintenance Supervisor will report to the facility's Safety Committee quarterly, beginning in September 2014.</p>	7/21/14

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

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OMB NO. 0938-0391

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K 070	Continued From page 9 19.7.8 Portable Space-Heating Devices. Portable space-heating devices shall be prohibited in all health care occupancies. Exception: Portable space-heating devices shall be permitted to be used in nonsleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C).	K 070			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001490</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: <b>01</b>  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>06/24/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>
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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 main Extended Care Facility is a single story, type V(111) construction, with a two hour wall at the 1960 original hospital building. The short term (west unit) portion of the nursing facility occupies a wing of the Hospital building and is separated by a smoke barrier from the remaining hospital building which is type I construction. The entire facility is fully sprinklered with corridor smoke detection and manual fire alarm system. The facility is licensed for 46 SNF beds and had a census of 40 on the day of the survey. Due to a lack of separation the entire building was surveyed.</p> <p>The following deficiencies were cited during the annual Life Safety Code Survey conducted on June 24, 2014. The facility was surveyed under the 2000 Life Safety Code, Existing Health Care Occupancies in accordance with 42 CFR 483.70(a) and IDAPA 16.03.02 Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities.</p> <p>The annual life safety survey was conducted by:</p> <p>Mark Grimes, Supervisor Facility Fire Safety and Construction Program</p>	C 000		
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</p>	C 226	<p>C 226 Refer to K012 Refer to K018 Refer to K029 Refer to K070</p>	7/21/14

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**FACILITY STANDARDS**

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>Carl Hanson</i>	TITLE <b>CEO</b>	(X6) DATE <b>7-18-14</b>
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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001490</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: <b>01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/24/2014</b>
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C 226	<p>Continued From page 1</p> <p>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 deficiencies listed on the federal form 2567:</p> <p>K012 Penetrations of Smoke and Fire Barrier Construction K018 Corridor Doors Latch Securely K029 Excessive Combustible Loading outside of a Hazardous Area K070 Portable Space Heaters</p>	C 226		