May 10, 2017

Joseph Rudd, Administrator
Riverview Rehabilitation
3550 West Americana Terrace
Boise, ID 83706-4728

Provider #: 135139

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Mr. Rudd:

On May 1, 2017, a Facility Fire Safety and Construction survey was conducted at Riverview Rehabilitation 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 May 23, 2017. Failure to submit an acceptable PoC by May 23, 2017, may result in the imposition of civil monetary penalties by June 12, 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 June 5, 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 June 5, 2017. A change in the seriousness of the deficiencies on June 5, 2017, may result in a change in the remedy.
The remedy, which will be recommended if substantial compliance has not been achieved by June 5, 2017, includes the following:

Denial of payment for new admissions effective August 1, 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 November 1, 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 May 1, 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 May 23, 2017. If your request for informal dispute resolution is received after May 23, 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
K 000 INITIAL COMMENTS

The facility is a single story Type V (111) structure approximately 26,000 square feet in size. Plans were approved in September of 2012 and construction completed in March of 2013. The facility is fully sprinklered, with corridor smoke detection and fire alarm system, along with a type 2 Essential Electrical Service. The building is divided into two smoke compartments, with seven exits to grade. Currently the facility is licensed for 30 SNF/NF beds.

The following deficiencies were cited during the annual Fire/Life Safety survey conducted on May 1, 2017. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy in accordance with 42 CFR 483.70.a

The survey was conducted by:

Sam Burbank
Health Facility Surveyor
Facility Fire Safety & Construction

K 161 NFPA 101 Building Construction Type and Height
Building Construction Type and Height
2012 EXISTING
Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5

Construction Type
1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered
2 II (111) One story

This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Riverview Rehabilitation does not stipulate or admit that the deficiencies listed herein, on the form CMS-2567 exist, nor does this facility admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiencies.

K161
1. On or before May 17, 2017 the Facility Maintenance Consultant filled the two identified penetrations with fire caulk.
2. On or before May 17, 2017 the Facility Maintenance Consultant audited smoke and fire barriers for additional penetrations in violation of NFPA 101. None were found.
K 161 Continued From page 1

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<tr>
<th>ID</th>
<th>ID</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX</th>
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<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
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<td>Maximum 1 story</td>
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Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5)

Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.

This Standard is not met as evidenced by:

Based on observation and interview, the facility failed to ensure the fire and smoke resistive properties of the structure were maintained. Failure to seal penetrations could allow fire, smoke and dangerous gases to pass between compartments. This deficient practice affected 10 residents, staff and visitors on the date of the survey. The facility is licensed for 30 SNF/NF beds and had a census of 20 on the day of the survey.

Findings include:

During the facility tour conducted on May 1, 2017

3. Effective May 17, 2017 any outside contractors performing construction work in the facility which may create penetrations in the smoke or fire barriers will be given a memo signed by the facility Executive Director instructing that any penetrations created in walls, ceilings, doorways, or conduit must be sealed with an appropriate fire/smoke barrier prior to validating completion of work in the facility.

4. Beginning on or before May 17, 2017 audits will be completed by the facility Executive Director, or designee, following the completion of any work projects that may cause penetrations in a smoke or fire barrier to validate that any penetrations created are appropriately sealed by the workman responsible for their creation. Beginning in June 2017, the results of these audits will be shared in the facility QAPI meeting monthly for three months, as part of the facility...
### Statement of Deficiencies and Plan of Correction

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<th>ID Prefix Tag</th>
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<th>Summary Statement of Deficiencies</th>
<th>ID Prefix Tag</th>
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<th>Provider's Plan of Correction</th>
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<td>K 161</td>
<td>Continued From page 2</td>
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<td>From approximately 10:00 AM to 10:45 AM, observation of the ceiling in the data room located in the 100 west hall revealed two (2) unsealed penetrations approximately 3/4&quot; in size entering the attic space above. Interview of the Administrator revealed he was not aware of the unsealed penetrations prior to the date of the survey. Actual NFPA standard: 19.1.6 Minimum Construction Requirements. 19.1.6.1 Health care occupancies shall be limited to the building construction types specified in Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7. (See 8.2.1.) 8.2 Construction and Compartmentation. 8.2.1 Construction. 8.2.1.1 Buildings or structures occupied or used in accordance with the individual occupancy chapters, Chapters 11 through 43, shall meet the minimum construction requirements of those chapters.</td>
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<td>Emergency Lighting Equipment was tested, by the facility Executive Director, or designee, without power for 90 minutes. Any lighting equipment found not to function following the 90-minute test period was repaired by replacing the battery components within the unit.</td>
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**K 161**

