



C.L. "BUTCH" OTTER - Governor  
RICHARD M. ARMSTRONG - Director

IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

DEBBY RANSOM, R.N., R.H.I.T. - Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, Idaho 83720-0009  
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**CERTIFIED MAIL: 7007 3020 0001 4051 1265**

March 1, 2013

James H. Hayes, Administrator  
River Ridge Care & Rehabilitation Center  
640 Filer Avenue West  
Twin Falls, ID 83301-4533

Provider #: 135106

Dear Mr. Hayes:

On **February 20, 2013**, a Facility Fire Safety and Construction survey was conducted at **River Ridge Care & Rehabilitation 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, and a similar State Form 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 both Statement of Deficiencies and Plan of Correction, Form CMS-2567 and State Form, in the spaces provided and return the originals to this office.

James H. Hayes, Administrator

March 1, 2013

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Your Plan of Correction (PoC) for the deficiencies must be submitted by **March 14, 2013**. Failure to submit an acceptable PoC by **March 14, 2013**, may result in the imposition of civil monetary penalties by **April 3, 2013**.

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.

All references to federal regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

**The date of this survey falls within the enforcement dates of the health survey Recertification and State Licensure survey conducted February 15, 2013. Therefore, remedies recommended in our letter of March 1, 2013 (enclosed) will apply as outlined in that letter. The facility will need to correct ALL deficiencies, both health and fire safety, in order to achieve substantial compliance.**

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **August 15, 2013**, 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

James H. Hayes, Administrator  
March 1, 2013  
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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 15, 2013**, 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:

<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:

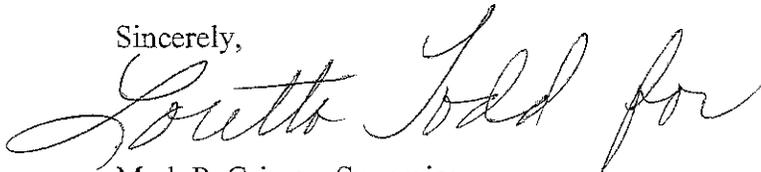
BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process  
2001-10 IDR Request Form

This request must be received by **March 14, 2013**. If your request for informal dispute resolution is received after **March 14, 2013**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,



Mark P. Grimes, Supervisor  
Facility Fire Safety and Construction

MPG/dmj

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

Printed: 02/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135106</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - ENTIRE BUILDING</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/20/2013</b>
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NAME OF PROVIDER OR SUPPLIER <b>RIVER RIDGE CARE &amp; REHABILITATION CENT</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>640 FILER AVENUE WEST TWIN FALLS, ID 83301</b>
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(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
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K 000	INITIAL COMMENTS  The facility is a single story Type V (111) fully sprinklered structure that was built in 1960. A renovation was completed in 1998. It has a basement area accessible by staff only. Currently the facility is licensed for 158 SNF/NF beds.  The following deficiencies were cited during the annual fire/life safety survey conducted on February 20, 2013. 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:  Tom Mroz CFI-II Health Facility Surveyor 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, River Ridge Care and Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4  This Standard is not met as evidenced by: Based on observation and interview, the facility failed to maintain the smoke resistive properties of smoke barrier walls and ceilings. The deficient	K 025	<b>K025</b>  The unsealed penetrations in the physical therapy room, housekeeping room 200, attic in the kitchen and kitchen dry storage room will be corrected by the Maintenance Director on or before 03/20/13.  The remainder of the center will be inspected by the maintenance Director and Administrator on or before 3/20/13 to identify any additional smoke barrier penetrations.  Beginning the week of 03/20/13, the Maintenance Director will inspect the work of all outside vendors upon completing of their work to assure that no smoke compartments have been compromised. The results of these inspections will be presented to the Performance Improvement (PI) Committee as a part of the maintenance department report for review and recommendations.	03/20/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>Administrator</b>	(X6) DATE <b>03-14-2013</b>
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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.

