



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

C.L. "BUTCH" OTTER – Governor  
RUSSELL S. BARRON – 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

June 15, 2018

Joseph Rudd, Administrator  
Riverview Rehabilitation  
3550 West Americana Terrace  
Boise, ID 83706-4728

Provider #: 135139

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

Dear Mr. Rudd:

On **June 5, 2018**, a Facility Fire Safety and Construction survey was conducted at **Riverview Rehabilitation** 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

Joseph Rudd, Administrator  
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Page 2 of 4

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 **June 28, 2018**. Failure to submit an acceptable PoC by **June 28, 2018**, may result in the imposition of civil monetary penalties by **July 18, 2018**.

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 may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **July 10, 2018**, (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 **July 10, 2018**. A change in the seriousness of the deficiencies on **July 10, 2018**, may result in a change in the remedy.

Joseph Rudd, Administrator  
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The remedy, which will be recommended if substantial compliance has not been achieved by **July 10, 2018**, includes the following:

Denial of payment for new admissions effective **September 5, 2018**.  
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 **December 5, 2018**, 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 **June 5, 2018**, 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:

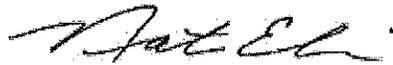
BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process  
2001-10 IDR Request Form

This request must be received by **June 28, 2018**. If your request for informal dispute resolution is received after **June 28, 2018**, 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: 07/03/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135139</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/05/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>RIVERVIEW REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3550 WEST AMERICANA TERRACE BOISE, ID 83706</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	
E 000	<p>Initial Comments</p> <p>The facility is a single-story Type V (111) structure approximately 26,000 square feet in size. Plans were approved in September of 2012 and construction completed in March of 2013. The facility is fully sprinklered, with corridor smoke detection and fire alarm system, along with a type 2 Essential Electrical Service. The building is divided into two smoke compartments, with seven exits to grade. Currently the facility is licensed for 30 SNF/NF beds, and had a census of 28 on the date of the survey.</p> <p>The facility was found to be in substantial compliance during the initial Emergency Preparedness Survey conducted on June 5, 2018. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.</p> <p>The survey was conducted by:</p> <p>Linda Chaney Health Facility Surveyor Facility Fire Safety &amp; Construction</p>	E 000			

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

TITLE

(X6) DATE

06/22/2018

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.

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

PRINTED: 06/14/2018  
FORM APPROVED  
OMB NO. 0938-0391

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K 000	INITIAL COMMENTS  The facility is a single-story Type V (111) structure approximately 26,000 square feet in size. Plans were approved in September of 2012 and construction completed in March of 2013. The facility is fully sprinklered, with corridor smoke detection and fire alarm system, along with a type 2 Essential Electrical Service. The building is divided into two smoke compartments, with seven exits to grade. Currently the facility is licensed for 30 SNF/NF beds, and had a census of 28 on the date of the survey.  The following deficiencies were cited during the annual fire/life safety survey conducted on June 5, 2018. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Chapter 19, Existing Healthcare Occupancies, in accordance with 42 CFR 483.70, 42 CFR 483.80 and 42 CFR 483.65.  The Survey was conducted by:  Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction	K 000	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Riverview Rehabilitation does not stipulate or admit that the deficiencies listed herein, on this State Form exist, nor does this facility admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiencies.		
K 222 SS=F	Egress Doors CFR(s): NFPA 101  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	K 222	K222  On or before June 22, 2018 the facility's contracted alarm company repaired the delayed egress magnetic lock on the door near rooms 113 & 114, to cause it to release in accordance with requirements at NFPA 101 7.2.1.6.1.		

