



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 17, 2017

Mary Ruth Butler, Administrator
Kindred Nursing and Rehabilitation-- Mountain Valley
601 West Cameron Avenue
Kellogg, ID 83837-2004

Provider #: 135065

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

Dear Ms. Butler:

On **February 8, 2017**, a Facility Fire Safety and Construction survey was conducted at **Kindred Nursing and Rehabilitation-- Mountain Valley** 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

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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 **March 2, 2017**. Failure to submit an acceptable PoC by **March 2, 2017**, may result in the imposition of civil monetary penalties by **March 22, 2017**.

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 **March 15, 2017**, (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 15, 2017**. A change in the seriousness of the deficiencies on **March 15, 2017**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **March 15, 2017**, includes the following:

Denial of payment for new admissions effective **May 8, 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 **August 8, 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 **February 8, 2017**, 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:

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<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 **March 2, 2017**. If your request for informal dispute resolution is received after **March 2, 2017**, 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: 02/16/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135065	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE NF STRUCTURE B. WING _____	(X3) DATE SURVEY COMPLETED 02/08/2017
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NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION-MI	STREET ADDRESS, CITY, STATE, ZIP CODE 601 WEST CAMERON AVENUE KELLOGG, ID 83837
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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 building is a type V (111) fully sprinklered, single story structure with complete fire alarm/detection system. The building was constructed in 1971 and is licensed for 68 beds. The following deficiencies were cited during the annual Fire/Life Safety survey conducted on February 8, 2017. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70. The survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction	K 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> RECEIVED MAR 01 2017 FACILITY STANDARDS	
K 232 SS=F	NFPA 101 Aisle, Corridor, or Ramp Width Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 This Standard is not met as evidenced by: Based on record review and interview, the facility failed to ensure that means of egress were maintained free of obstructions in the event of a fire or other emergency. Failure to provide planning and training for the relocation of wheeled equipment, could hinder egress of residents during a fire or other emergency. This deficient practice affected 63 residents, staff and visitors on the date of the survey. The facility is licensed for 68 SNF/NF beds and had a census of 63 on	K 232	K232 I. Inservice training will be conducted to educated staff on policy and procedure for the relocation of wheeled equipment in the case of fire or other emergency. II. The maintenance director will monitor compliance of relocation of wheeled equipment during routine fire drills with NFPA 19.2.3.4. III. Proper relocation of wheeled equipment will be monitored during routine fire drills by maintenance director following compliance of NFPA 19.2.3.4. IV. The Maintenance Director or designee will make preventative maintenance rounds and monitor on TELS for three months then quarterly, document findings on the audit tool, and report findings to Executive Director ongoing. Findings will also be reported to the Safety and Performance Improvement Committee on a monthly basis.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Maryruth Butler</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>2/28/17</i>
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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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NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION-MI		STREET ADDRESS, CITY, STATE, ZIP CODE 601 WEST CAMERON AVENUE KELLOGG, ID 83837		
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K 232	<p>Continued From page 1 the day of the survey.</p> <p>Findings include:</p> <p>1) During review of the facility fire safety plan conducted on February 8, 2017 from approximately 9:30 AM to 10:30 AM, no information was revealed in the plan provided, as to where wheeled equipment such as med carts; dietary carts; or housekeeping carts, would be relocated to in the event of a fire or other emergency. Further review of staff inservice training did not provide information as to training conducted on the relocation of such wheeled equipment.</p> <p>2) During the facility tour conducted on February 8, 2017 from approximately 10:30 AM to 12:00 PM, observation of the resident sleeping room corridors revealed the following:</p> <p>Three (3) wheeled linen and trash carts with the capacity of approximately ninety-six (96) gallons per cart, were stored in the hall between rooms 301 to 305.</p> <p>One (1) wheeled linen and trash cart with the capacity of approximately ninety-six cubic feet stored in the hall outside room 203.</p> <p>One (1) wheeled linen and trash cart with the capacity of approximately ninety-six cubic feet stored in the hall outside room 103.</p> <p>Further observation revealed these five (5) carts did not move for the approximately 1-1/2 hours of observation in the 100, 200, 300 and 400 halls.</p> <p>Interview of Housekeeping staff outside room 303 at approximately 11:37 AM, the Housekeeping staff stated that she was not aware of any training or policy for the relocation of carts in the event of</p>	K 232	<p>V. Corrective action will completed by 03/15/2017.</p>	

