



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 83720-0008
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7012 1010 0002 0836 3929

December 18, 2013

Darrin Radeke, Administrator
Mini-Cassia Care Center
PO Box 1224
Burley, ID 83318

Provider #: 135081

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Mr. Radeke:

On **December 10, 2013**, a Facility Fire Safety and Construction survey was conducted at **Mini-Cassia Care 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 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 **December 31, 2013**. Failure to submit an acceptable PoC by **December 31, 2013**, may result in the imposition of civil monetary penalties by **January 20, 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 **January 14, 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 **January 14, 2014**. A change in the seriousness of the deficiencies on **January 14, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **January 14, 2014**, includes the following:

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Denial of payment for new admissions effective **March 10, 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 **June 10, 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 **December 10, 2013**, 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 **December 31, 2013**. If your request for informal dispute resolution is received after **December 31, 2013**, 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 'Mark P. Grimes', followed by a long horizontal flourish.

Mark P. Grimes, Supervisor
Facility Fire Safety and Construction

MPG/lj
Enclosures

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

Printed: 12/17/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135081	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE BLDG B. WING _____	(X3) DATE SURVEY COMPLETED 12/10/2013
NAME OF PROVIDER OR SUPPLIER MINI-CASSIA CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1729 MILLER AVENUE BURLEY, ID 83318		
(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 (000) building that is fully sprinkled that was built in 1974 and is currently licensed for 68 SNF beds. The building is covered by fire alarm/smoke detection and automatic sprinkler systems. There is a basement that houses the laundry, maintenance shop, break room central supply, and offices. The facility completed a cosmetic upgrade of floors and walls in 2001. The following deficiencies were cited during the annual fire/life safety survey conducted on December 10, 2013. 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: Tom Mroz, CFI-II Health Facility Surveyor Facility Fire Safety and Construction	K 000	This plan of correction is submitted as required under Federal and State regulations and statutes applicable to long term care providers. This plan of correction does not constitute an admission of liability on the part of the facility and, such liability is hereby specifically denied. The submission of the plan does not constitute agreement by the facility that the surveyor's findings and/or conclusions are accurate, that the findings constitute a deficiency or that the scope and severity regarding any of the deficiencies cited are correctly applied. RECEIVED DEC 27 2013	
K 027 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This Standard is not met as evidenced by:	K 027	K 027 FACILITY STANDARDS The facility will ensure smoke doors are self closing or automatic closing in accordance with 19.2.2.2.6. 12 residents who could be affected are protected from smoke with the adjustment of the door jam and door spring. The smoke and fire doors will be checked during each fire drill and logged onto the fire drill tracking form. The results will be tracked by maintenance and brought to the QAPI committee for review.	12/13/13

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

TITLE

(X6) DATE

[Signature]
ADMINISTRATOR

12/23/13

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 027	<p>Continued From page 1</p> <p>Based on observation and operational testing it was determined that the facility did not ensure that smoke compartment doors were self-closing. This deficiency can allow smoke and fire gases to spread beyond the smoke compartment in the event of a fire. These deficiencies affected 12 residents and staff members in one of four smoke compartments. The facility is licensed for 68 beds and had a census of 53 residents on the day of survey.</p> <p>Findings include:</p> <p>During the tour of the facility on December 10, 2013 at 10:36 AM, observation of operational testing of the smoke compartment door by the Administrators' Office revealed that the door would not self-close and latch when released from the open position. The leading edge of the door hit the door jamb preventing it from fully closing. This was observed and noted by the Maintenance Supervisor and Surveyor.</p> <p>This deficiency was cited during the annual life safety code survey conducted on September 6, 2011 and September 25, 2012.</p> <p>The finding was acknowledged by the Administrator at the exit interview on December 10, 2013.</p> <p>Actual NFPA Standard:</p> <p>19.3.7.6 Doors in smoke barriers shall comply with 8.3.4 and shall be self-closing or automatic-closing in accordance with 19.2.2.2.6. Such doors in smoke barriers shall not be required to swing with egress travel. Positive latching hardware shall</p>	K 027		