Safety Committee review. Any negative variances will be addressed by the facility QAPI committee as with a Performance Improvement Plan.

**K 291**

1. On or before May 17, 2017 all Emergency Lighting Equipment was tested, by the facility Executive Director, or designee, without power for 90 minutes. Any lighting equipment found not to function following the 90-minute test period was repaired by replacing the battery components within the unit.

2. On or before May 17, 2017 all Emergency Lighting Equipment was tested by the facility.
## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

### PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:

135139

### MULTIPLE CONSTRUCTION

A. BUILDING 01 - RIVERVIEW REHABILITATION

B. WING

### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

### SUMMARY STATEMENT OF DEFICIENCIES

(Each deficiency must be preceded by full regulatory or LSC identifying information)

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (Each corrective action should be cross-referenced to the appropriate deficiency)</th>
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<tbody>
<tr>
<td>K 291</td>
<td>Executive Director, or designee, and found to meet the requirements under NFPA 101.</td>
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</table>

3. On or before May 17, 2017, the facility Executive Director was educated by the facility Maintenance Consultant regarding the emergency lighting testing requirements including appropriate documentation and recordkeeping. On or before May 17, 2017, Emergency Lighting Testing was added by the facility Executive Director as a regular task to the TELS electronic preventive maintenance program scheduler.

4. Beginning in June 2017 for three months, the facility Executive Director, or designee will present the completed TELS documentation for Emergency Lighting Equipment testing in the facility QAPI meeting monthly for three months, as part of the facility Safety Committee review. Any negative variances will be addressed by the facility QAPI.

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### NAME OF PROVIDER OR SUPPLIER

RIVERVIEW REHABILITATION

### STREET ADDRESS, CITY, STATE, ZIP CODE

3550 WEST AMERICANA TERRACE

BOISE, ID 83706

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### Findings include:

During review of the facility inspection and testing documentation conducted on May 1, 2017 from approximately 9:00 AM to 10:00 AM, no records were provided indicating installed battery powered emergency lighting was tested for thirty seconds monthly and ninety minutes annually. When asked about the missing documentation, the Administrator stated the facility had been checking light functions, but had not been conducting or documenting testing in accordance with the standard.

Actual NFPA standard:

7.9.3 Periodic Testing of Emergency Lighting Equipment.

7.9.3.1 Required emergency lighting systems shall be tested in accordance with one of the three options offered by 7.9.3.1.1, 7.9.3.1.2, or 7.9.3.1.3.

7.9.3.1.1 Testing of required emergency lighting systems shall be permitted to be conducted as follows:

1. Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, except as otherwise permitted by 7.9.3.1.1(2).

2. The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction.

3. Functional testing shall be conducted annually for a minimum of 11.2 hours if the emergency lighting system is battery powered.

4. The emergency lighting equipment shall be...
K 291 Continued From page 4

(5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction.

K 325 NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR)

ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met:

* Corridor is at least 6 feet wide
* Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols
* Dispensers shall have a minimum of 4-foot horizontal spacing
* Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room
* Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30
* Dispensers are not installed within 1 inch of an ignition source
* Dispensers over carpeted floors are in sprinklered smoke compartments
* ABHR does not exceed 95 percent alcohol
* Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11)
* ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485

This Standard is not met as evidenced by:

Based on record review, observation and interview, the facility failed to ensure automatically operated Alcohol Based Hand Rub Dispensers (ABHR) were maintained in accordance with NFPA 101. Failure to maintain ABHR dispenser clearances and test operation

committee as with a Performance Improvement Plan.

