



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

October 28, 2016

Debbie Freeze, Administrator
Kindred Transitional Care And 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 20, 2016**, a Facility Fire Safety and Construction survey was conducted at **Kindred Transitional Care And 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 one that comprises a pattern 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

Debbie Freeze, Administrator

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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 10, 2016**. Failure to submit an acceptable PoC by **November 10, 2016**, may result in the imposition of civil monetary penalties by **November 30, 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. If a State Form was issued as well, it should also be signed, dated and returned.

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, 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 **November 24, 2016**. A change in the seriousness of the deficiencies on **November 24, 2016**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **November 24, 2016**, includes the following:

Debbie Freeze, Administrator
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Denial of payment for new admissions effective **January 20, 2017**.
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, 2017**, 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 Nate Elkins, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, option 3; 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, 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>

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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 **November 10, 2016**. If your request for informal dispute resolution is received after **November 10, 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, option 3.

Sincerely,



Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosures

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

PRINTED: 10/27/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135021	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/20/2016
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB - LEWISTON	STREET ADDRESS, CITY, STATE, ZIP CODE 3315 8TH STREET LEWISTON, ID 83501
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000 INITIAL COMMENTS

The facility is a single story Type V(111) 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 20, 2016. The "A" wing or 100 corridor was not surveyed due to an infectious illness that required the use of PPE to enter the wing. 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:

Linda Chaney
Health Facility Surveyor
Facility Fire Safety & Construction

K 018 NFPA 101 LIFE SAFETY CODE STANDARD
SS=E

Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the

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.

RECEIVED
NOV 14 2016

FACILITY STANDARDS

Resident Specific:

- 1.) Contractor obtained and door has been ordered to replace door between kitchen and dining room that is latching and prevents the passage of smoke.
- 2.) All rooms listed on report have been checked and adjustments made to ensure there is no passage of smoke.

11/14/16

K 018

Other Residents/

All corridor doors were checked for smoke passage issues and adjustments made as necessary to ensure there is no smoke passage with any doors.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Debbie Shee Ex Director</i>	TITLE	(X6) DATE 11/9/16
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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 018	<p>Continued From page 1</p> <p>door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3</p> <p>This STANDARD is not met as evidenced by: Based on observation, operational testing, and interview, the facility failed to maintain doors that protect corridor openings. Failure to maintain corridor doors could allow smoke and dangerous gases to pass freely preventing defend in place. This deficient practice affected 42 residents, staff, and visitors on the date of survey. The facility is licensed for 96 SNF/NF beds with a census of 61 on the day of survey.</p> <p>Findings include:</p> <p>1.) During the facility tour on October 20, 2016 from approximately 10:00 AM to 4:00 PM, observation of the doors at the Kitchen revealed the doors, when closed, had an approximately 1/4" to 1/2" gap that would not resist the passage of smoke. When asked, the Maintenance Supervisor stated the facility was unaware the doors did not resist the passage of smoke.</p> <p>2.) During the facility tour on October 20, 2016 from approximately 10:00 AM to 4:00 PM, observation and operational testing of the following corridor doors revealed the doors did not close properly leaving an approximately 1/4" gap between the leading of edge of the door and the door frame large enough to feel positive airflow through the gap.</p> <ul style="list-style-type: none"> - Resident Room 207 - Resident Room 306 - Resident Room 309 	K 018	<p>Facility Systems:</p> <p>Any installation of new doors will be checked by maintenance personnel for prevention of smoke passage.</p> <p>MONITOR</p> <p>All corridors in the center will be checked on a monthly basis for smoke passage issues and added to the monthly preventative maintenance program. This will be reviewed monthly in PI x 3 months and then quarterly as necessary.</p> <p>*Note, per phone conversation with Nate Elkins, requesting 30 day extension for obtaining and installation of doors with a due date of December 24, 2016.</p> <p style="text-align: right;">11/24/16 → 12/24/16</p>

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K 018	<p>Continued From page 2</p> <ul style="list-style-type: none"> - Resident Room 311 - Resident Room 314 - Resident Room 315 - Resident Room 319 - Resident Room 320 - Resident Room 321 - Resident Room 325 <p>When asked, the Maintenance Supervisor stated the facility was unaware the doors were not closing and sealing properly.</p> <p>Actual NFPA standard:</p> <p>NFPA 101 19.3.6.3 Corridor Doors. 19.3.6.3.1*</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors.</p> <p>Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.</p> <p>Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke.</p>	K 018		

