



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER -- Governor
RICHARD M. ARMSTRONG -- 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

July 30, 2015

Robert Nahmensen, Administrator
Coeur d'Alene Health Care & Rehabilitation Center
2514 North Seventh Street
Coeur d'Alene, ID 83814-3720

Provider #: 135052

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

Dear Mr. Nahmensen:

On **July 21, 2015**, a Facility Fire Safety and Construction survey was conducted at **Coeur d'Alene Health Care & Rehabilitation Center** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

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

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you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office. If a State Form with deficiencies was issued, it should be signed, dated and returned along with the CMS-2567 Form.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **August 12, 2015**. Failure to submit an acceptable PoC by **August 12, 2015**, may result in the imposition of civil monetary penalties by **September 1, 2015**.

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 **August 25, 2015**, (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 **August 25, 2015**. A change in the seriousness of the deficiencies on **August 25, 2015**, 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 **August 25, 2015**, includes the following:

Denial of payment for new admissions effective **October 21, 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 **January 21, 2016**, 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 **July 21, 2015**, 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 **August 12, 2015**. If your request for informal dispute resolution is received after **August 12, 2015**, 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/lj
Enclosures

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

Printed: 07/29/2015
FORM APPROVED
OMB NO. 0938-0301

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135052	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - PINWOOD CARE CENTER B. WING _____	(X3) DATE SURVEY COMPLETED 07/21/2015
NAME OF PROVIDER OR SUPPLIER COEUR D'ALENE HEALTH CARE & REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The facility is a single story, type V (111) construction built in 1961. It is fully sprinklered with a complete fire alarm/smoke detection system that includes resident rooms. Currently the facility is licensed for 117 SNF/NF beds. The following deficiencies were cited during the special focus Fire/Life Safety survey conducted on July 20 and July 21, 2015. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy and in accordance with CFR 42, 483.70. The Survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	K 000	Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or correctness of the conclusions set forth on the statement of deficiencies, the plan of correction is prepared and submitted solely because of the requirements under State and Federal law. This Plan of Correction will serve as the Facility's allegation of substantial compliance	
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD 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 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that smoke and fire resistive properties of the structure were maintained.	K 025	K 025 1. The unsealed penetration was repaired. 2. Maintenance staff will conduct rounds to identify any other holes and repair as indicated. 3. Maintenance staff will continue to round quarterly through the QAPI process and report any findings and their action to the QAPI committee quarterly. 4. The ED will monitor via the QAPI process. 5. Date of completion August 25, 2015.	

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

TITLE

(X6) DATE

Sally A. Jenkins RA

manager Designee

8/11/15

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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OMB NO 0938-0391

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K 025	<p>Continued From page 1</p> <p>Failure to ensure the smoke and fire resistive properties of a structure could potentially allow fire, smoke and dangerous gases to migrate into corridors affecting egress during a fire event. This deficient practice affected 9 residents, staff and visitors in 2 of 6 smoke compartments on the day of the survey. The facility is licensed for 117 SNF/NF beds and had a census of 28 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on July 20, 2015 from 8:30 AM to 5:30 PM, observation of the soffit area above room 102 revealed an approximately four (4) inch by four (4) unsealed penetration left from the renovation of the Nurse call system. When asked, the Maintenance Supervisor stated he was not aware why the hole had not been patched.</p> <p>Actual NFPA standard:</p> <p>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.</p>	K 025		

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K 025	Continued From page 2 8.3 SMOKE BARRIERS 8.3.1* General. Where required by Chapters 12 through 42, smoke barriers shall be provided to subdivide building spaces for the purpose of restricting the movement of smoke. 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		
K029 SS=F	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 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	K 029		

