IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK– ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

November 5, 2015

Debbie Freeze, Administrator
Kindred Transitional Care & Rehab-- Lewiston
3315 8th Street
Lewiston, ID 83501-4966

Provider #: 135021

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

Dear Ms. Freeze:

On **October 27, 2015**, a Facility Fire Safety and Construction survey was conducted at **Kindred Transitional Care & Rehab - Lewiston** 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 **November 18, 2015**. Failure to submit an acceptable PoC by **November 18, 2015**, may result in the imposition of civil monetary penalties by **December 8, 2015**.

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 **December 1, 2015**, (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 **December 1, 2015**. A change in the seriousness of the deficiencies on **December 1, 2015**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **December 1, 2015**, includes the following:

Denial of payment for new admissions effective **January 27, 2016.**
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 27, 2016**, 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 27, 2015**, 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 **November 18, 2015**. If your request for informal dispute resolution is received after **November 18, 2015**, 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/lj
Enclosures

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135021	A. BUILDING 01 - ENTIRE BUILDING B. WING _____	10/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE & REHAB - LI	3315 8TH STREET LEWISTON, ID 83501

(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) building with a finished basement. The structure was built in 1965 with a complete renovation in 1998. It is fully sprinklered with smoke detection provided in corridors, open spaces and resident sleeping rooms. The facility is currently licensed for 96 SNF/NF beds. The following deficiencies were cited during the annual fire/life safety survey conducted on October 27, 2014. 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: Nate Elkins Health Facility Surveyor Facility Fire Safety & Construction	K 000	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Kindred Transitional Care and Rehabilitation does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.	
K 021 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2	K 021	K021 **Resident Specifie** No resident's were identified as affected only staff and visitors Any **Other Residents** No residents were identified as affected. This is not a passageway used by residents **Facility Systems** All Key holes will be checked by maintenance during monthly rounds and any breach will be reported to the ED and will be immediately fixed by maintenance.	11/25-1

RECEIVED
NOV 19 2015
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Debbie Flegg Ex Director 11-17-15

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 021	Continued From page 1 This Standard is not met as evidenced by: Based on observation and interview the facility failed to provide doors that resist the passage of smoke that protected vertical openings. Failure to protect vertical openings could allow smoke and dangerous gasses to spread rapidly into the stairwell and affect egress of occupants. This deficient practice affected 1 of 6 smoke compartments, staff and visitors on the date of survey. The facility is licensed for 96 SNF/NF beds with a census of 57 on the day of survey. Findings include: During the facility tour on October 27, 2015 at approximately 1:15 PM, observation of the door leading from the top of the stairwell to the basement revealed the key lock was missing creating an approximate 2 inch circular hole passing through the door that would not resist the movement of smoke. When asked, the Director of Nursing stated the facility was unaware of the hole in the door. The finding was acknowledged at the exit conference. Actual NFPA standard: 8.2.3.2.3* Opening Protectives. 8.2.3.2.3.1 Every opening in a fire barrier shall be protected to limit the spread of fire and restrict the movement of smoke from one side of the fire barrier to the other. The fire protection rating for opening protectives shall be as follows: (1) 2-hour fire barrier - 11/2-hour fire protection rating	K 021	MONITOR Any breach in a door causing a possibility of spread of smoke or gas will be reported to the ED and the PI committee with the date of resolution included in the report.	

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K 021	Continued From page 2 (2) 1-hour fire barrier - 1-hour fire protection rating where used for vertical openings or exit enclosures, or 3/4-hour fire protection rating where used for other than vertical openings or exit enclosures, unless a lesser fire protection rating is specified by Chapter 7 or Chapters 11 through 42 Exception No. 1: Where the fire barrier specified in 8.2.3.2.3.1(2) is provided as a result of a requirement that corridor walls or smoke barriers be of 1-hour fire resistance-rated construction, the opening protectives shall be permitted to have not less than a 20-minute fire protection rating when tested in accordance with NFPA 252, Standard Methods of Fire Tests of Door Assemblies, without the hose stream test. Exception No. 2: The requirement of 8.2.3.2.3.1(2) shall not apply where special requirements for doors in 1-hour fire resistance-rated corridor walls and 1-hour fire resistance-rated smoke barriers are specified in Chapters 18 through 21. Exception No. 3: Existing doors having a 3/4-hour fire protection rating shall be permitted to continue to be used in vertical openings and in exit enclosures in lieu of the 1-hour rating required by 8.2.3.2.3.1(2). (3) 1/2-hour fire barrier - 20-minute fire protection rating Exception: Twenty-minute fire protection-rated doors shall be exempt from the hose stream test of NFPA 252, Standard Methods of Fire Tests of Door Assemblies.	K 021		
K 029 SS=E	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	K 029		

