



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

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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CERTIFIED MAIL: 7007 3020 0001 4038 9789

November 4, 2014

Debbie Freeze, Administrator
Kindred Transitional Care & Rehab - Lewiston
3315 8th Street
Lewiston, ID 83501-4966

Provider #: 135021

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

Dear Ms. Freeze:

On **October 22, 2014**, a Facility Fire Safety and Construction survey was conducted at **Kindred Transitional Care & Rehab - Lewiston** 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 one that comprises a pattern 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 and a similar State Form 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.

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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 both Statement of Deficiencies and Plan of Correction, Form CMS-2567 and State Form, in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **November 17, 2014**. Failure to submit an acceptable PoC by **November 17, 2014**, may result in the imposition of civil monetary penalties by **December 7, 2014**.

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 and the state licensure survey report, State Form.

All references to federal regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **November 26, 2014**, (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 **November 26, 2014**. A change in the seriousness of the deficiencies on **November 26, 2014**, 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 **November 26, 2014**, includes the following:

Denial of payment for new admissions effective **January 22, 2015**.
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 **April 22, 2015**, 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 Mark P. Grimes, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, 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 **October 22, 2014**, 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 **November 17, 2014**. If your request for informal dispute resolution is received after **November 17, 2014**, 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.

Sincerely,



Mark P. Grimes, Supervisor
Facility Fire Safety and Construction

MPG/pmt
Enclosures

Corrected Copy
D. Freeze

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135021	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/22/2014
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB - LI	STREET ADDRESS, CITY, STATE, ZIP CODE 3315 8TH STREET LEWISTON, ID 83501
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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) building with a finished basement. The structure was built in 1965 with a complete renovation in 1998. It is fully sprinklered with smoke detection provided in corridors, open spaces and resident sleeping rooms. The facility is currently licensed for 96 SNF/NF beds.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on October 22, 2014. The facility was surveyed under the LIFE SAFETY CODE, 2000 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 Facility Fire Safety and Construction</p>	K 000	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Lewiston Rehabilitation & Care Center does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.</p> <p style="text-align: right;"><i>RECEIVED</i> <i>10/22/2014</i> <i>FACILITY STANDARDS</i></p>	
K 025 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility</p>	K 025	<p>Resident Specific A licensed contractor will be hired to seal the penetration per NFPA code. The referenced can lights found to be non-compliant will be replaced to meet compliant standards</p> <p>Other Residents A licensed contractor will inspect all fire walls to ensure there are no other breaches, any found will be repaired</p> <p>Facility Systems All contractors will be given a facility policy on any breaching of fire walls and their reporting responsibility Any time a contractor is utilized the facility maintenance person will round with them</p>	<p><i>12/1/14</i> <i>11/26/14</i></p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Debbie Freeze</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>11/13</i>
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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.

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

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FORM APPROVED
OMB NO. 0938-0391

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K 025	<p>Continued From page 1</p> <p>failed to ensure that smoke/fire barriers were maintained to resist the passage of smoke. Failure to ensure the continuity of smoke/fire barriers could allow smoke and dangerous gases to pass freely between smoke compartments affecting the safe egress of occupants. This deficient practice affected 5 residents, staff and visitors in 1 of 6 smoke compartments on the date of the survey. The facility is licensed for 96 SNF/NF beds and had a census of 60 on the day of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on October 22, 2014 from 10:00 AM to 12:30 PM, inspection above the ceiling by the surveyor and the Director of Maintenance at the copy room adjacent to the reception area, found a four inch wide by six inch tall unsealed hole cut into the smoke barrier directly above the attic access. Interview of the Director of Maintenance found he was not aware of this hole.</p> <p>2) During the facility tour conducted on October 22, 2014 from 10:00 AM to 12:30 PM, inspection above the ceiling at the copy room found that light was clearly visible from the floor below through the recessed can lighting installed in the hallway outside the copy room. Inspection of these lights found each had (2) one-inch diameter holes located at the top. When viewed from below, the roof sheathing above was clearly visible through these openings. When interviewed, the Director of Maintenance stated he had not been aware these lights were open and exposed the attic area above.</p> <p>Actual NFPA standard:</p>	K 025	<p>upon completion of their work to inspect for any breaches that may have occurred.</p> <p>Monitor The facility will monitor compliance through the facility preventative maintenance program</p>	
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K 025	Continued From page 2 19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour. Exception No. 1: Where an atrium is used, smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with Exception No. 2 to 8.2.5.6(1). Not less than two separate smoke compartments shall be provided on each floor. Exception No. 2*: Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.3 has been provided for smoke compartments adjacent to the smoke barrier. 8.3.2* Continuity. Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces. Exception: A smoke barrier required for an occupied space below an interstitial space shall not be required to extend through the interstitial space, provided that the construction assembly forming the bottom of the interstitial space provides resistance to the passage of smoke equal to that provided by the smoke barrier.	K 025		
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When	K 029		