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K 029	Continued From page 3 This Standard is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure that hazardous areas were protected with self-closing doors. Failure to provide self-closing doors to hazardous areas would allow smoke and dangerous gases to enter corridors hindering egress during a fire event. This deficient practice affected 18 residents, staff and visitors on the date of the survey. The facility is licensed for 117 SNF/NF beds and had a census of 28 on the day of the survey. Findings include: 1) During the facility tour conducted on July 20, 2015 from 8:30 AM to 5:30 PM, observation of rooms 207 and 305 found both rooms had been recently converted to storage and measured approximately twelve (12) feet by twelve (12) feet (144 square feet) in size. Further observation and operational testing of the doors leading into these rooms from the corridor found they would not self-close when activated. 2) During the facility tour conducted on July 20, 2015 from 8:30 AM to 5:30 PM, observation of the Maintenance shop and the Housekeeping office found the door into the Maintenance shop was held open with a drop-down door stop and the door into the Housekeeping office was held open with a door chock. Further observation of the Maintenance shop found it had an approximately twelve (12) inch by twelve (12) inch louvered vent cut into the wall between spaces. Actual NFPA standard:	K 029	K029 1. The doors in rooms 207 and 305 are now self-closing doors. 2. The door chock was removed in the housekeeping office and the door stop was removed in the maintenance shop. The vent will be removed and the wall appropriately repaired in the maintenance shop. 3. Staff will be in-serviced by the ED or designee regarding the propping of doors. 4. The ED or designee will make weekly rounds for one month and then monthly thereafter to ensure doors are not propped open. These findings will be brought to the QAPI meeting quarterly. 5. Date of completion August 25, 2015.	

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K 029	<p>Continued From page 4</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 Protection from Hazards. 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 19.3.6.4. 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 (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. <p>Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or</p>	K 029			

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K 029	Continued From page 5 field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door. 19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted.	K 029		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This Standard is not met as evidenced by: Based on record review and interview, the facility failed to perform one fire drill per shift per quarter. Failure to perform fire drills could hinder staff response during a fire event. This deficient practice affected 28 residents, staff and visitors on the date of the survey. The facility is licensed for 117 SNF/NF beds and had a census of 28 on the day of the survey. Findings include: During review of documented facility fire drills conducted on July 21, 2015 from 8:30 AM to 10:30 AM, the facility failed to produce documented fire drills for the second and third shift of the first quarter and the second shift of the fourth quarter. Interview of the Maintenance	K 050	K050 1. Fire drills will be conducted in accordance with the regulatory requirement and shall be documented. 2. A drill was conducted on 7/31/2015 for both AM and PM shifts. 3. The ED will review the drills monthly and ensure compliance. 4. The results of these reviews will be brought quarterly to the QAPI meeting. 5. Date of completion August 25, 2015.	

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K 050	Continued From page 6 Supervisor found he was unaware of the missing fire drills. Actual NFPA standard: 19.7.1.2* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building.	K 050		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.6 This Standard is not met as evidenced by: Based on record review, operational testing and interview, the facility failed to ensure that fire sprinkler installations were installed and maintained in accordance with NFPA 13 and 25. Failure to provide proper inspection and maintenance of fire suppression systems could result in lack of system performance during a fire event. This deficient practice affected 28	K 062		

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K 062	<p>Continued From page 7</p> <p>residents, staff and visitors on the date of the survey. The facility is licensed for 117 SNF/NF beds and had a census of 28 on the day of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on July 20, from 8:30 AM to 5:30 PM, observation of the fire suppression system found the following areas had painted or corroded sprinkler pendants:</p> <p>Conference Room (112), quantity of two (2) Laundry rear electrical room, one (1) Service corridor, two (2) Room 211, two (2) Room 305, one (1) 300 hall shower, one (1) 300 hall dining, two (2) Room 406, one (1) Room 501, one (1) 200 hall shower, (1) Two corroded pendants in the hallway outside Room 507</p> <p>Due to the extensive amount of painted heads, the condition was deemed widespread and further documentation was deemed unnecessary. Interview of the Maintenance Supervisor found he was not aware of the painted heads.</p> <p>2) During the facility tour conducted on July 20, from 8:30 AM to 5:30 PM, observation of the fire suppression system piping found non-sprinkler components attached to the pipes in the rear Laundry electrical room. When asked, the Maintenance Supervisor stated he was aware that non-sprinkler components were not allowed to be hung on sprinkler pipes.</p>	K 062	<p>K062</p> <ol style="list-style-type: none"> The sprinkler heads will be replaced by the fire system company. All sprinkler heads will be inspected and replaced, if indicated. The non-sprinkler components in the laundry room will be detached from the sprinkler pipes. The wind chime was removed. Maintenance staff or designee will in-service staff regarding not hanging items from any part of the sprinkler system. Maintenance staff will inspect other areas of the facility monthly to ensure compliance and will bring a summary of the inspection to the quarterly QAPI meeting. Date of completion August 25, 2015. 	

