



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

November 5, 2015

David Farnes, Administrator
Kindred Nursing & Rehabilitation-- Aspen Park
420 Rowe Street
Moscow, ID 83843-9319

Provider #: 135093

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

Dear Mr. Farnes:

On **October 28, 2015**, a Facility Fire Safety and Construction survey was conducted at **Kindred Nursing & Rehabilitation - Aspen Park** 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

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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 **November 18, 2015**. Failure to submit an acceptable PoC by **November 18, 2015**, may result in the imposition of civil monetary penalties by **December 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 **December 2, 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 **December 2, 2015**. A change in the seriousness of the deficiencies on **December 2, 2015**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **December 2, 2015**, includes the following:

Denial of payment for new admissions effective **January 28, 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 28, 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 28, 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:

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<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:

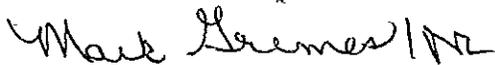
BFS Letters (06/30/11)

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

This request must be received by **November 18, 2015**. If your request for informal dispute resolution is received after **November 18, 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/j
Enclosures

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

Printed: 11/04/2015
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135093 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____ | (X3) DATE SURVEY COMPLETED 10/28/2015 |
|---|--|--|---|--|
| NAME OF PROVIDER OR SUPPLIER KINDRED NURSING & REHAB - ASPEN PARK | | STREET ADDRESS, CITY, STATE, ZIP CODE 420 ROWE STREET MOSCOW, ID 83843 | | |
| (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) building, with two partial basements. The facility is fully sprinklered, with smoke detectors in corridors and open spaces. It was built in 1965 and is currently licensed for 70 SNF/NF beds. The following deficiencies were cited during the annual fire/life safety survey conducted on October 28, 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: Nate Elkins Health Facility Surveyor Facility Fire Safety & Construction | K 000 | <i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> | |
| K 025 SS=E | 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 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 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 | K 025 | K 025 Resident Specific The facility will assure the continuity of smoke/fire barriers to impede the movement of fire or smoke between smoke compartments. The problem of two 2 inch. circular holes identified in the ceiling of the therapy storage room potentially effecting 23 residents will be properly sealed to prevent the passage of smoke. Other Resident An examination of the facility has been made to determine if there any other similar breeches. None have been identified at this time. Systemic Changes Whenever any repairs or construction take | 12/01/2015 |

RECEIVED
NOV 13 2015
FACILITY STANDARDS

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

TITLE

(X6) DATE

David D. [Signature] Executive Director 11/7/15

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 025 | <p>Continued From page 1</p> <p>could allow smoke and dangerous gases to pass freely between smoke compartments affecting egress during a fire event. This deficient practice affected 1 of 4 smoke compartments, 23 residents, staff and visitors on the date of the survey. The facility is licensed for 70 SNF/NF beds with a census of 52 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour on October 28, 2015 at approximately 11:45 AM, observation of the Therapy storage room on the north side of facility revealed two 2 inch circular holes penetrating through the ceiling that were unsealed and would not resist the passage of smoke. When asked, the Maintenance Supervisor stated the facility was unaware of the unsealed penetrations in the ceiling. This finding was acknowledged by the Assistant Administrator and the Director of Nursing at the exit conference.</p> <p>Actual NFPA standard:</p> <p>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</p> | K 025 | <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>place that might disturb a smoke barrier, the vendor will be required to include restoring any breeches as part of the work plan so that the integrity of the smoke barriers will be maintained.</p> <p>Monitoring</p> <p>The maintenance director will inspect fire/smoke barriers on a regular basis per the Kindred Preventative Maintenance Program. Any problems will be addressed and reported to the PI/Safety committee.</p> | |

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| K 025 | Continued From page 2 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 | <i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> | |
| K 029 SS=E | 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: Based on observation, operational testing and interview, the facility failed to ensure that hazardous areas were protected with self-closing | K 029 | K 029 Resident Specific The North hallway storage door will be fixed so that the self closure mechanism will cause the door to completely close as required by the Standard. Other Resident An inspection of other self closing doors in the facility was completed to identify if any other self closing doors were not working properly. None were found. Systemic changes Whenever doors, locks or latches are repaired or replaced, the maintenance | 12/01/2015 |

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| K 029 | <p>Continued From page 3</p> <p>doors. Failure to provide self-closing doors for hazardous areas would allow smoke and dangerous gases to pass freely into corridors hindering egress of occupants during a fire event. This deficient practice affected residents, staff and visitors utilizing the main dining room on the date of the survey. The facility is licensed for 70 SNF/NF beds and had a census of 52 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour on October 28, 2015 at approximately 12:00 PM, observation and operational testing of the North hallway storage room door revealed the door would not completely self-close, leaving an approximately 3/8 inch to 1/2 inch gap between the leading edge and the door frame. When asked, the Maintenance Supervisor stated the facility was unaware of the door not self closing properly. This finding was acknowledged by the Assistant Administrator and the Director of Nursing at the exit conference.</p> <p>Actual NFPA standard: NFPA 101, 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. 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:</p> | K 029 | <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>director will assure that doors with self-closing mechanisms continue to operate and close properly.</p> <p>Monitoring</p> <p>The maintenance director will monitor all doors on regular basis to ensure compliance as per the Kindred Preventative maintenance program. Any variance will be reported to the PI/safety committee.</p> | |

