



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 3436**

August 15, 2014

Shon Shuldberg, Administrator  
Ashton Living Center  
PO Box 838  
Ashton, ID 83420-0838

Provider #: 135097

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

Dear Mr. Shuldberg:

On **August 7, 2014**, a Facility Fire Safety and Construction survey was conducted at **Ashton Living 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

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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 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 **August 28, 2014**. Failure to submit an acceptable PoC by **August 28, 2014**, may result in the imposition of civil monetary penalties by **September 17, 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 **September 11, 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 **September 11, 2014**. A change in the seriousness of the deficiencies on **September 11, 2014**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **September 11, 2014**, includes the following:

Denial of payment for new admissions effective **November 7, 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 **February 7, 2015**, 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 **August 7, 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

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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 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 **August 28, 2014**. If your request for informal dispute resolution is received after **August 28, 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: 08/14/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135097</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02 - ENTIRE BUILDING</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/07/2014</b>
NAME OF PROVIDER OR SUPPLIER <b>ASHTON LIVING CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>PO BOX 838 ASHTON, ID 83420</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 000	INITIAL COMMENTS  The facility is a single story, Type V(111) construction. The building was completed April 4, 2002. It is fully sprinklered with Quick Response heads. Smoke detection coverage includes sleeping rooms, corridors and opens spaces to corridors. There is a propane powered generator for emergency power. Currently the Living Center is licensed for 38 SNF/NF beds.  The following deficiencies were cited during the annual Fire/Life Safety survey conducted on August 7, 2014. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy and in accordance with 42 CFR, 483.70.  The Survey was conducted by:  Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	K 000	Preparation and/or execution of the plan of correction does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in statement.	
K 012 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  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 on observation and interview, the facility failed to ensure smoke resistive properties of smoke barriers were maintained. Failure to ensure smoke barriers resist the passage of smoke would allow smoke and dangerous gases to pass freely between smoke compartments. This deficient practice affected 31 residents, staff, and visitors in 2 of 2 smoke compartments on the	K 012		

**RECEIVED**  
**AUG 27 2014**  
**FACILITY STANDARDS**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: SL Shubert TITLE: Administrator (X6) DATE: 8/25/14

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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K 012	<p>Continued From page 2</p> <p>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 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</p>	K 012		

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K 012	Continued From page 3 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 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1  This Standard is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure the protection of hazardous areas with self-closing doors. Failure to protect hazardous areas would result in smoke and dangerous gases passing freely into corridors affecting egress during a fire. This deficient practice affected 31 residents, staff and visitors in 2 of 2 smoke compartments on the date of the survey. The facility is licensed for 38	K 029		

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K 029	<p>Continued From page 4 SNF/NF beds and had a census of 31 on the day of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on August 7, 2014 from 9:00 AM to 11:00 AM, observation and operational testing of the Maintenance Shop door (134) found it would not self-close when activated. Interview of the Maintenance Supervisor indicated he was not aware this door was not self-closing.</p> <p>2) During the facility tour conducted on August 7, 2014 from 9:00 AM to 11:00 AM, observation of the Housekeeping storage door (164) found it was chocked open with a rubber door wedge. Interview of the Maintenance Supervisor and the Environmental Services Director indicated both were aware this door was not to be propped open.</p> <p>Actual NFPA standard:</p> <p>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> <p>(1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft<sup>2</sup> (9.3 m<sup>2</sup>)</p>	K 029	<p>Maintenance Shop door chock was removed and Housekeeping Storage room rubber door wedge was removed</p> <p>All door chocks locked in hazardous areas were removed from building so that doors can not be propped open.</p> <p>Systemic Changes: Training will be done with staff on 8/30/14 about why this is hazardous and that they are not to prop open doors of a identified hazardous area that have no automatic closing ability.</p> <p>Monitor Environmental Supervisor, will check randomly, weekly for door chocked open for a month. Then check quarterly randomly for any chocked doors and report to QA committee.</p>	Aug 18, 2014

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K 029	Continued From page 5 (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft <sup>2</sup> (4.6 m <sup>2</sup> ), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (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.	K 029		
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1  This Standard is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure doors provided a readily accessible means of exit access. Failure to allow rapid means of exit access would prevent occupants ability to safely evacuate in an emergency. This deficient practice affected 31 residents, staff and visitors in 1 of 2 smoke compartments on the date of the survey. The facility is licensed for 38 SNF/NF beds and had a census of 31 on the day of the survey.  Findings include:	K 038		

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K 038	Continued From page 6  During the facility tour conducted on August 7, 2014 from 9:00 AM to 11:00 AM, observation and operational testing of the common area bathrooms located adjacent to room 12 and between rooms 177 and 175 found throw bolts installed on interior side of each bathroom door. When asked, the Environmental Services Director stated these were installed for staff privacy.  Actual NFPA standard:  19.2.1 General. Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7. Exception: As modified by 19.2.2 through 19.2.11.  7.2.1.5.4* A latch or other fastening device on a door shall be provided with a releasing device having an obvious method of operation and that is readily operated under all lighting conditions. The releasing mechanism for any latch shall be located not less than 34 in. (86 cm), and not more than 48 in. (122 cm), above the finished floor. Doors shall be operable with not more than one releasing operation. Exception No. 1*: Egress doors from individual living units and guest rooms of residential occupancies shall be permitted to be provided with devices that require not more than one additional releasing operation, provided that such device is operable from the inside without the use of a key or tool and is mounted at a height not exceeding 48 in. (122 cm) above the finished floor. Existing security devices shall be permitted to have two additional releasing operations.	K 038	Throwbolts in rooms 177 and 175 were removed on 8/19/14. → AS CITED ON BATHROOMS Building was reviewed and looked at by Environmental supervisor and Maintenance supervisor reviewed building for others and 1 additional throw bolt was found and removed immediately. Systemic Changes: All staff notified of reasons why throw bolts were removed. Maintenance Department was trained on dangers of throwbolts. Monitor No more throw bolts will be installed in building. Environmental supervisor will monitor.	Aug 18, 2014 <i>FOR SHULBERG ADMIN 8/18/14</i>

