



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

TAMARA PRISOCK – ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

October 8, 2015

Todd "Shane" Bell, Administrator
Kindred Nursing & Rehabilitation-- Nampa
404 North Horton Street
Nampa, ID 83651-6541

Provider #: 135019

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

Dear Mr. Bell:

On **October 1, 2015**, a Facility Fire Safety and Construction survey was conducted at **Kindred Nursing & Rehabilitation - Nampa** 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 one that comprises a pattern 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

Todd "Shane" Bell, Administrator
October 8, 2015
Page 2 of 4

you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office. If a State Form with deficiencies was issued, it should be signed, dated and returned along with the CMS-2567 Form.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **October 21, 2015**. Failure to submit an acceptable PoC by **October 21, 2015**, may result in the imposition of civil monetary penalties by **November 10, 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 **November 5, 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 **November 5, 2015**. A change in the seriousness of the deficiencies on **November 5, 2015**, may result in a change in the remedy.

Todd "Shane" Bell, Administrator
October 8, 2015
Page 3 of 4

The remedy, which will be recommended if substantial compliance has not been achieved by **November 5, 2015**, includes the following:

Denial of payment for new admissions effective **January 1, 2016**.
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 **April 1, 2016**, 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 **October 1, 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:

Todd "Shane" Bell, Administrator
October 8, 2015
Page 4 of 4

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

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

BFS Letters (06/30/11).

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

This request must be received by **October 21, 2015**. If your request for informal dispute resolution is received after **October 21, 2015**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



Mark P. Grimes, Supervisor
Facility Fire Safety and Construction

MPG/lj
Enclosures

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

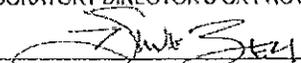
Printed: 10/06/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135019	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2015
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NAME OF PROVIDER OR SUPPLIER KINDRED NURSING & REHABILITATION - NANA	STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH HORTON STREET NAMPA, ID 83651
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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	<p>INITIAL COMMENTS</p> <p>The facility is a single story Type V (III) building built in 1959; an automatic fire sprinkler system was installed in 1973 as a retrofit and a new fire alarm/smoke detection system was installed in 2002. There had been an addition to the building in 1962. A remodel and extensions of A & B wing occurred in 1995 with a rehabilitation wing added in October 1995. The current rehab wing was remodeled extensively in 2006. The facility is currently licensed for 100 beds and had a census of 64 on the day of the survey.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on October 1, 2015. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.</p> <p>The survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	K 000	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Nampa Care Center does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The center reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.</p>	
K 062 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure sprinkler systems were maintained in accordance with NFPA 25. Failure to maintain sprinkler systems could result in lack</p>	K 062	<p>K 062</p> <p>Facility System</p> <p>Sprinklers throughout facility were checked. Two sprinklers in Kitchen were replaced and 2 sprinkler heads in Dietary office were replaced. We purchased 6 additional quick response sprinkler heads to be stored in the riser room to be used as spares.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE EXECUTIVE DIRECTOR	(X6) DATE 10/30/15
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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 062	<p>Continued From page 1 of suppression during a fire. This deficient practice affected staff and visitors on the date of the survey. The facility is licensed for 100 SNF/NF beds and had a census of 66 on the day of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on October 1, 2015 from 10:45 AM to 3:30 PM, observation of spinklers in the Kitchen revealed two (2) heads in the pantry/dry storage and two (2) heads in the Dietician office had non-factory applied paint on the pendants.</p> <p>2) During the facility tour conducted on October 1, 2015 from 10:45 AM to 3:30 PM, observation of the riser room spare sprinkler box revealed the box only contained three (3) spare sprinklers. Interview of the Maintenance Suprevisor indicated he was not aware of the lack of spare heads.</p> <p>Actual NFPA standard:</p> <p>Finding 1</p> <p>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</p>	K 062	<p>Monitor Maintenance Director will monitor fire sprinklers for paint. All painting projects must be preapproved by maintenance director and then checked by maintenance director.</p> <p>Date of Compliance October 21, 2015</p>	

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K 062	Continued From page 2 each scheduled shutdown. Finding 2 NFPA 25 2-4.1.4 A supply of at least six spare sprinklers shall be stored in a cabinet on the premises for replacement purposes. The stock of spare sprinklers shall be proportionally representative of the types and temperature ratings of the system sprinklers. A minimum of two sprinklers of each type and temperature rating shall be provided. The cabinet shall be so located that it will not be exposed to moisture, dust, corrosion, or a temperature exceeding 100°F (38°C). Exception: Where dry sprinklers of different lengths are installed, spare dry sprinklers shall not be required, provided that a means of returning the system to service is furnished. 2-4.1.5 The stock of spare sprinklers shall be as follows: (a) For protected facilities having under 300 sprinklers -no fewer than 6 sprinklers (b) For protected facilities having 300 to 1000 sprinklers -no fewer than 12 sprinklers (c) For protected facilities having over 1000 sprinklers -no fewer than 24 sprinklers	K 062		
K 064 SS=E	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 Facility System Maintenance supervisor checked height of extinguisher throughout facility and replaced fire extinguishers on 100 hall that were outside rooms 117 and 109 observed to be above 60 inches. Both Fire	