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| K 029 | Continued From page 4 (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. | K 029 | <i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> | 12/01/2015 |
| 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 7.1. 19.2.1 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure delayed egress doors were properly marked with the correct signage. Failure to ensure delayed egress doors are properly marked could confuse occupants during egress of the facility. This deficient practice affected all residents, staff and visitors on the date of the survey. The facility is licensed for 70 SNF/NF beds with a census of 52 on the day of the survey. Findings include: During the facility tour conducted on October 28, | K 038 | K 038 Resident Specific/Other resident/staff and visitors. All delayed egress doors will be properly marked with a sign adjacent to the release device that is readily visible stating "push until alarm sounds, door can be opened in 15 seconds". Systemic Changes N/A Monitor The maintenance director will monitor all delayed egress doors on periodic basis to ensure compliance as per the Kindred Preventative Maintenance program. Any variance noted will be reported to the PI/Safety committee. | |

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| K 038 | <p>Continued From page 5</p> <p>2015 between 10:00 AM and 3:30 PM, it was observed that the majority of the delayed egress doors found throughout the facility were not properly marked with signs adjacent to the release device that was readily visible stating PUSH UNTIL ALARM SOUNDS, DOOR CAN BE OPENED IN 15 SECONDS. When asked, the Director of Nursing and the Assistant Administrator stated the facility was unaware of the signs were missing and acknowledged the finding at the exit conference.</p> <p>Actual NFPA standard: 19.2.2 Means of Egress Components. 19.2.2.1 Components of means of egress shall be limited to the types described in 19.2.2.2 through 19.2.2.10.</p> <p>19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1: Door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. (See 19.1.1.1.5 and 19.2.2.2.5.) Exception No. 2*: Delayed-egress locks complying with 7.2.1.6.1 shall be permitted, provided that not more than one such device is located in any egress path. Exception No. 3: Access-controlled egress doors complying with 7.2.1.6.2 shall be permitted.</p> <p>7.2.1.6.1 Delayed-Egress Locks.</p> | K 038 | <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> | |

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| K 038 | Continued From page 6 Approved, listed, delayed-egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met. (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6. (b) The doors shall unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) * On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS | K 038 | <i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> | 12/01/2015 |
| K 070 SS=E | NFPA 101 LIFE SAFETY CODE STANDARD | K 070 | K 070 | |

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| NAME OF PROVIDER OR SUPPLIER KINDRED NURSING & REHAB - ASPEN PARK | | STREET ADDRESS, CITY, STATE, ZIP CODE 420 ROWE STREET MOSCOW, ID 83843 | | |
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| K 070 | <p>Continued From page 7</p> <p>Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8</p> <p>This Standard is not met as evidenced by: Based upon observation and interview the facility failed to prohibit portable space heating devices. Failure to prohibit portable heating devices posses a significant risk to the the facility due to the history of fires caused by space heaters. This deficient practice affected 6 residents, staff, and visitors using the Family Lounge on the day of survey. The facility is licensed for 70 SNF/NF beds with a census of 52 on the day of survey.</p> <p>Findings include:</p> <p>During the facility tour on October 28, 2015 at approximately 1:30 PM, observation revealed a portable electric/plug in fire place located in the Dining room. This device was observed to be plugged into a wall receptacle and not affixed to a permanent location. When asked, the Director of Nursing and the Assistant Administrator stated the facility was unaware the electric fire place was considered a portable space heater and acknowledged the finding at the exit conference.</p> <p>Actual NFPA Standard:</p> <p>NFPA 101, the Life Safety Code, 2000 Edition</p> <p>19.7.8 Portable Space-Heating Devices. Portable space-heating devices shall be prohibited in all health care occupancies.</p> | K 070 | <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>Specific Residents</p> <p>The portable heating device located in the family lounge that potentially affected six residents on the day of survey has been affixed to a permanent location by being fixed/hard wired into the electrical system.</p> <p>Other residents</p> <p>A review of all facility spaces was conducted and no other portable heating device was found.</p> <p>Systemic Change</p> <p>Anytime that new furnishings or equipment is purchased, the maintenance director will assess to see that they are compliant with applicable regulations and standards.</p> <p>Monitoring</p> <p>The maintenance director will monitor to see that portable space heaters are not brought in and/or used in the facility. Any variance will be reported to the PI/Safety committee.</p> | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135093 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____ | (X3) DATE SURVEY COMPLETED 10/28/2015 |
|--|---|--|--|--|
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| K 070 | Continued From page 8. Exception: Portable space-heating devices shall be permitted to be used in nonsleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C). | K 070 | <i>This Plan of Correction is the center's credible allegation of compliance.</i> | |
| K 076 SS=D | 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 on observation and interview, the facility failed to assure that medical gas cylinders were safely stored in a safe environment. Failure to provide a safe environment for medical gas cylinders could result in physical damage to the cylinders and create a propulsion hazard. This deficient practice affected staff and visitors on the date of survey. The facility had 70 SNF/NF beds with a census of 52 on the day of survey. Findings include: During the facility tour on October 28, 2015 at approximately 10:00 AM, observation of the outside oxygen transfilling room revealed an electrical outlet installed approximately 4 feet 4 inches above the floor. When asked, the Maintenance Supervisor stated the facility was | K 076 | <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> K 076 Specific Resident/Other resident The non-compliant electrical outlet in the oxygen trans-filling room has been removed to comply with the Standard. Systemic Change Upon review there were no other outlets that needed to addressed to comply with the standard. Monitoring No additional monitoring is needed at this time. | 12/01/2015 |

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

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| K 076 | Continued From page 9 unaware the electric outlet was not at the minimum height of 5 feet. This finding was acknowledged by the Assistant Administrator and the Director of Nursing at the exit conference. Actual NFPA Standard: NFPA 99, Sect. 4-3.1.1.2(a)(4) Requires that 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. | K 076 | | |