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K 029	Continued From page 3 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 This Standard is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure that hazardous areas were protected with self-closing doors. Failure to provide self-closing doors for hazardous areas would allow smoke and dangerous gases to pass freely into corridors and hinder egress of occupants during a fire event. This deficient practice affected 11 residents, staff and visitors on the date of the survey. The facility is licensed for 96 SNF/NF beds with a census of 57 on the day of the survey. Findings include: During the facility tour on October 27, 2015 at approximately 1:00 PM, observation and operational testing of the linen closet doors in the 300 hallway revealed the doors were not on a self closure. The room was measured to be over 50 square feet and held combustibles on open shelving. When asked, the Director of Nursing stated the facility was not aware the doors needed to be on a self closure. This finding was acknowledged at the exit conference. Actual NFPA standard: NFPA 101, 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a	K 029	K029 **Resident Specific** **There are no combustibles stored in the linen closet.** **Other Residents** **There are no combustibles stored in the linen closet.** **Facility Systems** **Signs have been posted on doors of linen closet stating that "No combustibles are to be stored in the Linen Closet"** **Monitor** **Linen closet is checked daily by laundry staff during linen stocking procedure. Discovery of any combustibles will be reported to the ED or the charge nurse for Immediate removal.**	11/25-15

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K 029	Continued From page 4 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: (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.	K 029		
K 046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This Standard is not met as evidenced by: Based on record review and interview the facility failed to provide monthly and annual emergency lighting system testing documentation. Failure to test the emergency lighting system could inhibit egress of residents during an emergency. This	K 046		

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K 046	Continued From page 5 deficient practice affected all residents, staff and visitors on the day of survey. The facility is licensed for 96 SNF/NF beds with a census of 57 on the date of survey. Findings include: During record review on October 27, 2015 between 8:30 AM and 10:00 AM, the facility was unable to provide monthly and annual documentation for testing of the emergency lighting system. When asked, Director of Nursing stated the facility was unaware the documentation was not being maintained. This finding was acknowledged at the exit conference. Actual NFPA reference: NFPA 101, 19.2.9.1 Emergency lighting shall be provided in accordance with Section 7.9. 7.9. 3 A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 11/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction.	K 046	K 046 **Resident Specific** All residents are protected by current procedure as all emergency lighting is tied to the generator and is tested with each generator test. The facility has no battery operated emergency lighting. **Other Residents** All residents are protected by current facility procedure as all emergency lighting is tied to the generator and is tested with each generator test. The facility has no battery operated emergency lighting **Facility Systems** Center will change preventative maintenance procedures to include documentation of operation of emergency lighting during generator test. **MONITOR** Emergency lighting will be observed and results documented. Generator comes on every week for 30 minutes and 1 time per month maintenance will document light response.	11/25/15
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10	K 064		