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K 027 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1o-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>This STANDARD is not met as evidenced by: Based on observation and operational testing, the facility failed to ensure smoke barrier doors would close completely and resist the passage of smoke when activated by the smoke detection system. Failure to ensure that smoke compartment doors close completely would allow the passage of smoke and dangerous gases to travel freely and negate the opportunity to defend in place. This deficient practice affected 17 residents, staff and visitors on the date of the survey. The facility is licensed for 96 SNF/NF beds and had a census of 61 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour on October 20, 2016, from approximately 10:00 AM to 4:00 PM, observation and operational testing of the cross corridor doors to the physical therapy wing revealed when closed, was an approximate 1/2" gap between the doors on the lower half of the doors that would not resist the passage of smoke. When asked, the Maintenance Supervisor stated the facility was unaware of the gap in the doors.</p>	K 027	<p>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.</p> <p>K - 027</p> <p>Resident Specific</p> <p>Doors to physical therapy wing have been fixed to ensure no passage of smoke</p> <p>Other Residents</p> <p>All doors between wings have been checked to ensure there is no opportunity for passage of smoke</p> <p>Facility Systems</p> <p>Monthly checking of these doors will be added to facility preventative maintenance program</p> <p>Monitor</p> <p>Reports from facility preventative maintenance program will be reviewed in PI on a monthly basis x 3 months and then quarterly as necessary.</p>	11/24/16	

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K 027 Continued From page 4
Actual NFPA standard:

19.3.6.3 Corridor Doors.
19.3.6.3.1*
Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors.
Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.
Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke

K 027

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 basis for the deficiency.

K- 038

Resident Specific

- 1) Egress door in Physical Therapy has been fixed
- 2) Egress door end of T hall has been fixed

Other Residents

All Egress doors were tested for proper release operation; any found to be out of compliance were fixed

Facility Systems

Monthly testing of egress doors will be added to monthly preventative maintenance program

K 038 NFPA 101 LIFE SAFETY CODE STANDARD
SS=E
Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1
This STANDARD is not met as evidenced by:
Based on operational testing, observation and interview, the facility failed to ensure that means of egress were free from impediments to their instant use in an emergency. Failure for delayed egress doors to operate as designed could hinder

K 038

11/24-16

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K 038	<p>Continued From page 5</p> <p>the safe evacuation of residents during a fire or other emergency. This deficient practice affected 26 residents, staff and visitors on the date of the survey. The facility is licensed for 96 SNF/NF beds and had a census of 61 on the day of the survey.</p> <p>Findings include:</p> <p>1.) During the facility tour conducted on October 20, 2016 from approximately 10:00 AM to 4:00 PM, observation and operational testing of the delayed egress exit door in the physical therapy room revealed the door would not initiate the irreversible process to release the automatic lock. Further observation and testing revealed the delayed egress component would not release the door, regardless of the amount of time or pressure applied. When asked, the Maintenance Supervisor stated the facility was unaware the door was un-operational.</p> <p>2.) During the facility tour conducted on October 20, 2016 from approximately 10:00 AM to 4:00 PM, observation and operational testing of the delayed egress exit door at the end of the "T" hallway next to the Nursing Office revealed the door required excessive force, exceeding 15 lbf to operate the door. When asked, the Maintenance Supervisor stated the facility was unaware the door was so difficult to operate and agreed it required excessive force.</p> <p>Actual NFPA standard:</p> <p>NFPA 101</p> <p>19.2 MEANS OF EGRESS REQUIREMENTS</p>	K 038	<p>Monitor</p> <p>Monthly preventative maintenance program will be monitored by PI monthly x 3 months and then quarterly as needed</p>	

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K 038	<p>Continued From page 6</p> <p>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.</p> <p>1.) 7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed-egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met. (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6. (b) The doors shall unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.</p>	K 038	

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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB - LEWISTON			STREET ADDRESS, CITY, STATE, ZIP CODE 3315 8TH STREET LEWISTON, ID 83501	
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K 038	Continued From page 7 (d) * On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS 2.) 7.2.1.4.5 The forces required to fully open any door manually in a means of egress shall not exceed 15 lbf (67 N) to release the latch, 30 lbf (133 N) to set the door in motion, and 15 lbf (67 N) to open the door to the minimum required width. Opening forces for interior side-hinged or pivoted-swinging doors without closers shall not exceed 5 lbf (22 N). These forces shall be applied at the latch stile. Exception No. 1: The opening force for existing doors in existing buildings shall not exceed 50 lbf (222 N) applied to the latch stile. Exception No. 2: The opening forces for horizontal sliding doors shall be as provided in Chapters 22 and 23. Exception No. 3: The opening forces for power-operated doors shall be as provided in 7.2.1.9.	K 038		
K 045 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture will not leave the area in darkness. Lighting system shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8, 7.8 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide illumination of a means of egress	K 045	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.	

