January 27, 2016

Corwin Lewis, Jr., Administrator
Parke View Rehabilitation & Care Center
2303 Parke Avenue
Burley, ID 83318-2106

Provider #: 135068

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Mr. Lewis, Jr.:

On January 21, 2016, a Facility Fire Safety and Construction survey was conducted at Parke View Rehabilitation & Care Center 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
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 February 9, 2016. Failure to submit an acceptable PoC by February 9, 2016, may result in the imposition of civil monetary penalties by February 29, 2016.

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 February 25, 2016, (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 February 25, 2016. A change in the seriousness of the deficiencies on February 25, 2016, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by February 25, 2016, includes the following:
Corwin Lewis, Jr., Administrator
January 27, 2016
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Denial of payment for new admissions effective April 21, 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 July 21, 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 do 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 January 21, 2016, 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:

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 February 9, 2016. If your request for informal dispute resolution is received after February 9, 2016, 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
The facility is a single story, protected non-combustible building. A new addition was completed in 1998, with cosmetic upgrades to the lobby and administration offices completed in 2015. The original building was constructed in 1963. It is fully sprinklered and has a partial basement with storage, classrooms and maintenance shop. The facility is licensed for 86 NF beds and had a census of 57 on the day of the survey.

The following deficiencies were cited at the above facility during the annual Life Safety Code survey conducted on January 21, 2016. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy and 42 CFR 483.70.

The survey was conducted by:

Sam Burbank
Health Facility Surveyor
Facility Fire Safety & Construction

One hour fire rated construction (with 0 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 hazardous

In response to K 029

Accordian doors separating kitchen from separating area was removed and a wall was constructed. The double doors from the kitchen to the corridor are being connected to the smoke detection system to close when activated. The manual release, hold open mechanisms were removed.

All residents have the potential to be affected by this practice.

(Continued)
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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<tr>
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<tr>
<td>K 028</td>
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<td>K 029</td>
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<td>Review of all partitions from the kitchen will be reviewed for non-smoke resisting barriers. Monthly audits of door closers will be performed by Administrator or designee monthly for 3 months, and quarterly for 2 quarters. The audits will be reviewed monthly by the QAA Committee until it has been determined by the committee that the systems are effective.</td>
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Areas were protected with self-closing doors in accordance with NFPA 101. Failure to provide doors to hazardous areas which would self-close and release upon activation of the smoke detection system could allow smoke and dangerous gases to pass into corridors, hindering evacuation of residents during a fire event. This deficient practice affected 19 residents, staff and visitors in 2 of 5 smoke compartments on the date of the survey. The facility is licensed for 86 SNF/NF beds and had a census of 57 on the day of the survey.

Findings include:

1) During the facility tour conducted on January 21, 2015 from approximately 10:30 AM to 1:30 PM, observation of the main Kitchen revealed an accordion door separating the Kitchen from a sitting area. Inspection of the accordion door revealed it was not equipped to self close and had a gap surrounding the perimeter of approximately one inch.

2) During the facility tour conducted on January 21, 2016 from approximately 10:30 AM to 1:30 PM, observation of the double doors which enter the Kitchen from the south, revealed the self-closing devices installed on the doors were equipped with manual release, hold-open mechanisms. When asked, the Maintenance Supervisor stated she was not aware these hold-open mechanisms should release with the activation of the smoke detection system.

Actual NFPA standard:

Finding 1&2

3.3.13.2 Area, Hazardous.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:** 135068

**X2) MULTIPLE CONSTRUCTION**

A. BUILDING 01 - ENTIRE BUILDING

**B. WING**

**X3) DATE SURVEY COMPLETED:** 01/21/2016

**NAME OF PROVIDER OR SUPPLIER:** PARKE VIEW REHABILITATION & CARE CENT

**STREET ADDRESS, CITY, STATE, ZIP CODE:** 2303 PARKE AVENUE BURLEY, ID 83318

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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.

