



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

March 19, 2015

Mark Barglof, Administrator
Avamere Transitional Care & Rehabilitation-- Boise
1001 South Hilton Street
Boise, ID 83705-1925

Provider #: 135077

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Mr. Barglof:

On **March 9, 2015**, a Facility Fire Safety and Construction survey was conducted at **Avamere Transitional Care & Rehab - Boise** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. Please provide **ONLY ONE** completion date for each federal and state tag in column (X5) Completion Date to signify when you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on 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.

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Your Plan of Correction (PoC) for the deficiencies must be submitted by **April 1, 2015**. Failure to submit an acceptable PoC by **April 1, 2015**, may result in the imposition of civil monetary penalties by **April 21, 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 **April 13, 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 **April 13, 2015**. A change in the seriousness of the deficiencies on **April 13, 2015**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **April 13, 2015**, includes the following:

Denial of payment for new admissions effective **June 9, 2015**.
42 CFR §488.417(a)

If you do not achieve substantial compliance within three (3) months after the last day of the

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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 **September 9, 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 **March 9, 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>

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

BFS Letters (06/30/11)

Mark Barglof, Administrator

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

This request must be received by **April 1, 2015**. If your request for informal dispute resolution is received after **April 1, 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,

A handwritten signature in black ink, appearing to be 'MP', followed by a long horizontal line extending to the right.

Mark P. Grimes, Supervisor
Facility Fire Safety and Construction

MPG/lj
Enclosures

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

Printed: 03/17/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135077	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 03/09/2015
NAME OF PROVIDER OR SUPPLIER AVAMERE TRANSITIONAL CARE & REHAB - B			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The facility construction is Type V(111) and was built in 1978. It is fully sprinklered with a complete fire alarm/smoke detection system including smoke detection in sleeping rooms. The facility is currently licensed for 111 SNF beds. The following deficiencies were cited during the annual fire/life safety survey conducted on March 9, 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: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	K 000	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Avamere Transitional Care and Rehab - Boise, does not admit that the deficiencies listed on Form CMS-2567 exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.	
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that sprinklers were maintained free of paint and obstructions such as lint. Failure to keep sprinklers clear of paint and obstructions could result in lack of system performance during a fire. This deficient practice affected 52 residents, staff and visitors in 3 of 4 smoke compartments. The facility is licensed for 111 SNF/NF beds and had a census of 68 on the day of the survey.	K 062	This Plan of Correction constitutes our allegation of compliance.	

RECEIVED

APR - 2 2015

FACILITY STANDARDS

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

TITLE

(X6) DATE

Michael Burbank

Administrator

3-31-15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 062	<p>Continued From page 1</p> <p>Findings include:</p> <p>During the facility tour conducted on March 9, 2015 from 10:00 AM to 3:00 PM, observation of sprinkler pendants found the following locations had sprinklers with non-factory applied paint or overspray: Front entrance—Lobby (3) Corridor outside of the Kitchen (1) Corridor outside Central Supply (1) 200 wing (3) Laundry room had three "loaded" heads; sprinkler heads filled with lint.</p> <p>Based on the quantity found in multiple locations, the condition was deemed widespread and further documentation was unnecessary.</p> <p>When asked, the Maintenance Engineer stated he had not been aware of the painted or loaded heads and that no recent painting had been conducted in the facility.</p> <p>Actual NFPA standard:</p> <p>2-2 Inspection. 2-2.1 Sprinklers. 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. 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</p>	K 062	<p>Replaced all identified sprinkler heads that were found to have non-factory applied paint or overspray and applied compressed air to clean the "loaded" laundry room sprinkler heads.</p> <p>Inspected all sprinkler heads to ensure a reliable operating condition. Any found to not be free of paint or "loaded" to be replaced.</p> <p>When future remodeling/painting is performed in the facility, sprinkler heads will be covered and taped off to prevent paint overspray. Sprinkler head inspection will be added to the Maintenance Engineer's monthly preventative maintenance rounds.</p> <p>Sprinkler head inspections will be added to our safety inspection worksheet and reported to the safety committee for one quarter.</p>	April 10, 2015

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K 062	Continued From page 2. are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown.	K 062		
K 072 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>This Standard is not met as evidenced by: Based on observation and operational testing, the facility failed to ensure that means of egress were free of impediments at all times. Failure to provide doors with an instant means of egress could inhibit safe evacuation during an emergency. This deficient practice affected staff and vendors on the date of the survey. The facility is licensed for 111 SNF/NF beds and had a census of 68 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on March 9, 2015 from 12:30 PM to 2:00 PM, observation and operational testing of Kitchen doors revealed that the main door from the Kitchen into the corridor was equipped with a deadbolt and keyed locking arrangement and the door of the dry storage was equipped with a hasp and padlock that prevented exiting from the egress side.</p> <p>Actual NFPA standard: 7.1.10 Means of Egress Reliability.</p>	K 072	<p>The keyed locking handle arrangement on the main door from the kitchen into the corridor was removed. The hasp and padlock on the door of the dry storage area was removed.</p> <p>Inspected all doors to ensure an instant means of egress was present. Any door found to be operable with more than one releasing operation, the additional impediment was removed.</p> <p>No additional releasing operation mechanism will be installed on any door in the facility without first receiving approval from the Maintenance Engineer and Administrator.</p> <p>Door inspections will be added to our safety inspection worksheet and reported to the safety committee for one quarter.</p>	April 10, 2015

