



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

BRAD LITTLE – Governor  
DAVE JEPPESEN – Director

TAMARA PRISOCK – ADMINISTRATOR  
DIVISION OF LICENSING & CERTIFICATION  
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

July 17, 2020

John Williams, Administrator  
Oneida County Hospital & Long Term Care Facility  
Po Box 126  
Malad, ID 83252

Provider #: 135062

**RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER**

Dear Mr. Williams:

On **July 7, 2020**, an Emergency Preparedness survey was conducted at Oneida County Hospital & Long Term Care Facility by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. Your facility was found to be in substantial compliance with Federal regulations during this survey.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, which states that the facility complies with the requirements of CFR 42, 483.70(a) of the federal requirements. This form is for your records only and does not need to be returned.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact this office at (208) 334-6626, option 3.

Sincerely,

Nate Elkins, Supervisor  
Facility Fire Safety and Construction

NE/lj  
Enclosure

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

PRINTED: 07/29/2020  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135062</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/07/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>ONEIDA COUNTY HOSPITAL &amp; LONG TERM CARE FACILITY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>150 NORTH 200 WEST MALAD, ID 83252</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	
E 000	<p>Initial Comments</p> <p>The facility is a single story, Type III (211) building with a partial basement completed in November 1970, an addition completed in 1993 and an attached Critical Access Hospital. The structure has a two-hour rated fire barrier which divides the building on the Long-Term Care side, but does not create a separation between the CAH and the LTC sections. The facility is equipped with piped in medical gas and an on-site, Emergency Power Supply System (EPSS), spark-ignited generator set. It is located within a rural fire district, and utilizes information as provided in the Bannock County All Hazards Mitigation plan and that information derived from the LEPC. The facility is currently licensed for 33 SNF/NF beds and had a census of 19 on the date of the survey.</p> <p>The facility was found to be in substantial compliance during the Emergency Preparedness survey conducted on July 7, 2020. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.</p> <p>The Survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	E 000			

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

TITLE

(X6) DATE

07/24/2020

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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3232 Elder Street  
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FAX 208-364-1888

July 17, 2020

John Williams, Administrator  
Oneida County Hospital & Long Term Care Facility  
PO Box 126  
Malad, ID 83252

Provider #: 135062

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

Dear Mr. Williams:

On **July 7, 2020**, a Facility Fire Safety and Construction survey was conducted at **Oneida County Hospital & Long Term Care Facility** 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. If applicable, a similar State Form will be provided 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.

John Williams, Administrator  
July 17, 2020  
Page 2 of 4

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 page 2). After each deficiency has been answered and dated, the administrator should sign the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office. If a State Form with deficiencies was issued, it should be signed, dated and returned along with the CMS-2567 Form.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **July 30, 2020**. Failure to submit an acceptable PoC by **July 30, 2020**, may result in the imposition of civil monetary penalties by **August 21, 2020**.

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. If a State Form was issued as well, it should also be signed, dated and returned.

All references to federal regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Remedies may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **August 11, 2020**, (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 **October 5, 2020**. A change in the seriousness of the deficiencies on **August 21, 2020**, may result in a change in the remedy.

John Williams, Administrator  
July 17, 2020  
Page 3 of 4

The remedy, which will be recommended if substantial compliance has not been achieved by **August 11, 2020**, includes the following:

Denial of payment for new admissions effective **October 7, 2020**.  
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 **January 7, 2021**, 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 Nate Elkins, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, option 3; 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 **July 7, 2020**, 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:

John Williams, Administrator  
July 17, 2020  
Page 4 of 4

<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 **July 30, 2020**. If your request for informal dispute resolution is received after **July 30, 2020**, 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, option 3.

