



IDAHO DEPARTMENT OF
HEALTH & WELFARE

.BRAD LITTLE – Governor
DAVE JEPPESEN – 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 17, 2019

Richard Strong, Administrator
Riverview Rehabilitation
3550 West Americana Terrace
Boise, ID 83706-4728

Provider #: 135139

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

Dear Mr. Strong:

On **June 5, 2019**, 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

Richard Strong, Administrator
June 17, 2019
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 **July 1, 2019**. Failure to submit an acceptable PoC by **July 1, 2019**, may result in the imposition of civil monetary penalties by **July 22, 2019**.

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, 2019**, (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 **September 3, 2019**. A change in the seriousness of the deficiencies on **July 20, 2019**, may result in a change in the remedy.

Richard Strong, Administrator
June 17, 2019
Page 3 of 4

The remedy, which will be recommended if substantial compliance has not been achieved by **July 10, 2019**, includes the following:

Denial of payment for new admissions effective **September 5, 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 **December 5, 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 **June 5, 2019**, 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:

Richard Strong, Administrator
June 17, 2019
Page 4 of 4

<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:

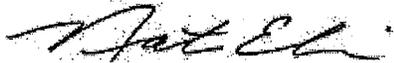
BFS Letters (06/30/11)

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

This request must be received by **July 1, 2019**. If your request for informal dispute resolution is received after **July 1, 2019**, 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

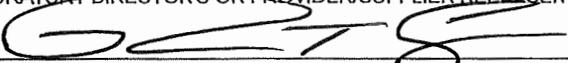
NE/lj
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135139	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - RIVERVIEW REHABILITATION B. WING _____	(X3) DATE SURVEY COMPLETED 06/05/2019
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NAME OF PROVIDER OR SUPPLIER RIVERVIEW REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 3550 WEST AMERICANA TERRACE BOISE, ID 83706
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	INITIAL COMMENTS The facility is a single story Type V (111) structure originally constructed in 2013. The building is fully sprinklered with an interconnected fire alarm system. Emergency power is provided through an on-site, diesel-fired emergency power supply system (EPSS) generator. Currently the facility is licensed for 30 SNF/NF beds and had a census of 19 on the date of the survey. The following deficiencies were cited during the annual fire/life safety survey conducted on June 5, 2019. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70. The survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction	K 000	<p style="text-align: center;">RECEIVED</p> <p style="text-align: center;">JUN 27 2019</p> <p style="text-align: center;">FACILITY STANDARDS</p> <p>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 the form CMS-2567 exist, nor does this facility admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiencies.</p> <p>K353</p> <p>Identified: Sprinkler dry system gauges were inspected by Facility Director of Maintenance on 06/08/2019. No issues noted or identified.</p> <p>Sprinkler dry system secured control valves were inspected by Facility Director of Maintenance on 06/08/2019. No Issues noted or identified</p> <p>Potential to be affected: A facility wide inspection was completed by</p>	
K 353 SS=F	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 _____ b) Who provided system test _____	K 353		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE EXECUTIVE DIRECTOR	(X6) DATE 6-26-19
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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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135139	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - RIVERVIEW REHABILITATION B. WING _____	(X3) DATE SURVEY COMPLETED 06/05/2019
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NAME OF PROVIDER OR SUPPLIER RIVERVIEW REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 3550 WEST AMERICANA TERRACE BOISE, ID 83706
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K 353	<p>Continued From page 1</p> <p>c) Water system supply source</p> <p>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 record review, the facility failed to ensure that fire suppression systems were maintained. Failure to inspect system components has the potential to hinder system performance during a fire event and/or render the facility not fully sprinklered after an activation or repair. This deficient practice affected 19 residents and staff on the date of the survey.</p> <p>Findings include:</p> <p>During review of provided facility inspection and testing records conducted on 6/5/19 from 8:30 - 10:30 AM, no records were available indicating the dry system gauges were inspected on a weekly basis, or the secured control valves were inspected on a monthly basis.</p> <p>Actual NFPA standard: NFPA 25</p> <p>5.2.4 Gauges. 5.2.4.2 Gauges on dry, preaction, and deluge systems shall be inspected weekly to ensure that normal air and water pressures are being maintained.</p> <p>13.3.2 Inspection. 13.3.2.1 All valves shall be inspected weekly. 13.3.2.1.1 Valves secured with locks or</p>	K 353	<p>the Director of Maintenance on or before 06/12/2019 with no other gauges and/or valves needing weekly/monthly inspections.</p> <p>Systematic Change/Education: On or before 06/20/2019 the Facility Executive Director was educated by the Facility Director of Maintenance regarding Gauge inspections on dry, preaction, and deluge systems weekly inspections to ensure that normal air and water pressures are being met. Valve inspections shall be inspected in non-secure areas while secured valves are inspected monthly.</p> <p>Monitoring: Beginning the week of June 10th, 2019 a weekly audit of wet and dry valves and pressure gauges will be completed by the Director of Maintenance or Designee. These audits will be ongoing as a part of the facility weekly/monthly tasks.</p> <p>The results of these audits will be reviewed in Monthly QAPI/Safety Meeting monthly x3 months.</p> <p>DATE OF COMPLIANCE: 06/28/2019</p>	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135139	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - RIVERVIEW REHABILITATION B. WING _____	(X3) DATE SURVEY COMPLETED 06/05/2019
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NAME OF PROVIDER OR SUPPLIER RIVERVIEW REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 3550 WEST AMERICANA TERRACE BOISE, ID 83706
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K 353	Continued From page 2 supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly.	K 353	K914	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure resident room electrical receptacles were maintained properly. Failure to test resident room electrical receptacles annually has the potential to hinder system response during an emergency that encompasses a loss of power. This deficient practice affected 19 residents and staff on the date of the survey.	K 914	<p>Identified: All resident room and resident care area receptacles were tested by Director of Maintenance on or before 06/11/2019. No issues noted or identified.</p> <p>Potential to be affected: The receptacle testing audit completed by the Director of Maintenance identified no other receptacles in resident rooms or care areas needing to be tested. This audit was completed on or before 06/11/2019.</p> <p>Systematic Change/Education: On or before 06/20/2019, Director of Maintenance was re-educated by Executive Director on resident room and care area electrical receptacles requiring annual testing (NFPA 99).</p> <p>On or before 06/11/2019, electrical receptacle testing was added to the facility annual testing task list by Director of Maintenance.</p>	

