June 15, 2016

James Hayes, Administrator
Payette Center
1019 Third Avenue South
Payette, ID 83661-2832

Provider #: 135015

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Mr. Hayes:

On June 6, 2016, a Facility Fire Safety and Construction survey was conducted at Payette 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 June 28, 2016. Failure to submit an acceptable PoC by June 28, 2016, may result in the imposition of civil monetary penalties by July 18, 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 July 11, 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 July 11, 2016. A change in the seriousness of the deficiencies on July 11, 2016, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by July 11, 2016, includes the following:
Denial of payment for new admissions effective September 6, 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 December 6, 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 June 6, 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 **June 28, 2016**. If your request for informal dispute resolution is received after **June 28, 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,

Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/Ij
Enclosures
### Initial Comments

The facility is a single story, type V(111) construction. The facility was originally built in 1961 and is fully sprinklered. The facility is equipped with an EPSS system in accordance with NFPA 110, is fully sprinklered and equipped with automatic fire detection system and manual pull stations. Currently the facility is licensed for 80 SNF/NF beds. The laundry is located in a separately detached building.

The following deficiencies were cited during the annual life safety code survey conducted on June 6, 2016. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Chapter 19, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.

The Survey was conducted by:

Sam Burbank  
Health Facility Surveyor  
Facility Fire Safety & Construction

### Deficiency:

**K029**  
**NFPA 101 LIFE SAFETY CODE STANDARD SS=D**  
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 that hazardous areas were equipped with self-closing doors.

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**Deficiency Statement Ending with an Asterisk:** This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, River Ridge Care and Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.

**K029**  
**Affected:** On 06/08/2016, the door to room 102 was equipped with a self-closing device, by the Maintenance Director.

**Potential:** On or before 06/17/16, the Maintenance Director will audit all rooms in the facility to identify any other rooms requiring a self-closing device.  
On or before 07/30/2016, the Maintenance Director will ensure self-closing devices are installed on the identified rooms and are operational.

**Systemic:** Effective 06/13/2016, any changes in room function will be reviewed by the Maintenance Director for NFPA compliance and reported in the daily inspection meeting. The Administrator will approve proposed changes to door closing devices.

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**Laboratory Director’s or Provider/Supplier Representative’s Signature:**

**Title:**

**Date:** 06/14/2016

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## Summary Statement of Deficiencies

### Findings include:

During the facility tour conducted on June 6, 2016 from approximately 11:30 AM to 4:00 PM, observation of room #102 revealed the room measured approximately twelve feet by twelve feet (144 sf) and had been converted to storage of furniture, mattresses and other equipment such as wheelchairs. Operational testing of the door from the room into the corridor revealed the door was not equipped to self-close.

Interview of the Maintenance Supervisor revealed he was not aware this door was required to self-close.

### Actual NFPA Standard:

- **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.

- **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

### QAPI

Effective 07/01/2016, Room utilization changes will be reported by the Maintenance Director monthly in the QA meeting. The Administrator will be responsible for monitoring and follow-up.
**K 029** Continued From page 2
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-resistant 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 062**

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX 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>
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</table>
| K 029         | Affected
On or before 08/15/2016, during the 5-year fire suppression system inspection, the identified sprinkler loop will be recharged to the correct % of Glycerin by our fire system maintenance contractor.

**Potential**
On 06/09/2016, the other sprinkler loop was audited by the Maintenance Director and identified as a dry system which does not contain antifreeze.

**Systemic**
Beginning 08/15/2016, the fire suppression loop containing antifreeze will be inspected annually for the proper Glycerin% QAPI
Beginning 07/01/2016, results from the annual fire suppression system inspection will be reported the monthly QAPI meeting by the Maintenance Director. The Administrator will be responsible for monitoring and follow-up.

**K 062**

- **NFPA 101 LIFE SAFETY CODE STANDARD SS=F**
- Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically.
- This Standard is not met as evidenced by:

   Based on record review, observation and interview, the facility failed to ensure that sprinkler system installations were maintained in...
K 062 Continued From page 3

accordance with NFPA 25. Failure to maintain sprinkler systems could result in a lack of system performance as designed. This deficient practice affected 26 residents, staff and visitors on the date of the survey. The facility is licensed for 80 SNF/NF beds and had a census of 26 on the day of the survey.

Findings include:

During a review of facility fire suppression system inspection records conducted on June 6, 2016 from approximately 8:30 AM to 11:30 AM, documentation provided for the quarterly and annual sprinkler inspections revealed the type of anti-freeze installed in the fire suppression system was Propylene Glycol and the concentration of anti-freeze installed was over the percentage allowed under NFPA 25.

