



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

June 26, 2015

Joe Rudd Jr., Administrator  
Marquis Care at Shaw Mountain  
909 Reserve Street  
Boise, ID 83712-6508

Provider #: 135090

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

Dear Mr. Rudd Jr:

On **June 17, 2015**, a Facility Fire Safety and Construction survey was conducted at **Marquis Care at Shaw Mountain** 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. 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

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Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign both Statement of Deficiencies and Plan of Correction, Form CMS-2567 and State Form, in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **July 9, 2015**. Failure to submit an acceptable PoC by **July 9, 2015**, may result in the imposition of civil monetary penalties by **July 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 **July 22, 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 **July 22, 2015**. A change in the seriousness of the deficiencies on **July 22, 2015**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **July 22, 2015**, includes the following:

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Denial of payment for new admissions effective **September 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 **December 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 **June 17, 2015**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

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Go to the middle of the page to Information Letters section and click on State and select the following:

BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process  
2001-10 IDR Request Form

This request must be received by **July 9, 2015**. If your request for informal dispute resolution is received after **July 9, 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

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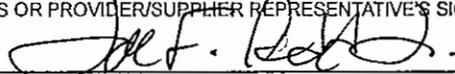
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135090	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  06/17/2015
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NAME OF PROVIDER OR SUPPLIER  MARQUIS CARE AT SHAW MOUNTAIN	STREET ADDRESS, CITY, STATE, ZIP CODE 909 RESERVE STREET BOISE, ID 83712
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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
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K 000	INITIAL COMMENTS  The facility is a Type V(111) single story building. The original building was built in 1963 with an addition in 1971. The east portion of the building was significantly re-modeled in 2007 and a special care unit set-up in the wing. The facility is fully sprinklered. There is a complete fire alarm/smoke detection system installed to include coverage in sleeping rooms. The facility is currently licensed for 98 SNF beds.  The following deficiencies were cited during the annual fire/life safety survey conducted on June 17, 2015. 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:  Nathan Elkins Health Facility Surveyor Facility Fire Safety & Construction  Mark Grimes, Supervisor Facility Fire Safety & Construction	K 000	This plan of correction constitutes the facility's written allegation of compliance for the deficiencies cited in the CMS 2567. However, the submission of this plan is not an admission that a deficiency exists. The Plan of Correction is prepared and executed solely because it is required by federal and state law. This response and Plan of Correction does not constitute an admission or agreement by the provider of the facts alleged or set forth in the statement of deficiencies.  Survey Definitions:  FLS – Fire and Life Safety ESS – Environmental Services Supervisor / Maintenance Supervisor Daily – Monday through Friday IDT – Interdisciplinary Team LN – Licensed Nurse RPT – Relocatable Power Tap	
K 018 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6	K 018	Corrective Action: 1. Cross Corridor Doors identified in items #1 and #2 , the following corrective action has been completed: Metal strip affixed to bottom of cross corridor doors, to reduce distance between bottom of doors and floor covering, to make them compliant with requirement. 2. Main Dining Room Door has been adjusted to close and latch, as required, when released from the magnetic hold device.  Continued on p. 2	

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FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 7/8/2015
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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.

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K 018	Continued From page 1 are permitted. 19.3.6.3  Roller latches are prohibited by CMS regulations in all health care facilities.  This STANDARD is not met as evidenced by: Based on observation, operational testing, and interview the facility failed to maintain doors that protect corridor openings. Failure to maintain corridor doors could allow smoke and dangerous gases to pass freely between smoke compartments. This deficient practice has the potential to affect all residents, staff, and visitors on the date of survey. The facility is licensed for 98 SNF/NF beds with a census of 68 on the day of survey.  Findings include:  1.) During the facility tour on June 17, 2015 between 10:00 AM and 3:30 PM, observation and operational testing of the cross corridor doors near room 113 revealed a 2 inch clearance between bottom of door and floor covering exceeding the 1 inch requirement when closed and latched.  2.) During the facility tour on June 17, 2015 between 10:00 AM and 3:30 PM, observation and operational testing of the cross corridor doors near room 200/201 revealed a 2 inch clearance	K 018	3. Door identified in 2567 as Hoyer Storage been adjusted to close and latch, as required, when released from the magnetic hold device. 4. Door to Resident Room #315 has been adjusted to close and latch as required. 5. Door to Resident Room #9 has been adjusted to close and latch as required.  Identification: All residents are identified as possibly being affected by this deficiency.  Systemic Changes: 1. ESS to continue performing monthly audit of corridor doors for compliance. 2. Staff inserviced regarding reporting of corridor door issues to ESS.  Monitor: Administrator / IDT Designee to review monthly audits for compliance. Audits to be completed at the following frequencies: 1. Monthly for 3 (three) months. 2. Quarterly for six (6) months.	7/22/2015