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K 062	Continued From page 8 3) During the facility tour conducted on July 20, from 8:30 AM to 5:30 PM, observation of Room 211 found a wind chime hanging from the sprinkler pendant. When asked, the Maintenance Supervisor stated he had not noticed the wind chime until this date. Actual NFPA standard: Finding 1 NFPA 25 2-2 Inspection. 2-2.1 Sprinklers. 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. Exception No. 1*: Sprinklers installed in concealed spaces such as above suspended ceilings shall not require inspection. Exception No. 2: Sprinklers installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown. Finding 2 & 3 NFPA 13 6-1.1.5* Sprinkler piping or hangers shall not be used to support nonsystem components.	K 062		
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with	K 064		

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K 064	Continued From page 9 9.7.4.1. 19.3.5.6, NFPA 10 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that fire extinguishers were mounted in accordance with NFPA 10. Failure to mount fire extinguishers at the correct height could result in injury or extinguisher damage. This deficient practice affected residents, staff and visitors utilizing the smoking area located on the east activities room patio on the date of the survey. The facility is licensed for 117 SNF/NF beds and had a census of 28 on the day of the survey. Findings include: During the facility tour conducted on July 20, 2015 from 8:30 AM to 5:30 PM, observation of the fire extinguisher at the smoking area located outside the east Activities room found it measured 63 inches from the ground to the top of the extinguisher. When asked, the Maintenance Supervisor stated he was not aware this extinguisher was not mounted correctly. Actual NFPA standard: NFPA 10 1-6.10 Fire extinguishers having a gross weight not exceeding 40 lb (18.14 kg) shall be installed so that the top of the fire extinguisher is not more than 5 ft (1.53 m) above the floor. Fire extinguishers having a gross weight greater than 40 lb (18.14 kg) (except wheeled types) shall be	K 064	K. 064 1. The fire extinguisher in the smoking area was mounted correctly on 7/28/2015. 2. Maintenance staff will inspect the facility to ensure all other extinguishers are at the appropriate height and will make immediate corrections, if indicated. 3. Maintenance director will monitor monthly to ensure that all fire extinguishers continue to be mounted in accordance with regulations. 4. Maintenance director will present his findings and corrections at the QAPI meeting. 5. Date of completion August 25, 2015.	

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K 064	Continued From page 10 so installed that the top of the fire extinguisher is not more than 3 1/2 ft (1.07 m) above the floor. In no case shall the clearance between the bottom of the fire extinguisher and the floor be less than 4 in. (10.2 cm).	K 064		
K 066 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that smoking regulations were followed in accordance with NFPA 101 and company policy. This deficient practice affected staff and visitors utilizing the smoking area</p>	K 066	<p>K 066</p> <ol style="list-style-type: none"> 1. The papers and wrappers were immediately removed from the smoking area. 2. Staff will be serviced by maintenance staff or a designee on designated smoking areas and smoking area safety. The proper receptacles were ordered. 3. Maintenance staff or a designee will monitor the smoking area monthly for safety and compliance with designated areas and will address any deficiencies at the time of occurrence. 4. A summary of these findings will be presented at the quarterly QAPI meetings. 5. Date of Completion-August 25, 2015. 	

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K 066	<p>Continued From page 11</p> <p>outside the employee breakroom and residents, staff and visitors using the north entrance outside the Kitchen on the date of the survey. The facility is licensed for 117 SNF/NF beds and had a census of 28 on the day of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on July 20, 2015 from 8:30 AM to 5:30 PM, observation of the smoking area outside the staff breakroom on the east side of the building found the disposal container for emptying ashtrays was a plastic container without a self-closing lid. Further examination found cigarette butts and packaging on top of newspapers. Interview of the Maintenance Supervisor found he was not aware of the requirement for smoking areas.</p> <p>2) During the facility tour conducted on July 20, 2015 from 8:30 AM to 5:30 PM, observation of the rear entrance to the main Kitchen on the north side of the building found a non-designated smoking area. Further inspection of this area found a "No Smoking" sign at the entrance to the building; no ashtrays or disposal containers and twenty-six (26) cigarette butts strewn about this entrance and adjoining grounds. When asked, the Kitchen aide smoking in the area stated this is where staff routinely take their smoke break. Interview of the Maintenance Supervisor confirmed this was a non-designated smoking area.</p> <p>2) During review of the facility smoking policy conducted on July 21, 2015 from 8:30 AM to 10:30 AM, found the policy stated smoking practices will be conducted in designated smoking areas only.</p>	K 066		

