



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

March 29, 2017

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 **March 20, 2017**, 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

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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 **April 11, 2017**. Failure to submit an acceptable PoC by **April 11, 2017**, may result in the imposition of civil monetary penalties by **May 1, 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 **April 24, 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 **April 24, 2017**. A change in the seriousness of the deficiencies on **April 24, 2017**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **April 24, 2017**, includes the following:

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Denial of payment for new admissions effective **June 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 **September 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 **March 20, 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:

<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 **April 11, 2017**. If your request for informal dispute resolution is received after **April 11, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135020</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - <b>BUILDING 0101</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/20/2017</b>
NAME OF PROVIDER OR SUPPLIER <b>RIVER'S EDGE REHABILITATION &amp; LIVING CE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>714 NORTH BUTTE AVENUE EMMETT, ID 83617</b>		
(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 March 20, 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 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 APR 14 2017 FACILITY STANDARDS	
K 111 SS=D	NFPA 101 Building Rehabilitation  Building Rehabilitation Repair, Renovation, Modification, or Reconstruction Any building undergoing repair, renovation, modification, or reconstruction complies with both of the following: * Requirements of Chapter 18 and 19 * Requirements of the applicable Sections 43.3, 43.4, 43.5, and 43.6 18.1.1.4.3, 19.1.1.4.3, 43.1.2.1 Change of Use or Change of Occupancy Any building undergoing change of use or change of occupancy classification complies with the	K 111	K111  Installed self-closing hinges On Therapy closet <u>4/07/2017</u> 1. Weekly audit in place for three Months and each month will be a different department head inspecting the security of close Therapy closet. 2. Safety Committee will ensure audits are completed on time and compliance.	4/21/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *M. S.* TITLE *Administrator* (X6) DATE *4/10/17*

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 111	<p>Continued From page 1</p> <p>requirements of Section 43.7, unless permitted by 18.1.1.4.2 or 19.1.1.4.2</p> <p>18.1.1.4.2 (4.6.7 and 4.6.11), 19.1.1.4.2 (4.6.7 and 4.6.11), 43.1.2.2 (43.7)</p> <p>Additions</p> <p>Any building undergoing an addition shall comply with the requirements of Section 43.8. If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a 2-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors with at least a 1-1/2-hour fire resistance rating. Additions comply with the requirements of Section 43.8.</p> <p>18.1.1.4.1 (4.6.7 and 4.6.11), 18.1.1.4.1.1 (8.3), 18.1.1.4.1.2, 18.1.1.4.1.3, 19.1.1.4.1 (4.6.7 and 4.6.11), 19.1.1.4.1.1 (8.3), 19.1.1.4.1.2, 19.1.1.4.1.3, 43.1.2.3(43.8)</p> <p>This Standard is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure modifications of the structure were completed in accordance with NFPA 101. Failure to follow guidelines for rehabilitation activities could reduce protections in place, increasing exposed risks to residents. This deficient practice affected 2 residents, staff and visitors on the date of the survey. The facility is licensed for 74 SNF/NF beds and had a census of 44 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on March 20, 2017 from approximately 10:00 AM to 2:30 PM, observation and operational testing of a new therapy storage closet which abutted room T3 revealed the door was not equipped to self-close.</p>	K 111		

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K 111	Continued From page 2 Interview of the Maintenance Manager revealed he had created this closet space from the closet in room T3 by walling in that door opening and modifying the corridor wall with a new door opening. He further stated he moved the door from the T3 closet to the new opening on the corridor side.  Actual NFPA standard:  43.1.2.1 Any building undergoing repair, renovation, modification, or reconstruction (see 43.2.2.1.1 through 43.2.2.1.4) shall comply with both of the following: (1) Requirements of the applicable existing occupancy chapters (see Chapters 13, 15, 17, 19, 21, 23, 24, 26, 29, 31, 33, 37, 39, 40, and 42). (2) Requirements of the applicable section of this chapter (see Sections 43.3, 43.4, 43.5, and 43.6)  43.5 Modifications. 43.5.1 General Requirements. 43.5.1.1 A modification, as defined in 43.2.2.1.3, in other than historic buildings shall comply with both of the following: (1) Section 43.5 (2) Section 43.4  43.5.1.3 Newly constructed elements, components, and systems shall comply with the requirements of other sections of this Code applicable to new construction.  18.1.1.4.1.1 Communicating openings in dividing fire barriers required by 18.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.)	K 111		
K 211 SS=F	NFPA 101 Means of Egress - General	K 211		