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K 029	<p>Continued From page 3</p> <p>the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This Standard is not met as evidenced by: Based on observation operational testing and interview, the facility failed to ensure doors protecting a hazardous area would resist the passage of smoke. Failure to provide smoke resistive doors to hazardous areas could allow smoke and dangerous gases to pass freely into corridors and hinder the safe egress of occupants during a fire event. This deficient practice affected residents, staff and visitors utilizing the main dining hall on the date of the survey. The facility is licensed for 96 SNF/NF beds and had a census of 60 on the day of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on October 22, 2014 from 10:00 AM to 12:30 PM, observation and operational testing of the doors to the Medical Records office; the storage room directly across from the Medical Records office which housed haphazard resident and facility storage; and the converted storage room 211 which contained haphazard facility storage housed during construction, found that these three doors were not equipped with self-closing devices. When asked, the Director of Maintenance stated he was aware these doors were required to self-close.</p>	K 029	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Kindred Transitional Care and Rehabilitation does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.</p> <p>Resident Specific Self Closures will be installed on the non-compliant doors. A licensed contractor will be secured to assess the doors and perform the necessary changes to ensure they meet compliant standards</p>	<p><i>elley</i> <i>12/11/14</i> <i>11-26-14</i></p>

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K 029	<p>Continued From page 4</p> <p>2) During the facility tour conducted on October 22, 2014 from 10:00 AM to 12:30 PM, observation and operational testing of the doors from the main dining room into the Kitchen found these doors were double-acting, with a gap between the leading edges of approximately 1 inch and from the outside edges of the doors to the frame of approximately 3/4 inch.</p> <p>Actual NFPA standard:</p> <p>3.3.13.2 Area, Hazardous. An area of a structure or building that poses a degree of hazard greater than that normal to the general occupancy of the building or structure, such as areas used for the storage or use of combustibles or flammables; toxic, noxious, or corrosive materials; or heat-producing appliances.</p> <p>19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:</p> <ol style="list-style-type: none"> (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft² (9.3 m²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms 	K 029	<p>Other Residents All doors are checked through the facilities preventative maintenance program</p> <p>Facility Systems Any non function door closers will be fixed by the facility maintenance person or a licensed contractor depending on the nature of the repair. This will be reviewed monthly in the facility preventative maintenance program.</p>	

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K 029	Continued From page 5 (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that electrical installations were in accordance with NFPA 70. Failure to ensure proper electrical installation would result in electrocution or fire. This deficient practice affected 5 residents, staff and visitors in 1 of 6 smoke compartments on the date of the survey. The facility is licensed for 96 SNF/NF beds and had a census of 60 on the day of the survey. Findings include: 1) During the facility tour conducted on October 22, 2014 from 10:00 AM to 12:30 PM, observation of the riser room located on the exterior found an open 4 inch square electrical junction box with exposed wiring.	K 147	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Lewiston Rehabilitation & Care Center does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. Resident Specific 4 inch box covers were installed during the survey by the maintenance director	

