



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 Eder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

September 1, 2015

Valeri Zaharie, Administrator
Life Care Center of Coeur d'Alene
500 West Aqua Avenue
Coeur d'Alene, ID 83815-7764

Provider #: 135122

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

Dear Ms. Zaharie:

On August 24, 2015, a Facility Fire Safety and Construction survey was conducted at **Life Care Center of Coeur D'Alene** 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 **September 14, 2015**. Failure to submit an acceptable PoC by **September 14, 2015**, may result in the imposition of civil monetary penalties by **October 4, 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 **September 28, 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 **September 28, 2015**. A change in the seriousness of the deficiencies on **September 28, 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 **September 28, 2015**, includes the following:

Denial of payment for new admissions effective **November 24, 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 **February 24, 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 **August 24, 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 **September 14, 2015**. If your request for informal dispute resolution is received after **September 14, 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: 09/07/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135122	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 08/24/2015
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF COEUR D'ALENE	STREET ADDRESS, CITY, STATE, ZIP CODE 500 WEST AQUA AVENUE COEUR D ALENE, ID 83815
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	INITIAL COMMENTS The facility is a Type V (111) construction with a 94,000 square foot building that is fully sprinklered with smoke detection coverage including resident sleeping rooms. The building was built in 1995-96 and currently licensed for 120 SNF beds. The following deficiencies were cited during the annual fire/life safety survey conducted on August 24, 2015. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70. The Survey was conducted by: Nathan Elkins Health Facility Surveyor Facility Fire Safety & Construction	K 000	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. <i>K-025</i> 1. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice; A 2 inch pipe conduit for communication lines located in the smoke barrier wall directly above the cross corridor doors near rooms 200 & 207, and above the smoke barrier wall above the cross corridor doors near rooms 218 & 219 were sealed by the Maintenance Director with a smoke resistant substance known as "rock wool". 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken; Smoke barrier walls above the cross corridor doors inspected by the Maintenance Director for unsealed penetrations and repaired as required.	
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 barriers were	K 025		9-14-15 9-14-15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Paul McVay</i>	TITLE <i>EXECUTIVE DIRECTOR</i>	(X8) DATE <i>9-11-15</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.

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K 025	<p>Continued From page 1</p> <p>maintained. Failure to maintain smoke barriers could allow smoke and dangerous gases to pass freely between smoke compartments affecting egress and inhibit suppression and initiating system performance during a fire event. This deficient practice affected 16 residents staff and visitors on the date of the survey. The facility is licensed for 120 SNF/NF beds with a census of 78 on the day of the survey.</p> <p>Findings include:</p> <p>1.) During the facility tour on August 24, 2016 at approximately 9:30 AM, observation of the smoke barrier wall above the cross corridor doors near rooms 200 and 207 revealed a 2 inch pipe penetrating through the smoke barrier wall with communication lines running through the piping that was unsealed and would not resist the passage of smoke. When asked, the Maintenance Supervisor stated they were unaware of the unsealed hole.</p> <p>2.) During the facility tour on August 24, 2015 at approximately 10:00 AM, observation of the smoke barrier wall above the cross corridor doors near rooms 218 and 219 revealed a 2 inch pipe penetrating through the smoke barrier wall with communication lines running through the piping that was unsealed and would not resist the passage of smoke. When asked, the Maintenance Supervisor stated they were unaware of the unsealed hole.</p> <p>Actual NFPA standards: 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.</p>	K 025	<p>3. What measures will be put into place or what systematic changes you will make to ensure the deficient practices does not recur; The Maintenance Director completed education regarding the requirement to seal penetrations in smoke barrier walls above cross corridor doors. The Maintenance Director to provide on-going supervision and monitoring of any work performed by contractors in smoke barrier walls above cross corridor walls to ensure smoke barrier penetrations sealed. The Maintenance Director will complete monthly inspections of smoke barrier walls above cross corridor doors to ensure penetrations through smoke barrier walls are sealed. Monthly inspections will be completed for 6 months.</p> <p>4. 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. During monthly inspections of barrier walls above cross corridor doors, any unsealed penetrations will be sealed immediately and forwarded to the Quality Assurance Committee for further review and systems changes as required.</p>	9-14-15

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K 025	Continued From page 2 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	<i>K-029</i> 1. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice; The oxygen trans-filling room door was repaired by the Maintenance Director to completely self-close, and a door closer was installed on the wheelchair storage room door. 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken; Hazardous areas doors were inspected by the Maintenance Director and repaired as necessary to ensure doors had self-closing devices, and doors were properly closing. 3. What measures will be put into place or what systematic changes you will make to ensure the deficient practices does not recur; The Maintenance Director completed education regarding the requirement of hazardous areas requiring doors with self-closing devices, and doors properly closing. The Maintenance Director will complete monthly inspections of hazardous areas storage doors to ensure doors have self-closing devices, and are self-closing properly.	<i>9-14-15</i> <i>9-14-15</i> <i>9-14-15</i>
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 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	K 029		

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K 029	<p>Continued From page 3</p> <p>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 that hazardous areas were protected with self-closing doors and would resist the passage of smoke. Failure to provide self-closing doors for hazardous areas would allow smoke and dangerous gases to pass freely into corridors and hinder egress of occupants during a fire event. This deficient practice affected 25 residents, staff and visitors on the date of the survey. The facility is licensed for 120 SNF/NF beds and had a census of 78 on the day of the survey.</p> <p>Findings include:</p> <p>1.) During the facility tour on August 24, 2015 at approximately 10:30 AM, observation and operational testing of the oxygen transfilling room door located in the 100 hallway would not completely self-close leaving an approximately 3/8 inch to 1/2 inch gap between the leading edge and the door frame that would not resist the passage of smoke. When asked, the Maintenance Supervisor stated the facility was unaware the door would not close completely.</p> <p>2.) During the facility tour on August 24, 2015 at approximately 2:00 PM, observation and operational testing of the wheel chair storage room located in the 300 hallway revealed the door was not on a self closure. The storage room measured greater than 50 ft2 and contained</p>	K 029	<p>4. 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. During monthly inspections of hazardous materials storage doors, any issues related to hazardous areas storage doors self-closing will be corrected immediately by the Maintenance Director and forwarded to the Quality Assurance Committee for further review and systems changes as required.</p>	