K 325

1. On or before May 17, 2017 all Alcohol Based Hand Rub dispensers were checked in accordance with NFPA 101 to ensure that all are functioning appropriately in accordance with NFPA 101 and Manufacturer Guidelines.

On or before May 17, 2017 the Alcohol Based Hand Rub dispenser located above the light switch in the soiled linen area was moved by the facility Maintenance Consultant to a safe area.

2. On or before May 17, 2017 all Alcohol Based Hand Rub dispensers in the facility were audited by the facility Executive Director, or designee, to check for proper function and for proper placement in accordance with NFPA 101. No variances to the regulation were identified.
K 325 Continued From page 5

as defined by the standard increases the risk of
fires from arcing, or the accidental dispersal of a
flammable liquid.

This deficient practice affected
20 residents, staff and visitors on the date of the
survey. The facility is licensed
for 30 SNF/NF
residents and had a census of 20 on the day of
the survey.

Findings include:

1) During the review of facility inspection records
conducted on May 1, 2017 from approximately
3:00 AM to 10:00 AM, no records were available
indicating inspection and testing of ABHR
dispensers was performed when refilling
dispensers in accordance with manufacturer's
care and use instructions.

2) During the facility tour conducted on May 1,
2017 from approximately 10:00 AM to 2:30 PM,
observation of installed ABHR dispensers
revealed automatic dispensers had been installed
throughout the facility. When asked about testing
and documentation during the refill process,
Housekeeping staff stated they were not aware
that dispensers were required to be tested each
time a refill was installed.

3) During the facility tour conducted on May 1,
2017 from approximately 10:00 AM to 2:30 PM,
observation of installed ABHR dispensers
revealed the ABHR dispenser installed beside the
doors inside the soiled linen area of the laundry,
was installed over the light switch.

Actual NFPA standard:

NFPA 101

19.3.2.6 Alcohol-Based Hand-Rub Dispensers.

3. On or before May 17, 2017 the
facility housekeeping staff were
educated by the Executive
Director, or designee, regarding
the requirement to test all
Alcohol Based Hand Rub
dispensers for proper function
each time the gel bag is changed,
to take out of service any unit
that does not meet compliance
under NFPA 101, to document
the results, and to notify the
Executive Director, or designee
of any negative findings for
correction.

4. Beginning in June 2017 for three
months, the facility Executive
Director, or designee will
present the completed ABHR dispenser
results testing in the facility QAPI
meeting monthly for three
months, as part of the facility
Safety Committee review. Any
negative variances will be
addressed by the facility QAPI
committee as with a Performance
Improvement Plan.
K 325 Continued From page 6

Alcohol-based hand-rub dispensers shall be protected in accordance with 8.7.3.1, unless all of the following conditions are met:

1. Where dispensers are installed in a corridor, the corridor shall have a minimum width of 6 ft (1830 mm).
2. The maximum individual dispenser fluid capacity shall be as follows:
   a. 0.32 gal (1.2 L) for dispensers in rooms, corridors, and areas open to corridors
   b. 0.53 gal (2.0 L) for dispensers in suites of rooms
3. Where aerosol containers are used, the maximum capacity of the aerosol dispenser shall be 18 oz. (0.51 kg) and shall be limited to Level 1 aerosols as defined in NFPA30B, Code for the Manufacture and Storage of Aerosol Products.
4. Dispensers shall be separated from each other by horizontal spacing of not less than 48 in. (1220 mm).
5. Not more than an aggregate 10 gal (37.8 L) of alcohol-based hand-rub solution or 1135 oz (32.2 kg) of Level 1 aerosols, or a combination of liquids and Level 1 aerosols not to exceed, in total, the equivalent of 10 gal (37.8 L) or 1135 oz (32.2 kg), shall be in use outside of a storage cabinet in a single smoke compartment, except as otherwise provided in 19.3.2.6(6).
6. One dispenser complying with 19.3.2.6(2) or (3) per room and located in that room shall not be included in the aggregated quantity addressed in 19.3.2.6(5).
7. Storage of quantities greater than 5 gal (18.9 L) in a single smoke compartment shall meet the requirements of NFPA 30. Flammable and
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135139