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K 018	<p>Continued From page 2</p> <p>between bottom of door and floor covering exceeding the 1 inch requirement when closed and latched.</p> <p>3.) During the facility tour on June 17, 2015 between 10:00 AM and 3:30 PM, observation and operational testing of the corridor door to the main dining room revealed the door would not close and latch properly when released from magnetic hold-open device.</p> <p>4.) During the facility tour on June 17, 2015 between 10:00 AM and 3:30 PM, observation and operational testing of the Hoyer storage room door revealed the door would not close and latch properly.</p> <p>5.) During the facility tour on June 17, 2015 between 10:00 AM and 3:30 PM, observation and operational testing of the door leading to room 315 revealed the door would not close and latch properly.</p> <p>6.) During the facility tour on June 17, 2015 between 10:00 AM and 3:30 PM, observation and operational testing of the door leading to room 9 revealed the door would not close and latch properly.</p> <p>When asked, the Maintenance Supervisor stated they were unaware of the 2 inch clearance between bottom of door and floor covering and that the corridor doors did not closing and latch properly.</p> <p>Actual NFPA standard: 19.3.6.3 Corridor Doors. 19.3.6.3.1*</p>	K 018		

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K 018	<p>Continued From page 3</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors.</p> <p>Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.</p> <p>Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke.</p> <p>19.3.6.3.2*</p> <p>Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.2.</p> <p>Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.</p> <p>Exception No. 2: Existing roller latches</p>	K 018		

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K 018	Continued From page 4 demonstrated to keep the door closed against a force of 5 lbf (22 N) shall be permitted to be kept in service.	K 018		
K 022 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that exit signs clearly identified exits. Failure to ensure that exits are identified clearly would hinder egress during an emergency. This deficient practice could potentially affect all residents, staff and visitors on the date of the survey. The facility is licensed for 98 SNF/NF beds with a census of 68 on the day of the survey.  Findings include:  1.) During the facility tour on June 17, 2015 at approximately 1:00 PM, observation of the Sun Lounge dining room revealed no exit signage on both doors leading to the outside. Upon further investigation of the facility evacuation plan revealed both doors leading to the outside from	K 022	<b>Corrective Action:</b> 1. Exit Signs have been installed on both doors leading to the outside in room identified in 2567 as Sun Lounge Dining Room. 2. Exit Sign has been installed at cross corridor door identified as being "near room 12". <b>Note:</b> As to the "further investigation" leading the Surveyor to the assumption that the exit sign had been "removed prior to the day of survey", this is a false assumption. The screws in the wall, which led to the assumption that there had been an exit sign there, are actually for a back-up alarm system to be affixed to the wall in the event the primary lock system should fail.  <b>Identification:</b> All residents are identified as possibly being affected by this deficiency.  <b>Systemic Changes:</b> 1. ESS to continue monthly audit of exit signs for compliance. 2. Staff inserviced regarding reporting of exit sign issues to ESS.  <b>Monitor:</b> Administrator / IDT Designee to review monthly audits for compliance. Audits to be completed at the following frequencies: 1. Monthly for 3 (three) months. 2. Quarterly for six (6) months.	7/22/2015

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K 022	Continued From page 5 the Sun Lounge dining room were marked as emergency exits. When asked, the Maintenance Supervisor stated they were unaware exit signage was needed.  2.) During the facility tour on June 17, 2015 at approximately 2:45 PM, observation of the exit cross corridor doors near room 12 in the Friendship House revealed no exit signage above the door. Upon further investigation it appeared the exit signage was removed prior to the day of survey. When asked, the Maintenance Supervisor stated they were unaware exit signage was needed.  Actual NFPA standard: 7.10.1.4* Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. Sign placement shall be such that no point in an exit access corridor is in excess of 100 ft (30 m) from the nearest externally illuminated sign and is not in excess of the marked rating for internally illuminated signs. Exception: Signs in exit access corridors in existing buildings shall not be required to meet the placement distance requirements.	K 022		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct	K 025	Please see p. 7	

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K 025	<p>Continued From page 6</p> <p>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: Based on observation and interview, the facility failed to ensure that smoke barriers were maintained. Failure to maintain smoke barriers could allow smoke and dangerous gases to pass freely between smoke compartments affecting egress and inhibit suppression and initiating system performance during a fire event. This deficient practice affected all residents staff and visitors on the date of the survey. The facility is licensed for 98 SNF/NF beds with a census of 68 on the day of the survey.</p> <p>Findings include:</p> <p>1.) During the facility tour on June 17, 2015 between 11:00 AM, observation of the outside generator room revealed a 3-4 inch exhaust pipe penetrating through an approximate 5-6 inch circular hole cut into the ceiling that was unsealed and would not resist the passage of smoke. When asked, the Maintenance Supervisor stated they were unaware of the unsealed hole.</p> <p>2.) During the facility tour on June 17, 2015 at approximately 2:30 PM, observation of the suspended ceiling near the South East exit found one (1) missing ceiling tile. When asked, the Maintenance Supervisor stated they were unaware of the missing ceiling tile.</p> <p>Actual NFPA standard:</p>	K 025	<p><b>Corrective Action:</b></p> <ol style="list-style-type: none"> <li>Ceiling area identified in the 2567 has been sealed as per regulation requirement. <b>Note:</b> This area was identified in 2567 as "Outside Generator Room" This is incorrect. The facility emergency generator is outside the facility, adjacent to this storage room. The area is identified on all Facility Floor Plan maps as "Store Room". This area is primarily used as Dietary Storage, but also houses two (2) water heaters. The "exhaust pipe" identified in the 2567 is actually the vent pipe for one of these water heaters and not an exhaust pipe for a generator.</li> <li>Ceiling tile replaced. ESS was aware of this tile needing to be replaced.</li> </ol> <p><b>Identification:</b> All residents are identified as possibly being affected by this deficiency.</p> <p><b>Systemic Changes:</b></p> <ol style="list-style-type: none"> <li>ESS to continue monthly audit of smoke barriers for compliance.</li> <li>Staff inserviced regarding reporting of smoke barrier issues to ESS.</li> </ol> <p><b>Monitor:</b> Administrator / IDT Designee to review monthly audits for compliance. Audits to be completed at the following frequencies:</p> <ol style="list-style-type: none"> <li>Monthly for 3 (three) months.</li> <li>Quarterly for six (6) months.</li> </ol>	7/22/2015