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K 232	Continued From page 2 a fire. Actual NFPA standard: NFPA 101 19.2.3.4* Any required aisle, corridor, or ramp shall be not less than 48 in. (1220 mm) in clear width where serving as means of egress from patient sleeping rooms, unless otherwise permitted by one of the following: (1) Aisles, corridors, and ramps in adjunct areas not intended for the housing, treatment, or use of inpatients shall be not less than 44 in. (1120 mm) in clear and unobstructed width. (2)*Where corridor width is at least 6 ft (1830 mm), noncontinuous projections not more than 6 in. (150 mm) from the corridor wall, above the handrail height, shall be permitted. (3) Exit access within a room or suite of rooms complying with the requirements of 19.2.5 shall be permitted. (4) Projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in.(1525 mm). (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c)*The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use	K 232		
K 321 SS=D	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 2012 EXISTING	K 321		

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NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION-MC		STREET ADDRESS, CITY, STATE, ZIP CODE 601 WEST CAMERON AVENUE KELLOGG, ID 83837						
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K 321	<p>Continued From page 3</p> <p>Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door.</p> <p>Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1</p> <table border="0"> <tr> <td style="padding-right: 20px;">Area</td> <td>Automatic Sprinkler</td> </tr> <tr> <td></td> <td>Separation N/A</td> </tr> </table> <p>a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)</p> <p>This Standard is not met as evidenced by: Based on observation and operational testing, the facility failed to ensure hold-open devices for hazardous area doors were interconnected to the fire alarm system. Failure to provide hold-open devices for hazardous areas which release under the fire alarm could result in fires growing beyond incipient stages and passing between compartments. This deficient practice affected staff and visitors using the southeast service corridor of the building.</p>	Area	Automatic Sprinkler		Separation N/A	K 321.	<p>K 321</p> <p>I. On February 8, 2017, the drop down door hold open device was removed.</p> <p>II. Inspection of facility demonstrated no other drop down door hold open devices were in use. The maintenance director will monitor compliance using NFPA 101, 19.3.2.1.</p> <p>III. On February 8, 2017, the drop down door hold open device was removed in compliance with NFPA 101, 19.3.2.1.</p> <p>IV. The Maintenance Director or designee will make preventive maintenance rounds each month and then once per year to ensure compliance. All findings will be documented on the audit tool, and report findings to Executive Director ongoing. Findings will also be reported to the Safety and Performance Improvement Committee on a quarterly basis.</p> <p>V. Corrective action was completed on 02/08/2017.</p>	
Area	Automatic Sprinkler							
	Separation N/A							

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K 321	<p>Continued From page 4</p> <p>Findings include:</p> <p>During the facility tour conducted on February 8, 2017 from approximately 10:30 AM to 2:30 PM, observation and operational testing of the door entering the boiler room from the southeast corridor, revealed the door was equipped with a drop down door hold open device which was not interconnected to the fire alarm system and prevented the door from self-closing as designed when activated.</p> <p>Actual NFPA standard:</p> <p>NFPA 101</p> <p>Chapter 3 Definitions</p> <p>3.3.21.4* Hazardous Area. 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.</p> <p>Chapter 19</p> <p>19.3.2 Protection from Hazards.</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 8.7.1.</p> <p>19.3.2.1.3 The doors shall be self-closing or automatic-closing.</p> <p>19.3.2.1.5 Hazardous areas shall include, but shall not be restricted to, the following:</p> <p>(1) Boiler and fuel-fired heater rooms</p> <p>(2) Central/bulk laundries larger than 100 ft² (9.3 m²)</p> <p>(3) Paint shops</p>	K 321		

