



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 Eder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7007 3020 0001 4038 9819

November 4, 2014

David Farnes, Administrator
Kindred Nursing & Rehabilitation - Aspen Park
420 Rowe Street
Moscow, ID 83843-9319

Provider #: 135093

**RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER
LETTER**

Dear Mr. Farnes:

On **October 20, 2014**, a Facility Fire Safety and Construction survey was conducted at **Kindred Nursing & Rehabilitation - Aspen Park** 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.

David Farnes, Administrator
November 4, 2014
Page 2 of 4

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.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **November 17, 2014**. Failure to submit an acceptable PoC by **November 17, 2014**, may result in the imposition of civil monetary penalties by **December 7, 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 **November 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 **November 24, 2014**. A change in the seriousness of the deficiencies on **November 24, 2014**, may result in a change in the remedy.

David Farnes, Administrator
November 4, 2014
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The remedy, which will be recommended if substantial compliance has not been achieved by **November 24, 2014**, includes the following:

Denial of payment for new admissions effective **January 20, 2015**.
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 **April 20, 2015**, 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 **October 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.

David Farnes, Administrator
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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 **November 17, 2014**. If your request for informal dispute resolution is received after **November 17, 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,



Mark P. Grimes, Supervisor
Facility Fire Safety and Construction

MPG/pmt
Enclosures

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

Printed: 10/30/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135093	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/20/2014
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NAME OF PROVIDER OR SUPPLIER KINDRED NURSING & REHABILITATION - ASP	STREET ADDRESS, CITY, STATE, ZIP CODE 420 ROWE STREET MOSCOW, ID 83843
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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	<p>INITIAL COMMENTS</p> <p>The facility is a single story Type V(111) building, with two partial basements. The facility is fully sprinklered, with smoke detectors in corridors and open spaces. It was built in 1965 and is currently licensed for 70 SNF/NF beds.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on October 20, 2014. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.</p> <p>The survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	K 000	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>	
K 022 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that exits were clearly identified by appropriate means. Failure to ensure exits are identified clearly would hinder the safe evacuation</p>	K 022	<p>K 022</p> <p>Specific Residents</p> <p>The facility will ensure that exits are clearly identified by an appropriate means to promote the safe evacuation of building occupants during an emergency in the 2 smoke departments noted that potentially could have affected 33 residents, staff and visitors.</p> <ol style="list-style-type: none"> 1) An additional exit sign will be installed that is visible from outside room 111 when the smoke compartment doors are open or closed. 2) The exit sign will be moved to the side so that the hallway light will not obstruct the view of the exit sign from the hallway outside room 111. 	<p>RECEIVED</p> <p>NOV 17 2014</p> <p>FACILITY STANDARDS</p> <p>Enter Date Here. 11/24/14</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Executive Director	(X6) DATE 11-17-14
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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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K 022	<p>Continued From page 1</p> <p>of occupants during an emergency. This deficient practice affected 33 residents, staff and visitors in 2 of 4 smoke compartments on the date of the survey. The facility is licensed for 70 SNF/NF beds and had a census of 43 on the day of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on October 20, 2014 from 1:30 PM to 3:45 PM, observation of the corridor in the 100 south wing found that when viewed from room 111, the exit sign located on the north side of the smoke compartment doors was not visible with the doors either in the open or closed (activated) positions.</p> <p>2) During the facility tour conducted on October 20, 2014 from 1:30 PM to 3:45 PM, observation of the exit sign located at the former Secure Care Unit exit door in the 100 south wing from room 111, found that the sign was fully obscured by the installation of a hallway light when facing south toward the exit.</p> <p>3) During the facility tour conducted on October 20, 2014 from 1:30 PM to 3:45 PM, observation of the exit sign located at the west exit access adjacent to room 104, found the exit sign indicated the appropriate direction of egress was to the left or right which led occupants into the walls. Interview of the Maintenance Supervisor and the Administrator in Training at the noted locations in findings 1, 2 and 3 found that neither staff member was aware of the confusing nature of these signs prior to the date of the survey.</p> <p>4) During the facility tour conducted on October 20, 2014 from 1:30 PM to 3:45 PM, of the 200 west corridor found no exit sign was visible when</p>	K 022	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>3) The arrows pointing left or right have been removed from the exit sign over the door of the exit access adjacent to room 104 to eliminate confusion over which direction to proceed.</p> <p>4) A new exit sign will be added so that someone on the 200 hall looking east can see an exit sign when the smoke department doors are closed.</p> <p>5) An appropriate direction arrow has been added to the exit sign for the end of the west corridor so that it will be clear that one has to turn to the right at the exit sign and proceed through the door.</p> <p>Other Residents</p> <p>Facility review determined no other halls or compartments had exit signs that were not visible or confusing.</p> <p>Systemic Changes</p> <p>The facility will ensure that any repairs, lighting fixture additions or construction in the hallways will not result in blocking clear</p>	

