



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

August 19, 2016

Mark Dudley, Administrator  
Kindred Nursing And Rehabilitation - Weiser  
331 East Park Street  
Weiser, ID 83672-2053

Provider #: 135010

FILE COPY

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

Dear Mr. Dudley:

On **August 8, 2016**, a Facility Fire Safety and Construction survey was conducted at **Kindred Nursing And Rehabilitation - Weiser** 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 an isolated 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 **September 1, 2016**. Failure to submit an acceptable PoC by **September 1, 2016**, may result in the imposition of civil monetary penalties by **September 21, 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. If a State Form was issued as well, it should also be signed, dated and returned.

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 **September 12, 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 **September 12, 2016**. A change in the seriousness of the deficiencies on **September 12, 2016**, 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 **September 12, 2016**, includes the following:

Denial of payment for new admissions effective **November 8, 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 **February 8, 2017**, 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 **August 8, 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:

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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 **September 1, 2016**. If your request for informal dispute resolution is received after **September 1, 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, option 3.

Sincerely,



Nate Elkins, Supervisor  
Facility Fire Safety and Construction

NE/lj  
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135010	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____		(X3) DATE SURVEY COMPLETED  08/08/2016
NAME OF PROVIDER OR SUPPLIER  KINDRED NURSING AND REHABILITATION - WEISER			STREET ADDRESS, CITY, STATE, ZIP CODE 331 EAST PARK STREET WEISER, ID 83672		
(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) construction with a partial basement beneath the kitchen. The facility was constructed in 1964, is fully sprinklered and has partial smoke detection coverage. Currently, the facility is licensed for 76 SNF/NF beds.  The following deficiencies were cited during the annual fire/life safety survey conducted on August 8, 2016. 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:  Linda Chaney Health Facility Surveyor Facility Fire, Safety and Construction  Nate Elkins Supervisor Facility Fire, Safety and Construction	K 000	This Plan of Correction is prepared and submitted as required by law. BY submitting this Plan of Correction, Kindred Nursing and Rehabilitation –Weiser 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 for 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.		
K 017 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Corridors are separated from use areas by walls constructed with at least 1/2 hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to corridor under certain conditions specified in the Code. Gift shops may be	K 017	<b>Corrective Action</b> The hole in wall behind water dispenser in the south hallway across from room 218, has been filled to meet the minimum smoke passage rating of ½ hour.  <b>Other Residents</b> In addition, the remainder of the building was inspected to identify other compromises to the smoke partition. None were found.  <b>Systematic Changes</b> Holes in smoke partitions caused by work by maintenance will be immediately filled.	RECEIVED AUG 31 2016 FACILITY STANDARDS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Mark Dault* TITLE *Executive Director* (X6) DATE *8/29/16*

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.

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

PRINTED: 08/19/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135010	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  08/08/2016
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K 017	<p>Continued From page 1</p> <p>separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2, 19.3.6.4, 19.3.6.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the fire and smoke resistive integrity of the building. Failure to ensure the smoke and fire resistive properties of the facility could allow smoke and dangerous gases to pass freely and add to the rapid development of fire in exposed wall cavities. This deficient practice affected 14 residents, staff and visitors on the date of the survey. The facility is licensed for 76 SNF/NF beds and had a census of 36 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on August 8, 2016 at approximately 2:00 PM, observation of the wall behind a water dispenser in the south hallway across from room 218, revealed an approximately 5 inch by 11 inch hole cut through the interior of the wall exposing the interior wall cavity and the wall framing. When asked, the Maintenance Supervisor stated that the water dispenser had recently been installed and he was unaware the hole had not been patched.</p> <p>Actual NFPA standard:</p> <p>19.3.6.2 Construction of Corridor Walls. 19.3.6.2.1* Corridor walls shall be continuous from the floor to the underside of the floor or roof deck above, through any concealed spaces, such as those above suspended ceilings, and through interstitial structural and mechanical spaces, and they shall have a fire resistance rating of not less than 1/2</p>	K 017	<p>Work completed by contractors will be inspected by Maintenance Supervisor for holes and filled immediately.</p> <p><b>Monitor</b> The Executive Director and/or Maintenance Supervisor will randomly round within the center to ensure no additional compromises to smoke partitions are noted. Results will be reviewed in the facility Performance Improvement Committee (PIC) monthly for 3 months and then periodically thereafter.</p> <p><b>Date of Completion</b> September 12, 2016</p>	