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K 321	<p>Continued From page 5</p> <p>(4) Repair shops</p> <p>(5) Rooms with soiled linen in volume exceeding 64 gal (242 L)</p> <p>(6) Rooms with collected trash in volume exceeding 64 gal (242 L)</p> <p>(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</p> <p>(8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard</p> <p>Chapter 7</p> <p>7.2.1.8 Self-Closing Devices.</p> <p>7.2.1.8.1* A door leaf normally required to be kept closed shall not be secured in the open position at any time and shall be self-closing or automatic-closing in accordance with 7.2.1.8.2, unless otherwise permitted by 7.2.1.8.3.</p> <p>7.2.1.8.2 In any building of low or ordinary hazard contents, as defined in 6.2.2.2 and 6.2.2.3, or where approved by the authority having jurisdiction, door leaves shall be permitted to be automatic-closing, provided that all of the following criteria are met:</p> <p>(1) Upon release of the hold-open mechanism, the leaf becomes self-closing.</p> <p>(2) The release device is designed so that the leaf instantly releases manually and, upon release, becomes selfclosing, or the leaf can be readily closed.</p> <p>(3) The automatic releasing mechanism or medium is activated by the operation of approved smoke detectors installed in accordance with the requirements for smoke detectors for door leaf release service in NFPA 72, National Fire Alarm and Signaling Code.</p>	K 321		

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K 321	Continued From page 6 (4) Upon loss of power to the hold-open device, the holdopen mechanism is released and the door leaf becomes self-closing. (5) The release by means of smoke detection of one door leaf in a stair enclosure results in closing all door leaves serving that stair.	K 321		
K 353 SS=D	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure the correct number of spare sprinklers for the fire suppression system was provided in accordance with NFPA 25. Failure to provide sprinklers of each type installed in the facility, could result in the facility being not fully sprinklered after an activation of the system or repair. This deficient practice affected staff and visitors using the service area on the date of the survey. The facility is licensed for 68 SNF/NF beds and had a census of 63 on the day of the	K 353	K 353 I. Simplex Grinnell will inventory all sprinkler heads in the center and stock the appropriate number of spare heads in a designated area in the center. II. The maintenance director will monitor compliance using NFPA 101 and NFPA 25. III. Simplex Grinnell will inventory sprinklers and stock the appropriate number of spare sprinkler heads in a designated area in the center in compliance with NFPA 101 and NFPA 25. IV. The Maintenance Director or designee will make preventive maintenance rounds each quarter for first year and then every six months to ensure compliance. All findings will be documented on the audit tool, and report findings to Executive Director ongoing. Findings will also be reported to the Safety and Performance Improvement Committee on a quarterly basis. V. Corrective action will be completed 03/15/2017.	

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K 353	Continued From page 7 survey. Findings include: During the facility tour conducted on February 8, 2017 from approximately 10:30 AM to 2:30 PM, observation of the fire suppression system spare sprinkler box did not reveal the presence of a spare 212 degree standard response sprinkler pendant. Further inspection of installed sprinklers in the building, revealed two (2) sprinklers installed in the facility which were rated at 212 degrees in the service area of the facility. This finding was substantiated by the Maintenance Director during the inspection. Interview of the Maintenance Director revealed he was not aware of the requirement for the number of spare sprinklers. Actual NFPA standard: NFPA 25 5.4 Maintenance. 5.4.1 Sprinklers. 5.4.1.5 The stock of spare sprinklers shall include all types and ratings installed and shall be as follows: (1) For protected facilities having under 300 sprinklers - no fewer than 6 sprinklers (2) For protected facilities having 300 to 1000 sprinklers - no fewer than 12 sprinklers (3) For protected facilities having over 1000 sprinklers - no fewer than 24 sprinklers	K 353		
K 364 SS=E	NFPA 101 Corridor - Openings Corridor - Openings Transfer grilles are not used in corridor walls or doors. Auxiliary spaces that do not contain	K 364		

