



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

December 26, 2014

Corwin Lewis, Jr., Administrator
Parke View Rehabilitation & Care Center
2303 Parke Avenue
Burley, ID 83318-2106

Provider #: 135068

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

Dear Mr. Lewis, Jr.:

On **December 17, 2014**, a Facility Fire Safety and Construction survey was conducted at **Parke View Rehabilitation & 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 **January 8, 2015**. Failure to submit an acceptable PoC by **January 8, 2015**, may result in the imposition of civil monetary penalties by **January 28, 2015**.

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 21, 2015**, (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 21, 2015**. A change in the seriousness of the deficiencies on **January 21, 2015**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **January 21, 2015**, includes the following:

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Denial of payment for new admissions effective **March 17, 2015**.
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 17, 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 **December 17, 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 **January 8, 2015**. If your request for informal dispute resolution is received after **January 8, 2015**, 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: 12/23/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135068	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 12/17/2014
NAME OF PROVIDER OR SUPPLIER PARKE VIEW REHABILITATION & CARE CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 2303 PARKE 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	<p>INITIAL COMMENTS</p> <p>The facility is a single story, protected non-combustible building. A new addition was completed in 1998. The original building was constructed in 1963. It is fully sprinklered and has a partial basement with storage, classrooms and maintenance shop. The facility is licensed for 86 NF beds and had a census of 60 on the day of the survey.</p> <p>The following deficiencies were cited at the above facility during the annual Life Safety Code survey conducted on December 17, 2014. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy and 42 CFR 483.70.</p> <p>The survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction</p>	K 000	<p>The facility alleges substantial compliance effective January 9, 2015. Response to the findings is required by law. The fact that Parke View Rehabilitation and Care Center responded to the citations does not constitute an admission that the citations are valid, that the finds listed are accurate, or that the "facts" listed are sufficient to support a conclusion that the Facility is not in substantial compliance with a particular regulation.</p> <p style="text-align: center;"><i>RECEIVED</i></p> <p style="text-align: center;"><i>JAN - 8 2015</i></p> <p style="text-align: center;"><i>FACILITY STANDARDS</i></p>	
K 025 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>This Standard is not met as evidenced by:</p>	K 025	<p>In response to K 025</p> <p>Ceiling tiles in all areas that were missing were replaced.</p> <p>All residents have the potential to be affected by this practice.</p> <p>Weekly room audits will be performed by Administrator or designee weekly for 3 weeks, monthly for 3 months, and quarterly for 2 quarters.</p> <p>The audits will be reviewed monthly by the QAA Committee until it has been determined by the committee that the systems are effective.</p>	1/9/15

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

TITLE

(X6) DATE

[Signature] Administrator 1/7/15

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 PARKE VIEW REHABILITATION & CARE CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 2303 PARKE 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 025	<p>Continued From page 1</p> <p>Based on observation and interview, the facility failed to ensure that smoke barriers were maintained to resist the passage of smoke. Failure to maintain smoke barriers would allow smoke and dangerous gases to pass freely and hinder performance of systems such as sprinklers and smoke detection. This deficient practice affected 11 residents, staff and visitors on the date of the survey. The facility is licensed for 86 SNF/NF beds and had a census of 53 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on December 17, 2014 from 9:45 AM to 12:00 PM, observation of the grid ceiling in the Cancer Unit and the IT room in the 400/500 wing found three missing ceiling tiles in the Cancer Unit and one missing ceiling tile in the IT room. Interview of the Maintenance Supervisor found she was not aware of these tiles being gone.</p> <p>Actual NFPA standard:</p> <p>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</p>	K 025		

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NAME OF PROVIDER OR SUPPLIER PARKE VIEW REHABILITATION & CARE CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 2303 PARKE AVENUE BURLEY, ID 83318		
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K 025	Continued From page 2 19.3.5.3 has been provided for smoke compartments adjacent to the smoke barrier. 8.3 SMOKE BARRIERS 8.3.1* General. Where required by Chapters 12 through 42, smoke barriers shall be provided to subdivide building spaces for the purpose of restricting the movement of smoke. 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 064 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1, 19.3.5.6, NFPA 10 This Standard is not met as evidenced by: Based on observation, physical examination and interview, the facility failed to ensure that fire extinguishers were installed in accordance with	K 064	In response to K 064 All fire extinguishers over the regulation height were adjusted to be in compliance. All residents have the potential to be affected by this practice. The fire extinguisher heights were audited for compliance and will be checked annually x2 after the annual extinguisher inspection. The audits will be reviewed by the QAA Committee until it has been determined by the committee that the systems are effective.	1/9/15