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K 017	Continued From page 2 hour. Exception No. 1*: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, a corridor shall be permitted to be separated from all other areas by non-fire-rated partitions and shall be permitted to terminate at the ceiling where the ceiling is constructed to limit the transfer of smoke. Exception No. 2: Existing corridor partitions shall be permitted to terminate at ceilings that are not an integral part of a floor construction if 5 ft (1.5 m) or more of space exists between the top of the ceiling subsystem and the bottom of the floor or roof above, provided that the following criteria are met: (a) The ceiling shall be part of a fire-rated assembly tested to have a fire resistance rating of not less than 1 hour in compliance with the provisions of 8.2.3.1. (b) The corridor partitions form smoketight joints with the ceilings (joint filler, if used, shall be noncombustible). (c) Each compartment of interstitial space that constitutes a separate smoke area is vented, in a smoke emergency, to the outside by mechanical means having sufficient capacity to provide not less than two air changes per hour but, in no case, a capacity less than 5000 ft <sup>3</sup> /min (2.36 m <sup>3</sup> /s). (d) The interstitial space shall not be used for storage. (e) The space shall not be used as a plenum for supply, exhaust, or return air, except as noted in 19.3.6.2.1(3). Exception No. 3*: Existing corridor partitions shall be permitted to terminate at monolithic ceilings that resist the passage of smoke where there is a smoketight joint between the top of the	K 017		

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K 017	Continued From page 3 partition and the bottom of the ceiling.	K 017		
K 018 SS=D	19.3.6.2.2* Corridor walls shall form a barrier to limit the transfer of smoke. NFPA 101 LIFE SAFETY CODE STANDARD 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 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 between compartments. This deficient practice affected 6 residents, staff, and visitors on the date of survey. The facility is licensed for 76 SNF/NF beds with a census of 36 on the day of survey.  Findings include:	K 018	<p><b>K 018</b></p> <p><b>Corrective Action</b> The maintenance supervisor has adjusted self-closing doors entering the dining area to ensure proper closure.</p> <p>The Maintenance Supervisor has adjusted door to the nursing station office adjacent to room 111 to ensure proper latching.</p> <p><b>Other Residents</b> In addition, remaining doors have been inspected to insure proper closure and latching.</p> <p><b>Systematic Changers</b> Doors shall be inspected monthly per our Preventive Maintenance Program to insure proper closure and latching.</p> <p><b>Monitor</b> Safety Committee will review Preventive Maintenance logs quarterly to ensure doors are being inspected. Preventive Maintenance logs will be reviewed with the PIC monthly for 3 months and then periodically thereafter.</p> <p><b>Date of Completion</b> September 12, 2016</p>	

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K 018	Continued From page 4  (1) During the facility tour on August 8, 2016 at approximately 2:30 PM, observation and operational testing of the self-closing doors entering the dining area revealed the doors did not self-close when released from the magnetic hold-open device, leaving a large gap. When asked, the Maintenance Supervisor and Administrator stated the facility was unaware that the corridor doors did not self-close properly.  (2) During the facility tour on August 8, 2016 at approximately 3:00 PM, observation and operational testing of the door to the nurses station office located adjacent to room 111 revealed that the door would not latch properly. When asked, the Maintenance Supervisor and Administrator stated the facility was unaware that the nurses station office door was not latching 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	K 018			

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K 018	Continued From page 5 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.  19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.2. 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: Existing roller latches demonstrated to keep the door closed against a force of 5 lbf (22 N) shall be permitted to be kept in service.	K 018	This Plan of Correction is prepared and submitted as required by law. BY submitting this Plan of Correction, Kindred Nursing and Rehabilitation –Weiser 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 for 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.		
K 022 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. Doors, passages or stairways that are not a way of exit that are likely to be mistaken for an exit have a sign designating "No Exit". 7.10, 18.2.10.1, 19.2.10.1 This STANDARD is not met as evidenced by:	K 022	<b>K 022</b> <b>Corrective Action</b> Sign removed that read, "Do Not Use As An Exit" from Exit door found on the 100 west wing corridor.  <b>Other Residents</b> In addition, the remainder of the exit doors were inspected to ensure improper signage was not posted. None were found.		

