



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  
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January 8, 2020

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 **December 19, 2019**, a Facility Fire Safety and Construction survey was conducted at **River's Edge Rehabilitation & Living Center** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. Please provide **ONLY ONE** completion date for each federal and state tag in column (X5)

Completion Date to signify when you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to 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 **January 21, 2020**. Failure to submit an acceptable PoC by **January 21, 2020**, may result in the imposition of civil monetary penalties by **February 12, 2020**.

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 **January 23, 2020**, (Opportunity to Correct). Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **March 18, 2020**. A change in the seriousness of the deficiencies on **February 2, 2020**, 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 **January 23, 2020**, includes the following:

Denial of payment for new admissions effective **March 19, 2020**.  
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 **June 19, 2020**, 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 **December 19, 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:

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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 **January 21, 2020**. If your request for informal dispute resolution is received after **January 21, 2020**, 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

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135020</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING 0101  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/19/2019</b>
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NAME OF PROVIDER OR SUPPLIER <b>RIVER'S EDGE REHABILITATION &amp; LIVING CE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>714 NORTH BUTTE AVENUE EMMETT, ID 83617</b>
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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><b>INITIAL COMMENTS</b></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 refurbished in 2000-2001 at which time the fire alarm system was updated. Currently the facility is licensed for 74 SNF/NF beds and had a census of 51 on the date of the survey..</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on December 19, 2019. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.</p> <p>The Survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Fire Life Safety &amp; Construction</p>	K 000	<p>The plan of correction is prepared and submitted as required by law. By submitting this Plan of Correction, River's Edge Rehabilitation and Living Center does not admit that the deficiency listed on this form exists, 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;"><b>RECEIVED</b> JAN 17 2019</p>	
K 232 SS=D	<p>Aisle, Corridor, or Ramp Width CFR(s): NFPA 101</p> <p>Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 This REQUIREMENT is not met as evidenced by:</p>	K 232	<p>K232 1. The Maintenance Director adjusted the mounting on the wall computers on the 200 hall by rooms 204 and 214. They are now in compliance with the NFPA Standard. 1/15/2020</p> <p style="text-align: center;"><b>FACILITY STANDARDS</b></p>	1/22/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>MS</i>	TITLE  <i>Administrator</i>	(X6) DATE  <i>1/17/2020</i>
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A 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 232	<p>Continued From page 1</p> <p>Based on observation and interview, the facility failed to ensure means of egress were maintained free of obstructions. Failure to eliminate items that project into the exit access corridors more than 4 inches has the potential to hinder egress during an emergency. This deficient practice affected 25 residents, staff, and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 12/19/19, from 11:00 AM - 3:00 PM, observation of the 200 hall revealed two (2) computer monitors, located outside rooms 204 and 214, that projected from the wall 4-1/2 inches at a height of 63 inches when measured from the floor.</p> <p>When asked at approximately 1:30 PM, the Maintenance Director stated the facility was unaware of the requirements for non-continuous projections.</p> <p>Actual NFPA Standard: 19.2.3.4 Any required aisle, corridor, or ramp shall be not less than 48 in. (1220 mm) in clear width where serving as means of egress from patient sleeping rooms, unless otherwise permitted by one of the following: (1) Aisles, corridors, and ramps in adjunct areas not intended for the housing, treatment, or use of inpatients shall be not less than 44 in. (1120 mm) in clear and unobstructed width. (2) *Where corridor width is at least 6 ft (1830 mm), non-continuous projections not more than 6 in. (150 mm) from the corridor wall, above the handrail height, shall be permitted. (3) Exit access within a room or suite of rooms complying with the requirements of 19.2.5 shall be permitted.</p>	K 232	<p>2.</p> <p>All other wall mounted computers were measured to ensure they are compliant with the NFPA Standard. 1/15/2020</p>	1/22/20

