March 1, 2017

Donna Nelson, Administrator
Midland Rehabilitation and Healthcare Center
46 North Midland Boulevard
Nampa, ID 83651

Provider #: 135076

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Ms. Nelson:

On February 22, 2017, a Facility Fire Safety and Construction survey was conducted at Midland Rehabilitation And Healthcare 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 March 14, 2017. Failure to submit an acceptable PoC by March 14, 2017, may result in the imposition of civil monetary penalties by April 3, 2017.

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 March 29, 2017, (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 March 29, 2017. A change in the seriousness of the deficiencies on March 29, 2017, may result in a change in the remedy.
The remedy, which will be recommended if substantial compliance has not been achieved by March 29, 2017, includes the following:

Denial of payment for new admissions effective May 22, 2017.
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 August 22, 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 Nate Elkins, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, option 3; 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 February 22, 2017, 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 March 14, 2017. If your request for informal dispute resolution is received after March 14, 2017, 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,

\[Signature\]

Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosures
The facility is a single story fully sprinklered structure of Type V (111) construction built in 1964. There is a partial basement area that houses the boiler room, maintenance shop and storage areas. The building is equipped with a fire alarm/smoke detection system installed in 1999. Some parts of the automatic sprinkler system were retrofitted in 1964 with subsequent additions to the system and some ordinary head replacement to quick response in 2009. An addition/remodel was completed in 2000 and a refurbish was completed in 2002. The facility is currently licensed for 112 SNF/NF beds.

The following deficiencies were cited during the annual fire/life safety survey conducted on February 22, 2017. The facility was surveyed under the LIFE SAFETY CODE, 2012 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

Means of Egress - General
Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.11 through 18/19.2.11.18.2.1.1, 19.2.1, 7.1.10.1
This Standard is not met as evidenced by:
Based on record review, observation and interview, the facility failed to ensure that smoke

Preparation and submission of this plan of correction by, Midland Rehabilitation and Healthcare Center, does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely pursuant to the requirements under state and federal laws.
and fire rated assemblies were inspected in accordance with NFPA 80 and NFPA 105. Failure to inspect and test rated doors could result in a lack of system performance as designed. This deficient practice affected 68 residents, staff and visitors on the date of the survey. The facility is licensed for 112 SNF/NF beds and had a census of 68 on the day of the survey.

Findings include:

1) During review of provided facility annual inspection records conducted on February 22, 2017 from approximately 9:00 AM to 10:30 AM, no record was available demonstrating an initial inspection and testing of rated door assemblies had been conducted. When asked about the missing documentation, the Maintenance Supervisor stated the facility had not completed any initial testing of rated assemblies.

2) During the facility tour conducted on February 22, 2017 from approximately 10:30 AM to 3:30 PM, observation of doors installed throughout the facility, revealed doors were tagged with fire labels ranging from 20 minute fire protection to 1-1/2 hour fire protection rating.

Actual NFPA standard:

NFPA 101
19.2 Means of Egress Requirements
19.2.2.2 Doors.
19.2.2.2.1 Doors complying with 7.2.1 shall be permitted.

7.2.1 Door Openings.
7.2.1.15 Inspection of Door Openings.
7.2.1.15.1* Where required by Chapters 11

Root Cause: With investigation by the IDT it was discovered that the Maintenance Director required education on Smoke and Fire rated assemblies to be inspected, tested and documentation that is required.

3. On 03/10/2017 the Administrator re-educated the Maintenance Director on the requirement of inspecting, testing and documentation of smoke and fire rated assemblies are completed annually, including:

(1) Door leaves equipped with panic hardware or fire exit hardware
(2) Door assemblies
(3) Electrically controlled egress doors
(4) Door assemblies with special locking Arrangements

4. Beginning the week of 03/10/17, the Maintenance Director or designee will conduct audits of doors in the facility weekly for 4 weeks then monthly for 2 months and quarterly thereafter to ensure that the requirement of inspecting, testing and documentation
of smoke and fire rated assemblies are completed per requirements. A report will be submitted to Quality Assurance Performance Improvement (QAPI) committee monthly for 3 months, at that time the QAPI committee will make recommendations for and determine continued monitoring. The Maintenance Director will be responsible for monitoring and follow-up.