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K 025	Continued From page 7 19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour. Exception No. 1: Where an atrium is used, smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with Exception No. 2 to 8.2.5.6(1). Not less than two separate smoke compartments shall be provided on each floor. Exception No. 2*: Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.3 has been provided for smoke compartments adjacent to the smoke barrier.  8.3.2* Continuity. Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces. Exception: A smoke barrier required for an occupied space below an interstitial space shall not be required to extend through the interstitial space, provided that the construction assembly forming the bottom of the interstitial space provides resistance to the passage of smoke equal to that provided by the smoke barrier.	K 025			
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Exit access is arranged so that exits are readily accessible at all times in accordance with section	K 038	Please see p. 9		

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NAME OF PROVIDER OR SUPPLIER  MARQUIS CARE AT SHAW MOUNTAIN			STREET ADDRESS, CITY, STATE, ZIP CODE 909 RESERVE STREET BOISE, ID 83712	
(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 038	Continued From page 8 7.1. 19.2.1  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure clear and unobstructed vision of the exit doors located in the corridors. Failure to maintain clear unobstructed vision of exit doors may cause confusion and hinder evacuation of all residents, staff, and visitors. The facility is licensed for 98 SNF/NF beds with a census of 68 on the day of survey.  Findings include:  1.) During the facility tour on June 17, 2015 at approximately 1:00 PM, observation of the door blinds covering the exit doors and the blinds covering the windows near the exit doors located in the Sun Lounge dining room revealed a camouflaged look disguising the doors of the intended purpose.  2.) During the facility tour on June 17, 2015 at approximately 2:30 PM, observation of the exit doors leading from the Friendship House near room 12 revealed a picture that was covering the exit doors disguising the exit doors of its purpose.  3.) During the facility tour on June 17, 2015 at approximately 2:45 PM, observation of the exit door leading from the Friendship House exit door to the outside revealed a picture that was covering the exit door disguising the door of its purpose.	K 038	<b>Corrective Action:</b>  1. Blinds on windowed exit doors in room identified as Sun Lounge Dining have been removed. <b>Note:</b> The blinds on these exit doors were installed on the windows and windowed exit doors of that room to reduce the radiant heat entering that room and NOT to "camouflage", "disguise", or conceal the fact that there are exit doors there. Residents, family, and staff use those doors on a regular basis to access the facility courtyard.  2. Pictures covering exit doors of Friendship House removed. <b>Note:</b> The Friendship House is a secured dementia unit within the facility. The pictures (murals) were put in place to help deter residents from eloping through those doors. The door cited in example #2 of this deficiency is clearly marked with an exit sign.  <b>Identification:</b> All residents are identified as possibly being affected by this deficiency.  <b>Systemic Changes:</b>  1. ESS to continue monthly audit of exit doors for compliance. 2. Staff inserviced regarding reporting of exit door issues to ESS.  <b>Monitor:</b> Administrator / IDT Designee to review monthly audits for compliance. Audits to be completed at the following frequencies:  1. Monthly for 3 (three) months. 2. Quarterly for six (6) months.	7/22/2015

