



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

Bryan Lindsay, Administrator
Life Care Center of Post Falls
460 North Garden Plaza Court
Post Falls, ID 83854-6437

Provider #: 135135

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

Dear Mr. Lindsay:

On **July 22, 2015**, a Facility Fire Safety and Construction survey was conducted at **Life Care Center of Post Falls** 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. 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 26, 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 26, 2015**. A change in the seriousness of the deficiencies on **August 26, 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 26, 2015**, includes the following:

Denial of payment for new admissions effective **October 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 **January 22, 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. Grines, 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 22, 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. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135135	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - LIFE CARE POST FALLS SNF B. WING _____	(X3) DATE SURVEY COMPLETED 07/22/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF POST FALLS		STREET ADDRESS, CITY, STATE, ZIP CODE 460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854		
(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	<p>INITIAL COMMENTS</p> <p>The facility is a single story type V (111) construction of approximately 64000 square feet with multiple exits to grade. The facility is divided into five smoke compartments and is protected throughout by an NFPA 13 Fire Sprinkler System, corridor smoke detection and manual fire alarm system. There is piped medical gas to 49 rooms, which meets NFPA 99 standards and a Type 1 essential electrical system. The plan review was August 2007 with the building being completed August 1, 2008. The facility was licensed on September 15, 2008 for 120 beds.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on July 21 and July 22, 2015. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, New Health Care Occupancy, in accordance with 42 CFR, 483.70.</p> <p>The surveyor conducting the survey was:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	K 000	<p>This plan of correction is submitted as required under Federal and State regulations and statutes applicable to long term care providers. This plan of correction does not constitute an admission of liability on the part of the facility and, such liability is hereby specifically denied. The submission of the plan does not constitute agreement by the facility that the surveyor's findings and/or conclusions are accurate, that the findings constitute a deficiency or that the scope and severity regarding any of the deficiencies cited are correctly applied.</p>	8-11-15
K 064 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that fire extinguishers were properly tagged in accordance with NFPA 10.</p>	K 064	<p>K064</p> <p>SPECIFIC DEFICIENCY The K rated fire extinguishers were inspected by Simplex Grinnel on 7/23/15.</p> <p>OTHER RESIDENTS No other "K" style fire extinguishers are found in the facility.</p>	

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

TITLE

(X8) DATE

Byron Lindsay

Executive Director

8-12-15

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.

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K 064	<p>Continued From page 1</p> <p>Failure to properly tag fire extinguishers eliminates the ability for properly documenting annual and monthly inspections increasing the risk of failing to properly identify defective equipment. This deficient practice affected staff and vendors of the main Kitchen on the date of the survey. The facility is licensed for 120 SNF/NF beds and had a census of 91 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on July 21, 2015 from 1:00 PM to 5:30 PM, observation of the two (2) K-style fire extinguishers installed in the main Kitchen found neither were equipped with inspection tags indicating last inspection or installation date. When asked why the tags were not present, the Maintenance Manager stated the vendor had left both extinguishers as temporary installations while in the process of replacing existing ones.</p> <p>Actual NFPA standard:</p> <p>NFPA 10 4-3.4 Inspection Recordkeeping. 4-3.4.1 Personnel making inspections shall keep records of all fire extinguishers inspected, including those found to require corrective action. 4-3.4.2 At least monthly, the date the inspection was performed and the initials of the person performing the inspection shall be recorded. 4-3.4.3 Records shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or in an electronic system (e.g., bar coding) that provides a permanent</p>	K 064	<p>SYSTEMIC CHANGES</p> <p>Any K-style extinguishers used as temporary units will have inspection tags while the permanent ones are repaired.</p> <p>MONITOR</p> <p>Executive Director or designee will audit monthly x3 months that the inspection tags are up to date.</p> <p>DATE OF COMPLIANCE: 8/11/15</p>	8-11-15

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K 064	Continued From page 2 record.	K 064		8-11-15
K 072 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>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 from impediments. Failure to maintain means of egress for full instant use could hinder the safe evacuation of residents during and emergency. This deficient practice affected 6 residents, staff and visitors in the 100/200 wings and residents, staff and visitors utilizing the main dining room on the date of the survey. The facility is licensed for 120 SNF/NF beds and had a census of 91 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on July 21, 2015 from 8:30 AM to 12:00 PM, observation of the two (2) controlled access doors located at the main entrance found both doors were equipped with keyed, hookbolt locks in addition to controlled access locking arrangements. Operational testing of both doors found that when these hookbolts were activated, the motion sensors would not open the doors and these locks would prohibit the doors from breaking away as designed. When asked why the hookbolt locks were installed, the Maintenance Manager</p>	K 072	<p>K072</p> <p>SPECIFIC DEFICIENCY The latches on the sliding doors by the front entrance were removed.</p> <p>OTHER RESIDENTS All other sliding doors were inspected for latches and none were found.</p> <p>SYSTEMIC CHANGES Maintenance was inserviced that latches or locks cannot be used on delayed egress doors and future purchases or repairs cannot have them.</p> <p>MONITOR Executive Director or designee will audit monthly that all access-controlled egress doors function properly.</p> <p>DATE OF COMPLIANCE: 8/11/15</p>	

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K 072	<p>Continued From page 3 stated they were for locking down the facility to prevent nighttime intrusions.</p> <p>Actual NFPA standard:</p> <p>7.1.10 Means of Egress Reliability. 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>NFPA 101 18.2.2.2.4 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 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 18.1.1.1.5 and 18.2.2.2.5.) 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.</p> <p>7.2.1.6.2 Access-Controlled Egress Doors. Where permitted in Chapters 11 through 42, doors in the means of egress shall be permitted to be equipped with an approved entrance and egress access control system, provided that the following criteria are met. (a) A sensor shall be provided on the egress side and arranged to detect an occupant approaching</p>	K 072		8-11-15
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K 072	<p>Continued From page 4</p> <p>the doors, and the doors shall be arranged to unlock in the direction of egress upon detection of an approaching occupant or loss of power to the sensor.</p> <p>(b) Loss of power to the part of the access control system that locks the doors shall automatically unlock the doors in the direction of egress.</p> <p>(c) The doors shall be arranged to unlock in the direction of egress from a manual release device located 40 in. to 48 in. (102 cm to 122 cm) vertically above the floor and within 5 ft (1.5 m) of the secured doors. The manual release device shall be readily accessible and clearly identified by a sign that reads as follows: PUSH TO EXIT When operated, the manual release device shall result in direct interruption of power to the lock - independent of the access control system electronics - and the doors shall remain unlocked for not less than 30 seconds.</p> <p>(d) Activation of the building fire-protective signaling system, if provided, shall automatically unlock the doors in the direction of egress, and the doors shall remain unlocked until the fire-protective signaling system has been manually reset.</p> <p>(e) Activation of the building automatic sprinkler or fire detection system, if provided, shall automatically unlock the doors in the direction of egress and the doors shall remain unlocked until the fire-protective signaling system has been manually reset.</p>	K 072		8-11-15