



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 85720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7012 1010 0002 0836 3998

May 28, 2014

James Hayes, Administrator
River Ridge Center
640 Filer Avenue West
Twin Falls, ID 83301-4533

Provider #: 135106

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Mr. Hayes:

On **May 20, 2014**, a Facility Fire Safety and Construction survey was conducted at **River Ridge 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

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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.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **June 10, 2014**. Failure to submit an acceptable PoC by **June 10, 2014**, may result in the imposition of civil monetary penalties by **June 29, 2014**.

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 and the state licensure survey report, State Form.

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 24, 2014**, (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 24, 2014**. A change in the seriousness of the deficiencies on **June 24, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **June 24, 2014**, includes the following:

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Denial of payment for new admissions effective **August 20, 2014**.
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 20, 2014**, 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 **May 20, 2014**, 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>

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Go to the middle of the page to Information Letters section and click on State and select the following:

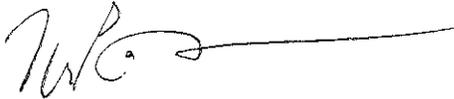
BFS Letters (06/30/11)

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

This request must be received by **June 10, 2014**. If your request for informal dispute resolution is received after **June 10, 2014**, 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,

A handwritten signature in black ink, appearing to read 'M. Grimes', followed by a long horizontal line extending to the right.

Mark P. Grimes, Supervisor
Facility Fire Safety and Construction

MPG/lj

Enclosures

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

Printed: 05/23/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135106	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/20/2014
NAME OF PROVIDER OR SUPPLIER RIVER RIDGE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 640 FILER AVENUE WEST TWIN FALLS, ID 83301	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The facility is a single story Type V (111) 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 April 20, 2014. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70 and IDAPA 16.03.02, Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities. The Survey was conducted by: Dan Holbrook Health Facility Surveyor	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.” RECEIVED JUN 10 2014 FACILITY STANDARDS	
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 the facility failed to maintain the smoke resistance of the basement	K 025	K 025 Affected: On 28 May 2014, the Maintenance Director sealed the penetration in the Maintenance Shop ceiling and taped the drywall seam in the same area. Potential: On 05 June 2014, the Maintenance Director inspected the entire facility for smoke/fire barrier penetrations and found no issues Systemic: The Maintenance Director was educated by the Administrator on 06 June 2014 regarding smoke/fire barrier penetration management.	06/24/14

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

TITLE

(X6) DATE

Jan A. Nye

Administrator

06/09/14

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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K 025	Continued From page 1 ceiling smoke barrier . This deficient practice will allow products of combustion to penetrate the directly into patient sleeping rooms. This condition affected 37 residents, staff, and visitors. The facility is licensed for 119 beds with a census of 37 the day of survey. Findings include: Observation on April 20, 2014 at 1:36 pm revealed that the maintenance shop in the basement had a penetration through the smoke barrier ceiling approximately 4 feet wide by 18 inches deep. 1 drywall seam was not fire taped in the same area. This condition was observed by the Maintenance Engineer and the Surveyor. The finding was acknowledged by the Administrator and the Maintenance Engineer at the exit interview on April 20, 2014 at 2:45 pm. Actual NFPA Standard: NFPA 101, 19.3.7.3. Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour.	K 025	QA Audit: Beginning 13 June 2014, The Maintenance Director will inspect the facility monthly for 4 months for smoke/fire barrier penetrations, making repairs as necessary. Inspection and repair results will be reviewed in the monthly PI Safety Committee meeting. Compliance will insured by the Administrator.		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1	K 029	K 029 Affected: On 26 May 2014, the corridor door to the Central Supply storage area was provided with self-closing device by the Maintenance Director. Potential: On 03 June 2014, all storage rooms and hazardous areas were inspected by the Maintenance Director for the presence of functioning door closers. All the rooms were found to have door closers in place.	06/24/14	

