



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

February 4, 2016

Bernardo Carotenuto, Administrator
Coeur d'Alene Health Care & Rehabilitation Center
2514 North Seventh Street
Coeur d'Alene, Idaho 83814-3720

Provider #: 135052

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Mr. Carotenuto:

On **January 27, 2016**, 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 you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must

Bernardo Carotenuto, Administrator
February 4, 2016
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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 **February 17, 2016**. Failure to submit an acceptable PoC by **February 17, 2016**, may result in the imposition of civil monetary penalties by **March 8, 2016**.

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 **March 2, 2016**, (Opportunity to Correct). Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **March 2, 2016**. A change in the seriousness of the deficiencies on **March 2, 2016**, 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 **March 2, 2016**, includes the following:

Denial of payment for new admissions effective **April 27, 2016**.
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 **July 27, 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 **January 27, 2016**, 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 **February 17, 2016**. If your request for informal dispute resolution is received after **February 17, 2016**, 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

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 01/27/2016.
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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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(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 K 000

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 January 27, 2016. 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:

Nate Elkins
Health Facility Surveyor
Facility Fire Safety and Construction

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 027 NFPA 101 LIFE SAFETY CODE STANDARD SS=E K 027

Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 10-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted.

Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7

This Standard is not met as evidenced by: Based on observation, operational testing, and interview the facility failed to maintain cross corridor doors. Failure to maintain cross corridor doors could allow smoke and dangerous gases to pass freely between compartments affecting egress and shelter in place during a fire event. This deficient practice affected 13 residents, staff,

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FEB 16 2016

FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Stanley Chubbuck</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>2/15/16</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.

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 01/27/2016
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K027 Continued From page 1
and visitors on the date of survey. The facility is licensed for 117 SNF/NF beds with a census of 21 on the day of survey.

Findings include:

1.) During the facility tour on January 27, 2016 at approximately 1:30 PM, observation and operational testing of the cross corridor doors near rooms 210/211 revealed 1-1/2 inch clearance between bottom of door and floor covering that would not resist the passage of smoke. When asked, the Maintenance Supervisor stated the facility was unaware of the gap between the door and the floor.

2.) During the facility tour on January 27, 2016 at approximately 3:30 PM, observation and operational testing of the cross corridor doors near the copy room and the DNS office revealed a 1-1/2 inch clearance between bottom of door and floor covering that would not resist the passage of smoke. When asked, the Maintenance Supervisor stated the facility was unaware of the gap between the door and the floor.

Actual NFPA standard:

NFPA 101
19.3.7.6*
Doors in smoke barriers shall comply with 8.3.4 and shall be self-closing or automatic-closing in accordance with 19.2.2.2.6. Such doors in smoke barriers shall not be required to swing with egress travel. Positive latching hardware shall not be required.

8.3.4 Doors.
8.3.4.1*

K 027
K027

1. No residents, staff, or visitors were adversely affected.
2. Facility door openings were audited and flashing was placed on Corridor Doors near Rooms 210 and 211 as well as doors near the copy room to prevent gases from passing between compartments.
3. The maintenance director was in-serviced on ensuring door openings / closures meet fire protection standards. The maintenance director will observe and test doors monthly to ensure door closure prevent gases from passing between compartments. Findings will be reported to the safety committee to ensure substantial compliance.
4. The ED will conduct a random audit of door closure to ensure fire protection standards are met. Results for the audit will be reported to the monthly QAPI committee to ensure substantial compliance.
5. AOC 2/14/16

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K 027 Continued From page 2
Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles.

K 027

K 056 NFPA 101 LIFE SAFETY CODE STANDARD
SS=E
Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13
This Standard is not met as evidenced by:
Based on observation and interview, the facility did not ensure that the sprinkler system was installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The deficient area would not have the ability to slow fire growth and provide more time for residents to evacuate during a fire event. The deficient practice affected 8 residents, staff and visitors. The facility is licensed for 117 SNF/NF beds with a census of 21 on the day of the survey.