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K 211	<p>Continued From page 3</p> <p>Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1</p> <p>This Standard is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure that smoke and fire rated assemblies were inspected in accordance with either NFPA 80 or NFPA 105. Failure to inspect and test rated doors could result in a lack of system performance as designed. This deficient practice affected 44 residents, staff and visitors on the date of the survey. The facility is licensed for 74 SNF/NF beds and had a census of 44 on the day of the survey.</p> <p>Findings include:</p> <p>1) During review of provided facility annual inspection records conducted on March 20, 2017 from approximately 9:00 AM to 10:00 AM, no record was available demonstrating an initial inspection and testing of rated assemblies had been conducted. When asked about the missing documentation, the Maintenance Supervisor stated he was not aware of this requirement.</p> <p>2) During the facility tour conducted on March 20, 2017 from approximately 10:00 AM to 2:30 PM, observation of installed doors revealed doors in the following locations were tagged with fire labels:</p> <p>Smoke barrier doors in the 100 North, 100 South and 200 halls</p>	K 211	<p>K211</p> <ol style="list-style-type: none"> <li>Smoke/Fire doors with in the building there was no documentation started a written inspection form NFPA-80 Annual Inspection of Fire doors</li> <li>Rivers Edge has four fire/smoke doors and one fire hatch all Annual inspections were completed <u>4/06/2017</u></li> <li>All doors will be inspected annually</li> <li>Plant Supervisor will ensure compliance.</li> </ol>	4/21/17

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

Printed: 03/29/2017  
FORM APPROVED  
OMB NO. 0938-0391

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K 211	<p>Continued From page 4 Maintenance Office/shop Boiler/Mechanical room</p> <p>Actual NFPA standard:  NFPA 101</p> <p>19.2 Means of Egress Requirements 19.2.2.2 Doors. 19.2.2.2.1 Doors complying with 7.2.1 shall be permitted.</p> <p>7.2.1 Door Openings. 7.2.1.15 Inspection of Door Openings. 7.2.1.15.1* Where required by Chapters 11 through 43, the following door assemblies shall be inspected and tested not less than annually in accordance with 7.2.1.15.2 through 7.2.1.15.8: (1) Door leaves equipped with panic hardware or fire exit hardware in accordance with 7.2.1.7 (2) Door assemblies in exit enclosures (3) Electrically controlled egress doors (4) Door assemblies with special locking arrangements subject to 7.2.1.6</p> <p>7.2.1.15.2 Fire-rated door assemblies shall be inspected and tested in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Smoke door assemblies shall be inspected and tested in accordance with NFPA 105, Standard for Smoke Door Assemblies and Other Opening Protectives.</p> <p>NFPA 80 5.2* Inspections. 5.2.1* Fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ.</p>	K 211		

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K 211	Continued From page 5 NFPA 105 5.2 Specific Requirements. 5.2.1* Inspections. 5.2.1.1 Smoke door assemblies shall be inspected annually. 5.2.1.2 Doors shall be operated to confirm full closure. 5.2.1.3 Hardware and gaskets shall be inspected annually, and any parts found to be damaged or inoperative shall be replaced.	K 211		
K 222 SS=F	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location	K 222	1.The proper signage was in house and installed on the Main Lobby,Therapy,100 North,200 North and 200 South doors <u>3/21/2017</u> 2.All residents potential to be affected, the required signage was affixed to all exterior doors with delayed egress (push handle for 15 seconds door will open) <u>completed 3/21/2017</u> 3. The signage will be checked monthly by the plant supervisor for ware and fading and submitted to the Safety Committee <u>Start date 4/1/2017 no end date</u> 4. Plant supervisor will ensure compliance.	4/21/17

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K 222	<p>Continued From page 6 within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 <b>DELAYED-EGRESS LOCKING ARRANGEMENTS</b> Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 <b>ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS</b> Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 <b>ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS</b> Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This Standard is not met as evidenced by: Based on observation and operational testing and interview, the facility failed to ensure doors equipped with special locking arrangements were provided with appropriate signs for their operation. Failure to clearly mark doors for special locking arrangements could hinder egress of residents during a fire or other emergency. This deficient practice affected 44 residents, staff and visitors on the date of the survey. The facility is licensed for 74 SNF/NF beds and had a census</p>	K 222		