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 CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER <b>RIVER RIDGE CARE &amp; REHABILITATION CENT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>640 FILER AVENUE WEST TWIN FALLS, ID 83301</b>		
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K 025	<p>Continued From page 1</p> <p>practice affected three of ten smoke compartments, staff, and 45 residents. The facility has the capacity for 158 beds with a census of 45 the day of survey.</p> <p>Findings include:</p> <p>1.) Observation on 02/20/13 at 11:43 a.m., revealed that there was a one half inch unsealed penetration for a wire that passed through the physical therapy room smoke barrier wall. Interview on 02/20/13 at 11:43 a.m., with the facility Maintenance Supervisor revealed that the facility was not aware of the unsealed penetration in the smoke barrier wall.</p> <p>2.) Observation on 02/20/13 at 11:55 a.m., revealed that there were five unsealed penetrations in the annular space around five pipes that passed through the smoke barrier ceiling into the attic in housekeeping room 200. Interview on 02/20/13 at 11:55 a.m., with the facility Maintenance Supervisor revealed that the facility was not aware of the unsealed penetrations in the smoke barrier ceiling.</p> <p>3.) Observation on 02/20/13 at 12:35 p.m., revealed that there was an approximately one inch unsealed penetration in the annular space around a wire that passed through the smoke barrier ceiling into the attic in the kitchen. Interview on 02/20/13 at 12:35 p.m., with the facility Maintenance Supervisor revealed that the facility was not aware of the unsealed penetration in the smoke barrier ceiling.</p> <p>4.) Observation on 02/20/13 at 12:44 p.m., revealed that there was an approximately one inch unsealed penetration in the annular space around the sprinkler head located in the kitchen</p>	K 025	The facility Maintenance Director will be responsible for compliance.		

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K 025	Continued From page 2 dry good storage room. Interview on 02/20/13 at 12:44 p.m., with the facility Maintenance Supervisor revealed that the facility was aware of the penetration but had not had time to fix it.  The finding was acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 02/20/13.  Actual NFPA Standard: NFPA 101, 8.3.6.1 (1) a. and b. Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected by filling the space between the penetrating item and the smoke barrier with a material that is capable of maintaining the smoke resistance of the smoke barrier or it shall be protected by an approved device that is designed for the specific purpose.	K 025			
K 038 SS=F	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 and interview, the facility failed to maintain exits free of obstructions. This potentially prevents patients from leaving a smoke or fire environment. The deficient practices affected two of ten smoke compartments, staff and 45 residents. The facility has the capacity for 158 beds with a census of 45 the day of survey.	K 038	<b>K038</b> The snow removal that was under-way at the time of the survey was completed for the emergency egress areas.  No additional areas were identified.  The maintenance staff will be educated on or before 3/20/13 by the Administrator as to the emergency egress regulation.  Beginning the week of 03/15/13, the emergency egress exits will be audited by the Maintenance Director weekly for 3 months to assure that they are clear from potential obstructions. The results of the audits will be reported to the PI committee for 3 months.  The Maintenance Director will be responsible for compliance.	03/20/13	

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K 038	Continued From page 3 Findings include  Observation on 02/20/13 between 11:40 a.m. and 1:00 p.m., revealed that the exit off of the 300 hall, 200 hall, 100 hall TV room and two of four dining room exits discharged onto walkways that were covered in approximately 1-3 inches of snow with no clear path leading to a public way. The exits were identified as a required emergency exits on the facility evacuation plan and were identified by emergency illuminated exit signs. Interview with the Maintenance Supervisor on 02/20/13 at 11:40 a.m., revealed that the facility did not have staff available to shovel all of the sidewalks.  The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 02/20/13.  Actual NFPA Standards: NFPA 101, 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K 038			
K 062 SS=F	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 had not ensured that the automatic fire sprinkler system had been maintained to respond	K 062	<b>K062</b>  The obstruction in the speech therapy closet was removed by the Maintenance Director on 03/15/13.  The facility was inspected by the Maintenance Director and Administrator on 03/15/13 for any further obstructions.  Beginning the week of 03/15/13, the Maintenance Director will audit the center weekly for 3 months to assure there are no obstructions that could potentially block water flow from the sprinkler heads.  The results of the audits will be presented to the PI committee by the Maintenance Director for 3 months.  The Maintenance Director will be responsible for compliance.	03/20/13	

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K 062	Continued From page 4 according to design. The deficient practice affected one of ten smoke compartments, staff, and 21 residents. The facility has the capacity for 158 beds with a census of 45 the day of survey.  Findings include:  Observation on 02/20/13 at 11:45 a.m., disclosed the sprinkler head in the speech therapy closet was obstructed by items stored on the top shelf within 18" of the sprinkler deflector. A partially blocked head would not allow a sprinkler head spray pattern to be diffused in an efficient manner as designed. Interview on 02/20/13 at 11:45 a.m., with the facility Maintenance Supervisor revealed that the facility was not aware that the sprinkler head was obstructed.  The finding was acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 02/20/13.  Actual NFPA Standard: NFPA 13 5-5.6 Clearance to Storage. The clearance between the deflector and the top of storage shall be 18 in. (457 mm) or greater.	K 062			
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2  This Standard is not met as evidenced by: Based on observation and interview, the facility failed to prohibit the use of extension cords for equipment that requires connection to permanent hard wired outlets. The deficient practice affected two of ten smoke compartments, staff, and residents. The facility has the capacity for 158	K 147	<u><b>K147</b></u>  The wiring of the Wifi system in the therapy department was corrected on 03/07/13.  The wiring on the laundry room was corrected on 03/07/13.  The facility was inspected by the Maintenance Director and Administrator on 03/08/13 to assure there are no other extension cords in use.  Beginning 03/15/13The Maintenance Director will inspect the center weekly for 3 months for the use of extension cords.  On or before 03/20/13, the Maintenance Director will be was educated by the Administrator as to the use of extension cords.  The Maintenance Director will report the results of the inspections to the PI committee for 3 months.  The Maintenance Director will be responsible for compliance.		