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K 027	Continued From page 2 not be required.	K 027		
K 029 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to provide separation of hazardous areas from other areas in the facility. Openings in smoke barriers can allow smoke and fire gasses to enter other smoke compartments in the event of a fire. The deficient practice affected two of four smoke compartments, staff, and 13 residents. The facility has the capacity for 68 beds with a census of 53 the day of survey.</p> <p>Findings include:</p> <p>1.) Observation on December 10, 2013 at 10:45 AM, revealed two approximately four inch by six inch open ceiling penetrations in the lower level hot water heater room. Interview with the Maintenance Supervisor revealed that he had been performing maintenance on piping above the sheetrock ceiling and had yet to close the open penetrations.</p>	K 029	<p>K 029</p> <p>The facility will ensure that the one hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system protects hazardous areas. Affecting all residents; 1.) The facility has repaired the ceiling penetration in the lower level hot water heater room and will maintain integrity of ceiling areas. Maintenance Supervisor or designee will make an inspection monthly of ceiling integrity and the results will be brought to the QAPI committee for review. 2.) The facility has installed a self closing device to the door of the pyxus. All closures will be checked on a weekly basis to ensure compliance and logged on the Maintenance Rounds form by the Maintenance Supervisor. The results will be brought to the QAPI committee for review.</p>	12-12-13

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K 029	Continued From page 3 2.) Observation on December 10, 2013 at 11:05 AM, revealed the door to the Pixus Room was not equipped with self closing device. The room was in excess of 50 square feet and was being used for storage of miscellaneous supplies in cardboard boxes. Interview with the Maintenance Supervisor revealed that the facility was not aware of the requirement for combustibile storage rooms in excess of 50 square feet to be equipped with self closing devices. The finding was acknowledged by the Administrator at the exit interview on December 10, 2013. Actual NFPA Standard: NFPA 101, 19.3.2.1. Hazardous areas shall be safeguarded by a fire barrier of one-hour fire resistance rating or provided with an automatic sprinkler system. The doors shall be self-closing or automatic-closing. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors.	K 029		
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 and interview it was	K 050	K 050 The facility ensures that fire drills are held under various conditions, at least quarterly on each shift. Affecting all residents, the fire drills will be performed on all three CNA shifts going forward and tracked in the Maintenance Rounds by Maintenance Supervisor or designee and the results will be brought to the QAPI committee for review.	12-12-13

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K 050	<p>Continued From page 4</p> <p>determined that the facility did not conduct one fire drill per shift per quarter. Failure to adequately conduct drills for all shifts can result in staff not being trained to act appropriately in an emergency. This deficiency affected all residents, staff, and visitors present on the day of the survey. The facility is licensed for 68 beds with a census of 53 the day of survey.</p> <p>Findings include:</p> <p>During record review on December 10, 2013 at 9:22 AM, the facility was unable to provide documentation for conducting a third shift drill during the first and second quarters and a first shift drill during the third quarter for the previous twelve month period. When questioned about the documentation for the drills the Maintenance Supervisor stated that he was unable to provide any further documentation.</p> <p>This deficiency was cited during the annual life safety code survey conducted on September 25, 2012.</p> <p>The finding was acknowledged by the Administrator at the exit interview on December 10, 2013.</p> <p>Actual NFPA Standard:</p> <p>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</p>	K 050		