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K 022	Continued From page 6 Based on observation and interview, the facility failed to ensure that exits were clearly identified by appropriate means. Failure to ensure exits are identified clearly would hinder the safe evacuation of occupants during an emergency. This deficient practice affected 13 residents, staff and visitors in the 100 west wing on the date of the survey. The facility is licensed for 76 SNF/NF beds and had a census of 36 on the day of the survey.  Findings Include:  During the facility tour on August 8, 2016 at approximately 2:00 PM, observation of the 100 west wing corridor found that the Exit door was marked "Not an Exit". When asked, the Maintenance Supervisor and Administrator revealed that the door had been marked "Not an Exit" to prevent staff from using it as an entrance/exit to the facility.  Actual NFPA Standard:  7.10.1.4* Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. Sign placement shall be such that no point in an exit access corridor is in excess of 100 ft (30 m) from the nearest externally illuminated sign and is not in excess of the marked rating for internally illuminated signs. Exception: Signs in exit access corridors in existing buildings shall not be required to meet the placement distance requirements. NFPA 101 LIFE SAFETY CODE STANDARD  Exit access is arranged so that exits are readily	K 022	<b>Systematic Changes</b> The Executive Director will approve signage to be placed on exterior doors.  <b>Monitor</b> The Executive Director and/or Maintenance Supervisor will weekly inspect exterior doors to ensure proper signage is posted. Results of inspection will be reviewed with the PIC committee monthly for 3 months and then periodically thereafter.  <b>Date of Completion</b> September 12, 2016	
K 038 SS=D		K 038	<b>K 038</b> <b>Corrective Action</b> Double action locking mechanism on kitchen exterior door replaced with a single	

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NAME OF PROVIDER OR SUPPLIER  KINDRED NURSING AND REHABILITATION - WEISER			STREET ADDRESS, CITY, STATE, ZIP CODE 331 EAST PARK STREET WEISER, ID 83672	
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K 038	<p>Continued From page 7</p> <p>accessible at all times in accordance with section 7.1. 19.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure exit door locks were single action locks. Failure to provide readily accessible means for egress would prevent occupants ability to safely evacuate in an emergency. This deficient practice affected staff and visitors on the date of the survey. The facility is licensed for 76 SNF/NF beds and had a census of 36 on the day of the survey.</p> <p>Findings Include:</p> <p>During the facility tour conducted on August 8, 2016 at approximately 2:30 PM, observation and operational testing of the exit door from the kitchen to the exterior of the facility marked "Exit" had a double action locking mechanism installed on the door. When asked, the Maintenance Supervisor and Administrator stated the facility was unaware of the requirement for exit doors to be single-action locking mechanisms.</p> <p>Actual NFPA standard:</p> <p>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.</p> <p>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</p>	K 038	<p>action locking mechanism.</p> <p><b>Other Residents</b> In addition the remainder of the exterior doors has been inspected to ensure single action mechanisms are in place. All exterior doors have single action locking mechanism</p> <p><b>Systematic Changes</b> Exterior doors needing locking mechanism replaced will be replaced with single action locking mechanisms.</p> <p><b>Monitor</b> The Executive Director and/or Maintenance Supervisor will randomly round within the center to ensure that no double action locking mechanisms have been installed on exterior doors. Results of the door audit will be reviewed with the facility PIC monthly for 3 months then periodically thereafter.</p> <p><b>Date of Completion</b> September 12, 2016</p>	

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K 038	Continued From page 8 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 038	This Plan of Correction is prepared and submitted as required by law. BY submitting this Plan of Correction, Kindred Nursing and Rehabilitation –Weiser 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 for 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.	
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  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  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that sprinkler systems were maintained in accordance with NFPA 25 and NFPA 13. Failure to maintain sprinkler systems could hinder performance during a fire. This deficient practice affected 6 residents, staff and	K 062	<b>K 062</b> <b>Corrective Action</b> License contractor to match sprinklers in Medical Records room with like characteristics.  <b>Other Residents</b> In addition, the Automatic Sprinkler System will be inspected by Licensed Contractor to ensure sprinklers within the same compartments are of similar characteristic.  <b>Systematic Changes</b> The Executive Director and/ or Maintenance Supervisor will consult with installer to	