Sincerely,



Nate Elkins, Supervisor  
Facility Fire Safety and Construction

NE/lj  
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135062</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/07/2020</b>
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NAME OF PROVIDER OR SUPPLIER <b>ONEIDA COUNTY HOSPITAL &amp; LONG TERM C</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>150 NORTH 200 WEST MALAD, ID 83252</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	<p><b>INITIAL COMMENTS</b></p> <p>The facility is a single story, Type III (211) building with a partial basement completed in November 1970, an addition completed in 1993 and an attached Critical Access Hospital. The structure has a two-hour rated fire barrier which divides the building on the Long-Term Care side, but does not create a separation between the CAH and the LTC sections. The facility is equipped with piped in medical gas and an on-site, Emergency Power Supply System (EPSS), spark-ignited generator set. The facility is currently licensed for 33 SNF/NF beds and had a census of 19 on the date of the survey.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on July 7, 2020. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.</p> <p>The Survey was conducted by: <b>JUL 27 2020</b></p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	K 000	<p><i>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths of the facts alleged or the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it.</i></p> <p><b>K161</b></p> <ul style="list-style-type: none"> <li>• <b>Corrective action for identified areas/residents.</b> The facility information Technology (IT) Supervisor conducted a sweep of all facility cabling wall penetrations on July 14<sup>th</sup>, 2020 and identified all areas that were not sealed in accordance with NFPA 101. Those areas that could be effectively sealed were thoroughly sealed on July 21<sup>st</sup>. The unsealed area identified during survey on July 7<sup>th</sup>, 2020 was completely sealed in accordance with NFPA 101. (See K161 Attachment).</li> <li>• <b>Identification residents with potential to be affected.</b> All residents and patients have the potential to be affected.</li> <li>• <b>Measures to prevent occurrence.</b> All affected cabling wall penetrations have been identified and addressed. Moving forward, when any facility IT repairs, cabling or wiring occurs, the IT Supervisor, or his designee, will review the wall penetrations in the associated area to make sure that the wall penetration has been appropriately sealed in accordance with NFPA 101.</li> <li>• <b>Monitoring and Quality Assurance</b> The IT Supervisor, or designee, will conduct a monthly audit demonstrating that the cabling/wiring wall penetrations have been checked after IT cabling/wiring repairs. This audit will be reported to the NHA weekly for three months. Progress will be reported to the Quality Assurance Committee (QAC)</li> </ul>	7/27/20
K 161 SS=D	<p>Building Construction Type and Height CFR(s): NFPA 101</p> <p>Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5</p> <p>Construction Type 1 I (442), I (332), II (222) Any number of stories</p>	K 161		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>John WMA</i>	TITLE <i>CEO/NHA</i>	(X6) DATE <i>7/24/20</i>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

Printed: 07/14/2020  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135062	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  07/07/2020
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NAME OF PROVIDER OR SUPPLIER <b>ONEIDA COUNTY HOSPITAL &amp; LONG TERM C</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>150 NORTH 200 WEST MALAD, ID 83252</b>
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K 161	<p>Continued From page 1</p> <p>non-sprinklered and sprinklered</p> <p>2 II (111) One story non-sprinklered Maximum 3 stories sprinklered</p> <p>3 II (000) Not allowed non-sprinklered</p> <p>4 III (211) Maximum 2 stories sprinklered</p> <p>5 IV (2HH)</p> <p>6 V (111)</p> <p>7 III (200) Not allowed non-sprinklered</p> <p>8 V (000) Maximum 1 story sprinklered</p> <p>Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5)</p> <p>Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, the facility failed to ensure data cabling penetrations through wall or ceiling membranes, were sealed in accordance with NFPA 101. Failure to ensure data cabling penetrations in the installed ceiling membrane are sealed, has the potential to allow fire, smoke and dangerous gases to pass into and between the interstitial attic space above, bypassing installed active fire systems and</p>	K 161	<p>monthly and as needed until a lesser frequency is deemed appropriate.</p> <ul style="list-style-type: none"> <li>Completion Date July 27<sup>th</sup>, 2020.</li> </ul>	