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135021	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/20/2016
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB - LEWISTON			STREET ADDRESS, CITY, STATE, ZIP CODE 3315 8TH STREET LEWISTON, ID 83501	
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K 045	Continued From page 8 so that failure of any single lighting unit would not leave the area in darkness. Failure to provide two (2) lighting units could hinder the safe evacuation of residents during a fire or other emergency. This deficient practice affected 9 residents, staff and visitors in the "T" hallway on the date of the survey. The facility is licensed for 96 SNF/NF beds and had a census of 61 on the day of the survey. Findings include: During the facility tour on October 20, 2016 from approximately 10:00 AM to 4:00 PM, observation of the exit discharge from the "T" hallway TV room revealed no exterior light fixture. Further observation of the area revealed that there were no additional light fixtures or means of illumination in the area that would meet the level of light required. When asked, the Maintenance Supervisor stated the facility was unaware of the lighting requirement. Actual NFPA standard: NFPA 101 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	Resident Specific Light fixture installed at T wing exit door Other Residents All exit doors were reviewed for adequate and required lighting. Facility Systems Review of exit lighting will be included in the monthly preventative maintenance Program Monitors: Monthly Preventative Facility Maintenance program will be monitored in PI monthly x 3 months and then quarterly	11/24/16
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 147		

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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB - LEWISTON		STREET ADDRESS, CITY, STATE, ZIP CODE 3315 8TH STREET LEWISTON, ID 83501	
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K 147	<p>Continued From page 9</p> <p>Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure electrical wiring was in accordance with the National Electrical Code (NFPA 70). Exposure of open electrical connections, wiring, or improper use of flexible cords, could result in fires by arcing or electrocution. The deficient practice affected 17 residents, staff, and visitors on the date of survey. The facility is licensed for 96 SNF/NF beds and had a census of 61 the day of survey.</p> <p>Findings include:</p> <p>1.) During the facility tour on October 20, 2016 from approximately 10:00 AM to 4:00 PM, observation revealed appliances plugged in to Relocatable Power Taps (RPTs) being used as a substitute to permanent wiring in the following areas:</p> <ul style="list-style-type: none"> -Tech. Room, Microwave -Case Manager's Office, Refrigerator & Microwave (fixed on the spot) -Business Manager's Office, Refrigerator -Nursing Office, Refrigerator & Microwave <p>When asked, the Maintenance Supervisor stated the facility was unaware of the appliances plugged in to relocatable power taps.</p> <p>2.) During the facility tour on October 20, 2016 from 10:00 AM to 4:00 PM, observation revealed Relocatable Power Taps (RPTs) "daisy chained" together being used as a substitute to permanent wiring in the following areas:</p> <ul style="list-style-type: none"> -HR Manager's Office -Administrator's Office 	K 147	<p>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.</p> <p>K 147</p> <p>Resident Specific</p> <p>All RPTs in identified areas have been removed.</p> <p>Other Residents</p> <p>All rooms in building have been surveyed for use of RPT's any found have been removed. Department managers and staff have been educated on the rules regarding use of electrical outlets</p> <p>Facility Systems</p> <p>Room checks will be done on a monthly basis to check for improper use of RPTs</p> <p>Monitor</p> <p>Monthly maintenance program will be reviewed monthly in PI x 3 months and then quarterly as necessary</p> <p style="text-align: right;">11/24/16</p>

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K 147	Continued From page 10 -Business Manager's Office When asked, the Maintenance Supervisor stated the facility was unaware of the RPTs being "daisy chained". Actual NFPA Standard: NFPA 70, 400-8. Uses Not Permitted Unless specifically permitted in Section 400-7, flexible cords and cables shall not be used for the following: 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 Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of Section 364-8. 5. Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors 6. Where installed in raceways, except as otherwise permitted in this Code Also refer to UL Online Certifications Directory XBYS.GuidelInfo Relocatable Power Taps	K 147			