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

February 10, 2016

Michael Crowley, Administrator
River's Edge Rehabilitation & Living Center
714 North Butte Avenue
Emmett, ID 83617-2725

Provider #: 135020

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

Dear Mr. Crowley:

On **February 2, 2016**, a Facility Fire Safety and Construction survey was conducted at **River's Edge Rehabilitation & Living 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. 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 **February 23, 2016**. Failure to submit an acceptable PoC by **February 23, 2016**, may result in the imposition of civil monetary penalties by **March 14, 2016**.

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 **March 8, 2016**, (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 **March 8, 2016**. A change in the seriousness of the deficiencies on **March 8, 2016**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **March 8, 2016**, includes the following:

Denial of payment for new admissions effective **May 2, 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 **August 2, 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 **February 2, 2016**, 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 **February 23, 2016**. If your request for informal dispute resolution is received after **February 23, 2016**, 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
	135020	A. BUILDING 01 - BUILDING 0101 B. WING _____	02/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER'S EDGE REHABILITATION & LIVING CE	714 NORTH BUTTE AVENUE EMMETT, ID 83617

(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) structure built in 1963 and is fully sprinklered. The facility is protected throughout by a complete fire alarm/smoke detection system which includes smoke detection in resident rooms as well as corridors and open spaces. There was an addition added to the facility in 1974 and the facility was fully refurbished in 2000-2001 at which time the fire alarm system was updated. Currently the facility is licensed for 74 SNF/NF beds. The following deficiencies were cited during the annual fire/life safety survey conducted on February 2, 2016. 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: Sam Burbank Health Facility Surveyor Fire Life Safety & Construction	K 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Rivers Edge Living Center and Rehabilitation 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 FEB 22 2016 FACILITY STANDARDS	
K 022 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. Doors, passages or stairways that are not a way of exit that are likely to be mistaken for an exit have a sign designating "No Exit". 7.10, 18.2.10.1, 19.2.10.1 This Standard is not met as evidenced by: Based on observation and operational testing, the facility failed to ensure that exits were clearly identified by appropriate means. Failure to ensure that exits are identified would hinder the safe evacuation of occupants during an emergency.	K 022	K022 Exit access corridors revealed no exits signs when smoke compartments doors were closed. Actions taken are: 1. Have installed Exits signs on the headers above all the compartment smoke doors in the Therapy Hall, 100 Hall and the 200 Hall and Exits signs are visible from any Hall way **2/15/2016**	3/18/16

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

M. S — Administrator — 2/19/16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined tha other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 day 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	Continued From page 1 This deficient practice affected 31 residents, staff and visitors on the date of the survey. The facility is licensed for 74 SNF/NF beds and had a census of 47 on the day of the survey. Findings include: During the facility tour conducted on February 2, 2016 from approximately 10:00 AM to 3:30 PM, observation of the exit access corridors, revealed no exit sign was visible indicating the egress path when the smoke compartment doors were closed in the following areas: Therapy Hall, facing both west and southeast 100 Hall, facing north and south Administration/Offices Hall, facing east and west 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	2. The Plant supervisor will do environmental rounds to ensure there are no obstruction with the signage. **2/16/2016** 3. All exit doors have been inspected to ensure they are in compliance with the Life Safety code standards. All doors are now compliant.**2/16/2016** 4. Plant Supervisor will ensure compliance. **2/16/2016**	
K 062 SS=E	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:	K 062	K062 There were (8) sprinkler heads either corroded or had paint on them, (7) were in the Kitchen and (1) in the Housekeeping Room next to the 200 hall Nurses station. 1. The Sprinkler Company will shut down system and replace all (8) sprinkler heads. By **3/18/2016**	3/18/16