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K 161	<p>Continued From page 2</p> <p>allowing fires to grow beyond incipient stages. This deficient practice affected staff utilizing the IT office and the egress corridor north of the main dining hall on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 7/7/2020 from 10:45 AM - 2:30 PM, observation of the ceiling of the IT office identified as room 75, revealed two (2) unsealed penetrations being used for category 5 data cabling, approximately four-inches in diameter. When asked at approximately 11:00 AM about this installation, the IT service personnel working in this office stated the unsealed holes and cabling were part of a current upgrade on the networking system.</p> <p>Further asked about the last time someone had been working on this installation, the staff stated it was approximately the Thursday prior, or 7/2/2020.</p> <p>Actual NFPA standard:</p> <p>NFPA 101</p> <p>8.3.5 Penetrations. The provisions of 8.3.5 shall govern the materials and methods of construction used to protect through-penetrations and membrane penetrations in fire walls, fire barrier walls, and fire resistance-rated horizontal assemblies. The provisions of 8.3.5 shall not apply to approved existing materials and methods of construction used to protect existing through-penetrations and existing membrane penetrations in fire walls, fire barrier walls, or fire resistance-rated horizontal assemblies, unless otherwise required by Chapters 11 through 43.</p>	K 161		

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K 161	Continued From page 3 8.3.5.1* Firestop Systems and Devices Required. Penetrations for cables, cable trays, conduits, pipes, tubes, combustion vents and exhaust vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a fire barrier shall be protected by a firestop system or device. The firestop system or device shall be tested in accordance with ASTM E 814, Standard Test Method for Fire Tests of Through Penetration Fire Stops, or ANSI/UL 1479, Standard for Fire Tests of Through-Penetration Firestops, at a minimum positive pressure differential of 0.01 in. water column (2.5 N/m <sup>2</sup> ) between the exposed and the unexposed surface of the test assembly.	K 161		
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101  Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure means of egress were maintained free of obstructions for full, instant use in accordance with NFPA 101. Placement of movable furniture in the corridor exit access, has the potential to hinder the safe egress of residents during a fire or other emergency. This deficient practice affected 10 residents, staff and visitors on the date of the survey.	K 211		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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K 211	<p>Continued From page 4</p> <p>Findings include:</p> <p>During the facility tour conducted on 7/7/2020 from 10:45 AM - 2:30 PM, observation of the southeast corridor, revealed placement of a chair and loveseat against the south wall of the exit access across from room 121. Further observation revealed the furniture was not fixed and measured approximately forty-one inches from the wall to the face of the furniture and an approximately combined length of seventy-four inches. Further observation revealed the remaining width of the exit access when measured from the wall to the arm of the chair across from room 121, was approximately thirty-six inches.</p> <p>Actual NFPA standard:</p> <p>NFPA 101</p> <p>19.2.3.4* Any required aisle, corridor, or ramp shall be not less than 48 in. (1220 mm) in clear width where serving as means of egress from patient sleeping rooms, unless otherwise permitted by one of the following:</p> <p>(1) Aisles, corridors, and ramps in adjunct areas not intended for the housing, treatment, or use of inpatients shall be not less than 44 in. (1120 mm) in clear and unobstructed width.</p> <p>(2)*Where corridor width is at least 6 ft (1830 mm), noncontinuous projections not more than 6 in. (150 mm) from the corridor wall, above the handrail height, shall be permitted.</p> <p>(3) Exit access within a room or suite of rooms complying with the requirements of 19.2.5 shall be permitted.</p> <p>(4) Projections into the required width shall be permitted for wheeled equipment, provided that</p>	K 211	<p><i>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths of the facts alleged or the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it.</i></p> <p><u>K211</u></p> <ul style="list-style-type: none"> <li>• <b>Corrective action for identified areas/residents.</b> The facility Maintenance Supervisor conducted a sweep of all facility means of egress July 8<sup>th</sup>, 2020 and identified all areas with potential obstructions to resident egress. All potential obstructions were removed. The furniture identified during survey on July 7<sup>th</sup>, 2020 were removed. (See K211 Attachment).</li> <li>• <b>Identification residents with potential to be affected.</b> All residents and patients have the potential to be affected.</li> <li>• <b>Measures to prevent occurrence.</b> All potential obstructions to resident egress have been identified and addressed. Additionally, a sweep of the fire suppression sprinklers for paint and corrosion will be conducted as part of the annual review.</li> <li>• <b>Monitoring and Quality Assurance</b> The Maintenance Supervisor, or designee, will conduct a monthly audit to assure that all resident egresses are free of obstruction. This audit will be reported to the NHA weekly for three months. Progress will be reported to the Quality Assurance Committee (QAC) monthly and as needed until a lesser frequency is deemed appropriate.</li> <li>• <b>Completion Date</b> July 27<sup>th</sup>, 2020.</li> </ul>	7/27/20