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K 038	Continued From page 9 When asked, the Maintenance Supervisor stated they were unaware of the obstructed vision of the exit doors.  Actual NFPA standard: 19.2.2.2.1 Doors complying with 7.2.1 shall be permitted. 7.2.1.1.2 Every door and every principal entrance that is required to serve as an exit shall be designed and constructed so that the path of egress travel is obvious and direct. 7.1.10.2.1 No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress therefrom, or visibility thereof.	K 038		
K 046 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.  This STANDARD is not met as evidenced by: Based on operational testing and interview the facility failed to ensure emergency lighting with battery back-up was maintained. Failure to ensure that battery powered emergency egress lighting operated under battery load could inhibit egress of residents during an emergency. This deficient practice affected 19 residents, staff and visitors on the date of the survey. The facility is licensed for 98 SNF/NF residents with a census of 68 on the day of the survey.  Findings include:  During the facility tour on June 17, 2015 at	K 046	<b>Corrective Action:</b> Battery in Emergency Lighting unit noted in 2567 has been replaced and is working as required. ESS stated at time of survey that on his monthly test performed in June, this light worked properly.  <b>Identification:</b> All residents in Friendship House unit of facility are identified as possibly being affected by this deficiency.  <b>Systemic Changes:</b> 1. ESS to continue monthly audit of emergency lighting lights for compliance. 2. Staff inserviced regarding reporting of emergency light issues to ESS.  <b>Monitor:</b> Administrator / IDT Designee to review monthly audits for compliance. Audits to be completed at the following frequencies: 1. Monthly for 3 (three) months. 2. Quarterly for six (6) months.	7/22/2015

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K 046	Continued From page 10 approximately 2:45 PM, operational testing of the emergency lighting system in the Friendship House dining room near the exit door found the light failed to operate when the test button was pushed. When asked, the maintenance supervisor stated they were unaware of the inoperable light.  Actual NFPA standard: NFPA 19.2.9.1 Emergency lighting shall be provided in accordance with Section 7.9. 7.9.2.1* Emergency illumination shall be provided for not less than 1 1/2 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10 lux) and, at any point, not less than 0.1 ft-candle (1 lux), measured along the path of egress at floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (6 lux) and, at any point, not less than 0.06 ft-candle (0.6 lux) at the end of the 1 1/2 hours. A maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded.	K 046		
K 047 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1  This STANDARD is not met as evidenced by: Based on observation and interview the facility	K 047	<b>Corrective Action:</b> Exit Sign in Main Dining Room replaced with a new unit and is and is working as required.  <b>Identification:</b> All residents are identified as possibly being affected by this deficiency.	

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K 047	Continued From page 11 failed to ensure exit signage was continuously illuminated. This deficient practice could confuse evacuation in a dark smoke filled corridor affecting all residents, staff members, and visitors on the date of survey. The facility is licensed for 98 SNF/NF beds with a census of 68 on the day of survey.  Findings include:  During the facility tour on June 17, 2015 at approximately 11:30 AM, observation reveled the exit sign in the main dining room was not operational. When asked, the Maintenance Supervisor stated they were unaware the exit sign was not working properly.  Actual NFPA reference: 19.2.10.1 Means of egress shall have signs in accordance with Section 7.10. Exception: Where the path of egress travel is obvious, signs shall not be required in one-story buildings with an occupant load of fewer than 30 persons.  7.10.5 Illumination of Signs. 7.10.5.1* General. Every sign required by 7.10.1.2 or 7.10.1.4, other than where operations or processes require low lighting levels, shall be suitably illuminated by a reliable light source. Externally and internally illuminated signs shall be legible in both the normal and emergency lighting mode.	K 047	<b>Systemic Changes:</b> 1. ESS to continue monthly audit of exit signs for compliance. 2. Staff inserviced regarding reporting of exit sign issues to ESS.  <b>Monitor:</b> Administrator / IDT Designee to review monthly audits for compliance. Audits to be completed at the following frequencies: 1. Monthly for 3 (three) months. 2. Quarterly for six (6) months.	7/22/2015
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Required automatic sprinkler systems are continuously maintained in reliable operating	K 062	Please see p. 13	

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K 062	<p>Continued From page 12 condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that fire suppression systems were tested and maintained in accordance with NFPA 25. Failure to provide proper testing, inspection and maintenance of sprinkler systems could result in these systems not performing as designed during a fire event. This deficient practice affected all residents, staff and visitors on the date of the survey. The facility is licensed for 98 SNF/NF beds and had a census of 68 on the day of the survey.</p> <p>Findings Include:</p> <p>1.) During record review on June 17, 2015 at approximately 10:00 AM, the facility was unable to provide documentation of antifreeze solution percentage in the automatic sprinkler system. When asked, the maintenance supervisor stated they were unaware the antifreeze percentage was not documented.</p> <p>2.) During the record review on June 17, 2015 at approximately 10:00 AM, the facility was unable to provide documented 5 year internal piping inspection reports of the automatic sprinkler system. When asked, the maintenance supervisor stated they were unaware the location of the documentation.</p> <p>3.) During the facility tour on June 17, 2015 at approximately 2:30 PM, observation of the</p>	K 062	<p><b>Corrective Action:</b></p> <ol style="list-style-type: none"> <li>1. Facility has received the documentation regarding the percentage of anti-freeze solution present in the automated sprinkler system obtained by qualified technician with equipment prescribed in regulation.</li> <li>2. Facility has obtained the required q. 5yr. internal pipe inspection of the automated sprinkler system.</li> <li>3. Sprinkler heads identified in 2567 have been inspected and cleaned.</li> </ol> <p><b>Identification:</b> All residents in Friendship House unit of the facility are identified as possibly being affected by this deficiency.</p> <p><b>Systemic Changes:</b> ESS to continue monthly audit of fire sprinklers for compliance.</p> <p><b>Monitor:</b> Administrator / IDT Designee to review monthly audits for compliance. Audits to be completed at the following frequencies:</p> <ol style="list-style-type: none"> <li>1. Monthly for 3 (three) months.</li> <li>2. Quarterly for six (6) months.</li> </ol>	7/22/2015