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K 062	<p>Continued From page 9</p> <p>visitors on the date of the survey. The facility is licensed for 76 SNF/NF beds and had a census of 36 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour on August 8, 2016, at approximately 2:30 PM, observation of the two sprinkler heads located in the Medical Records room revealed different types of sprinklers within the same room. It was observed that one sprinkler was quick response and the other was ordinary response. When asked, the Maintenance Supervisor stated that one of the sprinklers in the Medical Records room had been replaced due to it being painted. His staff had replaced it accidentally with a quick response sprinkler instead of the ordinary as already present in the room.</p> <p>Actual NFPA standard:</p> <p>NFPA 25</p> <p>2-4.1 Sprinklers. 2-4.1.1*</p> <p>Replacement sprinklers shall have the proper characteristics for the application intended. These include the following:</p> <ul style="list-style-type: none"> <li>(a) Style</li> <li>(b) Orifice size and K-factor</li> <li>(c) Temperature rating</li> <li>(d) Coating, if any</li> <li>(e) Deflector type (e.g., upright, pendant, sidewall)</li> <li>(f) Design requirements</li> </ul> <p>Exception No. 1: Spray sprinklers shall be permitted to replace old-style sprinklers.</p> <p>Exception No. 2: Replacement sprinklers for</p>	K 062	<p>ensure that the sprinkler to be replaced is of like characteristic to those sprinklers already in compartment.</p> <p><b>Monitor</b> Safety Committee will inspect Automatic Sprinkler inspection documentation quarterly. Vendor reports of related to the sprinkler heads will be reviewed by the Executive Director and presented to the PIC after the vendor has provided service.</p> <p><b>Date of Completion</b> September 12, 2016</p>	
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K 062	Continued From page 10 piers and wharves shall comply with NFPA 307, Standard for the Construction and Fire Protection of Marine Terminals, Piers, and Wharves.  2-4.1.3* Special and Quick-Response Sprinklers. Special and quick-response sprinklers as defined by NFPA 13, Standard for the Installation of Sprinkler Systems, shall be replaced with sprinklers of the same make, model, orifice, size, temperature range and thermal response characteristics, and K-factor. Exception: If the special or quick-response sprinkler is no longer manufactured, a special or quick-response sprinkler with comparable performance characteristics shall be installed.  A-2-4.1.3 It is imperative that any replacement sprinkler have the same characteristics as the sprinkler being replaced. If the same temperature range, response characteristics, spacing requirements, flow rates, and K-factors cannot be obtained, a sprinkler with similar characteristics should be used, and the system should be evaluated to verify the sprinkler is appropriate for the intended use. With regard to response characteristics, matching identical Response Time Index (RTI) and conductivity factors is not necessary unless special design considerations are given for those specific values.	K 062	This Plan of Correction is prepared and submitted as required by law. BY submitting this Plan of Correction, Kindred Nursing and Rehabilitation –Weiser 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 for 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.		
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10.18.3.5.6, 19.3.5.6 This STANDARD is not met as evidenced by:	K 064	<b>K 064</b> <b>Corrective Action</b> Sign removed that read, “Secondary Fire Extinguishing Back Up to Automatic Fire System” from above Class K fire extinguisher. A new sign was posted that read, “The fire protection system shall be activated prior to using the fire extinguisher”.		

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K 064	Continued From page 11 Based on observation and interview, the facility failed to ensure that proper signage for the Class K extinguisher was posted. Failure to provide proper signage could confuse staff on the appropriate use of the extinguisher. This deficient practice affected 6 residents, staff and visitors on the date of the survey. The facility is licensed for 76 SNF/NF beds and had a census of 36 on the day of the survey.  Findings include:  During the facility tour on August 8, 2016 at approximately 3:00 PM, it was discovered that the incorrect verbiage was being used as a placard for the Class K fire extinguisher in the kitchen. The signage stated, "Secondary fire extinguishing back up to automatic fire system". NFPA 10 requires that the placard read, "The fire protection system shall be activated prior to using the fire extinguisher". When asked, the Maintenance Supervisor stated the facility was not aware that there was specific verbiage that needed to be used on the placard.  Actual NFPA standard:  NFPA 10 2-3.2.1 A placard shall be conspicuously placed near the extinguisher that states that the fire protection system shall be activated prior to using the fire extinguisher.	K 064	<b>Other Residents</b> In addition, the remainder of extinguishers was inspected to identify improper signage. None were found.  <b>Systematic Changes</b> The Executive Director will approve all signage to be placed above extinguishers.  <b>Monitor</b> The Executive Director and/or Maintenance Supervisor will randomly inspect extinguishers to ensure proper signage is posted. The results will be presented to the PIC monthly for 3 months and then periodically thereafter.  <b>Date of Completion</b> September 12, 2016		
K 070 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Portable space heating devices shall be prohibited in all health care occupancies. Except it shall be permitted to be used in non-sleeping	K 070	<b>K 070</b> <b>Corrective Action</b> Portable space heater device removed that was located in the laundry, adjacent to resident room 119.		

