



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7012 1010 0002 0836 4049

July 9, 2014

Richard Cartney, Administrator
Owyhee Health & Rehabilitation Center
PO Box A
Homedale, ID 83628-2040

Provider #: 135087

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Mr. Cartney:

On **June 26, 2014**, a Facility Fire Safety and Construction survey was conducted at **Owyhee Health & Rehabilitation 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 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 22, 2014**. Failure to submit an acceptable PoC by **July 22, 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 31, 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 31, 2014**. A change in the seriousness of the deficiencies on **July 31, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **July 31, 2014**, includes the following:

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Denial of payment for new admissions effective **September 26, 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 26, 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 26, 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 22, 2014**. If your request for informal dispute resolution is received after **July 22, 2014**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



Mark P. Grimes, Supervisor
Facility Fire Safety and Construction

MPG/lj
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135087	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - ENTIRE NF STRUCTURE B. WING _____	(X3) DATE SURVEY COMPLETED 06/26/2014
NAME OF PROVIDER OR SUPPLIER OWYHEE HEALTH & REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE 108 WEST OWYHEE HOMEDALE, ID 83628		
(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 000	INITIAL COMMENTS The facility is a single story, type V(111) construction. The latest addition was in 1990. The facility was originally built in 1959. Currently it is licensed for 49 SNF/NF beds. The following deficiencies were cited during the annual fire/life safety survey conducted on June 26, 2014. The facility was surveyed under the LIFE SAFETY CODE 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70. The survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	K 000		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure smoke compartments were maintained to prevent the passage of smoke into adjacent compartments. Failure to ensure smoke	K 025	“This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Owyhee Health & Rehabilitation 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.” <u>K-025</u> 1. a) The escutcheons in room 21 & 22 were placed in the proper position on 9/27/14. b) Hole in the wall of the closet was sealed on 9/27/14. c) Escutcheon in the therapy room was installed on 9/27/14. 2. All sprinklers were inspected to ensure escutcheons were installed and properly seated against the ceiling or wall. Each room was inspected to ensure that no wall penetrations were present. 3. The Plant Manager will inspect all rooms monthly to ensure sprinkler	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE **7/21/14**

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER OWYHEE HEALTH & REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE 108 WEST OWYHEE HOMEDALE, ID 83628		
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K 025	<p>Continued From page 1</p> <p>compartment integrity would allow the passage of smoke and dangerous gases to pass freely between compartments affecting egress during a fire event. This deficient practice affected 29 residents, staff and visitors in 2 of 2 smoke compartments on the date of the survey. The facility is licensed for 49 SNF/NF beds and had a census of 29 on the day of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on June 26, 2014 between 9:15 AM and 12:00 PM, observation by the surveyor and the Maintenance Supervisor of the sprinkler escutcheons in resident rooms 21 and 22 revealed that three of four escutcheons had been dislodged from the ceiling leaving an approximate 1 inch gap in the rated smoke barrier. When asked, the Maintenance Supervisor stated he was unaware the escutcheons had dropped.</p> <p>2) During the facility tour conducted on June 26, 2014 between 9:15 AM and 12:00 PM, inspection of the copier closet located between the Business Office and the Nurses station across from resident rooms 23/24 revealed a square hole in the wall approximately four inches by four inches. Light was clearly visible through to the nurse station side. This finding was acknowledged by the Maintenance Supervisor who stated he was not aware that the hole had not been sealed.</p> <p>3) During the facility tour conducted on June 26, 2014 between 9:15 AM and 12:00 PM, it was observed by the surveyor and the Maintenance Supervisor that a sprinkler escutcheon was missing in the physical therapy room leaving a 1 inch wide gap in the rated smoke barrier. When asked, the Maintenance Supervisor stated he was not aware this escutcheon was missing.</p>	K 025	<p>escutcheons are seated properly and that no wall penetrations exist.</p> <p>4. Completed audits will be reported by the Plant Manager to the QA Committee.</p> <p>5. Compliance will be achieved by July 25, 2014.</p>	