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K 062	<p>Continued From page 13</p> <p>Friendship House dining area revealed multiple sprinkler heads loaded with excessive dust build up. When questioned about the sprinkler heads, the Maintenance Supervisor stated they were unaware of the dusty sprinkler heads.</p> <p>Actual NFPA standards:</p> <p>Item #1 NFPA 25, 2-3.4* Antifreeze Systems. The freezing point of solutions in antifreeze shall be tested annually by measuring the specific gravity with a hydrometer or refractometer and adjusting the solutions if necessary. Solutions shall be in accordance with Tables 2-3.4(a) and (b). The use of antifreeze solutions shall be in accordance with any state or local health regulations. [See Table 2-3.4(b).]</p> <p>Item #2 NFPA 25, 10-2.2 Obstruction Prevention. Systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This investigation shall be accomplished by examining the interior of a dry valve or preaction valve and by removing two cross main flushing connections.</p> <p>Item #3 NFPA 25, 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</p>	K 062		

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K 062	Continued From page 14 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. Exception No. 1*: Sprinklers installed in concealed spaces such as above suspended ceilings shall not require inspection. Exception No. 2: Sprinklers installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown.	K 062		
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 and interview, the facility failed to ensure that fire extinguishers were installed in accordance with NFPA 10. Failure to ensure fire extinguishers were installed at the correct height and readily accessible could inhibit their use during a fire event. This deficient practice affected all residents, staff and visitors on the date of the survey. The facility is licensed for 98 SNF/NF beds with a census of 68 on the day of the survey.  Findings include:  During the facility tour on June 17, 2015 between 10:00 AM and 3:30 PM, observation of the ABC fire extinguishers located throughout the facility	K 064	<b>Corrective Action:</b> 1. ABC extinguishers identified in 2567 have been replaced with extinguishers that are compliant and meet the height requirement of 60" or less. 2. ESS audited all ABC extinguishers in the facility and adjusted those not in compliance, as needed, to meet the height requirement of 60" or less. 3. Cabinet for K-Style extinguisher in the Kitchen has been lowered to be compliant with height requirement of 60" or less.  <b>Identification:</b> All residents are identified as possibly being affected by this deficiency.  <b>Systemic Changes:</b> ESS to continue monthly audit of fire extinguishers for compliance.  <b>Monitor:</b> Administrator / IDT Designee to review monthly audits for compliance. Audits to be completed at the following frequencies: 1. Monthly for 3 (three) months. 2. Quarterly for six (6) months.	7/22/2015

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K 064	Continued From page 15 and the K-Style fire extinguisher located in the kitchen were installed above the maximum height requirement of 60 inches. Four extinguishers were measured in various locations throughout facility and all measured between 64 inches to 67 inches to the top of the extinguishers. When asked, Maintenance Supervisor stated the facility was not aware of the extinguisher height requirements.  Actual NFPA standard: NFPA 10 Standard for Portable Fire Extinguishers 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).	K 064		
K 072 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10  This STANDARD is not met as evidenced by: Based on observation and interview, the facility	K 072	Please see p. 17	

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K 072	<p>Continued From page 16</p> <p>did not ensure that means of egress was maintained free from obstructions. Failure to provide exit access free of obstructions could prevent the safe evacuation of residents during an emergency. This deficient practice potentially could affected all residents, staff members, and visitors on the day of survey. the facility is licensed for 98 SNF/NF beds with a census of 68 on the day of survey</p> <p>Findings Include:</p> <p>During the facility tour on June 17, 2015, between 10:00 AM and 3:30 PM, observation revealed the facility was utilizing medical carts and charting carts as storage in the exit access corridors of the facility at the following locations: Near room #105 and #109 Intersection of 200 hallway and center corridor Near salon room and room #303 Friendship corridor near room #1</p> <p>Interview with direct care staff stated the carts were always stored in their present locations. When asked, the Maintenance Supervisor stated the facility was unaware the medical carts and chart carts were considered storage and obstructing exit access.</p> <p>Actual NFPA Standard: NFPA 101, 7.1.10 Means of Egress Reliability. 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. 7.1.10.2.1 No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress therefrom,</p>	K 072	<p><b>Corrective Action:</b></p> <ol style="list-style-type: none"> <li>1. Carts identified as "charting carts" are actually used Wound Care Treatment carts. They also have a laptop attached to provide additional stations for the nursing staff to document resident cares. When not being used by LN staff to provide wound care to facility residents, these carts will moved to the chart rooms in each hall.</li> <li>2. Licensed Nurses that use Medication Carts have received inservice regarding moving the Medication Carts with them as they administer medications to the residents and document resident cares.</li> <li>3. Facility Emergency Plan calls for all carts and/or equipment to be moved out of hallway immediately in the event of any emergency.</li> </ol> <p><b>Identification:</b> All residents are identified as possibly being affected by this deficiency.</p> <p><b>Systemic Changes:</b> See Corrective Action</p> <p><b>Monitor:</b> DNS to conduct random audits of cart placement and movement in facility hallways to ensure compliance. Audits to be conducted at the following frequencies:</p> <ol style="list-style-type: none"> <li>1. Daily for one week</li> <li>2. Weekly for four weeks</li> <li>3. Every other week for four weeks</li> <li>4. Monthly for 3 months</li> </ol>	7/22/2105