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K 050	Continued From page 5 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		
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 it was determined that the facility did not ensure that the sprinkler system was being maintained in accordance NFPA 25. Properly maintaining the sprinkler system helps to ensure system reliability. This deficiency affected all residents, staff, and visitors present on the day of the survey. The facility is licensed for 68 beds with a census of 53 the day of survey. Findings include: During record review on December 10, 2013 at 9:15 AM, the facility was unable to provide documented quarterly sprinkler system inspections for the previous twelve month period. When questioned about the inspections the Maintenance Supervisor stated that they were not performed and he was unsure who was responsible for performing the inspections. This deficiency was cited during the annual life	K 062	K 062 The facility will ensure that required automatic sprinkler systems are in continuously maintained operating condition and are inspected and tested each quarter. Affecting all residents, the facility Maintenance Supervisor has been trained by Delta Fire Systems on 12/13/13. The facility Maintenance Supervisor will perform quarterly sprinkler system checks and track the tests on the Maintenance Rounds. The tracking log will be brought to QAPI meeting and will be review by the team to ensure compliance.	12/13/13

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K 062	Continued From page 6 safety code survey conducted on September 6, 2011 and September 25, 2012. The finding was acknowledged by the Administrator at the exit interview on December 10, 2013. Actual NFPA Standard: NFPA 101 Life Safety Code 2000 Edition 9.7.5 Maintenance and Testing. All automatic sprinkler and standpipe systems required by this Code shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems 1998 Edition 2-2 Inspection. 2-2.1 Sprinklers. 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. 2-2.6 Alarm Devices. Alarm devices shall be inspected quarterly to verify that they are free of physical damage.	K 062		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in	K 144		

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K 144	Continued From page 7 accordance with NFPA 99. 3.4.4.1. This Standard is not met as evidenced by: Based on record review and interview, the facility failed to document weekly and monthly load testing and inspections on the emergency generator and its components. Failure to load test the generator monthly and inspect the generator on a weekly basis could result in the generator not starting or functioning properly in the event of a power outage. This deficiency affected all residents, staff, and visitors present on the day of the survey. The facility has the capacity for 68 beds with a census of 53 the day of survey. Findings include: 1.) During a review of the facility's emergency generator reports for the 12 months preceding the survey on December 10, 2013 at 10:05 AM, the facility was unable to provide documented weekly inspections of the facility generator for the month(s) of July, August, September, October, November and December 2013. Interview with the Maintenance Supervisor revealed that the facility was told by their regional office that weekly inspections were not required. 2.) During a review of the facility's emergency generator reports for the 12 months preceding the survey on December 10, 2013 at 10:10 AM,	K 144	K 144 The facility will ensure that the generator is inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. 1.) Affecting all residents, the facility Maintenance Supervisor will perform and document on the Maintenance Rounds, the weekly generator inspection. Maintenance will bring logs to the Quality Assurance Committee for review. 2.) Affecting all residents, the facility Maintenance Supervisor will perform and document on the Maintenance Rounds, and monthly generator load tests. Maintenance will bring logs to the Quality Assurance Committee for review.	12/13/13

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K 144	Continued From page 8 the facility was unable to provide a documented monthly load test of the facility generator for the month(s) of July and August. Interview with the Maintenance Supervisor revealed that the facility was unaware of the missing monthly load test reports. The finding was acknowledged by the Administrator at the exit interview on December 10, 2013. Actual NFPA Standard: NFPA 110, 6.4.1 and 6.4.2. Level 1 and level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load monthly for a minimum of 30 minutes. Actual NFPA Standard: NFPA 110, 6-3.4. A written record of the EPSS inspections, tests, exercising, operation, and repairs shall be maintained on the premises.	K 144		
K 147 SS=D	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 and interview the facility did not ensure that electrical equipment usage was in accordance with NFPA 70. Utilizing relocatable power taps can lead to overloaded wiring and start a fire. The deficient practice affected one of four smoke compartments, staff and no residents. The facility is licensed for 68 beds with a census of 53 the day of survey. Findings include:	K 147	K 147 The facility will ensure that electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code 9.1.2. 1.) The relocatable power tap observed in the data room has been secured to the wall to ensure safety. The Maintenance Supervisor will ensure that all power taps are mounted appropriately during weekly whole facility rounds. The rounds will be documented on the facility maintenance log and the log will be brought to QAPI committee for review. 2.) The air conditioner with the orange cord has been removed and the Maintenance Supervisor will monitor electrical equipment on Maintenance Rounds Form. The Maintenance Rounds Form will be taken to the Quality Assurance Committee for review.	12/13/13