(5) Date of Compliance: March 10, 2017
**ID** | **TX** | **SUMMARY STATEMENT OF DEFICIENCIES** (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | **PREFIX** | **PROVIDER'S PLAN OF CORRECTION** (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | **COMPLETION DATE**
--- | --- | --- | --- | --- | ---
211/353 | | Continued From page 3 | K 211 | |
| | 5.2.1.2 Doors shall be operated to confirm full closure. 5.2.1.3 Hardware and gaskets shall be inspected annually, and any parts found to be damaged or inoperative shall be replaced. | | | 
| S=D | NFPA 101 Sprinkler System - Maintenance and Testing | K 353 | | |
| | Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. | | | 
| | a) Date sprinkler system last checked | | | 
| | b) Who provided system test | | | 
| | c) Water system supply source | | | 
| | Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure fire suppression system pendants were maintained free of obstructions such as paint or corrosion. Failure to maintain fire sprinkler pendants free of obstructions could hinder system performance during a fire event. This deficient practice affected staff and vendors in the main Kitchen on the date of the survey. The facility is licensed for 112 SNF/NF beds and had a census of 68 on the day of the survey. Findings include: | | |
| | 1. On 2/23/17 the Maintenance Director contacted the facility contracted sprinkler company to replace the sprinkler pendants. The contracted sprinkler company is scheduled to replace the (2) sprinkler pendants above the dishwasher area that are corroded on 03/16/17. 2. On 02/23/2017 the Maintenance Director inspected the sprinkler pendants in the building to ensure there were not any other that were damaged or inoperable; no concerns were noted. **Root Cause**: With investigation by the IDT it was discovered that sprinkler heads in the dishwashing area of the main kitchen need to be non-corrosive type sprinkler pendants. 3. On 03/10/2017 the Administrator re-educated the Maintenance Director on the requirement of inspecting sprinkler pendants in the building to ensure there are not damaged or inoperable. | | |
**Summary Statement of Deficiencies**

During the facility tour conducted on February 22, 2017 from approximately 10:00 AM to 3:30 PM, observation of the installed fire sprinkler pendants revealed the following:

- Inspection of the sprinkler pendants above the dishwashing area in the main Kitchen revealed (2) corroded pendants.
- Interview of the Maintenance Supervisor revealed he was not aware of the corroded sprinkler pendants prior to the date of the survey.

Actual NFPA standard:

NFPA 25

5.2.1 Sprinklers.

5.2.1.1* Sprinklers shall be inspected from the floor level annually.

5.2.1.1.1* Sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., upright, pendent, or sidewall).

5.2.1.1.2 Any sprinkler that shows signs of any of the following shall be replaced:

1. Leaking
2. Corrosion
3. Physical damage
4. Loss of fluid in the glass bulb heat responsive element

4. Beginning the week of 03/10/17, the Maintenance Director or designee will conduct audits of sprinklers in the building weekly for 4 weeks then monthly for 2 months and quarterly thereafter to ensure that the requirement of inspecting sprinklers that show signs of any of the following shall be replaced:

1. Leakage
2. Corrosion
3. Physical Damage
4. Loss of fluid in the glass bulb heat responsive element
5. *Loading

6. Painted unless painted by the sprinkler manufacturer

A report will be submitted to QAPI committee monthly for 3 months, at that time the QAPI committee will make recommendations for and determine continued monitoring. The Maintenance Director will be responsible for monitoring and follow-up.

5. Date of Compliance: March 10, 2017
### Summary Statement of Deficiencies

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<td>353</td>
<td>Continued From page 5</td>
<td>K 353</td>
<td>K 923</td>
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**(5)** Loading

**(6)** Painting unless painted by the sprinkler manufacturer

**NFPA 101 Gas Equipment - Cylinder and Container Storage**

Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3.

>300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating.

Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum “CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING.” Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored...
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<td>K 923</td>
<td>4. Beginning the week of 03/10/17, the Maintenance Director or designee will conduct audits of oxygen cylinder storage weekly for 4 weeks then monthly for 2 months and quarterly thereafter to ensure that the requirement of segregation of the full oxygen cylinders from the empty oxygen cylinders are met. A report will be submitted to QAPI committee monthly for 3 months, at that time the QAPI committee will make recommendations for and determine continued monitoring. The Maintenance Director will be responsible for monitoring and follow-up.</td>
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<td>In the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4 (NFPA 99) This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure medical gases were stored in accordance with NFPA 99. Failure to segregate empty oxygen cylinders from full could result in using incorrect cylinders during an emergency. This deficient practice affected residents in need of supplemental oxygen, staff and visitors on the date of the survey. The facility is licensed for 112 SNF/NF beds and had a census of 68 on the day of the survey. Findings include: During the facility tour conducted on February 22, 2017 from approximately 10:30 AM to 3:30 PM, observation of the oxygen storage room in the 300 hall revealed six (6) &quot;E&quot; cylinders, identified as empty by the lead CNA, stored in the rack which was labeled as &quot;Full&quot;. When asked how to identify full from empty oxygen cylinders, the CNA stated the full cylinders have a plastic cap and empty cylinders do not, or they could hook up a regulator to check cylinder pressure. Actual NFPA standard: NFPA 99 11.6.5 Special Precautions - Storage of Cylinders and Containers. 11.6.5.1 Storage shall be planned so that cylinders can be used in the order in which they are received from the supplier. 11.6.5.2 If empty and full cylinders are stored within the same enclosure, empty cylinders shall be segregated from full cylinders. 11.6.5.3 Empty cylinders shall be marked to avoid</td>
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**STATEMENT OF DEFICIENCIES**

**PLAN OF CORRECTION**

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**STREET ADDRESS, CITY, STATE, ZIP CODE**

**LAND REHABILITATION AND HEALTHCARE**

46 NORTH MIDLAND BOULEVARD

Nampa, ID 83651

**PROVIDER'S PLAN OF CORRECTION**

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<td>Confusion and delay if a full cylinder is needed in a rapid manner.</td>
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**COMPLETION DATE**

02/22/2017