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K 038	Continued From page 7 Existing security devices other than automatic latching devices shall not be located more than 60 in. (152 cm) above the finished floor. Automatic latching devices shall not be located more than 48 in. (122 cm) above the finished floor. Exception No. 2: The minimum mounting height for the releasing mechanism shall not be applicable to existing installations.	K 038		
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 record review and interview, the facility failed to maintain sprinkler systems in accordance with NFPA 25. Failure to maintain sprinkler systems as required would result in insufficient suppression during a fire. This deficient practice affected 31 residents, staff and visitors in 2 of 2 smoke compartments on the date of the survey. The facility is licensed for 38 SNF/NF beds and had a census of 31 on the day of the survey.  Findings include:  During record review conducted at the facility on August 7, 2014 from 8:15 AM to 9:00 AM, inspection of the annual sprinkler report indicated (11) dry system pendants were due for 10 year sample testing or replacement. When interviewed, the Maintenance Supervisor stated no such replacements had been conducted. This	K 062	Contract signed with SimplexGrinnell LP to complete 10yr requirement for a testing sample be done on our sprinkler heads for our dry system on 8/7/14. Systemic Change: Sprinkler system will be sample tested every ten years this will be accomplished by placing a	Oct 1, 2014

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K 062	Continued From page 8 finding was acknowledged by the Administrator during the exit conference conducted on August 7, 2014 from 11:15 AM to 12:00 PM.  Actual NFPA standard:  4.6.12 Maintenance and Testing. 4.6.12.1 Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be continuously maintained in accordance with applicable NFPA requirements or as directed by the authority having jurisdiction.	K 062	reminder in the maintenance book. Discussion with SimplexGrinnell our 3rd party inspectors to follow up in their system with us also.  Monitor Maintenance department will review with administrator SimplexGrinnell inspections and plan course of action if any issues arise.	
K 076 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.  (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.  (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4  This Standard is not met as evidenced by: Based on observation and interview, the facility failed to secure medical gas cylinders in a cart, rack or by individual chaining. Failure to secure cylinders could result in a fire or explosion. This	K 076		

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NAME OF PROVIDER OR SUPPLIER <b>ASHTON LIVING CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>PO BOX 838 ASHTON, ID 83420</b>		
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K 076	<p>Continued From page 9</p> <p>deficient practice affected 11 residents, staff and visitors in 1 of 2 smoke compartments on the date of the survey. The facility is licensed for 38 beds and had a census of 31 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on August 7, 2014 from 9:00 AM to 11:00 AM, observation of the oxygen storage room in the service corridor found (2) E-size oxygen cylinders unsecured. Interview of the Environmental Services Director and the Maintenance Supervisor indicated both were aware oxygen cylinders were required to be secure.</p> <p>Actual NFPA standard:</p> <p>NFPA 99 4-3.1.1.1 Cylinder and Container Management. Cylinders in service and in storage shall be individually secured and located to prevent falling or being knocked over. (a) * Cylinders or supply containers shall be constructed, tested, and maintained in accordance with the U.S. Department of Transportation specifications and regulations. (b) Cylinder contents shall be identified by attached labels or stencils naming the components and giving their proportions. Labels and stencils shall be lettered in accordance with CGA Pamphlet C-4, Standard Method of Marking Portable Compressed Gas Containers to Identify the Material Contained. (c) Contents of cylinders and containers shall be identified by reading the labels prior to use. Labels shall not be defaced, altered, or removed.</p>	K 076	<p>(2) E Tanks were removed on 8/7/14.</p> <p>Systemic Changes Training will be conducted on 8/27/30 to remind staff of appropriate storage of E tanks. Maintenance will monitor and QA the back hall for any inappropriate placement of E tanks daily.</p> <p>Monitor Environmental Supervisor will check and monitor facility weekly for any E tanks not properly stored.</p>	Aug 27, 2014

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135097</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/07/2014</b>
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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 building was completed April 4, 2002. It is fully sprinklered with Quick Response heads. Smoke detection coverage includes sleeping rooms, corridors and opens spaces to corridors. There is a propane powered generator for emergency power. Currently the Living Center is licensed for 38 SNF/NF beds.</p> <p>The following deficiencies were cited during the annual Fire/Life Safety survey conducted on August 7, 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		
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>	C 226		

**RECEIVED**  
**AUG 27 2014**  
**FACILITY STANDARDS**

Idaho form  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *[Signature]* (X6) DATE *8/28/14*

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135097</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/07/2014</b>
NAME OF PROVIDER OR SUPPLIER <b>ASHTON LIVING CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>PO BOX 838 ASHTON, ID 83420</b>		
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C 226	Continued From Page 1  This Rule is not met as evidenced by: Please refer to "K" tags on CMS 2567  K 012 Smoke barrier continuity K 029 Hazardous areas K 038 Exit access K 062 Sprinkler system maintenance K 076 Medical gas storage	C 226	Refer to K012 Refer to K029 Refer to K038 Refer to K062 Refer to K076	9/15/2014 8/9/2014 8/18/2014 10/1/2014 8/9/2014