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

Printed: 12/17/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135081	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE BLDG B. WING _____	(X3) DATE SURVEY COMPLETED 12/10/2013
NAME OF PROVIDER OR SUPPLIER MINI-CASSIA CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1729 MILLER AVENUE BURLEY, ID 83318		
(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 147	<p>Continued From page 9</p> <p>1.) During the tour of the facility on December 10, 2013 at 10:10 AM, observation of the data room revealed a relocatable power tap suspended in midair by the power cord attached to it. When questioned about the relocatable power tap usage the Maintenance Supervisor stated that he was unaware it was not securely mounted.</p> <p>2.) During the tour of the facility on December 10, 2013 at 10:20 AM, observation revealed an orange extension cord run through a hole in the wall, plugged into a relocateable power tap that was plugged into an outlet in the laundry room. When questioned about the extension cord, the Maintenance Supervisor stated that although it was an extension cord, he hard wired it to the air conditioner that was mounted in the wall of the lower level interior corridor approximately fifty feet from the outlet.</p> <p>The finding was acknowledged by the Administrator at the exit interview on December 10, 2013.</p> <p>Actual NFPA Standard:</p> <p>Item #1 NFPA 70 National Electrical Code 1999 Edition 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</p>	K 147		

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K 147	<p>Continued From page 10 evidenced by listing or labeling.</p> <p>2. Mechanical strength and durability, including, for parts designed to enclose and protect other 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>Item #2 NFPA 70, 400.8 Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following:</p> <p>(1) As a substitute for the fixed wiring of a structure</p> <p>(2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors</p> <p>(3) Where run through doorways, windows, or similar openings</p> <p>(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.</p> <p>(5) Where concealed by walls, floors, or ceilings or located above suspended or dropped ceilings</p> <p>(6) Where installed in raceways, except as</p>	K 147		

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K 147	Continued From page 11 otherwise permitted in this Code	K 147		

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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 (000) building that is fully sprinkled that was built in 1974 and is currently licensed for 68 SNF beds. The building is covered by fire alarm/smoke detection and automatic sprinkler systems. There is a basement that houses the laundry, maintenance shop, break room central supply, and offices. The facility completed a cosmetic upgrade of floors and walls in 2001.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on December 10, 2013. The facility was surveyed under IDAPA 16.03.02, Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities.</p> <p>The surveyor conducting the survey was:</p> <p>Tom Mroz, CFI-II Health Facility Surveyor Facility Fire Safety and Construction</p>	C 000	<p style="text-align: center;">RECEIVED DEC 27 2013 FACILITY STANDARDS</p> <p>C 226</p> <p>The facility will ensure that the building meets 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	<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. This RULE: is not met as evidenced by: Refer to the following Federal "K" tags on the CMS - 2567:</p>	C 226		<p>See</p> <p>1. K027 Smoke compartment doors. 12/13/13</p> <p>2. K029 Hazardous area. 12/12/13</p> <p>3. K050 Fire drills. 12/12/13</p> <p>4. K062 Quarterly fire sprinkler inspection. 12/13/13</p> <p>5. K144 Generator testing. 12/13/13</p> <p>6. K147 Electrical. 12/13/13</p>

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

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

TITLE

(X6) DATE

ADMINISTRATOR

12/23/13

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C 226	Continued From Page 1 1. K027 Smoke compartment doors. 2. K029 Hazardous area. 3. K050 Fire drills. 4. K062 Quarterly fire sprinkler inspections. 5. K144 Generator testing. 6. K147 Electrical.	C 226		

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