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NAME OF PROVIDER OR SUPPLIER KINDRED NURSING & REHABILITATION - ASP		STREET ADDRESS, CITY, STATE, ZIP CODE 420 ROWE STREET MOSCOW, ID 83843		
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K 022	Continued From page 2 facing east toward the main exit when the smoke compartment doors located at room 203 were activated. 5) During the facility tour conducted on October 20, 2014 from 1:30 PM to 3:45 PM, observation of the 200 west corridor found that the exit sign located at the west exit access directed occupants straight ahead into the wall. Actual NFPA standard: 7.10.1.4* Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. Sign placement shall be such that no point in an exit access corridor is in excess of 100 ft (30 m) from the nearest externally illuminated sign and is not in excess of the marked rating for internally illuminated signs. Exception: Signs in exit access corridors in existing buildings shall not be required to meet the placement distance requirements.	K 022	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> view of the exit signs as required. Monitoring The maintenance director will inspect all exit signs on a regular basis per the Kindred Preventative Maintenance Program. The Executive Director will make rounds and verify that the new exit signs and changes as outlined above have been completed on or before the completion date.	
K 025 SS=E	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	K 025	K 025 Residents Specific The facility will ensure the continuity of smoke/fire barriers to impede the movement of fire or smoke between floors. The problem in 1 smoke compartment that had potential to effect 10 residents will be fixed. The open space around the 4 inch pipe that passes through the ceiling in the boiler room will be properly sealed and filled. The opening through which the subfloor was visible will be properly sealed as well. Other Resident	11/24/14

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K 025	Continued From page 3 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that smoke/fire barriers were maintained. Failure to ensure the continuity of smoke/fire barriers could allow the movement of fire between floors and smoke or dangerous gases to pass freely between smoke compartments affecting the egress of occupants. This deficient practice affected 10 residents, staff and visitors in 1 of 4 smoke compartments on the date of the survey. The facility is licensed for 70 SNF/NF beds and had a census of 43 on the day of the survey. Findings include: During the facility tour conducted on October 20, 2014 from 1:30 PM to 3:45 PM, observation by the surveyor and the Maintenance Supervisor of the boiler room ceiling found an approximately four inch diameter plumbing line installed in the floor above, passing through an approximately ten inch by ten inch unsealed square hole of the ceiling. Further observation noted that the subfloor of the upper level was visible from below. When asked, the Maintenance Supervisor stated he had not been aware this open area was unacceptable. Actual NFPA standard: 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. Exception No. 1: Where an atrium is used, smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with Exception No. 2 to 8.2.5.6(1). Not less than two	K 025	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> An examination has been made of the building to determine if any other areas need attention to preserve the smoke barrier. None were identified at this time. Systemic Changes Whenever any repairs or construction takes place that might disturb smoke barriers; the project plans will include restoring any breaches in an appropriate fashion to maintain the integrity of the smoke barrier. Monitoring The maintenance director will inspect fire/smoke barriers on a regular basis as per the Kindred Preventative Maintenance Program. Any problems will be reported to the PI/Safety committee.	

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K 025	Continued From page 4 separate smoke compartments shall be provided on each floor. Exception No. 2*: Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.3 has been provided for smoke compartments adjacent to the smoke barrier. 8.3.2* Continuity. Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces. Exception: A smoke barrier required for an occupied space below an interstitial space shall not be required to extend through the interstitial space, provided that the construction assembly forming the bottom of the interstitial space provides resistance to the passage of smoke equal to that provided by the smoke barrier.	K 025	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	
K 029 SS=F	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 Residents Specific The two doors from the hallway into the kitchen have been repaired so that they will self close as required to separate the hazardous area from the hallway. The door from the hallway into Medical Records will have a self closure installed to provide proper closure of this hazard area from the adjacent compartment. Other Resident Exposure / Areas A thorough check of the building was done to identify any other areas defined by the	11/24/14

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K 029	<p>Continued From page 5</p> <p>This Standard is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure that hazardous area doors were maintained. Failure to ensure hazardous area doors would self-close would allow smoke and dangerous gases to pass into corridors and affect the safe egress of occupants during a fire event. This deficient practice affected 6 residents, staff and visitors in 1 of 4 smoke compartments and all residents, staff and visitors occupying the main dining hall on the date of the survey. The facility is licensed for 70 SNF/NF beds and had a census of 43 on the day of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on October 20, 2014 from 1:30 PM to 3:45 PM, observation and operational testing of the doors leading from the kitchen into the main corridor found they would not self-close. Interview of the Maintenance Supervisor found he was aware these doors were required to self-close.</p> <p>2) During the facility tour conducted on October 20, 2014 from 1:30 PM to 3:45 PM, observation and operational testing of the door into the Medical Records office in the 200 west wing, which measured approximately sixteen feet by sixteen feet (256 ft²), found it was not equipped with a self-closing device. Interview of the Maintenance Supervisor indicated he was not aware this door was required to self-close.</p> <p>Actual NFPA standard:</p>	K 029	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>code as hazardous that did not have properly closing doors/access. None was found.</p> <p>Systemic Change</p> <p>Any building repairs or construction that involves hazardous areas will require a review to establish that a situation is not caused where there would be non-compliant door or closure.</p> <p>Monitoring</p> <p>The maintenance director will inspect all doors on a regular basis to ensure compliance as per the Kindred Preventative Maintenance Program. Any variance will be reported to the PI/Safety committee.</p>