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K 914	<p>Continued From page 3</p> <p>Findings include:</p> <p>During review of provided maintenance documents conducted on 6/5/19 from 8:30 - 10:30 AM, no documentation was available demonstrating an annual test conducted on resident room outlets.</p> <p>Interview of the Director of Maintenance on 6/5/19 at approximately 10:30 AM established he had not yet completed an annual test on resident room outlets.</p> <p>Actual NFPA standard:</p> <p>NFPA 99 Chapter 6 Electrical Systems</p> <p>6.3.3.2 Receptacle Testing in Patient Care Rooms. 6.3.3.2.1 The physical integrity of each receptacle shall be confirmed by visual inspection. 6.3.3.2.2 The continuity of the grounding circuit in each electrical receptacle shall be verified. 6.3.3.2.3 Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed. 6.3.3.2.4 The retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 g (4 oz).</p> <p>6.3.4.1 Maintenance and Testing of Electrical System. 6.3.4.1.1 Where hospital-grade receptacles are required at patient bed locations and in locations</p>	K 914	<p>Monitoring:</p> <p>Annual resident room and care area receptacle testing was added to the annual facility task list on or before 06/11/2019. A review of the next scheduled test will be conducted by the Executive Director and Director of Maintenance 06/2020.</p> <p>DATE OF COMPLIANCE: 06/28/2019</p>	
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K 927	<p>Continued From page 5</p> <p>19 residents and staff in 1 of 2 smoke compartments on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 6/5/19 from 11:00 AM - 12:00 PM, observation and operational testing by the Director of Maintenance of the mechanical ventilation in the oxygen transfill location abutting room 126, established the fan was operation, but lacked exhaust airflow when tested with a single sheet of note paper and a paper towel placed on the grille.</p> <p>Actual NFPA standard:</p> <p>NFPA 99</p> <p>9.3.7.5.3.2 Mechanical exhaust shall be at a rate of 1 L/sec of airflow for each 300 L (1 cfm per 5 ft3 of fluid) designed to be stored in the space and not less than 24 L/sec (50 cfm) nor more than 235 L/sec (500 cfm).</p>	K 927	<p>Systematic Change/Education:</p> <p>Director of Maintenance was educated by Executive Director on or before 06/6/2019 on changing the ventilation fans in the oxygen transfill locations from monthly testing to weekly testing to ensure fans are operational.</p> <p>A weekly audit of the ventilation fans in the oxygen transfill locations was created by the Director of Maintenance on 06/07/2019.</p> <p>Monitoring: Beginning the week of 06/10/2019, a weekly audit of the ventilation fans in the oxygen transfill locations will be completed by the Director of Maintenance or Designee. These audits will be ongoing as a part of the facility weekly testing tasks.</p> <p>The results of these audits will be reviewed in monthly QAPI/Safety meeting x3 months.</p> <p>DATE OF COMPLIANCE: 06/28/2019</p>	
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June 17, 2019