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K 064	<p>Continued From page 3</p> <p>Based on observation and interview, the facility failed to ensure that fire extinguishers were installed in accordance with NFPA 10. Failure to install fire extinguishers properly could inhibit emergency response by staff. This deficient practice affected 8 residents, staff and visitors of the 100 hall on the date of the survey. The facility is licensed for 100 SNF/NF beds and had a census of 66 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on October 1, 2015 from 10:45 AM to 3:30 PM, observation of fire extinguishers installed in the 100 hall found the extinguishers outside rooms 117 and 109 measured over 60 inches to the top of the extinguisher when measured from the floor. The extinguisher at room 117 measured 61-3/4 inches measured from the floor to the top of the extinguisher and the one outside room 109 measured 60-3/4 inches to the top of the extinguisher. When asked, the Maintenance Supervisor stated he was not aware these extinguishers were not mounted at the correct height.</p> <p>Actual NFPA standard:</p> <p>1-6.10 Fire extinguishers having a gross weight not exceeding 40 lb (18.14 kg) shall be installed so that the top of the fire extinguisher is not more than 5 ft (1.53 m) above the floor. Fire extinguishers having a gross weight greater than 40 lb (18.14 kg) (except wheeled types) shall be so installed that the top of the fire extinguisher is not more than 3 1/2 ft (1.07 m) above the floor. In no case shall the clearance between the bottom of the fire extinguisher and the floor be less than</p>	K 064	<p>extinguishers are under 60 inches in height from the floor to the top of the extinguisher.</p> <p>Monitor Maintenance supervisor will monitor the height of extinguishers when doing his monthly fire extinguisher checks</p> <p>Compliance October 21, 2015</p>	

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K 064	Continued From page 4 4 in. (10.2 cm).	K 064		
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, operational testing and interview, the facility failed to ensure that means of egress locking arrangements were available for immediate use during an emergency. Failure to provide instant use of a means of egress could hinder safe evacuation of residents during an emergency. This deficient practice affected staff and visitors on the date of the survey. The facility is licensed for 100 SNF/NF residents and had a census of 66 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on October 1, 2015 from 10:45 AM to 3:30 PM, observation and operational testing of the doors to the Business office, Director of Nursing office and the Maintenance office revealed these doors were equipped with keyed entry locks and keyed deadbolts which required more than a single releasing operation from the egress side.</p> <p>Interview of the Maintenance Supervisor revealed he was not aware of these locking arrangements.</p> <p>Actual NFPA standard:</p>	K 072	<p>K072</p> <p>Facility System</p> <p>Maintenance director checked all doors in facility to ensure that no other doors had a secondary locking mechanism. The throw in the deadbolt locks were removed on the Business Office, Director of Nursing Office and the Maintenance shop. All three doors are single releasing operated from the egress side.</p> <p>Monitor Monthly check on all doors will be conducted by Maintenance director ensuring no secondary locks have been added to any door. No door locks will be added without permission of Maintenance Director.</p> <p>Compliance October 21, 2015</p>	

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K 072	Continued From page 5 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. 7.2 MEANS OF EGRESS COMPONENTS 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 130 SS=D	NFPA 101 MISCELLANEOUS	K 130	K 130	

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K 130	<p>Continued From page 6 OTHER LSC DEFICIENCY NOT ON 2786</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure suppression system manual activation devices free of impediments to instant use during a fire event. Failure to keep manual pull stations free of obstructions could result in staff inability to activate the suppression system if necessary. This deficient practice affected staff and visitors in the Kitchen on the date of the survey. The facility is licensed for 100 SNF/NF beds and had a census of 66 of the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on October 1, 2015 from 10:45 AM to 3:30 PM, observation of the Ansel wet chemical pull station area revealed the pull station was blocked by a meat slicer, preventing access during a fire event.</p> <p>Actual NFPA standard:</p> <p>4.6.12 Maintenance and Testing. 4.6.12.1 Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be continuously maintained in accordance with applicable NFPA requirements or as directed by the authority having jurisdiction.</p>	K 130	<p>Facility System</p> <p>The meat slicer in the kitchen was relocated to another location in the kitchen. The Ansel wet chemical pull station area is now free from any obstruction.</p> <p>Monitor Dietary manager or designee will monitor that the ansel is free of obstruction in daily kitchen rounds.</p> <p>Compliance October 21, 2015</p>	

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K 130	Continued From page 7 NFPA 17A Standard for Wet Chemical Extinguishing Systems 3-2.1.6* A readily accessible means for manual activation shall be located in a path of exit or egress no more than 4 ft (1.2 m) above the floor and shall clearly identify the hazard protected. Exception: Automatic systems protecting common exhaust ducts only shall not require a remote manual actuator.	K 130		
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