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K 147	<p>Continued From page 6</p> <p>2) During the facility tour conducted on October 22, 2014 from 10:00 AM to 12:30 PM, inspection above the ceiling in the 200 wing found an open 4 inch square electrical junction box with exposed wiring. Interview of the Director of Maintenance indicated he was not aware of this box being left open.</p> <p>Actual NFPA standard:</p> <p>NFPA 70 110.12 Mechanical Execution of Work. Electrical equipment shall be installed in a neat and workmanlike manner.</p> <p>(A) Unused Openings. Unused cable or raceway openings in boxes, raceways, auxiliary gutters, cabinets, cutout boxes, meter socket enclosures, equipment cases, or housings shall be effectively closed to afford protection substantially equivalent to the wall of the equipment. Where metallic plugs or plates are used with nonmetallic enclosures, they shall be recessed at least 6 mm (¼ in.) from the outer surface of the enclosure.</p> <p>(B) Subsurface Enclosures. Conductors shall be racked to provide ready and safe access in underground and subsurface enclosures into which persons enter for installation and maintenance.</p> <p>(C) Integrity of Electrical Equipment and Connections. Internal parts of electrical equipment, including busbars, wiring terminals, insulators, and other surfaces, shall not be damaged or contaminated by foreign materials such as paint, plaster, cleaners, abrasives, or corrosive residues. There shall be no damaged parts that may adversely affect safe operation or mechanical strength of the equipment such as parts that are broken; bent; cut; or deteriorated by corrosion, chemical action, or overheating.</p>	K 147	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Lewiston Rehabilitation & Care Center does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.</p> <p>Other Residents The maintenance director has checked for any other non compliant issues</p> <p>Facility Systems Kindred preventative maintenance program in place.</p> <p>Monitor This will be monitored through the facility preventative maintenance program</p>	<p><i>12/1/14</i> <i>EDM</i> <i>11/26/14</i></p>

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K 147	Continued From page 7 314.17 Conductors Entering Boxes, Conduit Bodies, or Fittings. Conductors entering boxes, conduit bodies, or fittings shall be protected from abrasion and shall comply with 314.17(A) through (D). (A) Openings to Be Closed. Openings through which conductors enter shall be adequately closed....	K 147		

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB - LEWIS	STREET ADDRESS, CITY, STATE, ZIP CODE 3315 8TH STREET LEWISTON, ID 83501
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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) COMPLETE DATE
C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The facility is a single story Type V(111) building with a finished basement. The structure was built in 1965 with a complete renovation in 1998. It is fully sprinklered with smoke detection provided in corridors, open spaces and resident sleeping rooms. The facility is currently licensed for 96 SNF/NF beds.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on October 22, 2014. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70 and IDAPA 16.03.02, Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities.</p> <p>The survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	C 000	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Lewiston Rehabilitation & Care Center does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.</p> <p style="text-align: right;">RECEIVED NOV 21 2014 FACILITY STANDARDS</p>	
C 226	<p>02.106 FIRE AND LIFE SAFETY</p> <p>106. FIRE AND LIFE SAFETY. Buildings on the premises used as facilities shall meet all the requirements of local, state and national codes concerning fire and life safety standards that are applicable to health care facilities.</p> <p>This Rule is not met as evidenced by: Please refer to "K" tags on CMS 2567: K 025 Smoke barrier continuity</p>	C 226	<p>See Plan of correction for Federal Tags</p>	<p><i>[Signature]</i> 11-26-14</p>

Idaho form

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

TITLE

(X6) DATE

Debbie Page

Executive Director

11-17-14

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135021	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/22/2014
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB - LEWIS	STREET ADDRESS, CITY, STATE, ZIP CODE 3315 8TH STREET LEWISTON, ID 83501
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C 226	Continued From Page 1 K 029 Hazardous area doors K 147 Electrical installations	C 226		