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

Printed: 07/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135087	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - ENTIRE NF STRUCTURE B. WING _____	(X3) DATE SURVEY COMPLETED 06/26/2014	
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K 025	Continued From page 2 Actual NFPA standard: 19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour. Exception No. 1: Where an atrium is used, smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with Exception No. 2 to 8.2.5.6(1). Not less than two separate smoke compartments shall be provided on each floor. Exception No. 2*: Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.3 has been provided for smoke compartments adjacent to the smoke barrier. 8.3.2* Continuity. Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces. Exception: A smoke barrier required for an occupied space below an interstitial space shall not be required to extend through the interstitial space, provided that the construction assembly forming the bottom of the interstitial space provides resistance to the passage of smoke equal to that provided by the smoke barrier.	K 025		
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire	K 029		

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K 029	<p>Continued From page 3</p> <p>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</p> <p>This Standard is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure hazardous areas were protected with self-closing smoke resistive doors. Failure to protect resident common rooms and exit access corridors would expose residents, staff and visitors to dangerous smoke and gases during a fire event. This deficient practice affected 18 residents, staff and visitors in 1 of 2 smoke compartments on the date of the survey. The facility is licensed for 49 SNF/NF beds and had a census of 29 on the day of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on June 26, 2014 between 9:15 AM to 12:00 PM, observation and operational testing of the doors from the main dining/recreation room into the kitchen revealed that 1 of 2 doors were not equipped with a self-closing device. When interviewed, the Maintenance Supervisor stated he was not aware that self-closing doors were required in this area.</p> <p>2) During the facility tour conducted on June 26, 2014 between 9:15 AM to 12:00 PM, further examination of the kitchen area revealed a</p>	K 029	<p><u>K-029</u></p> <p>1. Contractor is installing a) a new magnetic system that will allow both doors to the kitchen to be held open without blocking and will release when the fire alarm activates and b) a sliding cover for the serving window in the kitchen that will close when the fire alarm is activated..</p> <p>2. No other doors or windows were affected by this deficiency.</p> <p>4. All completed work will be reported by the Plant Manager to the QA Committee.</p> <p>5. A waiver was requested and Compliance will be achieved by September 30, 2014.</p>	

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K 029	<p>Continued From page 4</p> <p>pass-through serving window from the kitchen into the main dining/recreation room which had no window, door or other mechanism for being shut during a fire event.</p> <p>3) During the facility tour conducted on June 26, 2014 between 9:15 AM to 12:00 PM, observation of the door into the dishwashing area of the kitchen revealed it was blocked open with a trash can. When asked, the Maintenance Supervisor stated he was aware this door could not be blocked open.</p> <p>Actual NFPA standard:</p> <p>19.3.2 Protection from Hazards. 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:</p> <ol style="list-style-type: none"> (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft² (9.3 m²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (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 	K 029		

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K 029	Continued From page 5 (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door. 3.3.13.2 Area, Hazardous. An area of a structure or building that poses a degree of hazard greater than that normal to the general occupancy of the building or structure, such as areas used for the storage or use of combustibles or flammables; toxic, noxious, or corrosive materials; or heat-producing appliances.	K 029		

Bureau of Facility Standards

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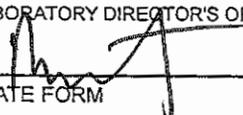
NAME OF PROVIDER OR SUPPLIER OWYHEE HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 108 WEST OWYHEE HOMEDALE, ID 83628
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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2.</p> <p>The facility is a single story, type V(111) construction. The latest addition was in 1990. The facility was originally built in 1959. Currently it is licensed for 49 SNF/NF beds.</p> <p>The following deficiency was cited during the annual fire/life safety survey conducted on June 26, 2014. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70 and IDAPA 16.03.02, Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities.</p> <p>The survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	C 000	<p><u>C-226</u></p> <p>See K-025 and K-029 above.</p>	
C 226	<p>02.106 FIRE AND LIFE SAFETY</p> <p>106. FIRE AND LIFE SAFETY. Buildings on the premises used as facilities shall meet all the requirements of local, state and national codes concerning fire and life safety standards that are applicable to health care facilities.</p> <p>This Rule is not met as evidenced by: Please refer to federal form 2567 "K" tags: K 012 - Building maintenance K 029 - Hazardous Area</p>	C 226		

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Idaho form

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	ADMINISTRATOR	7/2/14

STATE FORM 021199 OIVV21 If continuation sheet 1 of 2

Bureau of Facility Standards

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C 226	Continued From Page 1	C 226		
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