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135065	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE NF STRUCTURE B. WING _____	(X3) DATE SURVEY COMPLETED 02/08/2017
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION-MI			STREET ADDRESS, CITY, STATE, ZIP CODE 601 WEST CAMERON AVENUE KELLOGG, ID 83837	
(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 364	<p>Continued From page 8</p> <p>flammable or combustible materials are permitted to have louvers or be undercut. In other than smoke compartments containing patient sleeping rooms, miscellaneous openings are permitted in vision panels or doors, provided the openings per room do not exceed 20 square inches and are at or below half the distance from floor to ceiling. In sprinklered rooms, the openings per room do not exceed 80 square inches. Vision panels in corridor walls or doors shall be fixed window assemblies in approved frames. (In fully sprinklered smoke compartments, there are no restrictions in the area and fire resistance of glass and frames.) 18.3.6.5.1, 19.3.6.5.2, 8.3</p> <p>This Standard is not met as evidenced by: Based on observation, the facility failed to ensure transfer grilles were not installed in corridor walls. The installation of transfer grilles in corridors could allow fire, smoke and dangerous gases to pass between compartments and expose residents to the products of combustion during an evacuation. This deficient practice affected residents needing to be evacuated by ambulance through the south corridor, staff and visitors on the date of the survey. The facility is licensed for 68 SNF/NF beds and had a census of 63 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on February 8, 2017 from approximately 10:30 AM to 2:30 PM, observation of the corridor on the south side of the building revealed the boiler room wall was equipped with a transfer grille. Further observation from the inside of the boiler room viewing the corridor beyond, the corridor and exit doors to the ambulance loading area were clearly visible. Further evaluation of the wall assembly</p>	K 364	<p>K 364</p> <p>I. On March 1, 2017, the transfer grille was blocked off with sheet rock sheet metal and the fire wall was brought back a two hour fire rating.</p> <p>II. Inspection of facility demonstrated no other transfer grilles were in use. The maintenance director will monitor compliance using NFPA 101, 19.3.6.4.1.</p> <p>III. On March 1, 2017, the transfer grille was blocked off with sheet rock sheet metal and the fire wall was brought back a two hour fire rating in compliance with NFPA 101, 19.3.6.4.1.</p> <p>IV. The Maintenance Director or designee will make preventive maintenance rounds annually and then include in all required fire system inspections to ensure compliance. All findings will be documented on the audit tool, and report findings to Executive Director ongoing. Findings will also be reported to the Safety and Performance Improvement Committee on a quarterly basis.</p> <p>V. Corrective action was completed 03/01/2017.</p>	

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K 364	Continued From page 9 indicated the wall appeared to be rated as a two-hour barrier based on frame and door assembly ratings. Actual NFPA standard: NFPA 101 19.3.6.4 Transfer Grilles. 19.3.6.4.1 Transfer grilles, regardless of whether they are protected by fusible link-operated dampers, shall not be used in corridor walls or doors.	K 364		
K 521 SS=F	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This Standard is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure the inspection, maintenance and testing of fire dampers was completed in accordance with NFPA 80. Failure to complete inspection and testing of fire dampers could result in a failure of a crucial component for compartment protection, allowing fire, smoke and dangerous gases to pass between compartments. This deficient practice affected 63 residents, staff and visitors on the date of the survey. The facility is licensed for 68 SNF/NF residents and had a census of 63 on the day of the survey.	K 521	K 521 I. On February 17, 2017, fire dampers were inspected by a certified technician. II. On February 17, 2017, complete facility rounds were made with certified technician and no other fall dampers were identified. The maintenance director will monitor compliance using NFPA 101, 19.5.4.8.1. III. On February 17, 2017, fire dampers were inspected by a certified technician in compliance with NFPA 101, 19.5.4.8.1. IV. The Maintenance Director or designee will add an inspection and testing of fire dampers every two years to TELS Preventative Maintenance Program. All findings will be documented on the audit tool, and report findings to Executive Director ongoing. Findings will also be reported to the Safety and Performance Improvement Committee on a quarterly basis. V. Corrective action was completed 02/17/2017.	

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K 521	<p>Continued From page 10</p> <p>Findings include:</p> <p>1) During review of facility inspection, maintenance and testing records conducted on February 8, 2017 from approximately 9:30 AM to 10:30 AM, no records were provided for the inspection and testing of fire dampers. When asked if the facility was equipped with fire dampers, the Maintenance Director indicated there were two (2) fire dampers installed: one (1) in the smoke barrier separating the 300 hall and the 100, 200 and 400 hall and the second outside of the employee breakroom.</p> <p>2) During the facility tour conducted on February 8, 2017 from approximately 10:30 AM to 2:30 PM, an above the ceiling inspection outside the employee breakroom revealed one of the identified fire dampers equipped with a fusible link.</p> <p>Actual NFPA standard:</p> <p>9.2 Heating, Ventilating, and Air-Conditioning. 9.2.1 Air-Conditioning, Heating, Ventilating Ductwork, and Related Equipment. Air-conditioning, heating, ventilating ductwork, and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems, or NFPA 90B, Standard for the Installation of Warm Air Heating and Air-Conditioning Systems, as applicable, unless such installations are approved existing installations, which shall be permitted to be continued in service.</p> <p>NFPA 90 A</p> <p>5.4 Fire Dampers, Smoke Dampers, and Ceiling</p>	K 521		