During the facility tour conducted on June 6, 2016 from approximately 11:30 AM to 4:00 PM, observation of the fire suppression riser revealed the inspection tags attached to the riser indicated the concentration of anti-freeze installed was over the percentage allowed under NFPA 25 at 44.6 percent propylene glycol.

Interview of the Maintenance Supervisor revealed he was not aware the anti-freeze solution was not the correct percentage.

NFPA 25 2-3.4.4* Antifreeze Systems. The freezing point of solutions in antifreeze shall be tested annually by measuring the specific gravity with a hydrometer or refractometer and 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).]

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. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1 This Standard is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure that means of egress were free from impediments. Failure to maintain full instant use of a means of egress could hinder the safe evacuation of residents during an emergency. This deficient practice affected 24 residents, staff and visitors in 3 of 3 smoke compartments on the date of the survey. The facility is licensed for 80 SNF/NF beds and had a census of 26 on the day of the survey.

Findings include:

During the facility tour conducted on June 6, 2016 from 11:30 AM to 4:00 PM, observation of locking arrangements for facility doors found the following doors were equipped with non-single operational locking arrangements that required a key, tool or special knowledge to release from the egress side:

- Beauty Shop
- Social Services office
- Fire Riser room
- Director of Nursing office
- Administrator’s office
- Reception

**K062**
Continued From page 4

**K072**
**NFPA 101 LIFE SAFETY CODE STANDARD**

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. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1 This Standard is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure that means of egress were free from impediments. Failure to maintain full instant use of a means of egress could hinder the safe evacuation of residents during an emergency. This deficient practice affected 24 residents, staff and visitors in 3 of 3 smoke compartments on the date of the survey. The facility is licensed for 80 SNF/NF beds and had a census of 26 on the day of the survey.

Findings include:

During the facility tour conducted on June 6, 2016 from 11:30 AM to 4:00 PM, observation of locking arrangements for facility doors found the following doors were equipped with non-single operational locking arrangements that required a key, tool or special knowledge to release from the egress side:

- Beauty Shop
- Social Services office
- Fire Riser room
- Director of Nursing office
- Administrator’s office
- Reception

**K072**

**Affected**
On or before 07/31/2016, the Maintenance Director will replace the identified door locking arrangements with mechanisms which comply with the NFPA regulations.

**Potential**
On 06/13/2016, all facility doors were audited by the Maintenance Director to identify those which do not comply with the NFPA standard. Those found to be outside the standard will be replaced with mechanisms which comply with the NFPA regulations on or before 07/31/2016."

**Systemic**
Effective 06/13/2016, any changes in room function will be reviewed by the Maintenance Director for NFPA compliance in the daily standup meeting. The Administrator will approve proposed changes to the door latching mechanisms.

**QAPI**
Effective 07/01/2016, Room utilization changes will be reported by the Maintenance Director monthly in the QA meeting. The Administrator will be responsible for monitoring and follow-up.
K 072 Continued From page 5
Conference Room
MDS Coordinator office
Activities office
Room 102

When interviewed, the Maintenance Supervisor stated he was not aware these door locking arrangements were not allowed. Due to the extent and number of locations found, the deficiency was deemed widespread and further documentation was not required.

Actual NFPA standard:
NFPA 101
19.2 MEANS OF EGRESS REQUIREMENTS
19.2.1 General.
Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7.
Exception: As modified by 19.2.2 through 19.2.11.

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.

7.2.1.5 Locks, Latches, and Alarm Devices.
7.2.1.5.1 Doors shall be arranged to be opened readily from the egress side whenever the building is occupied. Locks, if provided, shall not require the use of a key, a tool, or special knowledge or effort for operation from the egress side.

Exception No. 1: This requirement shall not apply where otherwise provided in Chapters 18 through 23.

Exception No. 2: Exterior doors shall be
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<th>K 072</th>
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<td>permitted to have key-operated locks from the egress side, provided that the following criteria are met:</td>
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<tr>
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<td>(a) Permission to use this exception is provided in Chapters 12 through 42 for the specific occupancy.</td>
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<td>(b) On or adjacent to the door, there is a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high on a contrasting background that reads as follows:</td>
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<td></td>
<td><strong>THIS DOOR TO REMAIN UNLOCKED WHEN THE BUILDING IS OCCUPIED</strong></td>
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<td></td>
<td>(c) The locking device is of a type that is readily distinguishable as locked.</td>
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<td></td>
<td>(d) A key is immediately available to any occupant inside the building when it is locked.</td>
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<td></td>
<td>Exception No. 2 shall be permitted to be revoked by the authority having jurisdiction for cause.</td>
</tr>
<tr>
<td></td>
<td>Exception No. 3: Where permitted in Chapters 12 through 42, key operation shall be permitted, provided that the key cannot be removed when the door is locked from the side from which egress is to be made.</td>
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</table>