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K 072 K 076 SS=E	Continued From page 17 or visibility thereof. NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.  (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.  (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4  This STANDARD is not met as evidenced by: Based upon observation and interview the facility failed to ensure oxygen cylinders were secured and stored in a safe manner. Failure to secure and maintain cylinders can result in physical damage to the cylinder and could create an oxygen enriched atmosphere. This deficient practice affected 24 residents, staff and visitors in the 200 wing on the day of survey. The facility is licensed for 98 SNF/NF beds with a census of 68 on the day of survey.  Findings include:  1.) During the facility tour on June 17, 2015 at approximately 11:00 AM, observation of the exterior service wing oxygen storage area revealed three (3) "E" style oxygen tanks that were not properly secured in a cylinder stand or	K 072 K 076	<b>Corrective Action:</b>  1. Oxygen tanks identified in 2567 as "not secured" in "exterior service oxygen storage area" were secured immediately during survey. <b>Note:</b> ESS "unaware" of tanks left unsecured due to the fact that other staff left the tanks unsecured and ESS does not monitor this area 24/7.  2. Hospice company providing oxygen for resident in room #206 reduced the of bottles they will keep in the room to six (6).  3. ESS conducted an audit of all resident rooms, with regard to oxygen tanks in use and/or stored, to ensure no more than 300 cu feet being use and/or /stored in any one smoke compartment.  <b>Identification:</b> All residents are identified as possibly being affected by this deficiency.  <b>Systemic Changes:</b>  1. ESS to continue to conduct monthly audits oxygen storage in service area and in resident rooms for compliance.  2. Staff inserviced regarding oxygen storage requirements in service area and in resident rooms.  <b>Monitor:</b> Administrator / IDT Designee to review monthly audits for compliance. Audits to be completed at the following frequencies:  1. Monthly for 3 (three) months. 2. Quarterly for six (6) months.	7/22/2015

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135090	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____		(X3) DATE SURVEY COMPLETED  06/17/2015
NAME OF PROVIDER OR SUPPLIER  MARQUIS CARE AT SHAW MOUNTAIN		STREET ADDRESS, CITY, STATE, ZIP CODE 909 RESERVE STREET BOISE, ID 83712		
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K 076	<p>Continued From page 18</p> <p>cart. When asked, the Maintenance Supervisor stated he was unaware of the freestanding gas cylinders.</p> <p>2.) During the facility tour on June 17, 2015 at approximately 1:30 PM, observation of room 206 revealed one (1) unsecured "E" style oxygen cylinder freestanding near the oxygen rack. Upon further investigation it was found that thirteen (13) "E" style oxygen cylinders were being stored inside room 206 which exceeded the 300 cubic foot of oxygen allowed to be stored in one the 200 wing. When asked, the Maintenance Supervisor stated he was unaware of the unsecured oxygen cylinder and was unaware of storage requirements for each smoke compartment.</p> <p>Actual NFPA standard: NFPA 99 4-3.1.1.2 Storage Requirements (Location, Construction, Arrangement). (a)* Nonflammable Gases (Any Quantity; In-Storage, Connected, or Both) 1. Sources of heat in storage locations shall be protected or located so that cylinders or compressed gases shall not be heated to the activation point of integral safety devices. In no case shall the temperature of the cylinders exceed 130°F (54°C). Care shall be exercised when handling cylinders that have been exposed to freezing temperatures or containers that contain cryogenic liquids to prevent injury to the skin. 2.* Enclosures shall be provided for supply systems cylinder storage or manifold locations for oxidizing agents such as oxygen and nitrous oxide. Such enclosures shall be constructed of an assembly of building materials with a fire-resistive rating of at least 1 hour and shall not</p>	K 076		