Findings include:

During the facility tour on January 27, 2016 at approximately 11:45 AM, observation of the 100 hallway restroom revealed the room did not have sprinkler protection in place. When asked, the Maintenance Supervisor stated the facility was unaware the room did not have sprinkler

K 056

K 056

1. No residents, staff, or visitors were adversely affected.
2. Sprinkler head was ordered and installed in the 100 Hall restroom by Patriot Fire Protection our service vendor.
3. The maintenance director was in-serviced on ensuring the sprinkler system meets fire protection standards that would provide complete coverage for all portions of the building that would slow fire growth and provide more time for evacuation during a fire event. The maintenance director will audit the sprinkle head system monthly and report findings to the safety committee.
4. The ED will conduct a random audit of the sprinkler system to ensure the system meets fire protection standards. Findings will be reported to the monthly QAPI committee to ensure substantial compliance.
5. AOC 2/14/16

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K 056 Continued From page 3 coverage. K 056

Actual NFPA Standard:

NFPA 13
1-6 Level of Protection.
1-6.1

A building, where protected by an automatic sprinkler system installation, shall be provided with sprinklers in all areas.

Exception: This requirement shall not apply where specific sections of this standard permit the omission of sprinklers.

K062 NFPA 101 LIFE SAFETY CODE STANDARD SS=F K 062 K062

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, 9.7.5

This Standard is not met as evidenced by:
Based on record review and interview, the facility failed to provide quarterly inspection reports for the installed automatic sprinkler system. Failure to test the sprinkler system could allow the system to not operate effectively during a fire event. The deficient practice affected all residents, staff, and visitors on the date of survey. The facility is licensed for 117 SNF/NF beds with a census of 21 on the day of survey.

Findings include:

During record review on January 27, 2016 at approximately 10:00 AM, the facility could not produce quarterly sprinkler testing reports on the installed sprinkler system for the last 12 month period. When asked, the Maintenance Supervisor stated the facility was unaware of the quarterly testing requirements.

1. No residents, staff or visitors were adversely affected.
2. The maintenance director has scheduled quarterly inspections with Patriot Fire Protection our service provider to ensure sprinkler system meets fire protection standards.
3. The maintenance director will ensure the facility fire protection system is inspected quarterly and report findings the safety committee.
4. The ED will monitor sprinkler system inspection compliance through the monthly QAPI committee to ensure substantial compliance.
5. AOC 2/14/16.

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 01/27/2016
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K 062	Continued From page 4 Actual NFPA Standard: NFPA 101, 4.6.12.1. Every required sprinkler system shall be continuously maintained in proper operating condition. NFPA 25, 2-3.3. Water flow alarm devices including, but not limited to, mechanical water motor gongs, vane-type water-flow devices, and pressure switches that provide audible or visual signals shall be tested quarterly.	K 062	
K 067 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This Standard is not met as evidenced by: Based on observation, record review and interview, the facility failed to complete 4-year interval testing on the fire/smoke dampers as required under NFPA 90A. Failure to ensure dampers will operate to manufacturer's specifications would allow smoke and dangerous gases to pass freely throughout the facility during a fire event. This deficient practice affected staff and visitors on the date of survey. The facility is licensed for 117 SNF/NF beds with a census of 21 on day of the survey. Findings include: During the facility tour and record review on January 27, 2016 between 3:00 PM and 4:00 PM, observation revealed the facility had fire/smoke dampers installed in the heating, ventilation, and air conditioning (HVAC) system. Upon investigation of the facility records revealed the	K 067	K067 1. No residents, staff, or visitors were adversely affected. 2. Damper testing was conducted on 8/13/2015 to ensure the dampers operate to manufacture's specifications. 3. The maintenance director has been in-serviced on scheduling damper testing at four year intervals to ensure dampers meet manufacture's specifications. Results of the testing will be reported to the safety committee. 4. The ED will monitor compliance through the monthly QAPI committee. 5. AOC 2/14/16.

