



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 Eklar Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

July 7, 2015

Gerald Bosen, Administrator
Kindred Nursing & Rehabilitation-- Weiser
331 East Park Street
Weiser, ID 83672-2053

Provider #: 135010

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

Dear Mr. Bosen:

On **June 24, 2015**, a Facility Fire Safety and Construction survey was conducted at **Kindred Nursing & Rehabilitation - Weiser** 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 20, 2015**. Failure to submit an acceptable PoC by **July 20, 2015**, may result in the imposition of civil monetary penalties by **August 8, 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 29, 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 29, 2015**. A change in the seriousness of the deficiencies on **July 29, 2015**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **July 29, 2015**, includes the following:

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Denial of payment for new admissions effective **September 24, 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 24, 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 24, 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 §488.33I, 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 20, 2015**. If your request for informal dispute resolution is received after **July 20, 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 read 'Mark P. Grimes', with a long horizontal flourish 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: 07/06/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135010	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 06/24/2015
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING & REHABILITATION - WEISER			STREET ADDRESS, CITY, STATE, ZIP CODE 331 EAST PARK STREET WEISER, ID 83672	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The facility is a single story, type V(111) construction with a partial basement beneath the kitchen. The facility was constructed in 1964, is fully sprinklered and has partial smoke detection coverage. Currently, the facility is licensed for 76 SNF/NF beds. The following deficiencies were cited during the annual fire/life safety survey conducted on June 24, 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, Kindred Nursing and Rehabilitation - Weiser does not admit that the deficiencies listed on the CMS Form 2567L 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 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by:	K 029	K 029 Environment Specific Correction 1. The pocket doors from the main kitchen will be removed and a single self latching fire door will be installed. This door will be 48 inches wide and will be equipped with passage lock that will be able to be manipulated with single function. The door will also be equipped with electromagnetic hold open wired to our fire alarm panel.	

RECEIVED

JUL 20 2015

FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Sam Burbank* TITLE **Executive Director** (X6) DATE **7/18/15**

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 029	<p>Continued From page 1</p> <p>Based on observation, operational testing and interview, the facility failed to ensure hazardous areas open to the corridors were protected with self-closing doors. Failure to provide self-closing doors to hazardous areas would allow smoke and dangerous gases to pass freely into corridors affecting egress during a fire. This deficient practice affected 18 residents, staff and visitors on the date of the survey. The facility is licensed for 76 SNF/NF beds and had a census of 33 on the day of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on June 24, 2015 from 1:30 PM to 3:00 PM; observation and operational testing of the main doors into the Kitchen from the dining hall revealed they were not equipped to self-close. Further inspection found they were equipped with a chain-style lock for securing them when not in use (See K-tag 072). These doors were found to open into the main dining hall and adjoining corridor system.</p> <p>When asked, the Maintenance Supervisor stated he was unaware that these doors were required to self-close, or that the chain latch was not allowed.</p> <p>2) During the facility tour conducted on June 24, 2015 from 10:30 AM to 3:00 PM, observation and operational testing of the doors into the Housekeeping Storage areas abutting the main Laundry and the Social Services office found they housed chemicals, combustible paper products and measured approximately eight feet by eight feet (64 square feet) in size.</p> <p>3) During the facility tour conducted on June 24,</p>	K 029	<p>2. The Housekeeping storage areas are now equipped with self closing doors. Room 224 has been equipped with a self closing door while it is being used for storage.</p> <p>3. The Staff Development Office and Business Office have been cleaned and boxes and loose records have been removed or placed in closed file cabinets. These Offices are no longer posing a hazard greater than normal occupancy</p> <p>Center System and Monitoring</p> <p>The maintenance supervisor is responsible to ensure all doors, office space, and storage areas meet safety standards. He will check each door quarterly as outlined in the facilities maintenance program and to ensure compliance</p> <p>Compliance will be monitored thru the facilities preventative maintenance program. Any issue noted and will be brought to the attention of the Executive Director and discussed in the Performance Improvement meeting as needed. <i>(Due to the complex nature of the kitchen door project we are asking for a waiver of the below marked completion date for this project. All other projects will be completed by the below stated date.)</i></p> <p>Date of Completion: July 29, 2015</p> <p><i>REQUEST FOR EXTENSION UNTIL 9/15/15 PENDING APPROVAL (7/28/15 SB)</i></p>	

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K 029	<p>Continued From page 2</p> <p>2015 from 1:30 PM to 3:00 PM, observation and operational testing of the door into room 224 found it was not equipped to self-close. Further investigation found the room had recently been converted to storage and measured approximately ten feet by twelve feet (120 square feet). Interview of the Maintenance Supervisor found the room had been recently converted to house overflow storage of beds, mattresses and equipment.</p> <p>4) During the facility tour conducted on June 24, 2015 from 10:30 AM to 3:00 PM, observation and operational testing of the doors into the Staff Development office and the Buisness Office abutting room 100 found they were not equipped to self-close. Both offices housed boxed and loose records storage, measuring from eight feet by eight feet (64 square feet) to ten feet by ten feet (100 square feet). When asked, the Maintenance Supervisor stated he was not aware these doors were required to self-close.</p> <p>Actual NFPA standard:</p> <p>3.3.13.2 Area, Hazardous. An area of a structure or building that poses a degree of hazard greater than that normal to the general occupancy of the building or structure, such as areas used for the storage or use of combustibles or flammables; toxic, noxious, or corrosive materials; or heat-producing appliances.</p> <p>19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1.</p>	K 029		