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K 064	Continued From page 6 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that fire extinguishers were installed in accordance with NFPA 10. Failure to ensure fire extinguishers were installed correctly and readily accessible could inhibit their use during a fire event. This deficient practice affected staff utilizing the laundry room and visitors on the date of the survey. The facility is licensed for 96 SNF/NF beds with a census of 57 on the day of the survey. Findings include: During the facility tour on October 27, 2015 at approximately 11:15 PM, observation of the laundry room revealed linen carts blocking access to the fire extinguisher. When asked, the Director of Nursing stated the facility was unaware of the obstructions to the fire extinguisher. This finding was acknowledged at the exit conference. Actual NFPA standard: NFPA 10 Standard for Portable Fire Extinguishers 1-6.6* Fire extinguishers shall not be obstructed or obscured from view. Exception: In large rooms, and in certain locations where visual obstruction cannot be completely avoided, means shall be provided to indicate the location.	K 064	K 064 **Resident Specific** Placement of linen carts has been changed to not obstruct access to fire extinguishers **Other Residents** Placement of linen carts has been changed to not obstruct access to fire extinguishers **Facility Systems** Education was done with laundry workers regarding the need for easy access to the fire extinguisher and will be included in the orientation for new employees. **MONITOR** **Laundry Supervisor will monitor 3 x a week for 4 weeks to be sure laundry cart is in proper place and not blocking fire extinguisher**	11-25-15
K 072 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility	K 072		

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K 072	Continued From page 7 of exits. 7.1.10 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that means of egress was maintained free from obstructions. Failure to provide means of egress free of obstructions could prevent the safe evacuation of occupants during an emergency. This deficient practice affected 16 residents, staff and visitors on the date of survey. The facility is licensed for 96 SNF/NF beds with a census of 57 on the day of survey Findings include: 1.) Observation on October 27, 2015 at approximately 8:30 AM, 11:45 am, and 2:00 PM, revealed a Hoyer lift stored in the corridor near the conference room and the business center obstructing exit access. When asked, the Director of Nursing stated the facility was unaware the Hoyer lift was blocking the means of egress. This finding was acknowledged at the exit conference. 2.) During the facility tour on October 27, 2015 at approximately 11:15 AM, observation revealed the door in the laundry room leading to the outside of the facility marked "Emergency Exit" was blocked by a linen cart. When asked, the Director of Nursing stated the facility was unaware the linen cart was blocking the access to the door. This finding was acknowledged at the exit conference. Actual NFPA Standard: NFPA 101, 7.1.10 Means of Egress Reliability.	K 072	K 072 **Resident Specific** Hoyer and Linen cart were moved to an area so they were not obstructing egress or access to electrical panels. **Other Residents** All residents in the building had potential to be affected but by moving the items in question the danger was alleviated. **Facility Systems** All staff was inserviced on proper placement of items needing repaired and of the linen cart to not block egress or access to electrical panels. **MONITOR** **Laundry supervisor will monitor placement of laundry cart 3 xs a week x 4 weeks to be sure it is not blocking egress from the laundry room. Any issues will be reported to the ED and PI committee.**	11-25-15

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K 072	Continued From page 8 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 072		
K 147 SS=E	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 ensure proper clearance around electric circuit breakers in accordance with the National Electrical Code. Failure to provide proper clearance around electrical panels could prohibit the immediate shutdown or isolation of electrical power during an emergency event. This deficient practice affected 16 residents, staff and visitors on the date of survey. The facility is licensed for 96 SNF/NF beds with a census of 57 the day of survey. Findings include: Observation on October 27, 2015 at approximately 8:30 AM, 11:45 am, and 2:00 PM, revealed a Hoyer lift stored in the corridor near the conference room and the business center obstructing three electrical panels. When asked, the Director of Nursing stated the facility was unaware the Hoyer lift was obstructing the three electrical panels. This finding was acknowledged at the exit conference. Actual NFPA reference: NFPA 70.110.26 Spaces About Electrical Equipment.	K 147	K 147 **Resident Specific** Hoyer moved to an area so they were not obstructing access to electrical panels. **Other Residents** All residents in the building had potential to be affected but by moving the items in question the danger was alleviated. **Facility Systems** All staff was inserviced on proper placement of items needing repaired and or access to electrical panels. **MONITOR** **ED will monitor to be sure access to electrical panels is not blocked 3 x a week x 4 weeks.**	11/25-15

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE & REHAB - LI	3315 8TH STREET LEWISTON, ID 83501

(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 147	Continued From page 9 Sufficient access and working space shall be provided and maintained about all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons. (2) Width of Working Space. The width of the working space in front of the electric equipment shall be the width of the equipment or 750 mm (30 in.), whichever is greater. In all cases, the work space shall permit at least a 90 degree opening of equipment doors or hinged panels.	K 147		