(X2) MULTIPLE CONSTRUCTION
A. BUILDING 01 - RIVerview REHABILITATION
B. WING ________________

(X3) DATE SURVEY COMPLETED: 05/01/2017

NAME OF PROVIDER OR SUPPLIER: RIVERVIEW REHABILITATION
STREET ADDRESS, CITY, STATE, ZIP CODE: 3550 WEST AMERICANA TERRACE, BOISE, ID 83706

<table>
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<tr>
<th>ID</th>
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<td>K325</td>
<td>Continued From page 7</td>
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<td>Combustible Liquids Code.</td>
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<td>(8) Dispensers shall not be installed in the following locations:</td>
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<td>(a) Above an ignition source within a 1 in. (25 mm) horizontal distance from each side of the ignition source</td>
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<td>(b) To the side of an ignition source within a 1 in. (25mm) horizontal distance from the ignition source</td>
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<td>(c) Beneath an ignition source within a 1 in. (25 mm) vertical distance from the ignition source</td>
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<td>(9) Dispensers installed directly over carpeted floors shall be permitted only in sprinklered smoke compartments.</td>
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<td>(10) The alcohol-based hand-rub solution shall not exceed 95 percent alcohol content by volume.</td>
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<td>(11) Operation of the dispenser shall comply with the following criteria:</td>
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<td>(a) The dispenser shall not release its contents except when the dispenser is activated, either manually or automatically by touch-free activation.</td>
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<td>(b) Any activation of the dispenser shall occur only when an object is placed within 4 in. (100 mm) of the sensing device.</td>
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<td>(c) An object placed within the activation zone and left in place shall not cause more than one activation.</td>
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<td>(d) The dispenser shall not dispense more solution than the amount required for hand hygiene consistent with label instructions.</td>
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<td>(e) The dispenser shall be designed, constructed, and operated in a manner that ensures that accidental or malicious activation of the dispensing device is minimized.</td>
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<td>(f) The dispenser shall be tested in accordance with the manufacturer ' s care and use instructions each time a new refill is installed.</td>
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K 353 NFPA 101 Sprinkler System - Maintenance and Testing | K 353 |

FORM CMS-2567(02-99) Previous Versions Obsolete

If continuation sheet Page 8 of 16
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 residents, staff and visitors utilizing the ADA bath of the Physical Therapy on the date of the survey. The facility is licensed for 30 SNF/NF beds and had a census of 20 on the day of the survey.

Findings include:

During the facility tour conducted on May 1, 2017 from approximately 10:00 AM to 2:30 PM, observation of the installed fire sprinkler pendants revealed the cone and glass bulb of the fire suppression pendant above the tub in the ADA

K353

1. On or before May 17, 2017 the sprinkler head located in the bath area of the Rehab gym was replaced by All Valley Fire, the facility’s fire equipment maintenance, testing, and repair contractor.

2. On or before May 17, 2017 an inspection was completed by All Valley Fire, of all fire sprinkler equipment in the facility; including all sprinkler heads. Any equipment found to not meet the NFPA 101 standard was repaired or replaced. All Valley Fire has provided a report validating that all fire equipment, including sprinkler heads meets the requirement under NFPA 101.

3. On or before May 17, 2017 the facility Executive Director, has verified the current contract with a professional fire systems service and repair company, All Valley Fire, for the routine inspection and maintenance of fire suppression equipment in the facility.
<table>
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<tr>
<th>ID</th>
<th>PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
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<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tbody>
<tr>
<td>K 353</td>
<td>Continued From page 9 bath of Physical Therapy, was coated with a non-factory applied paint</td>
<td>K 353</td>
<td>4. Beginning June 2017 for three months, and ongoing thereafter as needed, the facility Executive Director, or designee will present, any inspection and repair reports from the facility's contracted fire systems service and repair company, as part of the facility Safety Committee review. Any negative variances will be addressed by the facility QAPI committee as with a Performance Improvement Plan.</td>
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Interview of the Administrator revealed he was not aware of the painted sprinkler pendant 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* 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).