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 01/27/2016
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K067	Continued From page 5 facility did not have any documentation stating the fire/smoke dampers were tested. When asked, the Maintenance Supervisor the facility was unaware of the fire/smoke dampers.	K 067		
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Actual NFPA standard:

NFPA 90A

3-4.7 Maintenance.

At least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify that they fully close; the latch, if provided, shall be checked; and moving parts shall be lubricated as necessary.

K069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 069	K069	
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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 cooking facilities were maintained on a 6 month basis. Failure to ensure that cooking equipment is maintained could expose the residents to fire risks due to failure of equipment. This deficient practice affected staff and visitors on the date of the survey. The facility is licensed for 117 SNF/NF beds with a census of 21 on the day of the survey.

Findings include:

During record review on January 27, 2016 at approximately 10:30 AM, the facility's kitchen hood fire extinguishing system inspection reports revealed no semi-annual inspection report prior to December 11, 2015. When asked, the Maintenance Supervisor stated the facility was unaware the kitchen suppression system was not inspected prior to December 11, 2015.

1. No residents, staff, or visitors were adversely affected.
2. The Hood inspections were conducted on 6/25/2015 and 12/20/2015 with the next scheduled for June of 2016.
3. The maintenance director and dietary director have been in-serviced on ensure hood inspections are conducted semi-annually.
4. The maintenance director will report findings to the safety committee. The ED will monitor inspection compliance through the QAPI process.
5. AOC 2/14/16

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 01/27/2016
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K 069	Continued From page 6	K 069			
	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 130	NFPA 101 MISCELLANEOUS	K 130			
SS=E	OTHER LSC DEFICIENCY NOT ON 2786 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that smoke barriers were maintained. Failure to maintain smoke barriers could allow smoke and dangerous gases to pass freely between compartments affecting egress during a fire event. This deficient practice affected 8 residents, staff and visitors on the date of the survey. The facility is licensed for 117 SNF/NF beds and had a census of 21 on the day of the survey.				
	Findings include:				
	During the facility tour on January 27, 2016 at approximately 11:40 AM, observation of the Physical Therapy bathroom revealed an approximate 3 inch hole in the ceiling. When asked, the Maintenance Supervisor stated the facility believes the hole was created by a falling tree that struck the facility prior to the survey date.				
	Actual NFPA standard:				
	19.1.6.2 Health care occupancies shall be limited to the types of building construction shown in Table				
			1. No residents, staff, or visitors were adversely affected. The three inch hole in therapy bathroom ceiling has been repaired.		
			2. Facility ceiling inspection has been completed and no other holes were observed that would affect the smoke barrier.		
			3. The maintenance director has been in-serviced to include ceiling observation inspection in the weekly environmental facility tour. Findings will be reported to the safety committee.		
			4. The ED will monitor safety inspections through the monthly QAPI committee to ensure substantial compliance.		
			5. APO 2/14/16		

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K 130	Continued From page 7 19.1.6.2. (See 8.2.1.) Exception*: Any building of Type I(443), Type I(332), Type II(222), or Type II(111) construction shall be permitted to include roofing systems involving combustible supports, decking, or roofing, provided that the following criteria are met: (a) The roof covering meets Class C requirements in accordance with NFPA 256, Standard Methods of Fire Tests of Roof Coverings. (b) The roof is separated from all occupied portions of the building by a noncombustible floor assembly that includes not less than 2 1/2 in. (6.4 cm) of concrete or gypsum fill. (c) The attic or other space is either unoccupied or protected throughout by an approved automatic sprinkler system. 8.2.4 Smoke Partitions. 8.2.4.1 Where required elsewhere in this Code, smoke partitions shall be provided to limit the transfer of smoke. 8.2.4.2 Smoke partitions shall extend from the floor to the underside of the floor or roof deck above, through any concealed spaces, such as those above suspended ceilings, and through interstitial structural and mechanical spaces. Exception*: Smoke partitions shall be permitted to terminate at the underside of a monolithic or suspended ceiling system where the following conditions are met: (a) The ceiling system forms a continuous membrane. (b) A smoketight joint is provided between the top of the smoke partition and the bottom of the suspended ceiling. (c) The space above the ceiling is not used as a	K 130			