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K 066	Continued From page 12 Actual NFPA standard: NFPA 101 19.7.4* Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the International symbol for no smoking. Exception: In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (2) Smoking by patients classified as not responsible shall be prohibited. Exception: The requirement of 19.7.4(2) shall not apply where the patient is under direct supervision. (3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.	K 066		
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This Standard is not met as evidenced by: Based on record review and interview, the facility failed to ensure that the Kitchen hood fire	K 069		

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K 069	Continued From page 13 suppression system was inspected semi-annually as required under NFPA 96. Failure to inspect fire suppression systems could hinder system performance during a fire event. This deficient practice affected staff and vendors on the date of the survey. The facility is licensed for 117 SNF/NF beds and had a census of 28 on the day of the survey. Findings include: During review of the facilities fire suppression reports conducted on July 21, 2015 from 8:30 AM to 10:30 AM, the facility failed to provide semi-annual kitchen hood suppression system inspection reports. When asked about the lack of system inspection records, the Maintenance Supervisor stated he was unaware the system had not been inspected. Actual NFPA standard: NFPA 96 11.2 Inspection of Fire-Extinguishing Systems. 11.2.1* An inspection and servicing of the fire-extinguishing system and listed exhaust hoods containing a constant or fire-actuated water system shall be made at least every 6 months by properly trained and qualified persons.	K 069	K 069 1. The kitchen fire suppression inspections have been completed and the records are on file at the facility. 2. The inspections will be conducted accordingly to maintain compliance. 3. The ED will monitor that the inspections are ordered and completed and will maintain a file in the facility. 4. These will be summarized and reviewed at the quarterly QAPI meetings. 5. Date of completion August 25, 2015.		
K 072 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10	K 072			

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K 072	Continued From page 14 This Standard is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure that means of egress were free of impediments to their instant use in the event of an emergency. Failure to provide instant use of egress components could hinder evacuation during an emergency. This deficient practice affected 18 residents, staff and visitors in 2 of 6 smoke compartments on the date of the survey. The facility is licensed for 117 SNF/NF beds and had a census of 28 on the day of the survey. Findings include: 1) During the facility tour conducted on July 20, 2015 from 8:30 AM to 5:30 PM, observation of the exit discharge located at the 300 wing private dining found a garden hose coiled up on the concrete pad directly outside the exit door blocking the path and creating a trip hazard. When asked why the hose was left here, the Maintenance Supervisor stated the facility had no irrigation system and was not aware this door was required to be free of obstructions. 2) During the facility tour conducted on July 20, 2015 from 8:30 AM to 5:30 PM, observation of the exit discharge located off the exit door abutting room 505 found a garden hose stretched across the length of the concrete path leading to the public way creating a trip hazard. 3) During the facility tour conducted on July 20, 2015 from 8:30 AM to 5:30 PM, observation and operational testing of the door to the Weight Room between rooms 408/409 found the door was equipped with a deadbolt and a passage lock.	K 072	K 072 1. Maintenance staff removed the hoses from the sidewalks at the egress areas. The deadbolt was removed on the weight room door. The main entrance foyer egress will have the deadbolt removed. The door will be repaired with appropriate hardware, allowing proper egress functioning. The doors on the 500 hall will have the deadbolts removed. The foyer door egress delay will be repaired by the vendor, so that it is wired with the delay egress system. The locks on the outside gates will be removed, as this is an unoccupied unit. 2. The ED in serviced the maintenance staff on not blocking the egress. 3. Maintenance staff will inspect the facility for any other doors with incorrect hardware and will repair. 4. Maintenance director will report his findings to the QAPI meeting. 5. Date of completion August 25, 2015	