**19.3.2 Protection from Hazards.**

**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:

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...
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<td>K029</td>
<td>Continued From page 3 than 48 in. (122 cm) above the bottom of the door. Finding 2: 19.2.2.2.6* Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier, or hazardous area enclosure shall be permitted to be held open only by an automatic release device that complies with 7.2.1.8.2. The automatic sprinkler system, if provided, and the fire alarm system, and the systems required by 7.2.1.8.2 shall be arranged to initiate the closing action of all such doors throughout the smoke compartment or throughout the entire facility. 7.2.1.8.2 In any building of low or ordinary hazard contents, as defined in 6.2.2.2 and 6.2.2.3, or where approved by the authority having jurisdiction, doors shall be permitted to be automatic-closing, provided that the following criteria are met: (1) Upon release of the hold-open mechanism, the door becomes self-closing. (2) The release device is designed so that the door instantly releases manually and upon release becomes self-closing, or the door can be readily closed. (3) The automatic releasing mechanism or medium is activated by the operation of approved smoke detectors installed in accordance with the requirements for smoke detectors for door release service in NFPA 72, National Fire Alarm Code®. (4) Upon loss of power to the hold-open device, the hold-open mechanism is released and the door becomes self-closing. (5) The release by means of smoke detection of one door in a stair enclosure results in closing all</td>
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Findings include:

During the review of the facility EPSS records conducted on January 21, 2016 from approximately 8:30 AM to 10:00 AM, inspection records provided revealed weekly inspections, but did not demonstrate the generator had been tested on a monthly basis for thirty minutes at thirty percent of the rated nameplate capacity. In addition, an annual service report provided by the generator vendor indicated the generator would not pass a load bank test.

When asked about the provided documentation, the Maintenance Supervisor stated the generator was run for thirty minutes monthly and documented that timeframe, but not any type of documentation indicating the load achieved.

**K 029**
Continued From page 4
doors serving that stair.

**K 144**
NFPA 101 LIFE SAFETY CODE STANDARD
Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110)
This Standard is not met as evidenced by:
Based on record review and interview, the facility failed to ensure that emergency power supply systems (EPSS) were tested in accordance with NFPA 110. Failure to test EPSS under load could hinder the ability of the system to supply emergency power during extended periods of power loss. This deficient practice affected 57 residents, staff and visitors on the date of the survey. The facility is licensed for 86 SNF/NF beds and had a census of 67 on the day of the survey.

Findings include:

In response to K 144
Generator servicing company to service generator and ensure can carry 30 percent load for 30 minutes. The generator will be tested at 30 percent of load and document results.

All residents have the potential to be affected by this practice.

Monthly generator tests to be completed and recorded with load status at testing. Log to be reviewed by safety committee.

The audits will be reviewed monthly by the QAA Committee until it has been determined by the committee that the systems are effective.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**ID NUMBER:** 135068

**MULTIPLE CONSTRUCTION**

**A. BUILDING 01 - ENTIRE BUILDING**

**DATE SURVEY COMPLETED:** 01/21/2016

**NAME OF PROVIDER OR SUPPLIER:** PARKE VIEW REHABILITATION & CARE CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE:** 2303 PARKE AVENUE, BURLEY, ID 83318

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| K 144  | Continued From page 5  
Actual NFPA standard:  
NFPA 99  
3-4.4.1 Maintenance and Testing of Essential Electrical System.  
3-4.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches.  
(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.  
(b) Inspection and Testing.  
1. * Test Criteria. Generator sets shall be tested twelve (12) times a year with testing intervals between not less than 20 days or exceeding 30 days. Generator sets serving emergency and equipment systems shall be in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6.  
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.  
3. Test Personnel. The scheduled tests shall be 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.  
3-3.4.3 Recordkeeping.  
3-3.4.3.1 General. | K 144 | | | |
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.

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.

The date and time of day for required testing shall be decided by the owner, based on facility operations.