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NAME OF PROVIDER OR SUPPLIER <b>ONEIDA COUNTY HOSPITAL &amp; LONG TERM C</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>150 NORTH 200 WEST MALAD, ID 83252</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 211	<p>Continued From page 5</p> <p>all of the following conditions are met:</p> <p>(a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in. (1525 mm).</p> <p>(b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency.</p> <p>(c)*The wheeled equipment is limited to the following:</p> <p>i. Equipment in use and carts in use</p> <p>ii. Medical emergency equipment not in use</p> <p>iii. Patient lift and transport equipment</p> <p>(5)*Where the corridor width is at least 8 ft (2440 mm), projections into the required width shall be permitted for fixed furniture, provided that all of the following conditions are met:</p> <p>(a) The fixed furniture is securely attached to the floor or to the wall.</p> <p>(b) The fixed furniture does not reduce the clear unobstructed corridor width to less than 6 ft (1830 mm), except as permitted by 19.2.3.4(2).</p> <p>(c) The fixed furniture is located only on one side of the corridor.</p> <p>(d) The fixed furniture is grouped such that each grouping does not exceed an area of 50 ft<sup>2</sup> (4.6 m<sup>2</sup>).</p> <p>(e) The fixed furniture groupings addressed in 19.2.3.4(5)(d) are separated from each other by a distance of at least 10 ft (3050 mm).</p> <p>(f)*The fixed furniture is located so as to not obstruct access to building service and fire protection equipment.</p> <p>(g) Corridors throughout the smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the fixed furniture spaces are arranged and located to allow direct supervision</p>	K 211		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135062</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/07/2020</b>
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NAME OF PROVIDER OR SUPPLIER <b>ONEIDA COUNTY HOSPITAL &amp; LONG TERM C</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>150 NORTH 200 WEST MALAD, ID 83252</b>
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K 211	Continued From page 6 by the facility staff from a nurses' station or similar space. (h) The smoke compartment is protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.8.	K 211	<i>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths of the facts alleged or the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it.</i>	7/27/20
K 353 SS=E	<p>Sprinkler System - Maintenance and Testing CFR(s): NFPA 101</p> <p>Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure fire suppression systems were maintained free of obstructions in accordance with NFPA 25. Failure to ensure fire suppression system pendants were not obstructed by paint or corrosion, has the potential to hinder system performance during a fire event. This deficient practice affected residents and staff utilizing the Physical Therapy on the main floor and staff accessing the basement level Janitor's storage.</p>	K 353	<p><u>K353</u></p> <ul style="list-style-type: none"> <li>• Corrective action for identified areas/residents. The facility Maintenance Supervisor conducted a sweep of all facility fire suppression sprinkler heads on July 8<sup>th</sup>, 2020 and identified all sprinklers that had paint or other debris on the casing. Those sprinklers that could be effectively cleaned were thoroughly cleaned. Viking Fire Protection was notified and came to the facility on July 21<sup>st</sup>, 2020. During their on-site visit, Viking Fire Protection replaced all sprinkler heads that were identified to have paint on them or any degree of corrosion. The three sprinkler heads identified during survey on July 7<sup>th</sup>, 2020 were replaced. (See K353 Attachment).</li> <li>• Identification residents with potential to be affected. All residents and patients have the potential to be affected.</li> <li>• Measures to prevent occurrence. All affected sprinkler heads have been identified and addressed. Moving forward, when any facility repairs or painting occurs, the Maintenance Supervisor, or his designee, will review the fire suppression sprinkler heads in the repaired/repainted area to make sure that paint has not been dripped or applied to the sprinkler head. Additionally, a sweep of the fire suppression sprinklers for paint and corrosion will be conducted as part of the annual review.</li> <li>• Monitoring and Quality Assurance</li> </ul>	