5.2.1.2 Any sprinkler that shows 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) Painting unless painted by the sprinkler manufacturer

K 918 NFPA 101 Electrical Systems - Essential Electric Syste K 918

Electrical Systems - Essential Electric System.
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<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tbody>
<tr>
<td>K918</td>
<td>Continued From page 10</td>
<td>Maintenance and Testing</td>
<td>K918</td>
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</table>

The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.

Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.

6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)

This Standard is not met as evidenced by:

1. On or before May 17, 2017 the facility generator was tested for a 90-minute interval by the facility van driver or designee. The results of the test were documented.

2. On or before May 17, 2017 a second 90-minute generator test was performed by the facility Executive Director. The results of the test were documented.

3. On or before May 17, 2017 the facility Executive Director educated facility staff responsible for generator testing and documentation regarding the NFPA 110 guidance on this topic. On or before May 17, 2017 generator testing, as required under NFPA 110 was added to the electronic Preventive Maintenance schedule and tracking program TELS.

4. Beginning in June 2017 for three months, the facility Executive Director, or designee will present the completed TELS documentation for Generator...
## Statement of Deficiencies and Plan of Correction

### (X1) Provider/Supplier/CUA Identification Number

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<tr>
<th>ID</th>
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<td>K 918</td>
<td>Continued From page 11</td>
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</table>

### (X2) Multiple Construction

| (A) Building 01 - Riverview Rehabilitation |
| (B) Wing |

### (X3) Date Survey Completed

<table>
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<tr>
<th>Date Survey Completed</th>
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<tbody>
<tr>
<td>05/01/2017</td>
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</tbody>
</table>

### Name of Provider or Supplier

| Riverview Rehabilitation |

### Street Address, City, State, Zip Code

| 3550 West Americana Terrace |
| Boise, ID 83706 |

### Summary Statement of Deficiencies

(Each deficiency must be preceded by full regulatory or LSC identifying information)

<table>
<thead>
<tr>
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### Provider's Plan of Correction

(Each corrective action should be cross-referenced to the appropriate deficiency)

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<tr>
<td>K 923</td>
<td>NFPA 101 Gas Equipment - Cylinder and Container Storage</td>
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</tbody>
</table>

### Findings Include:

During review of provided generator inspection and monthly load testing documentation conducted on May 1, 2017 from approximately 9:00 AM to 10:00 AM, records provided for weekly inspections revealed missing documentation for three of five weeks in March of 2017 and two of four weeks in April 2017. Further review revealed no monthly load test had been conducted since January of 2017. When asked about the missing documentation, the staff assigned to generator inspection and load testing stated he was unaware of the NFPA 110 requirements.

### Actual NFPA Standard:

NFPA 110

8.4 Operational Inspection and Testing.

8.4.1* EPSSs, including all appurtenant components, shall be inspected weekly and exercised under load at least monthly.

8.4.2* Diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:

1. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer
2. Under operating temperature conditions and at not less than 30 percent of the EPS nameplate kW rating

K 923 testing in the facility QAPI meeting monthly for three months, as part of the facility Safety Committee review. Any negative variances will be addressed by the facility QAPI committee as with a Performance Improvement Plan.

K 918
**K 923 Continued From page 12**

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 in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (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

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<tr>
<td>1. On or before May 17, 2017 the gas cylinders, both empty and full, were removed from the facility by the facility's oxygen supply company, SMS.</td>
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<tr>
<td>2. On or before May 17, 2017 SMS checked all areas of the facility for empty or full gas oxygen cylinders. None were found.</td>
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<tr>
<td>3. On or before May 17, 2017 the Executive Director educated the oxygen supply company, SMS, of the need to keep empty and full gas cylinders separate; or otherwise indicate their empty or full status. Additionally, the gas cylinders were removed from the facility, except for the single cylinder kept on the &quot;crash&quot; cart, which is replaced when used. On or before May 17, 2017 the oxygen storage rooms were checked by the facility Executive Director to ensure that no gas oxygen cylinders remain.</td>
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<td>4. Beginning the week of May 15, 2017 the oxygen supply and transfill rooms will be checked</td>
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### ID SUMMARY

#### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

<table>
<thead>
<tr>
<th>(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:</th>
<th>(X2) A. BUILDING 01 - RIVERVIEW REHABILITATION</th>
<th>(X3) DATE SURVEY COMPLETED</th>
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<tr>
<td>135139</td>
<td>B. WING</td>
<td>05/01/2017</td>
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#### NAME OF PROVIDER OR SUPPLIER

RIVERVIEW REHABILITATION

#### STREET ADDRESS, CITY, STATE, ZIP CODE

3550 WEST AMERICANA TERRACE
BOISE, ID 83706

#### ID PREFIX TAG

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<tr>
<td>K 923</td>
<td>Continued From page 13 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 30 SNF/NF beds and had a census of 20 on the day of the survey. Findings include: During the facility tour conducted on May 1, 2017 from approximately 10:30 AM to 2:30 PM, observation of the oxygen storage room in the 100 hall west, revealed six (6) full cylinders in the same rack with one (1) empty cylinder. When asked how to identify full from empty oxygen cylinders, the Administrator stated the full cylinders have a plastic cap and empty cylinders do not, or staff could check the gauge to confirm 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 confusion and delay if a full cylinder is needed in a rapid manner. <strong>K 927</strong> NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders <strong>K 927</strong> weekly for one month and monthly thereafter by the facility Executive Director to ensure that they meet the requirements under NFPA 110 Beginning in June 2017 for three months, the facility Executive Director, or designee will present the results of those checks in the facility QAPI meeting monthly for three months, as part of the facility Safety Committee review. Any negative variances will be addressed by the facility QAPI committee as with a Performance Improvement Plan.</td>
<td>K 923</td>
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Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99).

This Standard is not met as evidenced by:

Based on observation and operational testing, the facility failed to ensure liquid oxygen transfilling was conducted in accordance with NFPA 99. Failure to transfill liquid oxygen with mechanical ventilation could result in creating an oxygenated environment, increasing the risk of accidental combustion. This deficient practice affected 10 residents, staff and visitors on the date of the survey. The facility is licensed for 30 SNF/NF beds and had a census of 20 on the day of the survey.

Findings include:

During the facility tour conducted on May 1, 2017 from approximately 10:00 AM to 2:30 PM, observation and operational testing of the fan for the oxygen storage/transfill area abutting room 125, revealed the fan was operational, but would not draw gases out of the space, as the damper to the ducting was shut.

Actual NFPA standard:

NFPA 99
11.5.2.3 Transfilling Liquid Oxygen. Transfilling of
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<td>Continued From page 15 liquid oxygen shall comply with 11.5.2.3.1 or 11.5.2.3.2, as applicable. 11.5.2.3.1 Transfilling to liquid oxygen base reservoir containers or to liquid oxygen portable containers over 344.74 kPa (50 psi) shall include the following: (1) A designated area separated from any portion of a facility wherein patients are housed, examined, or treated by a fire barrier of 1 hour fire-resistive construction. (2) The area is mechanically ventilated, is sprinklered, and has ceramic or concrete flooring. (3) The area is posted with signs indicating that transfilling is occurring and that smoking in the immediate area is not permitted. (4) The individual transfilling the container(s) has been properly trained in the transfilling procedures. 9.3.7.5.3.2 Mechanical exhaust shall be at a rate of 1 L/sec of airflow for each 300 L (1 cfm per 5 ft³ of fluid) designed to be stored in the space and not less than 24 L/sec (50 cfm) nor more than 235 L/sec (500 cfm).</td>
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<td>under NFPA 99. Beginning in June 2017 for three months, the facility Executive Director, or designee will present the results of those checks in the facility QAPI meeting monthly for three months, as part of the facility Safety Committee review. Any negative variances will be addressed by the facility QAPI committee as with a Performance Improvement Plan.</td>
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