September 21, 2016

Todd "Shane" Bell, Administrator
Kindred Nursing And Rehabilitation - Nampa
404 North Horton Street
Nampa, ID 83651-6541

Provider #: 135019

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Mr. Bell:

On September 15, 2016, a Facility Fire Safety and Construction survey was conducted at Kindred Nursing And Rehabilitation - Nampa 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 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 October 4, 2016. Failure to submit an acceptable PoC by October 4, 2016, may result in the imposition of civil monetary penalties by October 24, 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 October 20, 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 October 20, 2016. A change in the seriousness of the deficiencies on October 20, 2016, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by October 20, 2016, includes the following:
Denial of payment for new admissions effective December 15, 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 March 15, 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 September 15, 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 October 4, 2016. If your request for informal dispute resolution is received after October 4, 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
The facility is a single story Type V (111) building built in 1959; an automatic fire sprinkler system was installed in 1973 as a retrofit and a new fire alarm/smoke detection system was installed in 2002. There had been an addition to the building in 1962. A remodel and extensions of A & B wing occurred in 1995 with a rehabilitation wing added in October 1995. The current rehab wing was remodeled extensively in 2006. The facility is currently licensed for 100 beds and had a census of 68 on the day of the survey.

The following deficiencies were cited during the annual fire/life safety survey conducted on September 15, 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:

Sam Burbank
Health Facility Surveyor
Facility Fire Safety and Construction

K 025
NFPA 101 LIFE SAFETY CODE STANDARD

Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames.

8.3, 19.3.7.3, 19.3.7.5
This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that smoke barriers would resist

K 025
No Residents were affected by deficiency

Facility System
Smoke barrier wall penetrations located at rooms 108 and 109 were sealed with fire caulking.

Monitor
Maintenance Director will monitor facility for penetration holes in fire barriers monthly

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

TITLE

10/03/2016
### Statement of Deficiencies and Plan of Correction

#### Provider/Supplier/CLIA Identification Number:
135019

#### Date Survey Completed:
09/15/2016

#### Name of Provider or Supplier
Kindred Nursing and Rehabilitation - Nampa

#### Kindred Nursing and Rehabilitation - Nampa
404 North Horton Street
Nampa, ID 83651

<table>
<thead>
<tr>
<th>ID 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 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>K025</td>
<td></td>
<td>Continued From page 1 the passage of smoke. Unsealed smoke barrier penetrations could allow smoke and dangerous gases to pass between compartments, hindering the ability to defend in place. This deficient practice affected 14 residents, staff and visitors on the date of the survey. The facility is licensed for 100 SNF/NF beds and had a census of 68 on the day of the survey. Findings include: During the facility tour conducted on September 15, 2016 from approximately 2:00 PM to 3:00 PM, an above the ceiling inspection of the smoke barrier wall located at rooms 108 and 109 revealed seven (7) unsealed penetrations, ranging in size from an approximate 3/4 inch diameter hole to four inch by one inch opening. The Maintenance Supervisor confirmed the identified penetrations and stated he was not aware of these prior to the date of the survey. Actual NFPA standard: NFPA 101 8.3 Smoke Barriers 8.3.2 Continuity. Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces. Exception: A smoke barrier required for an occupied space below an interstitial space shall not be required to extend through the interstitial.</td>
<td>K025</td>
<td></td>
<td>through TELS system and/or monthly rounds monitor form, to ensure all fire barriers are sealed to code. Date of Compliance October 20, 2016</td>
<td></td>
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</tbody>
</table>
### Summary Statement of Deficiencies

**K025** Continued from page 2

- Space, provided that the construction assembly forming the bottom of the interstitial space provides resistance to the passage of smoke equal to that provided by the smoke barrier.

**K038** NFPA 101 LIFE SAFETY CODE STANDARD

- Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1
  - This STANDARD is not met as evidenced by:
    - Based on observation, operational testing and interview, the facility failed to ensure means of egress were not impeded to full, instant use in the event of an emergency. Failure to provide instant access to a means of egress could hinder evacuation during a fire or other emergency. This deficient practice affected two residents, staff and visitors on the date of the survey. The facility is licensed for 100 SNF/NF beds and had a census of 68 on the day of the survey.

**Findings include:**

- During the facility tour conducted on September 15, 2016 from approximately 10:00 AM to 11:00 AM, observation and operational testing of the door to the doctor's office revealed the door was equipped with a deadbolt and keyed entry locking arrangement that required more than one releasing operation from the egress side. When asked, the Maintenance Supervisor stated he was aware of the single operational requirement for door locking arrangements.