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K 029	Continued From page 3 The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029			
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	K 062	K 062 Environment Specific Correction The facility contracted with an outside sprinkler company to come into the facility to come and identify the type of antifreeze used in our fire sprinkler system. Further they will mark/label installation placards on all three loops with the percentage of		

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K 062	<p>Continued From page 4</p> <p>This STANDARD is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure that sprinkler systems were maintained in accordance with NFPA 25 and NFPA 13. Failure to keep sprinkler systems maintained could hinder performance during a fire. This deficient practice affected 33 residents, staff and visitors on the date of the survey. The facility is licensed for 76 SNF/NF beds and had a census of 33 on the day of the survey.</p> <p>Findings include:</p> <p>1) During record review conducted on June 24, 2015 from 9:30 AM to 10:30 AM, examination of the fire suppression inspection reports found no information indicating the type or percentage of antifreeze solution installed in the three (3) anti-freeze loops of the wet sprinkler system.</p> <p>2) During the facility tour conducted on June 24, 2015 from 1:30 PM to 3:00 PM, observation of the installation placards and annual inspection tags located on the three (3) anti-freeze loops, found the systems were not identified for the type of anti-freeze solution in the system and were not labeled with the percentage of solution installed. When asked, the Maintenance Supervisor stated he was not aware of the requirement for testing anti-freeze systems by percentage, or the requirement of labeling the type of anti-freeze installed.</p> <p>3) During the facility tour conducted on June 24, 2015 from 1:30 PM to 3:00 PM, observation of sprinklers located in the Kitchen and the Medical records room found two corroded sprinklers in the Kitchen and one painted sprinkler in Medical</p>	K 062	<p>solution used. The maintenance supervisor checked all fire sprinklers in the facility for corrosion, foreign materials, paint, and other issues and found no other issues. This same company mentioned above will also replace the sprinklers in the kitchen and Medical records office.</p> <p>Center System and Monitoring</p> <p>The contracted sprinkler company will check all sprinklers in the facility for corrosion, foreign materials, paint, and other during the quarterly inspections. Any problems found will be fixed and will be brought to the attention of the Executive Director and discussed in the Performance Improvement meeting as needed.</p> <p>Date of Completion: July 29, 2015</p>		

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K 062	<p>Continued From page 5 Records.</p> <p>Actual NFPA standard:</p> <p>Findings 1 & 2: NFPA 13 4-5 Antifreeze Systems.</p> <p>4-5.1* Where Used. The use of antifreeze solutions shall be in conformity with state and local health regulations.</p> <p>4-5.2* Antifreeze Solutions. 4-5.2.1 Where sprinkler systems are supplied by potable water connections, the use of antifreeze solutions other than water solutions of pure glycerine (C.P. or U.S.P. 96.5 percent grade) or propylene glycol shall not be permitted. Suitable glycerine-water and propylene glycol-water mixtures are shown in Table 4-5.2.1.</p> <p>Chapter 12 System Inspection, Testing, and Maintenance</p> <p>12-1* General. A sprinkler system installed in accordance with this standard shall be properly inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, to provide at least the same level of performance and protection as designed.</p> <p>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</p>	K 062		

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K 062	Continued From page 6 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).] Finding 3: NFPA 25 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 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:	K 064	K 064 Environment Specific Correction All fire extinguishers in the hallways (totaling 6) will be replaced with extinguishers that do not measure more than 60 inches from the floor. The Maintenance	

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K 064	<p>Continued From page 7</p> <p>Based on observation, the facility failed to ensure fire extinguishers were installed in accordance with NFPA 10. Failure to mount fire extinguishers at the proper height could prevent the ability to use them in the event of a fire. This deficient practice affected 33 residents, staff and visitors on the date of the survey. The facility is licensed for 76 SNF/NF beds and had a census of 33 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on June 24, 2015 from 10:30 AM to 3:00 PM, observation of all fire extinguishers installed in the facility found the top of the fire extinguisher measured 64 inches from the floor.</p> <p>Actual NFPA standard:</p> <p>NFPA 10 1-6.10 Fire extinguishers having a gross weight not exceeding 40 lb (18.14 kg) shall be installed so that the top of the fire extinguisher is not more than 5 ft (1.53 m) above the floor. Fire extinguishers having a gross weight greater than 40 lb (18.14 kg) (except wheeled types) shall be so installed that the top of the fire extinguisher is not more than 3 1/2 ft (1.07 m) above the floor. In no case shall the clearance between the bottom of the fire extinguisher and the floor be less than 4 in. (10.2 cm).</p>	K 064	<p>Supervisor also checked all other extinguishers in the facility and found them to be less than 40 pounds in weight and none were at a level higher than 60 inches.</p> <p>Center System and Monitoring</p> <p>The maintenance supervisor will monitor all fire extinguishers on a monthly basis as outlined in the facilities maintenance program and to ensure that they are placed within the proper level for staff to use if the need were to arise. If there is any concerns the Executive Director will be notified immediately. All issues will be addressed and fixed as needed. All concerns brought to the Executive Director will discussed in the monthly Performance Improvement meeting as needed.</p> <p>Date of Completion: July, 29, 2015</p>		