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K 072	<p>Continued From page 3</p> <p>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.</p> <p>7.2.1.5 Locks, Latches, and Alarm Devices. 7.2.1.5.1 Doors shall be arranged to be opened readily from the egress side whenever the building is occupied. Locks, if provided, shall not require the use of a key, a tool, or special knowledge or effort for operation from the egress side. Exception No. 1: This requirement shall not apply where otherwise provided in Chapters 18 through 23. Exception No. 2: Exterior doors shall be permitted to have key-operated locks from the egress side, provided that the following criteria are met: (a) Permission to use this exception is provided in Chapters 12 through 42 for the specific occupancy. (b) On or adjacent to the door, there is a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high on a contrasting background that reads as follows: THIS DOOR TO REMAIN UNLOCKED WHEN THE BUILDING IS OCCUPIED (c) The locking device is of a type that is readily distinguishable as locked. (d) A key is immediately available to any occupant inside the building when it is locked. Exception No. 2 shall be permitted to be revoked by the authority having jurisdiction for cause. Exception No. 3: Where permitted in Chapters 12 through 42, key operation shall be permitted, provided that the key cannot be removed when the door is locked from the side from which egress is to be made.</p>	K 072		

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K 072	Continued From page 4 7.2.1.5.4* A latch or other fastening device on a door shall be provided with a releasing device having an obvious method of operation and that is readily operated under all lighting conditions. The releasing mechanism for any latch shall be located not less than 34 in. (86 cm), and not more than 48 in. (122 cm), above the finished floor. Doors shall be operable with not more than one releasing operation. Exception No. 1*: Egress doors from individual living units and guest rooms of residential occupancies shall be permitted to be provided with devices that require not more than one additional releasing operation, provided that such device is operable from the inside without the use of a key or tool and is mounted at a height not exceeding 48 in. (122 cm) above the finished floor. Existing security devices shall be permitted to have two additional releasing operations. Existing security devices other than automatic latching devices shall not be located more than 60 in. (152 cm) above the finished floor. Automatic latching devices shall not be located more than 48 in. (122 cm) above the finished floor. Exception No. 2: The minimum mounting height for the releasing mechanism shall not be applicable to existing installations.	K 072		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144		

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K 144	Continued From page 5 This Standard is not met as evidenced by: Based on record review and interview, the facility failed to document generator load testing or transfer time in accordance with NFPA 110. Failure to document results of load testing and transfer time provides no evidence for completion of generator testing under load and time needed for full transfer to emergency power potentially resulting in possible non-performance when needed. This deficient practice affected 68 residents, staff and visitors on the date of the survey. The facility is licensed for 111 SNF/NF beds and had a census of 68 on the day of the survey. Findings include: 1) During record review conducted on March 9, 2015 from 9:00 AM to 10:00 AM, review of facility generator logs from December 4, 2013 to February 25, 2015 found the logs were not completed and did not indicate any method of a load test being performed under applicable guidelines. In addition, no record of the transfer time of the generator was indicated in the reviewed logs. Review of the service log performed by the vendor associated with the emergency generator found no documentation the generator was exercised under load. 2) During record review conducted on March 9, 2015 from 9:00 AM to 10:00 AM, no record of the generator testing was made available for the week of March 1, 2015 to March 7, 2015. When interviewed, the Maintenance Engineer	K 144	Generator was load tested for 30 minutes and transfer time was documented on the service log. Generator load testing to be conducted monthly for a minimum of 30 minutes. The generator service log will be updated to include results of load testing and transfer time needed for full transfer to emergency power. Service log will include which items have met or have failed to meet the performance requirements. Maintenance Engineer will meet with approved generator vendor on scheduled testing date to review service log and generator testing documentation for service performed that day. Failed measures will be corrected or scheduled for correction and records will be obtained to validate correction. Monthly generator service logs and records will be presented to the safety committee by the Maintenance Engineer for review and confirmation of proper load testing and transfer time and service documentation for one quarter.	April 10, 2015

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K 144	<p>Continued From page 6</p> <p>stated he was not aware of the requirement to document the transfer time of the EES, nor of specific methods required to adequately test the generator under load. He further stated that he was certain an inspection of the generator had been done during the first week in March, but wasn't sure why the log was not with his records.</p> <p>Actual NFPA standard:</p> <p>NFPA 99</p> <p>3-4.4.1 Maintenance and Testing of Essential Electrical System.</p> <p>3-4.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches.</p> <p>(a) Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-4.3.1. Maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6.</p> <p>(b) Inspection and Testing.</p> <p>1. * Test Criteria. Generator sets shall be tested twelve (12) times a year with testing intervals between not less than 20 days or exceeding 40 days. Generator sets serving emergency and equipment systems shall be in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6.</p> <p>2. Test Conditions. The scheduled test under load conditions shall include a complete simulated cold start and appropriate automatic and manual transfer of all essential electrical system loads.</p> <p>3. Test Personnel. The scheduled tests shall be</p>	K 144		

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K 144	<p>Continued From page 7</p> <p>conducted by competent personnel. The tests are needed to keep the machines ready to function and, in addition, serve to detect causes of malfunction and to train personnel in operating procedures.</p> <p>3-3.4.3 Recordkeeping. 3-3.4.3.1* General. A record shall be maintained of the tests required by this chapter and associated repairs or modification. At a minimum, this record shall contain the date, the rooms or areas tested, and an indication of which items have met or have failed to meet the performance requirements of this chapter.</p> <p>NFPA 110 Chapter 6 6-4 Operational Inspection and Testing. 6-4.1* Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly. Exception: If the generator set is used for standby power or for peak load shaving, such use shall be recorded and shall be permitted to be substituted for scheduled operations and testing of the generator set, provided the appropriate data are recorded. 6-4.2* Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (a) Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating (b) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer</p>	K 144			

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K 144	Continued From page 8 The date and time of day for required testing shall be decided by the owner, based on facility operations.	K 144		
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