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K 029	<p>Continued From page 4</p> <p>combustible items. When asked, the Maintenance Supervisor stated the facility was unaware the door needed to be on a self closure.</p> <p>Actual NFPA standard: NFPA 101, 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> <ul 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. 	K 029	<p><i>K-062</i></p> <p>1. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice; The sprinkler heads located in the laundry facility were cleaned by the Maintenance Director to eliminate the excessive dust and lint build up.</p> <p>2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken; Sprinkler heads were inspected and cleaned by the Maintenance Director to eliminate excessive dust and lint build up.</p> <p>3. What measures will be put into place or what systematic changes you will make to ensure the deficient practices does not recur; The Maintenance Director completed education regarding the requirement of sprinkler heads to be free of excessive dust and lint built up.</p>	<p><i>9-14-15</i></p> <p><i>9-14-15</i></p> <p><i>9-14-15</i></p>
K 062 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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,</p>	K 062		

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K 062	<p>Continued From page 5 9.7.5</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that fire suppression systems were maintained in accordance with NFPA 25. Failure to provide proper maintenance of the sprinkler systems could result in the systems not performing as designed during a fire event. This deficient practice affected laundry staff on the date of the survey. The facility is licensed for 120 SNF/NF beds and had a census of 78 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour on August 24, 2015 at approximately 2:00 PM, observation of the laundry facility revealed multiple sprinkler heads heavily loaded with excessive dust and lint build up. When asked, the Maintenance Supervisor stated they were unaware of the loaded sprinkler heads.</p> <p>Actual NFPA standard:</p> <p>NFPA 25,2-2.1.1* 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</p>	K 062	<p>4. 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. During monthly inspections of fire sprinkler heads by the Maintenance Director, any issues related to sprinkler heads with excessive dust or lint build up will be corrected immediately by the Maintenance Director and forwarded to the Quality Assurance Committee for further review and systems changes as required.</p>	

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K 064	Continued From page 7 the ABC fire extinguisher. When asked, the Maintenance Supervisor stated the facility was unaware of the blocked fire extinguisher. Actual NFPA standards: NFPA 10 Standard for Portable Fire Extinguishers Item #1 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 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). Item #2 1-6.6* Fire extinguishers shall not be obstructed or obscured from view. Exception: In large rooms, and in certain locations where visual obstruction cannot be completely avoided, means shall be provided to indicate the location.	K 064	During monthly inspections of fire extinguishers by the Maintenance Director, any issues related to fire extinguishers mounting height or unobstructed view of fire extinguishers will be corrected immediately by the Maintenance Director and forwarded to the Quality Assurance Committee for further review and systems changes as required K-072 1. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice; B wing exit corridors cleared of beds, hoyer lifts, wheel chairs, cleaning carts, a platform cart, a luggage cart, chairs, and cardboard boxes to maintain a means of egress continuously maintained free of obstructions or impediments to full instant use in case of fire or other emergency.	9-14-15
K 072 SS=D	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	Exit corridors inspected by the Executive Director to ensure clear of stored items such as beds, hoyer lifts, wheel chairs, cleaning carts, a platform cart, a luggage cart, chairs, and cardboard boxes. 3. What measures will be put into place or what systematic changes you will make to ensure the deficient practices does not recur;	9-14-15

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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF COEUR D'ALENE		STREET ADDRESS, CITY, STATE, ZIP CODE 500 WEST AQUA AVENUE COEUR D ALENE, ID 83815		
(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 072	<p>Continued From page 8</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure means of egress was maintained free from obstructions. Failure to provide exit access free of obstructions could prevent safe evacuation during an emergency. This deficient practice affected staff members, vendors, and visitors on the day of survey. The facility is licensed for 120 SNF/NF beds with a census of 78 on the day of survey.</p> <p>Findings include:</p> <p>During the facility tour on August 24, 2015 at approximately 11:00 AM and again at 2:30 PM, observation of the both B wing exit corridors revealed beds, hoier lifts, wheel chairs, cleaning carts, a platform cart, a luggage cart, chairs, and cardboard boxes stored in the exit corridors blocking means of egress. When asked, the Maintenance Supervisor stated the facility was aware of the storage in the corridors.</p> <p>Actual NFPA Standard: NFPA 101, 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. 7.1.10.2.1 No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress therefrom, or visibility thereof</p>	K 072	<p>The Executive Director completed education regarding the requirement that exit corridors remain clear of stored items such as beds, hoier lifts, wheel chairs, cleaning carts, a platform cart, a luggage cart, chairs, and cardboard boxes. Executive Director, or designee, to complete daily inspections, Monday through Friday to ensure exit corridors remain clear of stored items such as beds, hoier lifts, wheel chairs, cleaning carts, a platform cart, a luggage cart, chairs, and cardboard boxes. Daily inspections, Monday through Friday, to be completed for 1 month, then weekly for an additional 2 months.</p> <p>4. 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. During exit corridor inspections, any issues related to exit corridors remaining clear of stored items such as beds, hoier lifts, wheel chairs, cleaning carts, a platform cart, a luggage cart, chairs, and cardboard boxes, will be corrected immediately forwarded to the Quality Assurance Committee for further review and systems changes as required.</p>	