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K 222	Continued From page 7 of 44 on the day of the survey.  Findings include:  During the facility tour conducted on March 20, 2017 from approximately 10:00 AM to 1:00 PM, observation and operational testing of exit doors revealed doors were equipped with magnetic locks controlled by a Wanderguard system. Interview of the Maintenance Manager revealed this system was equipped with a delayed egress component.  Further observation revealed signs on only 1 of 6 doors indicating operation of the delayed egress component. When asked about the missing signs, the Maintenance Manager stated he was not aware signs were required for this system.  Actual NFPA standard:  7.2.1.6* Special Locking Arrangements. 7.2.1.6.1 Delayed-Egress Locking Systems. 7.2.1.6.1.1 Approved, listed, delayed-egress locking systems shall be permitted to be installed on door assemblies 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 11 through 43, provided that all of the following criteria are met: (1) The door leaves shall unlock in the direction of egress upon actuation of one of the following:	K 222		
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	K 232		

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K 232	<p>Continued From page 8</p> <p>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</p> <p>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 44 residents, staff and visitors on the date of the survey. The facility is licensed for 74 SNF/NF beds and had a census of 44 on the day of the survey.</p> <p>Findings include:</p> <p>1) During review of the facility fire safety plan conducted on March 20, 2017 from approximately 9:00 AM to 10:00 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 2:00 PM, observation of the resident sleeping room corridors revealed the following:</p> <p>Housekeeping carts parked outside the Cherry Blossom Dining and the Utility room of 100 North. Nurse's medication carts positioned at both</p>	K 232	<p>K232</p> <p>1. The staff will be in-service at General Staff training <u>4/10/2017</u> on the important of getting all rolled equipment out of the hallways during any Emergency.</p> <p>2. In the event of any Emergency all wheeled equipment will be removed from the hallways and put into a common area and locked was put into the Emergency Response Plan under section Fire Discovery and Announcement. <u>4/7/2017</u></p> <p>3. Plant Supervisor will ensure compliance</p>	4/21/17

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K 232	<p>Continued From page 9 nurse's stations.</p> <p>Interview of Housekeeping staff outside the Cherry Blossom Dining room and the caregiver at 200 North Nurse's station from approximately 1:30 PM to 2:30 PM, the staff stated they were not aware of any training or policy for the relocation of carts in the event of an emergency.</p> <p>Actual NFPA standard: NFPA 101</p> <p>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</p>	K 232		

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K 232	Continued From page 10 following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use	K 232		
K 324 SS=D	NFPA 101 Cooking Facilities  Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2  This Standard is not met as evidenced by: Based on observation, the facility failed to ensure kitchen hood systems were maintained in accordance with NFPA 96. Failure to ensure grease laden vapors do not bypass hood filters could allow grease build-up inside the exhaust system, increasing the risk of grease fires. This deficient practice affected staff and visitors of the main Kitchen on the date of the survey. The	K 324	K324  1. The spacer for the Hood Filters far right was taken to a machine shop and new spacer was made of the same gage stainless steel and 1/4 " was added on either side. This was corrected to meet NFPA 96 on <u>4/4/2017</u>	4/21/17

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K 324	Continued From page 11 facility is licensed for 74 SNF/NF beds and had a census of 44 on the day of the survey.  Findings include:  During the facility tour conducted on March 20, 2017 from approximately 12:30 PM to 1:30 PM, observation of the main Kitchen hood system revealed a gap of approximately 5/8 inch between the first two filters on the left hand side when facing the hood, allowing exhaust air to bypass the filters.  Actual NFPA standard:  NFPA 96  6.2.3 Grease Filters. 6.2.3.3 Grease filters shall be arranged so that all exhaust air passes through the grease filters.	K 324		
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	K 353	K353  1. The top shelf in the Therapy closet was removed to meet the 18" from the bottom of the sprinkler pendant to be in complaint with NFPA-25  <u>4/10/2017</u>	4/21/17