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K 232	<p>Continued From page 2</p> <p>(4) Projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met:</p> <p>(a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in. (1525 mm).</p> <p>(b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency.</p> <p>(c)*The wheeled equipment is limited to the following:</p> <p>i. Equipment in use and carts in use</p> <p>ii. Medical emergency equipment not in use</p> <p>iii. Patient lift and transport equipment</p> <p>(5)*Where the corridor width is at least 8 ft (2440 mm), projections into the required width shall be permitted for fixed furniture, provided that all of the following conditions are met:</p> <p>(a) The fixed furniture is securely attached to the floor or to the wall.</p> <p>(b) The fixed furniture does not reduce the clear unobstructed corridor width to less than 6 ft (1830 mm), except as permitted by 19.2.3.4(2).</p> <p>(c) The fixed furniture is located only on one side of the corridor.</p> <p>(d) The fixed furniture is grouped such that each grouping does not exceed an area of 50 ft<sup>2</sup> (4.6 m<sup>2</sup>).</p> <p>(e) The fixed furniture groupings addressed in 19.2.3.4(5)(d) are separated from each other by a distance of at least 10 ft (3050 mm).</p> <p>(f)*The fixed furniture is located so as to not obstruct access to building service and fire protection equipment.</p> <p>(g) Corridors throughout the smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the fixed furniture spaces are</p>	K 232		

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K 232	Continued From page 3 arranged and located to allow direct supervision by the facility staff from a nurses ' station or similar space. (h) The smoke compartment is protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.8.	K 232		
K 293 SS=F	Exit Signage CFR(s): NFPA 101  Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure exit signs were not obstructed and were clear and identifiable. Installing decorations that obstruct exit signs from view, has the potential to hinder egress during emergencies. This deficient practice affected 51 residents on the date of the survey.  Findings include:  During the facility tour conducted on 12/19/19 from 11:00 AM - 3:00 PM, observation of installed exit signs revealed all exit signs were blocked by holiday decorations either attached to, or hanging directly in front of, obstructing clear view of the signs. When asked at approximately 11:15 AM if he was aware the exit signs were blocked from view, the Maintenance Director stated he had not been aware of the blocked signs prior to the survey date.	K 293	K293  1.  The Holiday Decorations that were obstructing the views of the exit signs were removed. 1/2/2020  2.  The Maintenance Director and Administrator educated the Activities Director on the findings from the Life Safety Survey and the importance of maintaining the NFPA Standards. 1/15/2020  3.  The facility will no longer place decorations in any areas that obstruct the views of exit signs.	1/22/20

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K 293	Continued From page 4  Actual NFPA standard:  7.10.1.8* Visibility. Every sign required in Section 7.10 shall be located and of such size, distinctive color, and design that it is readily visible and shall provide contrast with decorations, interior finish, or other signs. No decorations, furnishings, or equipment that impairs visibility of a sign shall be permitted. No brightly illuminated sign (for other than exit purposes), display, or object in or near the line of vision of the required exit sign that could detract attention from the exit sign shall be permitted.	K 293		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101  Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the	K 918	K918  1.  The facility has contracted with Northwest Power Company to upgrade the display panel on the generator so that it will show the amperes when the monthly load test of the EPSS generator is conducted. The quote was provided on 1/17/2020. The upgrade is scheduled to be done on 1/22/2020.  2.  The Maintenance Director will do monthly load tests on the EPSS generator and document the information from the new panel which will display both volts and amperes to check the EPS kW rating and ensure that it does not drop to less than the 30% of the EPS nameplate.	1/22/20

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K 918	<p>Continued From page 5</p> <p>components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.</p> <p>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure the EPSS generator set was maintained in accordance with NFPA 110. Failure to maintain the EPSS generator as defined under NFPA standards has the potential to render the facility without emergency power during extended power outages or other disasters. This deficient practice affected 63 residents and staff on the date of the survey.</p> <p>Findings include:</p> <p>During review of provided maintenance and inspection records conducted on 12/19/19 from 8:45 - 11:00 AM, no records were provided indicating the load on the EPSS was achieved using either allowed method from NFPA 110</p> <p>Further review of the past 12 months of documentation, established the load test being documented, demonstrated the method of testing was by documenting the volts, and amperes, however the section for all three phases of the EPSS in the reports, listed the section marked "amps" as "N/A" and the section labeled "load" had entries ranging from 0 percent to 70 percent achieved.</p>	K 918		