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K 076	<p>Continued From page 19</p> <p>communicate directly with anesthetizing locations. Other nonflammable (inert) medical gases may be stored in the enclosure. Flammable gases shall not be stored with oxidizing agents. Storage of full or empty cylinders is permitted. Such enclosures shall serve no other purpose.</p> <p>3. Provisions shall be made for racks or fastenings to protect cylinders from accidental damage or dislocation.</p> <p>4. The electric installation in storage locations or manifold enclosures for nonflammable medical gases shall comply with the standards of NFPA 70, National Electrical Code, for ordinary locations. Electric wall fixtures, switches, and receptacles shall be installed in fixed locations not less than 152 cm (5 ft) above the floor as a precaution against their physical damage.</p> <p>5. Storage locations for oxygen and nitrous oxide shall be kept free of flammable materials [see also 4-3.1.1.2(a)7].</p> <p>6. Cylinders containing compressed gases and containers for volatile liquids shall be kept away from radiators, steam piping, and like sources of heat.</p> <p>7. Combustible materials, such as paper, cardboard, plastics, and fabrics, shall not be stored or kept near supply system cylinders or manifolds containing oxygen or nitrous oxide. Racks for cylinder storage shall be permitted to be of wooden construction. Wrappers shall be removed prior to storage. Exception: Shipping crates or storage cartons for cylinders.</p> <p>8. When cylinder valve protection caps are supplied, they shall be secured tightly in place unless the cylinder is connected for use.</p> <p>9. Containers shall not be stored in a tightly closed space such as a closet [see 8-2.1.2.3(c)].</p> <p>10: Location of Supply Systems.</p>	K 076		

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K 076	<p>Continued From page 20</p> <p>a. Except as permitted by 4-3.1.1.2(a)10c, supply systems for medical gases or mixtures of these gases having total capacities (connected and in storage) not exceeding the quantities specified in 4-3.1.1.2(b)1 and 2 shall be located outdoors in an enclosure used only for this purpose or in a room or enclosure used only for this purpose situated within a building used for other purposes.</p> <p>b. Storage facilities that are outside, but adjacent to a building wall, shall be in accordance with NFPA 50, Standard for Bulk Oxygen Systems at Consumer Sites.</p> <p>c. Locations for supply systems shall not be used for storage purposes other than for containers of nonflammable gases. Storage of full or empty containers shall be permitted. Other nonflammable medical gas supply systems or storage locations shall be permitted to be in the same location with oxygen or nitrous oxide or both. However, care shall be taken to provide adequate ventilation to dissipate such other gases in order to prevent the development of oxygen-deficient atmospheres in the event of functioning of cylinder or manifold pressure-relief devices.</p> <p>d. Air compressors and vacuum pumps shall be located separately from cylinder patient gas systems or cylinder storage enclosures. Air compressors shall be installed in a designated mechanical equipment area, adequately ventilated and with required services.</p> <p>11. Construction and Arrangement of Supply System Locations.</p> <p>a. Walls, floors, ceilings, roofs, doors, interior finish, shelves, racks, and supports of and in the locations cited in 4-3.1.1.2(a)10a shall be constructed of noncombustible or limited-combustible materials.</p> <p>b. Locations for supply systems for oxygen,</p>	K 076		

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K 076	<p>Continued From page 21</p> <p>nitrous oxide, or mixtures of these gases shall not communicate with anesthetizing locations or storage locations for flammable anesthetizing agents.</p> <p>c. Enclosures for supply systems shall be provided with doors or gates that can be locked.</p> <p>d. Ordinary electrical wall fixtures in supply rooms shall be installed in fixed locations not less than 5 ft (1.5 m) above the floor to avoid physical damage.</p> <p>e. Where enclosures (interior or exterior) for supply systems are located near sources of heat, such as furnaces, incinerators, or boiler rooms, they shall be of construction that protects cylinders from reaching temperatures exceeding 130°F (54°C). Open electrical conductors and transformers shall not be located in close proximity to enclosures. Such enclosures shall not be located adjacent to storage tanks for flammable or combustible liquids.</p> <p>f. Smoking shall be prohibited in supply system enclosures.</p> <p>g. Heating shall be by steam, hot water, or other indirect means. Cylinder temperatures shall not exceed 130°F (54°C).</p> <p>(b) Additional Storage Requirements for Nonflammable Gases Greater Than 3000 ft<sup>3</sup> (85 m<sup>3</sup>).</p> <p>1. Oxygen supply systems or storage locations having a total capacity of more than 20,000 ft<sup>3</sup> (566 m<sup>3</sup>) (NTP), including unconnected reserves on hand at the site, shall comply with NFPA 50, Standard for Bulk Oxygen Systems at Consumer Sites.</p> <p>2. Nitrous oxide supply systems or storage locations having a total capacity of 3200 lb (1452 kg) [28,000 ft<sup>3</sup> (793 m<sup>3</sup>) (NTP)] or more, including unconnected reserves on hand at the site, shall comply with CGA Pamphlet G-8.1,</p>	K 076		