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

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FORM APPROVED
OMB NO. 0938-0391

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K 521	Continued From page 11 Dampers. 5.4.8 Maintenance 5.4.8.1 Fire Dampers and ceiling dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80 19.4* Periodic Inspection and Testing. 19.4.1 Each damper shall be tested and inspected 1 year after installation. 19.4.1.1 The test and inspection frequency shall then be every 4 years, except in hospitals, where the frequency shall be every 6 years.	K 521		

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION-MOUNT	STREET ADDRESS, CITY, STATE, ZIP CODE 601 WEST CAMERON AVENUE KELLOGG, ID 83837
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C 000	16.03.02 INITIAL COMMENTS The building is a type V (111) fully sprinklered, single story structure with complete fire alarm/detection system. The building was constructed in 1971 and is licensed for 68 beds. The following deficiencies were cited during the annual Fire/Life Safety survey conducted on February 8, 2017. The facility was surveyed under the LIFE SAFETY CODE, 2012 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 & Construction	C 000		
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 CMS "K" tags on federal 2567: K-232 Wheeled equipment relocation K-300 Fire Dampers K-321 Hazardous areas K-353 Sprinkler system maintenance	C 226	See K 232 Plan of Correction K 321 Plan of Correction K 353 Plan of Correction K 364 Plan of Correction K 521 Plan of Correction	

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MAR 01 2017
FACILITY STANDARDS

Idaho form

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Maryruth Butler</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>2-28-17</i>
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STATE FORM 021199 CIKT21 If continuation sheet 1 of 3

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C 226	Continued From Page 1	C 226		
C 260	<p>K-364 Transfer Grilles in corridors</p> <p>02.106,07,h</p> <p>h. All range hoods and filters shall be cleaned at least weekly. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that Kitchen hood filters were cleaned at least weekly. Failure to clean Kitchen hood filters weekly could increase the potential for fires due to grease build-up. This deficient practice affected staff and visitors of the main Kitchen on the date of the survey. The facility is licensed for 68 SNF/NF beds and had a census of 63 on the day of the survey.</p> <p>Findings include:</p> <p>1) During review of the facility inspection and maintenance records conducted on February 8, 2017 from approximately 9:30 AM to 10:30 AM, no records were provided to indicate weekly cleaning was performed for the Kitchen hood filters.</p> <p>2) During the facility tour conducted on February 8, 2017 from approximately 10:30 AM to 2:30 PM, interview of the Dietary staff present in the main Kitchen revealed she was not aware of the requirement for weekly cleaning of the hood filters and was unsure of how often this task was performed. When asked, the Maintenance Director stated he cleaned the filters monthly, but was not aware of the requirement to clean them weekly.</p> <p>Actual IDAPA standard: IDAPA 16.03.02.07 (h)</p>	C 260	<p>C 226</p> <p>I. On February 8, 2017, kitchen hood filters were inspected and cleaned.</p> <p>II. Inspection of facility demonstrated no other hood filters in use. The maintenance director will monitor compliance using IDAPA 16.03.02.07.</p> <p>III. On February 8, 2017, the kitchen hold filters were inspected and cleaned in compliance with IDAPA 16.03.02.07. Weekly cleaning of the kitchen hold filters was added to the TELS Preventative Maintenance Program.</p> <p>IV. The Maintenance Director or designee will review preventive maintenance documentation each week to ensure compliance. All findings will be documented on the audit tool, and report findings to Executive Director ongoing. Findings will also be reported to the Safety and Performance Improvement Committee on a quarterly basis.</p> <p>V. Corrective action was completed 03/01/2017.</p>	

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C 260	Continued From Page 2 07. Maintenance of Equipment. The facility shall establish routine test, check and maintenance procedures for all equipment. h. All range hoods and filters shall be cleaned at least weekly.	C 260		