Richard Strong, Administrator
Riverview Rehabilitation
3550 West Americana Terrace
Boise, ID 83706-4728

Provider #: 135139

RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER

Dear Mr. Strong:

On **June 5, 2019**, an Emergency Preparedness 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 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. 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 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

Richard Strong, Administrator

June 17, 2019

Page 2 of 4

Form in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **July 1, 2019**. Failure to submit an acceptable PoC by **July 1, 2019**, may result in the imposition of civil monetary penalties by **July 22, 2019**.

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, 2019**, (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 . A change in the seriousness of the deficiencies on **August 1, 2019**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **July 10, 2019**, includes the following:

Denial of payment for new admissions effective **September 5, 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.

Richard Strong, Administrator

June 17, 2019

Page 3 of 4

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **December 5, 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 **June 5, 2019**, 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>

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

Richard Strong, Administrator

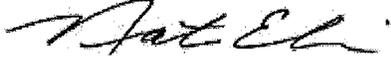
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This request must be received by **July 1, 2019**. If your request for informal dispute resolution is received after **July 1, 2019**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date 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,

A handwritten signature in black ink, appearing to read "Nate Elkins".

Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135139	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/05/2019
NAME OF PROVIDER OR SUPPLIER RIVERVIEW REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 WEST AMERICANA TERRACE BOISE, ID 83706	
(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	Initial Comments The facility is a single story Type V (111) structure originally constructed in 2013. The building is fully sprinklered with an interconnected fire alarm system. It is located within a municipal fire district, with both state and county EMS services available. Emergency power is provided through an on-site, diesel-fired emergency power supply system (EPSS) generator. Currently the facility is licensed for 30 SNF/NF beds and had a census of 19 on the date of the survey. The following deficiency was cited during the annual Emergency Preparedness survey conducted on June 5, 2019. The facility was surveyed under the Emergency Preparedness Rule as established by CMS, in accordance with 42.CFR 483.73. The survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction	E 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 the form CMS-2567 exist, nor does this facility admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiencies. RECEIVED JUN 27 2019 E039 FACILITY STANDARDS	
E 039 SS=F	EP Testing Requirements CFR(s): 483.73(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the	E 039	Identified: A full scale individual-facility based earthquake drill is scheduled for 07/08/2019. A facility-based active shooter tabletop exercise is scheduled for 07/02/2019. Potential to be affected: Full-Scale community-based emergency drill(s) and/or individual facility-based drill will be scheduled for the following year by 07/08/2019.	

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

TITLE

(X6) DATE



EXECUTIVE DIRECTOR **6-26-19**

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135139	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/05/2019
NAME OF PROVIDER OR SUPPLIER RIVERVIEW REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 WEST AMERICANA TERRACE BOISE, ID 83706		
(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 039	Continued From page 1 following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an	E 039	Facility-based tabletop exercises will be scheduled for the following year by 07/08/2019. Systematic Change/Education: On or before 07/08/2019, both community-based and/or individual facility-based emergency drills were scheduled and added to the facility calendar and maintenance task list. On or before 07/08/2019, facility based tabletop exercises were scheduled and added to the facility calendar and maintenance task list. Monitoring: The results of the individual based evacuation drill and earthquake tabletop exercise will be reviewed in August 2019 QAPI/Safety Meeting. Date of Compliance: 07/08/2019		

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

PRINTED: 06/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135139	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/05/2019
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E 039	<p>Continued From page 2</p> <p>emergency plan.</p> <p>(ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, the facility failed to complete two (2) full scale drills as required. Failure to complete two full-scale exercises for the activation of the Emergency plan (EP), has the potential to hinder staff performance during an actual emergency. This deficient practice affected 19 residents and staff on the date of the survey.</p> <p>Findings include:</p> <p>During review of the facility EP testing records conducted on 6/5/19 from 9:00 - 10:00 AM, records provided established full documentation of a tabletop exercise, but lacked substantial, complete documentation for a full-scale facility-based exercise, resulting in only 1 of 2 of the required testing exercises having been conducted.</p> <p>Reference: 42 CFR 483.73 (d) (1)</p>	E 039			