**Actual NFPA standard:**

- 19.2 MEANS OF EGRESS REQUIREMENTS
  - 19.2.1 General.
### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CUA Identification Number:** 135019

**KINDRED NURSING AND REHABILITATION - NAMPA**

**Street Address, City, State, Zip Code:**

404 NORTH HORTON STREET
NAMPA, ID 83651

**Date Survey Completed:** 09/15/2016

### Summary Statement of Deficiencies

<table>
<thead>
<tr>
<th>ID Prefix Tag</th>
<th>Description</th>
</tr>
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</table>
| K 038         | Continued From page 3  
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.  
7.2.1.5.4*  
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 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 130         | No residents were affected by Deficiency |

*ID Prefix Tag is not applicable to K 038.*

**ID Prefix Tag:** K 038

**Provider's Plan of Correction:** (Each corrective action should be cross-referenced to the appropriate deficiency)

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**NFPA 101 MISCELLANEOUS**

**Other LSC Deficiency Not On 2786**

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**Event ID:** AMRP21  
**Facility ID:** MDS001550  
**If continuation sheet Page:** 4 of 8
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

<table>
<thead>
<tr>
<th>(X1) PROVIDER/SUPPLIER/CMS IDENTIFICATION NUMBER:</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
<th>(X3) DATE SURVEY COMPLETED</th>
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<tbody>
<tr>
<td>135019</td>
<td>A. BUILDING 01 - ENTIRE BUILDING</td>
<td>09/15/2016</td>
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<tr>
<td>B. WING</td>
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NAME OF PROVIDER OR SUPPLIER

KINDRED NURSING AND REHABILITATION - NAMPA

STREET ADDRESS, CITY, STATE, ZIP CODE

404 NORTH HORTON STREET

NAMPA, ID 83651

<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
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<tbody>
<tr>
<td>K 130</td>
<td>Continued From page 4 This STANDARD is not met as evidenced by:</td>
<td>K 130</td>
<td>Facility System</td>
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<tr>
<td></td>
<td>Based on observation and interview, the facility failed to ensure that renovation projects were isolated and sufficient interim life safety measures were in place. Failure to isolate substantial, ongoing renovation projects and provide interim life safety measures, could expose residents to increased hazards associated with facility renovations and affect egress during an emergency. This deficient practice affected staff and visitors on the date of the survey. The facility is licensed for 100 SNF/NF beds and had a census of 68 on the day of the survey. Findings include:</td>
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<td>1) During the entrance conference conducted on September 15, 2016 from approximately 9:45 AM to 10:00 AM, the Administrator stated the facility was undergoing renovations to the 300 wing. When asked about the extent and type of renovations, the Administrator stated the flooring was being replaced in that wing and during the demolition of the old flooring, asbestos was discovered, requiring abatement.</td>
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<td>2) During review of facility inspection records conducted on September 15, 2016 from approximately 10:00 AM to 10:45 AM, no record was provided indicating the facility had conducted any interim life safety measure assessments prior to the conduction of renovations. When asked about the missing documentation, the Maintenance Supervisor stated he was not aware of the requirement for conducting an interim life safety measure assessment.</td>
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<td>3) During the facility tour conducted on</td>
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### Continued From page 5

September 15, 2016 from approximately 10:45 AM to 2:30 PM, observation of the 300 wing revealed the barrier separating the asbestos abatement from the remainder of the facility was a single sheet of clear plastic sheeting. Further observation revealed this barrier was not sealed from either side to isolate the area. This observation was confirmed by the Maintenance Supervisor when he examined the barrier containment.

4) During the facility tour conducted on September 15, 2016 from approximately 10:45 AM to 2:30 PM, observation of the 300 wing means of egress revealed an exit sign above the plastic membrane to the renovation area, indicating the direction of travel was to proceed forward through the barrier. When asked, the Maintenance Supervisor stated he had not been aware of this condition prior to the survey date.

5) During the exit conference conducted on September 15, 2016 from approximately 3:30 PM to 4:00 PM, interview of the Maintenance Supervisor revealed he had no knowledge of the local fire authority having been consulted as to the renovations of the 300 wing and the rendering of that wing as inaccessible due to the extent of the renovations.

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**Actual NFPA standard:**

**NFPA 101**

19.7.9 Construction, Repair, and Improvement Operations.

19.7.9.1 Construction, repair, and improvement operations shall comply with 4.6.10.
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| K 130             | Continued From page 6  
19.7.9.2 The means of egress in any area undergoing construction, repair, or improvements shall be inspected daily for compliance with of 7.1.10.1 and shall also comply with NFPA 241, Standard for Safeguarding Construction, Alteration, and Demolition Operations.  
4.6.10 Construction, Repair, and Improvement Operations.  
4.6.10.1* Buildings or portions of buildings shall be permitted to be occupied during construction, repair, alterations, or additions only where required means of egress and required fire protection features are in place and continuously maintained for the portion occupied or where alternative life safety measures acceptable to the authority having jurisdiction are in place.  
NFPA 241  
Chapter 1 Administration  
1.3.2* The public fire department and other fire protection authorities also shall be consulted for guidance.  
Chapter 8 Safeguarding Construction and Alteration Operations  
8.6.2 Temporary Separation Walls.  
8.6.2.1 Protection shall be provided to separate an occupied portion of the structure from a portion of the structure undergoing alteration, construction, or demolition operations when such operations are considered as having a higher level of hazard than the occupied portion of the building. | K 130 | | |
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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<td>K 130</td>
<td>Continued From page 7</td>
<td></td>
<td>8.6.2.2. Walls shall have at least a 1-hour fire resistance rating.</td>
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<td>09/15/2016</td>
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</tbody>
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