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K 029	Continued From page 2 This Standard is not met as evidenced by: Based on observation and operational testing the facility failed to provide separation of hazardous areas from other areas in the facility. Failing to provide separation can result in products of combustion to pass through a smoke barrier. The deficient practice affected 37 residents and staff. The facility is licensed for 119 beds and had a census of 37 the day of survey. Findings include: Observation and operational testing on April 20, 2014 at 1:10 pm revealed that the corridor door to the central supply storage room was not equipped with a self closing device. This room was in excess of 50 square feet and was being used for storage of combustible material. This condition was observed by the Maintenance Engineer and the Surveyor. The finding was acknowledged by the Administrator and the Maintenance Engineer at the exit interview on April 20, 2014 at 2:45. Actual NFPA Standard: NFPA 101, 19.3.2.1. Hazardous areas shall be safeguarded by a fire barrier of one-hour fire resistance rating or provided with an automatic sprinkler system. Doors shall be self closing or be equipped with automatic closing devices. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors.	K 029	Systemic: On 06 June 2014, the Maintenance Director was educated by the Administrator on the importance of installing closers on storage room doors as the utilization of the rooms change. On 04 June 2014, room utilization changes were added as an agenda item to the daily Stand Up meeting. QA Audit: Beginning 13 June 2014, the Maintenance Director will inspect storage rooms and hazardous areas for the presence of functioning door closers monthly for 4 months. The results of this audit will be reviewed in the monthly PI Safety Committee meeting. Compliance will be monitored by the Administrator.	
K 045 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single	K 045	K 045 Affected: On 30 May 2014, a light fixture was installed outside the 200 hallway exit door.	06/24/14

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K 045	Continued From page 3 lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This Standard is not met as evidenced by: Observation revealed the facility did not provide exit discharge lighting. This deficiency can leave the exit discharge in darkness resulting in unsafe egress. This deficiency affected 10 residents, visitors and staff members. The facility is licensed for 119 beds had a census of 37 on the day of survey. Findings include: Observation on April 20, 2014 at 1:05 pm observation of the exit discharge from the 200 hallway revealed that it was not equipped with a lighting fixture. This condition was observed by the Maintenance Engineer and Surveyor. The finding was acknowledged by the Administrator and Maintenance Engineer at the exit interview on April 20, 2014 at 2:45 pm. Actual NFPA Standard: 19.2.8 Illumination of Means of Egress. Means of egress shall be illuminated in accordance with Section 7.8. 7.8.1.4* Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area.	K 045	Potential: On 12 June 2014, all exit doors were inspected by the Maintenance Director for the presence of a functioning light on the outside wall. All exits were found to be in compliance. Systemic: On 06 June 2014, the Maintenance Director was educated by the Administrator regarding the presence of outside safety lighting. QA Audit: Beginning 13 June 2014, the Maintenance Director will inspect all outside exit lighting monthly for 4 months to insure all lights are present and functioning. The results of this inspection will be presented in the Monthly PI Safety Committee meeting. Compliance will be monitored by the Administrator.	
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD	K 062	K 062 Affected: On 03 June 2014, the sprinkler heads identified by the State Surveyor were repaired by a licensed fire protection contractor.	06/24/14

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K 062	<p>Continued From page 4</p> <p>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</p> <p>This Standard is not met as evidenced by: Based on observation and interview the facility did not ensure that the sprinkler system was maintained in accordance with NFPA 25. Maintaining the sprinkler system helps to ensure system reliability. The facility is licensed for 119 beds and had a census of 37 on the day of survey. This deficiency affected all residents, visitors, and staff.</p> <p>Findings include:</p> <p>During the survey of the facility on April 20, 2014 between the hours of 12:15 pm and 2:30 pm, observation revealed sprinkler heads which are positioned below the ceiling more than when installed. Interview with the Administrator and Maintenance Engineer revealed recent work had been performed on the system leading them to speculate work by the facility workers had been the cause. The location of the heads noted are as follows; room #118 at 12:40 pm, room # 210 at 1:00 pm, room # 307 at 1:20 pm, and the TV room at 2:30 pm. More were observed but not documented due to system wide observation. This deficiency creates an annular space around the pipe allowing products of combustion to pass. This condition was observed by Maintenance Engineer and Surveyor.</p> <p>The finding was acknowledged by the Administrator and Maintenance Supervisor at the</p>	K 062	<p>Potential: On 03 June 2014, the entire facility was inspected by the Maintenance Director and a licensed fire protection contractor for the presence of protruding sprinkler heads. On 03 June 2014, all sprinkler heads found not to be in compliance were repaired by the licensed fire protection contractor.</p> <p>Systemic: On 06 June 2014 The Maintenance Director was educated by the Administrator regarding the proper alignment of the fire suppression system sprinkler heads. Beginning 01 June 2014, sprinkler heads will be inspected for protrusions by the Maintenance Director after contractors have access to the attic area.</p> <p>QA Audit: Beginning at 13 June 2014, the Maintenance Director will inspect sprinkler heads for proper alignment monthly for four months. The results of this inspection will be presented in the Monthly PI Safety Committee meeting. Compliance will be monitored by the Administrator.</p>	