RECEIVED

JUN 22 2018

FACILITY STANDARDS

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

TITLE

(X8) DATE

*JBRudd*

Executive Director

6/22/2018

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 222	Continued From page 1 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 <b>SPECIAL NEEDS LOCKING ARRANGEMENTS</b> 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 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.	K 222	On or before June 22, 2018 the facility's contracted alarm company repaired the delayed egress magnetic lock on the door near the library, to cause it to release in accordance with requirements at NFPA 101 7.2.1.6.1.  On or before June 22, 2018 all delayed egress doors in the facility were tested by the facility administrator, or designee, to ensure proper function in accordance with the requirements at NFPA 101 7.2.1.6.1. No concerns were noted.  Beginning July 2018 the delayed egress doors in the facility will be tested weekly for three months, and then monthly for three months, by the facility administrator, or designee, to ensure proper function in accordance with the requirements at NFPA 101 7.2.1.6.1. Any concerns identified will be corrected.  Results of these checks will be reported to the facility's Quality Assessment and Assurance (QAA) committee beginning in August 2018 for three months.  An appropriate Root Cause Analysis and Corrective Action Plan will be initiated, in accordance with the facility's Quality Assurance and Performance Improvement (QAPI) plan for any identified concerns.  Date of Compliance: 6/22/2018	

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K 222	<p>Continued From page 2 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS 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 REQUIREMENT is not met as evidenced by: Based on operational testing, observation and interview, the facility failed to ensure means of egress were free from deficiencies to their instant use in an emergency. Failure for delayed egress doors to operate as designed could hinder the safe evacuation of residents during a fire or other emergency. This deficient practice affected 28 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on June 5, 2018, from approximately 10:00 AM to 12:00 PM, operational testing of the delayed egress component on each exit door revealed two doors were non-operational. The exit door at the end of the hallway by rooms 113-114, and the exit door next to the Library, would not release the magnetic locking mechanism when the panic bar was engaged. The doors were labeled appropriately for delayed egress, but the feature was not operational. Exit was only possible using the key pad and code. When asked about the locking arrangement, the Administrator stated the facility had recently experienced some problems with the door at the end of the hallway releasing.</p>	K 222			

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K 222	<p>Continued From page 3</p> <p>The alarm company had been out to repair the door, and the facility believed it was operational. The facility was not aware the door by the Library was also not releasing the magnetic lock.</p> <p>Actual NFPA standard:</p> <p>NFPA 101 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: (a) Approved, supervised automatic sprinkler system in accordance with Section 9.7 (b) Not more than one heat detector of an approved, supervised automatic fire detection system in accordance with Section 9.6 (c) Not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6 (2) The door leaves shall unlock in the direction of egress upon loss of power controlling the lock or locking mechanism. (3)*An irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device</p>	K 222		

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K 222	Continued From page 4 required in 7.2.1.5.10 under all of the following conditions: (a) The force shall not be required to exceed 15 lbf (67 N). (b) The force shall not be required to be continuously applied for more than 3 seconds. (c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening. (d) Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only. (4)*A readily visible, durable sign in letters not less than 1 in. (25 mm) high and not less than 1/8 in. (3.2 mm) in stroke width on a contrasting background that reads as follows shall be located on the door leaf adjacent to the release device in the direction of egress: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS	K 222		
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101  Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9.18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to provide monthly emergency lighting test documentation. Failure to test the emergency lighting could inhibit egress of residents during an emergency. This deficient practice affected 95	K 291	K291  On or before June 22, 2018 emergency lights in the facility were tested and documented, by the facility administrator or designee, in accordance with NFPA 101 7.9.3.1.1. No concerns with the Emergency Lighting System were identified.	

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K 291	Continued From page 5 residents, staff and visitors on the day of survey.  Findings include:  During review of the emergency lighting test logs on June 5, 2018, from approximately 8:30 AM to 10:00 AM, no documentation for 30 second monthly testing of the emergency lighting could be produced for calendar year 2017. When asked, the Administrator stated the facility was using an online tracking program for preventive maintenance in 2017. They dropped their subscription at the end of the year and did not print out the documentation. The facility no longer has access to the site and the documentation.  Actual NFPA reference:  NFPA 101 19.2.9 Emergency Lighting. 19.2.9.1 Emergency lighting shall be provided in accordance with Section 7.9. 7.9.3 Periodic Testing of Emergency Lighting Equipment. 7.9.3.1 Required emergency lighting systems shall be tested in accordance with one of the three options offered by 7.9.3.1.1, 7.9.3.1.2, or 7.9.3.1.3. 7.9.3.1.1 Testing of required emergency lighting systems shall be permitted to be conducted as follows: (1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, except as otherwise permitted by 7.9.3.1.1(2). (2)*The test interval shall be permitted to be extended beyond 30 days with the approval of the	K 291	On or before June 22, 2018 the protocol and practice for verifying and documenting functionality of the Emergency Lighting System was evaluated by the facility Administrator to confirm that the system is sustainable, and in accordance with NFPA 101 7.9.3.1.1.  Beginning July 2018 and ongoing for the following three months, and then quarterly for six months, the results of these lighting tests will be reviewed by the facility's Quality Assessment and Assurance (QAA) committee. An appropriate Root Cause Analysis and Corrective Action Plan will be initiated, in accordance with the facility's Quality Assurance and Performance Improvement (QAPI) plan for any identified concerns.  Date of Compliance: 6/22/2018		

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K 291	Continued From page 6 authority having jurisdiction. (3) Functional testing shall be conducted annually for a minimum of 1-1/2 hours if the emergency lighting system is battery powered. (4) The emergency lighting equipment shall be fully operational for the duration of the tests required by 7.9.3.1.1(1) and (3). (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. 7.9.3.1.2 Testing of required emergency lighting systems shall be permitted to be conducted as follows: (1) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall be provided. (2) Not less than once every 30 days, self-testing/self-diagnostic battery-operated emergency lighting equipment shall automatically perform a test with a duration of a minimum of 30 seconds and a diagnostic routine. (3) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall indicate failures by a status indicator. (4) A visual inspection shall be performed at intervals not exceeding 30 days. (5) Functional testing shall be conducted annually for a minimum of 1-1/2 hours. (6) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall be fully operational for the duration of the 1-1/2-hour test. (7) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. 7.9.3.1.3 Testing of required emergency lighting systems shall be permitted to be conducted as follows: (1) Computer-based, self-testing/self-diagnostic battery-operated	K 291		

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135139</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - RIVERVIEW REHABILITATION  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/05/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>RIVERVIEW REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3550 WEST AMERICANA TERRACE BOISE, ID 83706</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 291	Continued From page 7 emergency lighting equipment shall be provided. (2) Not less than once every 30 days, emergency lighting equipment shall automatically perform a test with a duration of a minimum of 30 seconds and a diagnostic routine. (3) The emergency lighting equipment shall automatically perform annually a test for a minimum of 1-1/2 hours. (4) The emergency lighting equipment shall be fully operational for the duration of the tests required by 7.9.3.1.3(2) and (3). (5) The computer-based system shall be capable of providing a report of the history of tests and failures at all times.	K 291		
K 926 SS=D	Gas Equipment - Qualifications and Training CFR(s): NFPA 101  Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on record review, and interview, the facility failed to ensure staff were properly trained on the risks associated with the use and handling of medical gases. Failure to provide an education program which includes periodic review of safety guidelines and usage requirements for medical gases and their cylinders, could result in a life threatening or catastrophic accident. This	K 926	K926  On or before June 22, 2018 facility employees concerned with the application, maintenance and handling of medical gases have been trained by the facility's licensed oxygen vendor on the associated risks, in accordance with NFPA 99 11.5.2.1.  There have been no incidents or injury in the facility associated with the application maintenance and handling of medical gases.  Beginning in June 2018, training has been added, by the facility administrator to the facility's orientation agenda and annual staff education requirements related to the application, maintenance and handling of medical gases, for at risk employees.	



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

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K 926	Continued From page 9 11.5.2.1.3 Continuing education programs shall include periodic review of safety guidelines and usage requirements for medical gases and their cylinders.	K 926			