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K 918	<p>Continued From page 6</p> <p>When asked at approximately 10:30 AM about the conflict in the documentation of the available load and how a percentage of load was identified without documenting the amp draw, the Maintenance Director stated he was not aware of the conflicting information and the lack of documentation of the amp draw. When asked at this time if he had performed an annual load test on the EPSS generator, the Maintenance Director stated he had not.</p> <p>Actual NFPA standard:</p> <p>NFPA 110</p> <p>Chapter 8 Routine Maintenance and Operational Testing</p> <p>8.1* General.</p> <p>8.1.1 The routine maintenance and operational testing program shall be based on all of the following:</p> <p>(1) Manufacturer's recommendations (2) Instruction manuals (3) Minimum requirements of this chapter (4) The authority having jurisdiction</p> <p>8.4 Operational Inspection and Testing.</p> <p>8.4.1* EPSSs, including all appurtenant components, shall be inspected weekly and exercised under load at least monthly.</p> <p>8.4.2* Diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>(1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS nameplate kW rating</p>	K 918		

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

Printed: 12/31/2019  
FORM APPROVED  
OMB NO. 0938-0391

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K 918	Continued From page 7 8.4.2.1 The date and time of day for required testing shall be decided by the owner, based on facility operations. 8.4.2.2 Equivalent loads used for testing shall be automatically replaced with the emergency loads in case of failure of the primary source. 8.4.2.3 Diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS load and shall be exercised annually with supplemental loads at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. 8.4.2.4 Spark-ignited generator sets shall be exercised at least once a month with the available EPSS load for 30 minutes or until the water temperature and the oil pressure have stabilized.	K 918		



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Dear Mr. Crowley:

On **December 19, 2019**, an Emergency Preparedness 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 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 Form in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **January 21, 2020**. Failure to submit an acceptable PoC by **January 21, 2020**, may result in the imposition of civil monetary penalties by **February 12, 2020**.

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 **January 23, 2020**, (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 **February 22, 2020**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **January 23, 2020**, includes the following:

Denial of payment for new admissions effective **March 19, 2020**.  
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 **June 19, 2020**, 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 **December 19, 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

Michael Crowley, Administrator

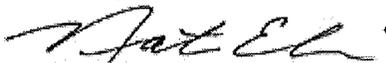
January 8, 2020

Page 4 of 4

This request must be received by **January 21, 2020**. If your request for informal dispute resolution is received after **January 21, 2020**, 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

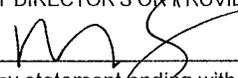
Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135020</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/19/2019</b>
NAME OF PROVIDER OR SUPPLIER <b>RIVER'S EDGE REHABILITATION &amp; LIVING CE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>714 NORTH BUTTE AVENUE EMMETT, ID 83617</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments  The facility is a single story, Type V (111) structure, originally built in 1963, located within a municipal fire district, with both county and state EMS services available. The facility is fully sprinklered, with an interconnected fire alarm/smoke detection system. The building emergency power is provided by an on-site, spark-ignited Emergency Power Supply System (EPSS) generator. Currently the facility is licensed for 74 SNF/NF beds and had a census of 51 on the date of the survey.  The following deficiencies were cited during the Emergency Preparedness Survey conducted on December 19, 2019. The facility was surveyed under the Emergency Preparedness Rule 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	The plan of correction is prepared and submitted as required by law. By submitting this Plan of Correction, River's Edge Rehabilitation and Living Center does not admit that the deficiency listed on this form exists, 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.	
E 036 SS=D	EP Training and Testing CFR(s): 483.73(d)  *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at	E 036	E036 1. FACILITY STANDARDS  The facility has created a test that demonstrates the staff's knowledge of information taught pertaining to the Emergency Operation Plan (EOP). 1/15/2020.	1/22/20