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135062</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/07/2020</b>
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NAME OF PROVIDER OR SUPPLIER <b>ONEIDA COUNTY HOSPITAL &amp; LONG TERM C</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>150 NORTH 200 WEST MALAD, ID 83252</b>
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K 353	<p>Continued From page 7</p> <p>Findings include:</p> <p>During the facility tour conducted on 7/7/2020 from 10:45 AM - 2:30 PM, observation of installed fire suppression system pendants revealed the following obstructions:</p> <ul style="list-style-type: none"> <li>- The two (2) fire suppression pendants installed in the ceiling of the Physical Therapy were observed to have non-factory applied paint on the uprights and the deflectors of both pendants.</li> <li>- The fire suppression system pendant installed in the B3 Janitor closet was observed to be corroded.</li> </ul> <p>Actual NFPA standard:</p> <p>NFPA 25</p> <p>5.2* Inspection.</p> <p>5.2.1 Sprinklers.</p> <p>5.2.1.1* Sprinklers shall be inspected from the floor level annually.</p> <p>5.2.1.1.1* Sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., upright, pendent, or sidewall).</p> <p>5.2.1.1.2 Any sprinkler that shows signs of any of the following shall be replaced:</p> <ol style="list-style-type: none"> <li>(1) Leakage</li> <li>(2) Corrosion</li> <li>(3) Physical damage</li> <li>(4) Loss of fluid in the glass bulb heat responsive element</li> <li>(5)*Loading</li> <li>(6) Painting unless painted by the sprinkler manufacturer</li> </ol> <p>5.2.1.1.3* Any sprinkler that has been installed in</p>	K 353	<p>The Maintenance Supervisor, or designee, will conduct a monthly audit demonstrating that the fire suppression sprinklers have been checked after repairs/repainting. This audit will be reported to the NHA weekly for three months. Progress will be reported to the Quality Assurance Committee (QAC) monthly and as needed until a lesser frequency is deemed appropriate.</p> <ul style="list-style-type: none"> <li>• Completion Date July 27<sup>th</sup>, 2020.</li> </ul>	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135062	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  07/07/2020
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K 353	Continued From page 8 the incorrect orientation shall be replaced.	K 353	<i>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths of the facts alleged or the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it.</i>	7/27/20
K 511 SS=F	<p>Utilities - Gas and Electric CFR(s): NFPA 101</p> <p>Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure electrical installations were installed in accordance with NFPA 70. Failure to ensure service boxes and disconnects are free of obstructions and enclose junction boxes or those installations housing live parts, has a potential to hinder access to power disconnects during emergencies, while failure to enclose exposed wiring potentially exposes residents to accidental of contact live parts or fires from arcing. This deficient practice affected 19 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 7/7/2020 from approximately 10:45 AM - 2:30 PM, observation of installed electrical systems revealed the following:</p> <ul style="list-style-type: none"> <li>- A missing protective cover for an approximately three-inch diameter junction box in</li> </ul>	K 511	<p><u>K511</u></p> <ul style="list-style-type: none"> <li>• <b>Corrective action for identified areas/residents.</b> The facility Maintenance Supervisor conducted a sweep of all facility service boxes, disconnects and electrical panels on July 8<sup>th</sup>, 2020 and identified any obstructions to electrical panels and any electrical junctions, disconnects and switches that were not covered appropriately. Obstructions to electrical panels were removed. Electrical service boxes, disconnects and junction boxes were appropriately capped and/or covered. The areas identified during survey on July 7<sup>th</sup>, 2020 were addressed. (See K511 Attachments "A" through "F").</li> <li>• <b>Identification residents with potential to be affected.</b> All residents and patients have the potential to be affected.</li> <li>• <b>Measures to prevent occurrence.</b> All electrical panels have been observed by the Maintenance Supervisor, and obstructions have been removed. Also, all electrical boxes, disconnects and junction boxes have been capped and/or covered. Moving forward, when any facility repairs or painting occurs, the Maintenance Supervisor, or his designee, will audit facility electrical service boxes, disconnects and junctions to make sure that they are appropriately capped, covered and enclosed.</li> <li>• <b>Monitoring and Quality Assurance</b> The Maintenance Supervisor, or designee, will conduct a monthly audit</li> </ul>	