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K 029	<p>Continued From page 6</p> <p>3.3 13.2 Area, Hazardous. An area of a structure or building that poses a degree of hazard greater than that normal to the general occupancy of the building or structure, such as areas used for the storage or use of combustibles or flammables; toxic, noxious, or corrosive materials; or heat-producing appliances.</p> <p>19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:</p> <ul style="list-style-type: none"> (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft² (9.3 m²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft² (4.6 m²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more 	K 029	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>		

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NAME OF PROVIDER OR SUPPLIER KINDRED NURSING & REHABILITATION - ASP		STREET ADDRESS, CITY, STATE, ZIP CODE 420 ROWE STREET MOSCOW, ID 83843		
(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 029	Continued From page 7 than 48 in. (122 cm) above the bottom of the door.	K 029	<i>This Plan of Correction is the center's credible allegation of compliance.</i>	
K 038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>This Standard is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure that doors provided a readily available means of exit access. Failure to allow rapid means of exit access would prevent occupants ability to safely evacuate during an emergency. This deficient practice affected all residents, staff and visitors using the common area bathrooms located in the main entrance adjacent to room 102 and in the 300 north corridor on the date of the survey. The facility is licensed for 70 SNF/NF beds and had a census of 43 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on October 20, 2014 from 1:30 PM to 3:45 PM, observation and operational testing of the doors to the restrooms in the 300 north corridor and adjacent to room 102 in the main entrance found both bathroom doors were equipped with throw bolts installed on the egress side of the door. When interviewed, the Maintenance Supervisor and the Administrator in Training both stated they had not recognized the risk of occupants being trapped inside during an emergency prior to the survey date.</p>	K 038	<p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>K038</p> <p>Resident Specific / Other Resident / Staff & Visitor</p> <p>The throw bolts on the egress side of each of the bathrooms noted at left will be removed. They will be replaced with a new latch system that can be released from the non egress side of the door.</p> <p>Systemic Change</p> <p>Whenever doors, locks and/or latches are repaired or replaced a review will be conducted to assure that the changes do not create a problem with this code.</p> <p>Monitoring</p> <p>The PI committee will be responsible to see that such reviews are conducted for any projects effecting this requirement.</p>	11/24/14

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

Printed: 10/30/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135093	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2014
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K 038	Continued From page 8 Actual NFPA standard: 19.2.1 General. Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7. Exception: As modified by 19.2.2 through 19.2.11. 7.2.1.5.4* A latch or other fastening device on a door shall be provided with a releasing device having an obvious method of operation and that is readily operated under all lighting conditions. The releasing mechanism for any latch shall be located not less than 34 in. (86 cm), and not more than 48 in. (122 cm), above the finished floor. Doors shall be operable with not more than one releasing operation. Exception No. 1*: Egress doors from individual living units and guest rooms of residential occupancies shall be permitted to be provided with devices that require not more than one additional releasing operation, provided that such device is operable from the inside without the use of a key or tool and is mounted at a height not exceeding 48 in. (122 cm) above the finished floor. Existing security devices shall be permitted to have two additional releasing operations. Existing security devices other than automatic latching devices shall not be located more than 60 in. (152 cm) above the finished floor. Automatic latching devices shall not be located more than 48 in. (122 cm) above the finished floor. Exception No. 2: The minimum mounting height for the releasing mechanism shall not be applicable to existing installations.	K 038	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>		

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER KINDRED NURSING & REHABILITATION - ASPEN P		STREET ADDRESS, CITY, STATE, ZIP CODE 420 ROWE STREET MOSCOW, ID 83843		
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C 000	16.03.02 INITIAL COMMENTS The facility is a single story Type V(111) building, with two partial basements. The facility is fully sprinklered, with smoke detectors in corridors and open spaces. It was built in 1965 and is currently licensed for 70 SNF/NF beds. The following deficiencies were cited during the annual fire/life safety survey conducted on October 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: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	C 000	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	
C 226	02.106 FIRE AND LIFE SAFETY 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: Please refer to "K" tags on CMS form 2567: K 022 Exit signage K 025 Smoke barrier continuity K 029 Hazardous areas	C 226	C226 Please refer to the plan of correction for K022, K025, K 029, K038.	11/24/14

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NOV 17 2014
FACILITY STANDARDS

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

TITLE

Executive Director 11/14/14

(X6) DATE

Bureau of Facility Standards

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C 226	Continued From Page 1. K 038 Egress accessibility	C 226	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>	