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K 062	Continued From page 5 exit interview on April 20, 2014 at 2:45 pm. Actual NFPA Standards NFPA 101, 4.6.12.1 Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be continuously maintained in accordance with applicable NFPA requirements or as directed by the authority having jurisdiction. NFPA 13, 3-2.7.2* Escutcheon plates used with a recessed or flush-type sprinkler shall be part of a listed sprinkler assembly. NFPA 101, 4.6.12.1. Every required sprinkler system shall be continuously maintained in proper operating condition.	K 062			
K 147 SS=D	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 the facility failed to prohibit the use of relocatable power taps or extension cords for medical equipment that require connection to permanent hard wired outlets. This deficient practice may cause the medical equipment to fail. The deficient practice affected 1 resident. The facility is licensed for 119 beds and had a census of 37 the day of survey.	K 147	K 147 Affected: On 21 May 2014, the oxygen concentrator in room 206 was plugged into a proper receptacle. Potential: On 12 June 2014, the Maintenance Director inspected all resident rooms to ensure medical equipment electrical plugs were connected to proper receptacles. No issues were found.	06/24/14	

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K 147	<p>Continued From page 6</p> <p>Findings include:</p> <p>Observation on April 20, 2014 at 12:57 pm in room #206 revealed an oxygen concentrator machine plugged into a relocatable power tap. This condition was observed by the Maintenance Engineer and the Surveyor.</p> <p>The findings were acknowledged by the General Manager and the Maintenance Engineer at the exit interview on April 20, 2014 at 2:45 pm.</p> <p>Actual NFPA Standard</p> <p>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"> 1. As a substitute for the fixed wiring of a structure 2. Where run through holes in walls, structural ceilings suspended ceilings, dropped ceilings, or floors 3. Where run through doorways, windows, or similar openings 4. Where attached to building surfaces <p>Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of Section 364-8.</p> <ol style="list-style-type: none"> 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	<p>Systemic: On 06 June 2014, the Maintenance Director was educated by the Administrator regarding surveillance of medical equipment connections in resident rooms. On or before 24 June 2014, facility staff will be educated on the importance of connecting medical equipment to the proper receptacles.</p> <p>QA Audit: Beginning 13 June 2014, the Maintenance Director will inspect all resident rooms to ensure medical equipment is connected to proper electrical receptacles, weekly for 4 weeks and monthly for 3 months. The results of these inspections will be presented in the monthly PI Safety Committee meeting. Compliance will be monitored by the Administrator.</p>		

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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 April 20, 2014. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70 and IDAPA 16.03.02, Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities.</p> <p>The Survey was conducted by:</p> <p>Dan Holbrook Health Facility Surveyor</p>	C 000		
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 form 2567</p> <p>K 25 Basement ceiling K 29 Central Supply Door K 45 Exterior Discharge Lights K 62 Sprinkler Heads</p>	C 226	<p>C 226</p> <p>Please refer to the following Plans of Correction on the form 2567: K 025 Basement Ceiling K 029 Central Supply Door K 045 Exterior Discharge Lights K 062 Sprinkler Heads K 147 O2 Concentrator</p>	06/24/14

RECEIVED
JUN 10 2014
FACILITY STANDARDS

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

TITLE

(X6) DATE

J. D. Dg

Administrator

06/09/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135106	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/20/2014
NAME OF PROVIDER OR SUPPLIER RIVER RIDGE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 640 FILER AVENUE WEST TWIN FALLS, ID 83301		
(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
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If deficiencies are cited, an approved plan of correction is requisite to continued program participation.