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K 072	<p>Continued From page 15</p> <p>requiring more than one operation to open. When asked, the Maintenance Supervisor stated he was not aware of the requirement for single-operational locking arrangements.</p> <p>4) During the facility tour conducted on July 20, 2015 from 8:30 AM to 5:30 PM, observation of the following doors revealed the locking arrangements would hinder delayed egress functions and require keys or special knowledge to operate:</p> <p>a) The door located at the main entrance foyer was equipped with a deadbolt; magnetic locks; an installed ResidentGuard sensor and a push plate for releasing the deadbolt when tested from the egress side.</p> <p>b) When examining two exit doors in the 500 wing, the first located at the Secured Unit Dining and the second located at the southwest exit, it was determined both were equipped with deadbolt locks; magnetic locking arrangements; ResidentGuard; keypad override and push plates which would unlock the deadbolt from the egress side. Further observation and operational testing demonstrated these exits were equipped to operate under delayed egress, but this function was not functional with the deadbolt engaged.</p> <p>c) The door leading into the foyer from the facility lobby was equipped with ResidentGuard. Operational testing of this door demonstrated it would not release under delayed egress in the presence of a resident security pendant. When asked, the Maintenance Supervisor stated he was aware that doors were required to release with delayed egress in the presence of a resident pendant.</p>	K 072		

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K 072	<p>Continued From page 16</p> <p>5) During the facility tour conducted on July 20, 2015 from 8:30 AM to 5:30 PM, observation and operational testing of a gate leading from the 500 wing southwest courtyard, revealed it was equipped with a magnetic locking device which would not release under a power loss and was not equipped with delayed egress. This gate measured approximately twenty (20) feet from the southwest rear exit and created a second delay in a means of egress component. When asked about the gate, the Maintenance Supervisor stated he was aware the lock did not release on the loss of power and further stated it would not release upon activation of the facility fire alarm system.</p> <p>Actual NFPA standard:</p> <p>Findings 4 & 5</p> <p>7.1.9 Impediments to Egress. Any device or alarm installed to restrict the improper use of a means of egress shall be designed and installed so that it cannot, even in case of failure, impede or prevent emergency use of such means of egress unless otherwise provided in 7.2.1.6 and Chapters 18, 19, 22, and 23.</p> <p>Findings 1 - 5</p> <p>7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.</p> <p>Finding 3</p> <p>7.2.1.5.4*</p>	K 072		

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K 072	<p>Continued From page 17</p> <p>A latch or other fastening device on a door shall be provided with a releasing device having an obvious method of operation and that is readily operated under all lighting conditions. The releasing mechanism for any latch shall be located not less than 34 in. (86 cm), and not more than 48 in. (122 cm), above the finished floor. Doors shall be operable with not more than one releasing operation.</p> <p>Exception No. 1*: Egress doors from individual living units and guest rooms of residential occupancies shall be permitted to be provided with devices that require not more than one additional releasing operation, provided that such device is operable from the inside without the use of a key or tool and is mounted at a height not exceeding 48 in. (122 cm) above the finished floor. Existing security devices shall be permitted to have two additional releasing operations. Existing security devices other than automatic latching devices shall not be located more than 60 in. (152 cm) above the finished floor. Automatic latching devices shall not be located more than 48 in. (122 cm) above the finished floor.</p> <p>Exception No. 2: The minimum mounting height for the releasing mechanism shall not be applicable to existing installations.</p> <p>Findings 4 & 5</p> <p>7.2.1.6 Special Locking Arrangements. 7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed-egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7,</p>	K 072		

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K 072	<p>Continued From page 18</p> <p>and where permitted in Chapters 12 through 42, provided that the following criteria are met.</p> <p>(a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6.</p> <p>(b) The doors shall unlock upon loss of power controlling the lock or locking mechanism.</p> <p>(c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.</p> <p>(d) * On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS</p> <p>Finding 5</p> <p>19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1: Door-locking arrangements without delayed egress shall be permitted in</p>	K 072		

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K 072	Continued From page 19 health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. (See 19.1.1.1.5 and 19.2.2.2.5.) Exception No. 2*: Delayed-egress locks complying with 7.2.1.6.1 shall be permitted, provided that not more than one such device is located in any egress path. Exception No. 3: Access-controlled egress doors complying with 7.2.1.6.2 shall be permitted.	K 072		
K 074 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3), 10.3.4. 19.7.5.3 This Standard is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure that	K 074	K 074 1. The draperies in the Social Service office, the 112 conference room, Room 116, and the 300 hall dining Room will be removed and either treated with flame resistance spray or replaced altogether. 2. Documentation will be on file for the treatment and /or replacement drapes. 3. Maintenance staff will inspect the facility at least quarterly to ensure no other draperies are hung without the proper flame resistance labeling. 4. A summary of this inspection will be presented at the quarterly QAPI meeting. 5. Date of completion August 25, 2015.	