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

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OMB NO. 0938-0391

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K 353	<p>Continued From page 12 system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This Standard is not met as evidenced by: Based on observation, the facility failed to ensure adequate clearance below sprinkler deflectors. Failure to maintain proper clearance below sprinklers due to storage or other obstructions could allow fires to grow beyond incipient stages. This deficient practice affected 2 residents, staff and visitors on the date of the survey. The facility is licensed for 74 SNF/NF beds and had a census of 44 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on March 20, 2017 from approximately 1:00 PM to 2:30 PM, observation of the Therapy storage closet abutting room T3 revealed the clearance from the bottom of the sprinkler pendant installed in the closet and the top of the shelf measured approximately ten inches.</p> <p>Actual NFPA standard:</p> <p>NFPA 25</p> <p>5.2.1.2* The minimum clearance required by the installation standard shall be maintained below all sprinkler deflectors.</p> <p>NFPA 13</p> <p>8.5.6* Clearance to Storage. 8.5.6.1* Unless the requirements of 8.5.6.2, 8.5.6.3, 8.5.6.4, or 8.5.6.5 are met, the clearance between the deflector and the top of storage shall be 18 in. (457 mm) or greater.</p>	K 353		
K 374 SS=D	NFPA 101 Subdivision of Building Spaces - Smoke Barrie	K 374		

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K 374	Continued From page 13  Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This Standard is not met as evidenced by: Based on observation and operational testing, the facility failed to ensure that smoke barrier doors would resist the passage of smoke. Failure for smoke barrier doors to resist the passage of smoke could allow smoke and dangerous gases to pass between smoke compartments during a fire, eliminating the ability to defend in place. This deficient practice affected 20 residents, staff and visitors on the date of the survey. The facility is licensed for 74 SNF/NF beds and had a census of 44 on the day of the survey.  Findings include:  During the facility tour conducted on March 20, 2017 from approximately 10:00 AM to 10:45 AM, observation and operational testing of the smoke barrier doors located in the 100 North wing, revealed a gap between the face of the primary leaf and the secondary leaf astragal, measuring approximately one inch at the bottom to 5/8 inch at the top. Further observaion revealed the gap failed to fully close the opening hindering the	K 374	K374  1. Smoke Door 100 wing north had a gap from 5/8" – 1" on the North swinging door installed weather stripping on the interior secondary leaf on <u>4/06/2017</u> .  2. Plant Supervisor will do smoke door checks monthly for the life safety requirement for Company Policies and will follow the guide line set in the Annual fire inspection, will make reports to the Safety Committee on an ongoing basis.  3. Plant supervisor will ensure compliance.	4/21/17

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K 374	Continued From page 14 ability of the doors to resist the passage of smoke.  Actual NFPA standard:  19.3.7.8* Doors in smoke barriers shall comply with 8.5.4 and all of the following: (1) The doors shall be self-closing or automatic-closing in accordance with 19.2.2.2.7. (2) Latching hardware shall not be required (3) The doors shall not be required to swing in the direction of egress travel.  8.5.4.1* Doors in smoke barriers shall close the opening, leaving only the minimum clearance necessary for proper operation, and shall be without louvers or grilles. The clearance under the bottom of a new door shall be a maximum of 3.4 in. (19 mm).	K 374		

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C 000	16.03.02 INITIAL COMMENTS	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 2567 "K" tags:  K-111 Building Modifications K-211 Egress doors K-222 Special locking arrangements K-232 Wheeled Equipment K-324 Grease hood maintenance K-353 Sprinkler system maintenance K-374 Smoke Barrier Doors	C 226	"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."  <i>RECEIVED</i> <i>APR 10 2017</i>  <i>FACILITY STANDARDS</i>	
C 260	02.106,07,h  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 Kitchen hood grease filters were cleaned weekly. Failure to clean hood filters weekly could allow excessive build-up of grease laden vapors in the hood exhaust system, which has been historically linked to kitchen fires. This deficient practice affected staff and visitors on the date of the survey. The facility is licensed for 74 SNF/NF beds and had a census of 44 on the day	C 260	C260 1. Kitchen Staff will be in services on the need to clean the range hood and filters on a weekly basis. The cleaning of hoods and filters was added to the weekly cleaning sheet on <u>4/5/2017</u>	4/24/17

Idaho form

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



TITLE

Administrator 4/10/17

(X6) DATE

Bureau of Facility Standards

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C 260	Continued From Page 1  of the survey.  Findings include:  During the facility tour conducted on March 20, 2017 from approximately 12:30 PM to 1:30 PM, no weekly cleaning reports of hood filters were available in the main Kitchen. When asked how often the Kitchen hood filters were cleaned, the Dietary Manager stated she only cleaned them when they looked dirty.  Actual IDAPA standard:  IDAPA 16.03.02.106.07(h) h. All range hoods and filters shall be cleaned at least weekly.	C 260	2. Plant supervisor will conduct inspections to insure cleaning is being done and documented when conducting life safety fire Environment rounds.  3. Plant Supervisor will ensure compliance	