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

TITLE

(X6) DATE



Administrator

1/17/2020

A 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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E 036	<p>Continued From page 1</p> <p>paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years.</p> <p>*[For LTC at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.</p> <p>*[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i).</p> <p>*[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph</p>	E 036	<p>2. Anytime the facility conducts trainings on the EOP the test will be administered. The tests will be collected and reviewed by the Director of Staff Development or Designee and if it is determined that any individuals require further training, the training will be provided.</p> <p>3. Test results will be reported in the Facility QA meeting on an ongoing basis and recommendations will be made as appropriate.</p>	1/22/20

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E 036	Continued From page 2 (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure staff testing was conducted on knowledge of the EP program. Failure to provide a testing program on the staff knowledge of contents of the EP program, has the potential to create confusion to facility response during emergencies. This deficient practices affected 51 residents, staff and visitors on the date of the survey.  Findings include:  During review of provided EP training records conducted on 12/19/19 from 8:45 - 11:00 AM, no documentation was provided demonstrating a testing program was being provided for staff knowledge of the contents of the EP. Interview of the staff development coordinator (SDC) at approximately 11:30 AM, confirmed the facility did not provide a testing program on staff knowledge of the contents of the EP.  Reference: 42 CFR 483.73 (d)	E 036		
E 041 SS=F	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e)  (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section.	E 041		

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E 041	<p>Continued From page 3</p> <p>§483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section.</p> <p>§482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated.</p> <p>482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code.</p> <p>482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates.</p> <p>*[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the</p>	E 041	<p>E041</p> <p>1. The facility has contracted with Northwest Power Company to upgrade the display panel on the generator so that it will show the amperes when the monthly load test of the EPSS generator is conducted. The quote was provided on 1/17/2020. The upgrade is scheduled to be done on 1/22/2020.</p> <p>2. The Maintenance Director will do monthly load tests on the EPSS generator and document the information from the new panel which will display both volts and amperes to check the EPS kW rating and ensure that it does not drop to less than the 30% of the EPS nameplate.</p>	1/22/20

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

Printed: 12/31/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135020</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>12/19/2019</b>
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E 041	<p>Continued From page 4</p> <p>Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: <a href="http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html">http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html</a>.</p> <p>If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes.</p> <p>(1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000.</p> <p>(i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011.</p> <p>(ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011.</p> <p>(iii) TIA 12-3 to NFPA 99, issued August 9, 2012.</p> <p>(iv) TIA 12-4 to NFPA 99, issued March 7, 2013.</p> <p>(v) TIA 12-5 to NFPA 99, issued August 1, 2013.</p> <p>(vi) TIA 12-6 to NFPA 99, issued March 3, 2014.</p> <p>(vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011.</p> <p>(viii) TIA 12-1 to NFPA 101, issued August 11, 2011.</p> <p>(ix) TIA 12-2 to NFPA 101, issued October 30, 2012.</p> <p>(x) TIA 12-3 to NFPA 101, issued October 22, 2013.</p> <p>(xi) TIA 12-4 to NFPA 101, issued October 22, 2013.</p> <p>(xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.</p>	E 041		

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E 041	<p>Continued From page 5</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure EPSS generator sets were maintained in accordance with NFPA 110. Failure to perform monthly load testing and annual load bank testing if required, has the potential to hinder system response during emergencies such as a loss of power. This deficient practice affected 51 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During review of provided maintenance and inspection records conducted on 12/19/19 from 8:45 - 11:00 AM, no records were provided indicating the load on the EPSS was achieved using either allowed method from NFPA 110. Further review of the past 12 months of documentation, established the load test being documented, demonstrated the method of testing was by documenting the volts, and amperes, however the section for all three phases of the EPSS in the reports, listed the section marked "amps" as "N/A" and the section labeled "load" had entries ranging from 0 percent to 70 percent achieved.</p> <p>When asked at approximately 10:30 AM about the conflict in the documentation of the available load and how a percentage of load was identified without documenting the amp draw, the Maintenance Director stated he was not aware of the conflicting information and the lack of documentation of the amp draw. When asked at this time if he had performed an annual load test on the EPSS generator, the Maintenance Director stated he had not.</p>	E 041		
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E 041	Continued From page 6 Reference: 42 CFR 483.73 (e) (1)	E 041		