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NAME OF PROVIDER OR SUPPLIER COEUR D'ALENE HEALTH CARE & REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814		
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K 074	Continued From page 20 draperies and curtains were flame resistant in accordance with NFPA 701. Failure to provide curtains, drapes and other loose hanging fabrics with are flame resistive could allow fires to grow beyond incipient stages. This deficient practice affected 28 residents, staff and visitors on the date of the survey. The facility is licensed for 117 SNF/NF beds and had a census of 28 on the day of the survey. Findings include: During the facility tour conducted on July 20, 2015 from 8:30 AM to 5:30 PM, observation of the following areas found loosely hanging drapes and curtains which were not tagged as being flame resistive per NFPA 701: Social Services Office Conference Room (112) Room 116 300 hall dining room When asked, the Maintenance Supervisor stated there was no documentation of flame resistance testing on file for the curtains and drapes. Actual NFPA standard: NFPA 101 10.3 CONTENTS AND FURNISHINGS 10.3.1* Where required by the applicable provisions of this Code, draperies, curtains, and other similar loosely hanging furnishings and decorations shall be flame resistant as demonstrated by testing in accordance with NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films.	K 074		
K 076	NFPA 101 LIFE SAFETY CODE STANDARD	K 076		

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K 076 SS=F	<p>Continued From page 21</p> <p>Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that medical gases were properly secured to prevent falling in accordance with NFPA 99. Failure to secure high pressure oxygen cylinders could cause damage to cylinders resulting in injury or explosion. This deficient practice affected 13 residents, staff and visitors on the date of the survey. The facility is licensed for 117 SNF/NF beds and had a census of 28 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on July 20, 2015 from 8:30 AM to 5:30 PM, observation of room 211 found an unsecured "E" size oxygen cylinder. When asked, the Maintenance Supervisor stated he was aware oxygen cylinders were required to be secured in racks.</p> <p>Actual NFPA standard:</p>	K 076	<p>K 076</p> <ol style="list-style-type: none"> 1. The oxygen tank in room 211 was secured immediately. 2. Staff will be serviced by the Maintenance staff or designee on proper oxygen storage. 3. Mock survey staff will conduct daily inspections to ensure compliance. 4. Findings of the inspections will be presented to the quarterly QAPI meetings. 5. Date of completion August 25, 2015. 	

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K 076	Continued From page 22 NFPA 99 4-3.1.1.1 Cylinder and Container Management. Cylinders in service and in storage shall be individually secured and located to prevent falling or being knocked over. (a) * Cylinders or supply containers shall be constructed, tested, and maintained in accordance with the U.S. Department of Transportation specifications and regulations. (b) Cylinder contents shall be identified by attached labels or stencils naming the components and giving their proportions. Labels and stencils shall be lettered in accordance with CGA Pamphlet C-4, Standard Method of Marking Portable Compressed Gas Containers to Identify the Material Contained. (c) Contents of cylinders and containers shall be identified by reading the labels prior to use. Labels shall not be defaced, altered, or removed.	K 076		
K 141 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Non-smoking and no smoking signs in areas where oxygen is used or stored are in accordance with 19.3.2.4, NFPA 99, 8.6.4.2. This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that oxygen storage areas were properly signed. Failure to identify areas used for bulk oxygen storage could result in an oxidized environment exposing residents and staff to increased risk of fire and/or explosion without proper awareness. This deficient practice affected 9 residents, staff and visitors on the date of the survey. The facility is licensed for 117 SNF/NF beds and had a census of 28 on the day	K 141		

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K 141	Continued From page 23 of the survey. Findings include: During the facility tour conducted on July 20, 2015 from 8:30 AM to 5:30 PM, observation of the Central Supply storage found 24 "E" size oxygen cylinders stored inside. Further observation of the door entering this area from the corridor found no signage indicating this as an oxygen storage location. Interview of the Maintenance Supervisor found he was not aware this area was being used for oxygen storage. Actual NFPA standard: NFPA 99 8-3.1.11.3 Signs. A precautionary sign, readable from a distance of 5 ft (1.5 m), shall be conspicuously displayed on each door or gate of the storage room or enclosure. The sign shall include the following wording as a minimum: CAUTION OXIDIZING GAS(ES) STORED WITHIN NO SMOKING	K 141	K 141 1. The appropriate signage was placed on the entrance to the Central Supply room. 2. No other rooms are used for oxygen storage. 3. Maintenance staff will conduct monthly checks to ensure compliance. 4. Findings of compliance rounds will be presented at the quarterly QAPI meeting. 5. Date of Completion August 25, 2015	
K 144 SS-F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144		