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K 062	Continued From page 2 Based on observation and interview, the facility failed to ensure fire suppression system pendants were free of obstructions such as corrosion or paint. Failure to keep suppression system pendants free of obstructions could hinder their performance during a fire event. This deficient practice affected 7 residents, staff and visitors on the date of the survey. The facility is licensed for 74 SNF/NF beds and had a census of 47 on the day of the survey. Findings include: During the facility tour conducted on February 2, 2016 from approximately 10:00 AM to 3:30 PM, observation of the fire suppression system revealed eight (8) sprinkler pendants with the following deficiencies: 1) Three (3) corroded sprinkler pendants in the Kitchen with four (4) painted pendants. 2) One (1) corroded sprinkler pendant in the Housekeeping closet next to the 200 wing nurse's station. Actual NFPA standard: NFPA 25 2-2 Inspection. 2-2.1 Sprinklers. 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.	K 062	2. Charge the system back up and check for correct operation of the system, system will be put back on line to ready status by **3/18/2016** 3. All sprinklers heads in the facility have been inspected to ensure that they are in compliance with the Life Safety code standards. All heads with the exception of the (8) schedule to be replaced are in compliance..**3/18/2016** 4. Plant Superior will ensure compliance **3/18/2016**	

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K 062	Continued From page 3 Exception No. 1*: Sprinklers installed in concealed spaces such as above suspended ceilings shall not require inspection. Exception No. 2: Sprinklers installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown.	K 062		
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1 This Standard is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure means of egress were available to full, instant use in the event of an emergency. Failure to maintain locking arrangements which provide instant use from the egress side, could hinder evacuation during a fire or other emergency. This deficient practice affected staff and vendors on the date of the survey. The facility is licensed for 74 SNF/NF beds and had a census of 47 on the day of the survey. Findings include: During the facility tour conducted on February 2, 2016 from approximately 10:00 AM to 3:30 PM, observation and operational testing of door locking arrangements revealed the following: 1) The door to the Laundry in the 100 wing was equipped with a throwbolt lock placed at approximately 72 inches from the floor on the corridor side, preventing egress from the interior	K 072	K072 The Laundry Room had a throw bolt lock, Kitchen Door had a deadbolt for extra security and the Wheelchair storage Room had a hook and eye lock. 1. All additional locks on the above Rooms have been removed and holes have been filled in for fire stops. **2/17/2016** 2. Any door modifications will be cleared by Plant supervisor to ensure they meet the Life Safety code standards . **2/17/2016** 3. All doors in the facility have been audited to ensure they meet the Life Safety code standards all doors are in compliance.**2/17/2016** 4. Plant Supervisor will ensure compliance. **2/17/2016**	3/18/16

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K 072	Continued From page 4 of the Laundry to the corridor when activated. 2) The door entering into the Kitchen from the corridor was equipped with a deadbolt and keypad entry lock. When asked why the deadbolt lock was installed with a keypad entry lock, the Maintenance Supervisor stated the deadbolt was added for extra security. 3) The Wheelchair storage door in the 200 wing was equipped with a hook and eye latch installed at approximately 72 inches from the floor on the corridor side, preventing egress from the interior of the room to the corridor when activated. Actual NFPA standard: 7.1.10 Means of Egress Reliability. 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. 7.2.1.5 Locks, Latches, and Alarm Devices. 7.2.1.5.1 Doors shall be arranged to be opened readily from the egress side whenever the building is occupied. Locks, if provided, shall not require the use of a key, a tool, or special knowledge or effort for operation from the egress side. Exception No. 1: This requirement shall not apply where otherwise provided in Chapters 18 through 23. Exception No. 2: Exterior doors shall be permitted to have key-operated locks from the egress side, provided that the following criteria are met: (a) Permission to use this exception is provided in Chapters 12 through 42 for the specific	K 072		

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K 072	Continued From page 5 occupancy. (b) On or adjacent to the door, there is a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high on a contrasting background that reads as follows: THIS DOOR TO REMAIN UNLOCKED WHEN THE BUILDING IS OCCUPIED (c) The locking device is of a type that is readily distinguishable as locked. (d) A key is immediately available to any occupant inside the building when it is locked. Exception No. 2 shall be permitted to be revoked by the authority having jurisdiction for cause. Exception No. 3: Where permitted in Chapters 12 through 42, key operation shall be permitted, provided that the key cannot be removed when the door is locked from the side from which egress is to be made.	K 072		