April 13, 2016

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

Provider #: 135077

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Mr. Barglof:

On April 5, 2016, a Facility Fire Safety and Construction survey was conducted at Avamere Transitional Care & Rehab - Boise by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be 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
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 **April 26, 2016**. Failure to submit an acceptable PoC by **April 26, 2016**, may result in the imposition of civil monetary penalties by **May 16, 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 **May 10, 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 **May 10, 2016**. A change in the seriousness of the deficiencies on **May 10, 2016**, may result in a change in the remedy.
The remedy, which will be recommended if substantial compliance has not been achieved by May 10, 2016, includes the following:

Denial of payment for new admissions effective July 5, 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 October 5, 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) 334-5626, 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 April 5, 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 April 26, 2016. If your request for informal dispute resolution is received after April 26, 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
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

<table>
<thead>
<tr>
<th>PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:</th>
<th>MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING</th>
<th>DATE SURVEY COMPLETED</th>
</tr>
</thead>
<tbody>
<tr>
<td>135077</td>
<td>B. WING</td>
<td>04/05/2016</td>
</tr>
</tbody>
</table>

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135077

MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING

B. WING

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>K 000</td>
<td>INITIAL COMMENTS</td>
<td>K 000</td>
<td>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Avamere Transitional Care and Rehab – Boise, does not admit that the deficiency listed on Form CMS-2567 exists, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiency. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. This Plan of Correction constitutes our allegation of compliance.</td>
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<tr>
<td>K 018</td>
<td>NFPA 101 LIFE SAFETY CODE STANDARD</td>
<td>K 018</td>
<td>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3</td>
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</tbody>
</table>

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

Administrator

DATE: 4-25-16

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.
This Standard is not met as evidenced by: Based on observation, operational testing, and interview the facility failed to maintain doors that protect corridor openings. Failure to maintain corridor doors could allow smoke and dangerous gases to pass freely into exit corridors affecting egress. This deficient practice affected 3 of 4 smoke compartments, 39 residents, staff, and visitors on the date of survey. The facility is licensed for 111 SNF/NF beds with a census of 60 on the day of survey.

Findings include:

1.) During the facility tour on April 5, 2016 at approximately 10:30 AM, observation and operational testing of the self-closing corridor door to the conference room revealed the door would not close completely when released from the magnetic hold open device leaving an approximate 1-1/2 inch gap between the leading edge of the door and the door frame.

2.) During the facility tour on April 5, 2016 at approximately 11:00 AM, observation and operational testing of the corridor door to room 214 revealed a 1/2 inch gap between the top of the door and the door frame when closed and latched that would not resist the passage of smoke.

3.) During the facility tour on April 5, 2016 at approximately 11:45 AM, observation and operational testing of the corridor door to room 115 revealed a 1/2 inch gap between the top of the door and the door frame when closed and latched that would not resist the passage of smoke.

When asked about the doors, the Maintenance Director or designee will inspect all doors protecting corridor openings weekly as part of the automated preventative maintenance program.

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Monitoring:
The automated preventative maintenance schedule will be printed each month and reviewed with the QAPI committee. The review will ensure the completion of the required maintenance inspection of the doors protecting corridor openings and any that required adjustment. The review will occur for three months or longer if needed for substantial compliance.
K018  Continued From page 2
Supervisor stated the facility was unaware of the corridor doors not closing properly.

Actual NFPA standard:
19.3.6.3 Corridor Doors.
19.3.6.3.1*
Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors.
Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.
Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke.