



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

November 19, 2018

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 **November 6, 2018**, 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

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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 **December 3, 2018**. Failure to submit an acceptable PoC by **December 3, 2018**, may result in the imposition of civil monetary penalties by **December 24, 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 **December 11, 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 **February 4, 2019**. A change in the seriousness of the deficiencies on **December 21, 2018**, 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 **December 11, 2018**, includes the following:

Denial of payment for new admissions effective **February 6, 2019**.
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 **May 6, 2019**, 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 **November 6, 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:

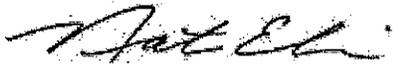
BFS Letters (06/30/11)

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

This request must be received by **December 3, 2018**. If your request for informal dispute resolution is received after **December 3, 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

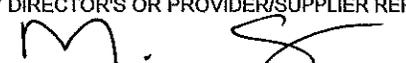
NE/lj
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135020	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING 0101 B. WING _____	(X3) DATE SURVEY COMPLETED 11/06/2018
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NAME OF PROVIDER OR SUPPLIER RIVER'S EDGE REHABILITATION & LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 714 NORTH BUTTE AVENUE EMMETT, ID 83617
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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	<p>INITIAL COMMENTS</p> <p>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 re-furbished in 2000-2001 at which time the fire alarm system was updated. The Essential Electrical System is supplied by a natural gas powered, on-site automatic generator. Currently the facility is licensed for 74 SNF/NF beds and had a census of 41 on the dates of the survey.</p> <p>The following deficiencies were cited during the annual life safety code survey conducted on November 5 - 6, 2018. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70, and 42 CFR 483.80.</p> <p>The Survey was conducted by:</p> <p>Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction</p>	K 000	<p>“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.”</p> <p style="text-align: center;">RECEIVED</p> <p style="text-align: center;">NOV 28 2018</p> <p style="text-align: center;">FACILITY STANDARDS</p>	
K 100 SS=F	<p>General Requirements - Other CFR(s): NFPA 101</p> <p>General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.</p>	K 100	<p>K100</p> <p>1. The Maintenance supervisor contacted Industrial Hygiene Resources and received their testing protocols for Legionella testing on 11/26/18.</p>	12/7/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 11/28/18
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 100	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, and interview, the facility failed to develop and implement a comprehensive water management plan. Failure to develop and implement a facility specific water management plan could increase risk of growth and spread of Legionella and other opportunistic pathogens in building water systems. This deficient practice could potentially affect 41 residents, visitors and staff on the dates of the survey.</p> <p>Findings include:</p> <p>During the review of facility records on November 5, 2018, from approximately 8:15 AM to 11:45 AM, review of the facility water management plan revealed it was lacking required testing protocols, and the facility had not yet implemented control measures as outlined in the plan. When asked, the Maintenance Supervisor stated the facility was aware of the requirements and was working to complete the plan and implement the required control measures.</p> <p>Actual Standard:</p> <p>42 CFR § 483.80 Infection control.</p> <p>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</p> <p>Additional Reference:</p>	K 100	<p>2. Maintenance will be implementing a plan to frequently run and flush the water in the shower room 2 on the 100 Hall, and resident showers when they're unoccupied for no longer than 90 days. The water temperatures in the building remain between 105-120 degrees. The testing of these areas will be documented in the current water temperature logs starting 11/27/2018.</p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 100	Continued From page 2	K 100		
K 281 SS=F	Centers for Medicare/Medicaid Services S&C Letter 17-30. Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide illumination of a means of egress so that failure of any single lighting unit would not leave the area in darkness. Failure to provide two (2) lighting units could hinder the safe evacuation of residents during a fire or other emergency. This deficient practice affected 41 residents, staff and visitors on the dates of the survey. Findings include: During the facility tour conducted on November 6, 2018, from approximately 8:30 AM to 11:00 AM, observation of the exit discharge from the Butte View Room, and 100 Hallway revealed only one exterior light fixture. The exit discharge from the 200 Hallway had no exterior light fixture. Further observation of the area revealed no additional light fixtures or means of illumination in the area that would meet the level of light required. When asked, the Maintenance Supervisor stated the facility was unaware of the lighting deficiency. Actual NFPA standard:	K 281	K281 1. Exterior lighting at 3 exits, North 100 hall, South 100 hall, and North 200 hall will have double lighting fixture installed with sensors that will activate at night. 2. Contractors will run exterior conduit for the new lighting, completion date <u>12/6/18</u> 3. The lighting will be checked every month by Maintenance to insure proper function. Starting <u>12/6/18</u> .	12/7/18

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K 281	Continued From page 3 NFPA 101 19.2.8 Illumination of Means of Egress. Means of egress shall be illuminated in accordance with Section 7.8. 7.8.1.4* Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area.	K 281			
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 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 <u>7/10/2018 RH</u> b) Who provided system test <u>Phoenix Fire Protection</u> c) Water system supply source <u>City Water System</u> 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 REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure fire suppression system pendants	K 353	K353 1. 1 sprinkler head in the kitchen walk in fridge and 1 sprinkler head in the kitchen storage had signs of corrosion and were replaced by contractor on 11/13/2018 . 2. The Maintenance supervisor preformed a visual check and inventory of all of the sprinkler heads in the building and found no other deficiencies on 11/16/2018 . 3. A Visual inspection of the sprinkler heads will be conducted monthly by the maintenance department.	12/7/18	

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K 353	<p>Continued From page 4</p> <p>were maintained free of obstructions such as paint or corrosion. Failure to maintain fire sprinkler pendants free of obstructions could hinder system performance during a fire event. This deficient practice affected staff and visitors on the dates of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on November 6, 2018, from approximately 8:30 AM to 11:00 AM, observation of the sprinkler heads revealed corroded sprinkler heads in the following locations:</p> <ol style="list-style-type: none"> 1.) Walk-in cooler in the kitchen. 2.) Kitchen storage closet off the main corridor by the soiled linen room. <p>When asked, the Maintenance Supervisor stated the facility would be investigating the corroded sprinkler head in the walk-in cooler because it was replaced last year due to corrosion. He also stated the facility was unaware of the corroded head in the kitchen storage closet.</p> <p>Actual NFPA standard:</p> <p>NFPA 25</p> <p>5.2.1 Sprinklers. 5.2.1.1* Sprinklers shall be inspected from the floor level annually. 5.2.1.1.1* Sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., upright, pendent, or sidewall).</p>	K 353		

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K 353	Continued From page 5 5.2.1.1.2 Any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical damage (4) Loss of fluid in the glass bulb heat responsive element (5)*Loading (6) Painting unless painted by the sprinkler manufacturer	K 353			
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames	K 363	K363 1. The corridor door in room 117 and room 203 have been adjusted by the maintenance supervisor to meet the maximum 1/2 inch gap distance between the face of the door and the frame when closed 11/19/2018 . 2. Maintenance Supervisor completed corridor door audit of all the doors latch and Gap measurements and found a total of 6 doors that needed adjusted. Completed 11/19/2018 . 3. Corridor doors will continue to be checked annually by maintenance.	12/7/18	

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K 363	<p>Continued From page 6</p> <p>shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.</p> <p>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485</p> <p>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, operational testing, and interview the facility failed to maintain doors that protect corridor openings. Failure to maintain corridor doors could allow smoke and dangerous gases to pass freely, preventing defend in place. This deficient practice has the potential to affect 2 residents, staff, and visitors on the dates of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on November 6, 2018, from approximately 8:30 AM to 11:00 AM, observation and operational testing of the resident room doors revealed resident room #117 had an approximately 3/4" gap between the face of the door and the frame of the door when fully closed and resident room #203 had an approximately 5/8" gap. When asked, the Maintenance Supervisor stated the facility was not aware the maximum distance between the face of the door and frame is 1/2" when fully closed.</p>	K 363		

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K 363	Continued From page 7 Actual NFPA Standards: NFPA 101 19.3.6.3* Corridor Doors. 19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be doors constructed to resist the passage of smoke and shall be constructed of materials such as the following: (1) 1-3/4 in. (44 mm) thick, solid-bonded core wood (2) Material that resists fire for a minimum of 20 minutes Additional Reference: Centers for Medicare/Medicaid Services S&C Letter 07-18.	K 363			
K 511 SS=E	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that electrical systems were	K 511	K511 1. Maintenance supervisor performed audit of all the relocatable power taps (RPT) in the building to make sure they were being used properly and removed the ones that were a problem. 11/13/18.	12/7/18	

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NAME OF PROVIDER OR SUPPLIER RIVER'S EDGE REHABILITATION & LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 714 NORTH BUTTE AVENUE EMMETT, ID 83617	
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K 511	<p>Continued From page 8</p> <p>installed, maintained and used in accordance with NFPA 70. Failure to ensure proper electrical installations and follow manufacturer recommendations for intended use could result in electrocution or fire. This deficient practice affected 1 resident, staff and visitors on the dates of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on November 6, 2018, from approximately 8:30 AM to 11:00 AM, observation of the facility revealed the following:</p> <p>1.) Resident room #108 had two Relocatable Power Taps (RPTs) plugged into each other creating a daisy chain and a small refrigerator plugged into an RPT. 2.) Physical Therapy office had a microwave plugged into an RPT. 3.) Business office had a small refrigerator plugged into an RPT.</p> <p>When asked, the Maintenance Supervisor stated the facility was unaware of the inappropriate use of relocatable power taps.</p> <p>Actual NFPA standard:</p> <p>NFPA 70 400.8 Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors</p>	K 511	<p>2. Maintenance Supervisor removed the power tap that was daisy chained to another power tap in room 208. Maintenance also rearranged the small refrigerator so it is plugged directly into the wall. 11/13/2018. Power tap was removed from the Therapy office and the Microwave was plugged directly into an outlet. 11/13/2018. The power tap in the business office was removed and the refrigerator was plugged directly into the wall. 11/13/2018.</p> <p>3. The Maintenance supervisor will perform a monthly check to verify the proper use of power strips.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135020	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING 0101 B. WING _____		(X3) DATE SURVEY COMPLETED 11/06/2018
NAME OF PROVIDER OR SUPPLIER RIVER'S EDGE REHABILITATION & LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 714 NORTH BUTTE AVENUE EMMETT, ID 83617		
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K 511	Continued From page 9 (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of 368.8. (5) Where concealed by walls, floors, or ceilings or located above suspended or dropped ceilings (6) Where installed in raceways, except as otherwise permitted in this Code	K 511			
K 911 SS=F	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the Essential Electrical System (EES) generator was equipped with a remote manual stop station in accordance with NFPA 110. Failure to provide a remote manual stop station has the potential to prevent shutdown of the emergency generator during a system malfunction, or unintentional operation. This deficient practice affected 41 residents, staff and visitors on the dates of the survey. Findings include: During the facility tour conducted on November 6, 2018, from approximately 8:30 AM to 11:00 AM, a	K 911	K911 1. A contractor is coming to install an Emergency Stop for the generator. Proposed date of installation on <u>12/7/18</u>	<u>12/7/18</u>	

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

PRINTED: 11/15/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135020	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING 0101 B. WING _____		(X3) DATE SURVEY COMPLETED 11/06/2018
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K 911	Continued From page 10 remote manual stop station for the EES generator could not be located. When asked, the facility Maintenance Supervisor stated the facility was not equipped with a remote stop station. Actual NFPA standard: NFPA 99 6.4.1.1.16.2 Safety indications and shutdowns shall be in accordance with Table 6.4.1.1.16.2. (SEE TABLE) NFPA 110 5.6.5.6* All installations shall have a remote manual stop station of a type to prevent inadvertent or unintentional operation located outside the room housing the prime mover, where so installed, or elsewhere on the premises where the prime mover is located outside the building.	K 911			



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

November 19, 2018

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

Provider #: 135020

RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER

Dear Mr. Crowley:

On **November 6, 2018**, an Emergency Preparedness survey was conducted at River's Edge Rehabilitation & Living Center by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. Your facility was found to be in substantial compliance with Federal regulations during this survey.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, which states that the facility complies with the requirements of CFR 42, 483.70(a) of the federal requirements. This form is for your records only and does not need to be returned.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact this office 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

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NAME OF PROVIDER OR SUPPLIER RIVER'S EDGE REHABILITATION & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 714 NORTH BUTTE AVENUE EMMETT, ID 83617		
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E 000	<p>Initial Comments</p> <p>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 re-furbished in 2000-2001 at which time the fire alarm system was updated. The Essential Electrical System is supplied by a natural gas powered, on-site automatic generator. Currently the facility is licensed for 74 SNF/NF beds and had a census of 41 on the dates of the survey.</p> <p>The facility was found to be in substantial compliance during the initial Emergency Preparedness Survey conducted on November 5 - 6, 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 & Construction</p>	E 000		

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

TITLE

(X6) DATE

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.