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NAME OF PROVIDER OR SUPPLIER <b>RIVER RIDGE CARE &amp; REHABILITATION CENT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>640 FILER AVENUE WEST TWIN FALLS, ID 83301</b>		
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K 147	<p>Continued From page 5 beds with a census of 45 the day of survey.</p> <p>Findings include:</p> <p>1.) Observation on 02/20/13 at 11:57 a.m. revealed that an extension cord in housekeeping room 200 was plugged into an outlet, run through the attic space to the physical therapy room to power an internet Wi-Fi system. Interview with the facility Maintenance Supervisor on 02/20/13 at 11:57 a.m., revealed the facility was unaware the extension cord use was not permitted.</p> <p>2.) Observation on 02/20/13 at 12:15 p.m. revealed that a furnace condensate pump in the laundry room was plugged into an extension cord and not directly into the adjacent wall outlet. Interview with the facility Maintenance Supervisor on 02/20/13 at 12:15 p.m., revealed the facility intended having an electrician fix the outlet next to the pump someday.</p> <p>The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 02/20/13.</p> <p>Actual NFPA Standard: NFPA 70 400-8. Uses Not Permitted Unless specifically permitted in Section 400-7, flexible cords and cables shall not be used for the following:</p> <ol style="list-style-type: none"> <li>1. As a substitute for the fixed wiring of a structure</li> <li>2. Where run through holes in walls, structural ceilings suspended ceilings, dropped ceilings, or floors</li> <li>3. Where run through doorways, windows, or similar openings</li> <li>4. Where attached to building surfaces</li> </ol>	K 147			

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K 147	Continued From page 6 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			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001650</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - ENTIRE BUILDING</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/20/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>RIVER RIDGE CARE &amp; REHABILITATION CENT</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>640 FILER AVENUE WEST TWIN FALLS, ID 83301</b>
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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2.</p> <p>The facility is a single story Type V (111) fully sprinklered structure that was built in 1960. A renovation was completed in 1998. It has a basement area accessible by staff only. Currently the facility is licensed for 158 SNF/NF beds.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on February 20, 2013. The facility was surveyed under IDAPA 16.03.02, Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities.</p> <p>The surveyor conducting the survey was:</p> <p>Tom Mroz CFI-II Health Facility Surveyor Facility Fire Safety and Construction</p>	C 000	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, <b>CENTER NAME Care &amp; Rehabilitation Center</b> does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p> <p style="text-align: center;">RECEIVED MAR 15 2013 FACILITY STANDARDS</p>	
C 226	<p>02.106 FIRE AND LIFE SAFETY</p> <p>106. FIRE AND LIFE SAFETY. Buildings on the premises used as facilities shall meet all the requirements of local, state and national codes concerning fire and life safety standards that are applicable to health care facilities. This Rule is not met as evidenced by: Refer to the following Federal "K" tags on the CMS - 2567:</p> <p>1. K025 Penetrations.</p>	C 226	<p>C226</p> <p>See Plan of Corrections for K025, K062, K072, and K147</p> <p>038 ADJUSED ADMIN 3/22/13 F</p>	

Bureau of Facility Standards	<i>James H. Hagle</i>	TITLE <i>Administrator</i>	(X6) DATE <b>03-14-2013</b>
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001650</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - ENTIRE BUILDING</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/20/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>RIVER RIDGE CARE &amp; REHABILITATION CENT</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>640 FILER AVENUE WEST TWIN FALLS, ID 83301</b>		
(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) COMPLETE DATE
C 226	Continued From page 1 2. K062 Sprinkler Obstruction 3. <del>K072</del> Means of egress. <i>Revised Admin 2/22/13 39 -TSC</i> 4. K147 Extension Cords.	C 226		