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K 144	<p>Continued From page 24</p> <p>This Standard is not met as evidenced by: Based on observation, record review and interview, the facility failed to keep audible alarms functional and document a load test for the Emergency Power Supply System in accordance with NFPA 99 and NFPA 110. Failure to maintain audible alarms and perform load tests for the EPSS could result in a lack of system performance during a power failure. This deficient practice affected 28 residents, staff and visitors on the date of the survey. The facility is licensed for 117 SNF/INF beds and had a census of 28 on the day of the survey.</p> <p>Findings include:</p> <p>1) During review of the facility generator records conducted on July 21, 2015 from 8:30 AM to 10:30 AM, the facility failed to provide records demonstrating the generator load testing was being conducted at thirty (30) percent of capacity for thirty (30) minutes monthly. When asked how the generator was confirmed to be under load, the Maintenance Supervisor stated that he took readings from the generator dials when the generator was running either during an automatic or manual transfer. He further stated he was not aware of how to, or the requirement for, documenting thirty (30) percent load capacity of generators.</p> <p>2) During the facility tour conducted on July 20, 2015 from 8:30 AM to 5:30 PM, observation of the generator alarm panel located at the nurse's station in the 100/200 wing corridor revealed the alarm annunciator on the generator panel in the "Off" position. When asked, the Maintenance Supervisor stated he had turned the switch off and failed to turn the switch back on after</p>	K 144	<p>K 144</p> <ol style="list-style-type: none"> 1. The generator load test was conducted on 7/31/2015. The alarm annunciator was turned on. 2. Generator testing will be conducted to meet NFPA compliance. The annunciator panel will function in compliance with the NFPA codes. 3. Maintenance Director or designee will conduct testing/inspections. 4. Records will be kept by Maintenance Director/designee and reviewed quarterly by QAPI. 5. Date of compliance August 25, 2015. 	

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K 144	<p>Continued From page 25 inspecting the generator during the week of July 13, 2015.</p> <p>Actual NFPA standard:</p> <p>NFPA 99 Standard for Healthcare Facilities 1999 Edition</p> <p>3-4.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches.</p> <p>(a) Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-4.3.1. Maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6.</p> <p>(b) Inspection and Testing.</p> <p>1. * Test Criteria. Generator sets shall be tested twelve (12) times a year with testing intervals between not less than 20 days or exceeding 40 days. Generator sets serving emergency and equipment systems shall be in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6.</p> <p>2. Test Conditions. The scheduled test under load conditions shall include a complete simulated cold start and appropriate automatic and manual transfer of all essential electrical system loads.</p> <p>3. Test Personnel. The scheduled tests shall be conducted by competent personnel. The tests are needed to keep the machines ready to function and, in addition, serve to detect causes of malfunction and to train personnel in operating procedures.</p>	K 144		

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K 144	<p>Continued From page 26</p> <p>3-4.4.2 Recordkeeping. A written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction.</p> <p>3-4.1.1.15 + Alarm Annunciator. A remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work-station (see NFPA 70, National Electrical Code, Section 700-12.) The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows: (a) Individual visual signals shall indicate the following: 1. When the emergency or auxiliary power source is operating to supply power to load 2. When the battery charger is malfunctioning (b) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate the following: 1. Low lubricating oil pressure 2. Low water temperature (below those required in 3-4.1.1.9) 3. Excessive water temperature 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply 5. Overcrank (failed to start) 6. Overspeed Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur, but need not display these conditions individually. [110: 3-5.5.2]</p>	K 144		

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K 144	Continued From page 27 NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6 6-3 Maintenance and Operational Testing. 6-3.1* The EPSS shall be maintained to ensure to a reasonable degree that the system is capable of supplying service within the time specified for the type and for the time duration specified for the class. 6-3.3 A written schedule for routine maintenance and operational testing of the EPSS shall be established. 6-3.4 A written record of the EPSS inspections, tests, exercising, operation, and repairs shall be maintained on the premises. The written record shall include the following: (a) The date of the maintenance report (b) Identification of the servicing personnel (c) Notation of any unsatisfactory condition and the corrective action taken, including parts replaced (d) Testing of any repair for the appropriate time as recommended by the manufacturer	K 144		
K 147 SS=F	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 electrical systems are installed properly could	K 147		