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K 070	Continued From page 12 staff and employee areas where the heating elements of such devices do not exceed 212 degrees F (100 degrees C). 18.7.8, 19.7.8 This STANDARD is not met as evidenced by: Based upon observation and interview, the facility failed to prohibit portable space heating devices in sleeping compartments.. This deficient practice is considered a significant risk due to the history of fires caused by space heaters. This deficient practice affected 3 residents, staff and visitors on the date of survey. The facility is licensed for 76 SNF/NF beds with a census of 36 on the day of survey  Findings include:  During the facility tour on August 8, 2016 at approximately 4:00 PM, observation revealed a portable space heating device located in the laundry, adjacent to resident room 119. When asked, the Maintenance Supervisor and Administrator indicated the facility was not aware the space heater was in the facility.  Actual NFPA Standard:  NFPA 101, the Life Safety Code, 2000 Edition  19.7.8 Portable Space-Heating Devices. Portable space-heating devices shall be prohibited in all health care occupancies. 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). NFPA 101 LIFE SAFETY CODE STANDARD	K 070	<b>Other Residents</b> In addition, remainder of rooms inspected to identify other portable space heater devices. None were found.  <b>Systematic Changes</b> Staff will be in-serviced on the code about portable space heater devices and nursing facilities.  <b>Monitor</b> Maintenance supervisor will audit rooms quarterly for one year following the noted issue to ensure no portable space heater devices are being used. Results will be presented to PIC monthly for 3 months, then periodically thereafter.  <b>Date of Completion</b> September 12, 2016	
K 147 SS=D		K 147	<b>K147 Corrective Action</b> Clutter removed from in the front of the electrical breaker panels in Maintenance office.	

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K 147	<p>Continued From page 13</p> <p>Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure electrical wiring and proper clearance around electric circuit breakers was in accordance with the National Electrical Code. This deficient practice affected 9 residents, staff and visitors on the date of survey. The facility is licensed for 76 SNF/NF beds with a census of 36 the day of survey.</p> <p>Findings include:</p> <p>1.) During the facility tour on August 8, 2016 at approximately 3:00 PM, observation of the Maintenance Office revealed miscellaneous items stacked in front of the electrical breaker panels. When asked, the Maintenance Supervisor stated the facility was unaware of the deficient practice.</p> <p>2.) During the facility tour on August 8, 2016 at approximately 4:00 PM, observation of the Laundry room revealed a refrigerator plugged into an RPT (relocatable power tap) utilized as fixed wiring. When asked, the Maintenance Supervisor and Administrator stated the facility was unaware the refrigerator was plugged into an RPT.</p> <p>3.) During the facility tour on August 8, 2016 at approximately 4:00 PM, observation of the electrical breaker panel in the basement revealed a blank cover missing, exposing the interior of the electrical panel. When asked, the Maintenance Supervisor stated the facility was unaware of the cover missing from the panel.</p> <p>Actual NFPA standard:</p>	K 147	<p>Refrigerator was immediately unplugged and removed from Laundry room.</p> <p>Cover placed on electrical breaker panel in the basement.</p> <p><b>Other Residents</b> In addition, the remainder of rooms will be inspected to ensure appliances are not plugged into relocatable power tap, electrical panels are free of clutter immediately in front of them, and that all covers on electrical panels are in place.</p> <p><b>Systematic Changes</b> Appliances are to be installed by Maintenance Supervisor.</p> <p>Area in front of electrical panels to be marked and signs posted notifying individuals not to store items immediately in front.</p> <p><b>Monitor</b> Maintenance supervisor will conduct monthly room audits per the Preventive Maintenance program. Results will be presented to PIC monthly for 3 months, then periodically thereafter.</p> <p><b>Date of Completion</b> September 12, 2016</p>	

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K 147	Continued From page 14  1.) NFPA 70.110.26 Spaces About Electrical Equipment. Sufficient access and working space shall be provided and maintained about all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons. (2) Width of Working Space. The width of the working space in front of the electric equipment shall be the width of the equipment or 750 mm (30 in.), whichever is greater. In all cases, the work space shall permit at least a 90 degree opening of equipment doors or hinged panel  2.) NFPA 70 National Electrical Code 1999 Edition 400-8. Uses Not Permitted Unless specifically permitted in Section 400-7, flexible cords and cables shall not be used for the following: 1. As a substitute for the fixed wiring of a structure 2. Where run through holes in walls, structural ceilings suspended ceilings, dropped ceilings, or floors 3. Where run through doorways, windows, or similar openings 4. Where attached to building surfaces Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of Section 364-8. 5. Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors 6. Where installed in raceways, except as otherwise permitted in this Code	K 147		

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K 147	Continued From page 15  Also see UL listings: XBYS Guide information XBZN2 Guide information  3.) NFPA 70 110.12 Mechanical Execution of Work. Electrical equipment shall be installed in a neat and workmanlike manner. (A) Unused Openings. Unused cable or raceway openings in boxes, raceways, auxiliary gutters, cabinets, cutout boxes, meter socket enclosures, equipment cases, or housings shall be effectively closed to afford protection substantially equivalent to the wall of the equipment. Where metallic plugs or plates are used with nonmetallic enclosures, they shall be recessed at least 6 mm (¼ in.) from the outer surface of the enclosure.	K 147			