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K 076	Continued From page 22 Standard for the Installation of Nitrous Oxide Systems at Consumer Sites. 3. The walls, floors, and ceilings of locations for supply systems of more than 3000 ft <sup>3</sup> (85 m <sup>3</sup> ) total capacity (connected and in storage) separating the supply system location from other occupancies in a building shall have a fire resistance rating of at least 1 hour. This shall also apply to a common wall or walls of a supply system location attached to a building having other occupancy. 4. Locations for supply systems of more than 3000 ft <sup>3</sup> (85 m <sup>3</sup> ) total capacity (connected and in storage) shall be vented to the outside by a dedicated mechanical ventilation system or by natural venting. If natural venting is used, the vent opening or openings shall be a minimum of 72 in.2 (0.05 m <sup>2</sup> ) in total free area. (c) Storage Requirements for Nonflammable Gases Less Than 3000 ft <sup>3</sup> (85 m <sup>3</sup> ). Doors to such locations shall be provided with louvered openings having a minimum of 72 in.2 (0.05 m <sup>2</sup> ) in total free area. Where the location of the supply system door opens onto an exit access corridor, louvered openings shall not be used, and the requirements of 4-3.1.1.2(b)3 and 4 and the dedicated mechanical ventilation system required in 4-3.1.1.2(b)4 shall be complied with.	K 076		
K 147 SS=F	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 wiring was in	K 147	Please see p. 24	

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K 147	<p>Continued From page 23</p> <p>accordance with the National Electrical Code. The deficient practice affected four of eleven smoke compartments, 25 residents, staff, and visitors on the date of survey. The facility is licensed for 98 SNF/NF beds with a census of 68 on the day of survey.</p> <p>Findings include:</p> <p>1.) During the facility tour on June 17, 2015 at approximately 11:30 AM, observation of the dish room in the kitchen area revealed open electrical receptacle boxes with exposed live wiring from two locations along the wall. When asked, the Maintenance Supervisor stated that he was unaware of the live wires</p> <p>2.) During the facility tour on June 17, 2015 at approximately 10:00 AM, observation of the smoke barrier wall above the suspended ceiling located near room #12 revealed an open electric receptacle box with exposed live wiring. When asked, the Maintenance Supervisor stated they were unaware of the cover plates missing.</p> <p>3.) During the facility tour on June 17, 2015 at approximately 3:00 PM, observation revealed a microwave plugged into a relocatable power tap in the Maintenance/Housekeeping office. When asked, the maintenance supervisor stated they were unaware the microwave was plugged in a relocatable power tap.</p> <p>4.) During the facility tour on June 17, 2015 at approximately 3:00 PM, observation revealed a oxygen concentrator and a nebulizer plugged into a relocatable power tap in room 304. When asked, the maintenance supervisor stated they were unaware the medical equipment was</p>	K 147	<p><b>Corrective Action:</b></p> <ol style="list-style-type: none"> <li>1. Electrical receptacle box in Dish Room covered with appropriate cover plate. <b>Note:</b> ESS WAS aware of the exposed wires due to having to move some equipment to repair the floor in that area. The wires were NOT "live" as indicated in 2567. The ESS had "Lock-out Tag-out" in place at the electrical panel. The two circuits for the wires exposed had been turned off at that electrical panel.</li> <li>2. Open receptacle box identified in 2567 near resident room #12 has been covered with appropriate cover.</li> <li>3. Relocatable Power Tap (RPT) in Maintenance/Housekeeping office has been removed</li> <li>4. Equipment in resident room #304 that was plugged into RPT was plugged into electrical receptacle during survey. Also, an additional electrical receptacle has been installed in this resident's room. <b>Note:</b> ESS has been auditing this resident's room on a weekly basis for compliance regarding the RPT as family, visitors, and staff would occasionally move items plugged into wall to RPT, at the resident's insistence. ESS would move these items back and inservice staff, family, and visitors. This is why ESS may not have been "aware" that items had been plugged into RPT at the time of survey.</li> </ol> <p style="text-align: right;">Continued on p. 25</p>	

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K 147	Continued From page 24 plugged into a relocatable power tap.  Actual NFPA standard:  NFPA 70 National Electrical Code 1999 Edition ARTICLE 406 Receptacles, Cord Connectors, and Attachment Plugs (Caps) 406.5 Receptacle Faceplates (Cover Plates). Receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface.  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 evidenced by listing or labeling. 2. Mechanical strength and durability, including, for parts designed to enclose and protect other equipment, the adequacy of the protection thus provided 3. Wire-bending and connection space 4. Electrical insulation 5. Heating effects under normal conditions of use and also under abnormal conditions likely to arise in service 6. Arcing effects 7. Classification by type, size, voltage, current capacity, and specific use 8. Other factors that contribute to the practical safeguarding of persons using or likely to come in	K 147	<b>Identification:</b> All residents are identified as possibly being affected by this deficiency.  <b>Systemic Changes:</b> 1. ESS to continue to monthly audit electrical receptacles in the facility and for usage of RPT to ensure compliance 2. Staff inserviced regarding reporting issues with electrical receptacles to ESS. 3. Staff inserviced regarding policy for pertaining to use of RPT in the facility.  <b>Monitor:</b> Administrator / IDT Designee to review monthly audits for compliance. Audits to be completed at the following frequencies: 1. Monthly for 3 (three) months. 2. Quarterly for six (6) months.	7/22/2015

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K 147	Continued From page 25 contact with the equipment (b) Installation and Use. Listed or labeled equipment shall be installed and used in accordance with any instructions included in the listing or labeling. See UL listings: XBYS Guide Information XBZN2 Guide Information	K 147			