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K 147	<p>Continued From page 29 an application.</p> <p>6) During the facility tour conducted on July 20, 2015 from 8:30 AM to 5:30 PM, observation of the Conference Room (112) and Central Supply (114) revealed two (2) open electrical junction boxes in the Conference Room and one (1) open junction box in Central Supply. Both boxes measured approximately two (2) inches by three (3) inches.</p> <p>Actual NFPA standard:</p> <p>Findings 1 & 5 NFPA 70</p> <p>400.8 Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following:</p> <p>(1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of 368.8. (5) Where concealed by walls, floors, or ceilings or located above suspended or dropped ceilings (6) Where installed in raceways, except as otherwise permitted in this Code</p> <p>Findings 4 & 6 NFPA 70</p> <p>110.12 Mechanical Execution of Work.</p>	K 147		

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K 147	<p>Continued From page 30</p> <p>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> <p>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).</p> <p>(A) Openings to Be Closed. Openings through which conductors enter shall be adequately closed.....</p> <p>Findings 2 & 3</p> <p>IDAPA 16.03.02.120</p>	K 147		

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K 147	Continued From page 31 10. Electrical and Lighting. All electrical and lighting installation shall be in accordance with the National Electrical Code (1984 ed.) and as follows: c. Plug adaptors and multiple outlets are prohibited.	K 147		
K 211 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that alcohol-based hand rub dispensers were installed per NFPA and CMS requirements. Failure to maintain ABHR dispensers away from ignition sources could result in combustible liquids fires created by arcing. This deficient practice affected 11 residents in the 100 wing; residents, staff and visitors using the main entrance and Physical Therapy on the date of the survey. The facility is licensed for 117 SNF/NF beds and had a census	K 211	K 211 1. The ABHR dispensers were removed from over the keypad and from over the wall air conditioning unit, immediately. 2. Maintenance or a designee will inspect the facility to ensure no other ABHR dispensers are placed over an ignition source. 3. The ED or designee will conduct monthly checks to ensure compliance of proper installation. 4. A summary of these findings will be presented at the quarterly QAPI meeting. 5. Date of Completion August 25, 2015	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135052	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - PINWOOD CARE CENTER B. WING _____	(X3) DATE SURVEY COMPLETED 07/21/2015
NAME OF PROVIDER OR SUPPLIER COEUR D'ALENE HEALTH CARE & REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 211	<p>Continued From page 32 of 28 on the day of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on July 20, 2015 from 8:30 AM to 5:30 PM, observation of the front entrance foyer revealed an ABHR dispenser installed directly over the interior electronic keypad for the main entrance door.</p> <p>2) During the facility tour conducted on July 20, 2015 from 8:30 AM to 5:30 PM, observation of Physical Therapy revealed an ABHR dispenser installed directly above the wall air conditioning unit. When interviewed, the Maintenance Supervisor stated he was not aware of the requirement for keeping ABHR dispensers away from ignition sources.</p> <p>Actual NFPA standard: TIA 00-1 (NFPA 101-2000) 19.3.2.7* Alcohol-based Hand-rub Solutions. Alcohol-based hand-rub dispensers shall be protected in accordance with 8.4.3 unless all of the following conditions are met: (1) Where dispensers are installed in a corridor, the corridor shall have a minimum width of 6 ft (1.8 m). (2) The maximum individual dispenser fluid capacity shall be: (a) 0.3 gallons (1.2 liters) for dispensers in rooms, corridors, and areas open to corridors (b) 0.5 gallons (2.0 liters) for dispensers in suites of rooms (3) The dispensers shall have a minimum horizontal spacing of 4 ft (1.2 m) from each other. (4) Not more than an aggregate 10 gallons (37.8 liters) of alcohol-based hand rub solution shall be in use in a single smoke compartment outside of a storage cabinet.</p>	K 211		

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

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K211	Continued From page 33 (5) Storage of quantities greater than 5 gallons (18.9 liters) in a single smoke compartment shall meet the requirements of NFPA 30, Flammable and Combustible Liquids Code.	K211		