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

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135062	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  07/07/2020
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NAME OF PROVIDER OR SUPPLIER <b>BLAINE COUNTY HOSPITAL &amp; LONG TERM C</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>150 NORTH 200 WEST MALAD, ID 83252</b>
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511	<p>Continued From page 9</p> <p>the ceiling area above the Maintenance Director's desk. Interview of the Maintenance Director at approximately 11:15 AM revealed this condition was due to the replacement of a lighting fixture.</p> <ul style="list-style-type: none"> <li>- The light switch adjacent to the door of the Maintenance Director office was missing the protective coverplate.</li> <li>- The electrical disconnect panels located in the Maintenance Director's office were obstructed by storage.</li> <li>- The electrical disconnect panel in the EPSS transfer switch room was obstructed by storage.</li> <li>- Electrical disconnect panels "HD", "RC" and "EL", located in the alcove outside of room 121, were obstructed from access by a loveseat and a chair.</li> <li>- Observation of the Activities area revealed the outlet installed in the backsplash of the dietary service counter was missing the protective coverplate. Interview of the Maintenance Director at approximately 11:30 AM established the coverplate was not installed after the tile installation as he was not able to find a coverplate of matching color.</li> <li>- Observation of a decorative tree in the Activities area revealed a 3-1, non-grounded extension cord being used to supply power to the tree lights.</li> <li>- Observation of the northwest wall of the main dining room revealed two (2) electrical boxes, approximately two inches by three inches in size, without protective coverplates. Further observation established one was an electrical outlet and one was a data cabling installation.</li> </ul> <p>Actual NFPA standard:</p> <p>110.3 Examination, Identification, Installation, and Use of Equipment.          (A) Examination. In judging equipment,</p>	K 511	<p>demonstrating that the electrical panels are not obstructed and that electrical boxes, disconnects and junction boxes are capped and/or covered. This audit will be reported to the NHA weekly for three months. Progress will be reported to the Quality Assurance Committee (QAC) monthly and as needed until a lesser frequency is deemed appropriate.</p> <ul style="list-style-type: none"> <li>• Completion Date July 27<sup>th</sup>, 2020.</li> </ul>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 511	<p>Continued From page 10</p> <p>considerations such as the following shall be evaluated:</p> <p>(1) Suitability for installation and use in conformity with the provisions of this Code</p> <p>Informational Note: 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. Special conditions of use or other limitations and other pertinent information may be marked on the equipment, included in the product instructions, or included in the appropriate listing and labeling information. Suitability of equipment may be 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>110.26 Spaces About Electrical Equipment. Access and working space shall be provided and maintained about all electrical equipment to permit ready and safe operation and maintenance of such equipment.</p>	K 511		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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K 511	<p>Continued From page 11</p> <p><b>ARTICLE 314</b> Outlet, Device, Pull, and Junction Boxes; Conduit Bodies; Fittings; and Handhole Enclosures</p> <p>314.25 Covers and Canopies. In completed installations, each box shall have a cover, faceplate, lampholder, or luminaire canopy, except where the installation complies with 410.24(B).</p> <p>400.8 Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following:            (1) As a substitute for the fixed wiring of a structure            (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors            (3) Where run through doorways, windows, or similar openings            (4) Where attached to building surfaces            Exception to (4): Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of 368.56(B)            (5) Where concealed by walls, floors, or ceilings or located above suspended or dropped ceilings            (6) Where installed in raceways, except as otherwise permitted in this Code            (7) Where subject to physical damage</p>	K 511		