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NAME OF PROVIDER OR SUPPLIER PARKE VIEW REHABILITATION & CARE CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 2303 PARKÉ AVENUE BURLEY, ID 83318		
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K 064	<p>Continued From page 3</p> <p>NFPA 10. Failure to install fire extinguishers properly could inhibit emergency response by staff. This deficient practice affected 53 residents, staff and visitors on the date of the survey. The facility is licensed for 86 SNF/NF beds and had a census of 53 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on December 17, 2014 from 9:45 AM to 12:30 PM, observation of fire extinguishers installed in the corridors found they were installed in cases of varying types. When measured, the tops of the fire extinguishers were found to be at approximately 64". When asked, the Maintenance Supervisor stated she was not aware of the height and distance requirement prior to the survey.</p> <p>Actual NFPA standard:</p> <p>1-6.10 Fire extinguishers having a gross weight not exceeding 40 lb (18.14 kg) shall be installed so that the top of the fire extinguisher is not more than 5 ft (1.53 m) above the floor. Fire extinguishers having a gross weight greater than 40 lb (18.14 kg) (except wheeled types) shall be so installed that the top of the fire extinguisher is not more than 3 1/2 ft (1.07 m) above the floor. In no case shall the clearance between the bottom of the fire extinguisher and the floor be less than 4 in. (10.2 cm).</p> <p>3-1 General Requirements. 3-1.1* The minimum number of fire extinguishers needed to protect a property shall be determined as outlined in this chapter. Frequently, additional extinguishers can be installed to provide more</p>	K 064		

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K 064	Continued From page 4 suitable protection. Fire extinguishers having ratings less than specified in Tables 3-2.1 and 3-3.1 can be installed, provided they are not used in fulfilling the minimum protective requirements of this chapter.	K 064		
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 failed to ensure electrical installations were in accordance with NFPA 70. Failure to ensure proper electrical installations could result in electrocution or fire. This deficient practice affected nine residents, staff and visitors on the date of the survey. The facility is licensed for 86 SNF/NF beds and had a census of 53 on the day of the survey. Findings include: 1) During the facility tour conducted on December 17, 2014 from 9:45 AM to 12:30 PM, observation of the main Kitchen found a switch/outlet combination with a missing cover plate. 2) During the facility tour conducted on December 17, 2014 from 9:45 AM to 12:30 PM, observation of the Rehab center currently under remodel found a four space outlet with a missing cover plate. Interview of the Maintenance Supervisor found she was not aware of either of these outlets missing their covers.	K 147	In response to K 147 All cover plates have been replaced. All residents have the potential to be affected by this practice. Education to be done with maintenance staff regarding replacing cover plates when not directly working on them. Education given to dietary staff regarding work order process to get things fixed by facility. Audits to be done on cover switches weekly x3, monthly x3, and quarterly x2. The audits will be reviewed monthly by the QAA Committee until it has been determined by the committee that the systems are effective.	1/9/15

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K 147	Continued From page 5 Actual NFPA standard: NFPA 70 110.12 Mechanical Execution of Work. Electrical equipment shall be installed in a neat and workmanlike manner. (A) Unused Openings. Unused cable or raceway openings in boxes, raceways, auxiliary gutters, cabinets, cutout boxes, meter socket enclosures, equipment cases, or housings shall be effectively closed to afford protection substantially equivalent to the wall of the equipment. Where metallic plugs or plates are used with nonmetallic enclosures, they shall be recessed at least 6 mm (¼ in.) from the outer surface of the enclosure. (B) Subsurface Enclosures. Conductors shall be racked to provide ready and safe access in underground and subsurface enclosures into which persons enter for installation and maintenance. (C) Integrity of Electrical Equipment and Connections. Internal parts of electrical equipment, including busbars, wiring terminals, insulators, and other surfaces, shall not be damaged or contaminated by foreign materials such as paint, plaster, cleaners, abrasives, or corrosive residues. There shall be no damaged parts that may adversely affect safe operation or mechanical strength of the equipment such as parts that are broken; bent; cut; or deteriorated by corrosion, chemical action, or overheating. 314.17 Conductors Entering Boxes, Conduit Bodies, or Fittings. Conductors entering boxes, conduit bodies, or fittings shall be protected from abrasion and shall comply with 314.17(A) through (D). (A) Openings to Be Closed. Openings through which conductors enter shall be adequately closed.	K 147		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135068	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 12/17/2014
NAME OF PROVIDER OR SUPPLIER PARKE VIEW REHABILITATION & CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2303 PARKE 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) COMPLETE DATE
C 000	16.03.02 INITIAL COMMENTS The facility is a single story, protected non-combustible building. A new addition was completed in 1998. The original building was constructed in 1963. It is fully sprinklered and has a partial basement with storage, classrooms and maintenance shop. The facility is licensed for 86 NF beds and had a census of 53 on the day of the survey. The following deficiencies were cited at the above facility during the annual Life Safety Code survey conducted on December 17, 2014. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy and 42 CFR 483.70 and IDAPA 16.03.02, Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities. The survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction	C 000	The facility alleges substantial compliance effective January 9, 2015. Response to the findings is required by law. The fact that Parke View Rehabilitation and Care Center responded to the citations does not constitute an admission that the citations are valid, that the finds listed are accurate, or that the "facts" listed are sufficient to support a conclusion that the Facility is not in substantial compliance with a particular regulation. RECEIVED JAN - 8 2015 FACILITY STANDARDS	
C 226	02.106 FIRE AND LIFE SAFETY 106. FIRE AND LIFE SAFETY. Buildings on the premises used as facilities shall meet all the requirements of local, state and national codes concerning fire and life safety standards that are applicable to health care facilities. This Rule is not met as evidenced by: Please refer to federal "K" tags on CMS 2567:	C 226	In response to C 226 Refer to K025 Refer to K064 Refer to K147	1/9/15

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

TITLE

(X6) DATE

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135068	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 12/17/2014
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C 226	Continued From Page 1 K 025 Building continuity K 064 Fire extinguisher installations K 147 Electrical installations	C 226		