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(A) 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 130	Continued From page 8 plenum.	K 130		
K 144 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110)</p> <p>This Standard is not met as evidenced by: Based on record review and interview, the facility failed to maintain generator weekly inspection records and operate the generator under load monthly. Failure to inspect and document weekly inspections and operate the generator system under load monthly could lead to the system not operating correctly when required. This deficient practice affected all residents, staff and visitors on the day of survey. The facility is licensed for 117 SNF/NF beds with a census of 21 on the day of survey.</p> <p>Findings include:</p> <p>During record review on January 27, 2016 at approximately 11:00 AM, the facility failed to provide weekly generator inspection logs and monthly load testing results from January 2015 through August 2015. When asked, the Maintenance Supervisor stated the facility was not aware of the missing documentation.</p> <p>Actual NFPA Standard:</p> <p>NFPA 110 6.4.1. Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly. Exception: If the generator set is used for standby power or for peak load shaving, such use</p>	K 144	K144	
			<ol style="list-style-type: none"> 1. No residents, staff, or visitors were adversely affected. The Generator was tested the next morning to insure it's operation. 2. The generator will be tested weekly under full load to ensure proper function. 3. The maintenance director has been in-serviced to routine generator testing and documentation of such. Findings will be reported to the safety committee. 4. The ED will monitor compliance through the monthly QAPI committee to ensure the generator testing and documentation are completed as scheduled. 5. AOC 2/14/16 	

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 01/27/2016
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 144	Continued From page 9 shall be recorded and shall be permitted to be substituted for scheduled operations and testing of the generator set, provided the appropriate data are recorded.	K 144			
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code, 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure electrical wiring was covered and protected in accordance with the National Electrical Code. Failure to cover exposed live wiring increases the likelihood of electrical shocks and fires. This deficient practice affected 8 residents, staff, and visitors on the date of survey. The facility is licensed for 117 SNF/NF beds with a census of 21 on the day of survey. Findings include: 1.) During the facility tour on January 27, 2016 at approximately 11:30 AM, observation of room 109 revealed the faceplate missing from an electrical outlet. When asked, the Maintenance Supervisor stated that he was unaware of the missing faceplate. 2.) During the facility tour on January 27, 2016 at approximately 12:00 PM, observation of room 104 revealed a broken electrical outlet faceplate. When asked, the Maintenance Supervisor stated that he was unaware of the broken faceplate. 3.) During the facility tour on January 27, 2016 at approximately 3:45 PM, observation of the Physical Therapy room revealed the faceplate missing from an electrical outlet located under the wall heater. When asked, the Maintenance	K 147 K147	<ol style="list-style-type: none"> No residents, staff or visitors were adversely affected. Electrical faceplates have been replaced in rooms 109 and 104 and the physical therapy department. The maintenance director completed an audit of the electrical outlets to ensure there were no other missing or broken faceplates. The maintenance director has been in-serviced to include electrical faceplate inspection on weekly environmental safety rounds. Facility staff will be in-serviced to report missing or broken electrical faceplates immediately to the maintenance director, director supervisor, or facility administration to ensure prompt repair. The ED / designee will conduct random environmental safety rounds, findings will be reported to the monthly QAPI committee to ensure substantial compliance. AOC 2/14/16 		

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

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FORM APPROVED
OMB NO. 0938-0331

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <p style="text-align: center;">135052</p>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - PINWOOD CARE CENTER B. WING _____	(X3) DATE SURVEY COMPLETED <p style="text-align: center;">01/27/2016</p>
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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 147	Continued From page 10 Supervisor stated that he was unaware of the missing faceplate. Actual NFPA standard: NFPA 70 406.5 Receptacle Faceplates (Cover Plates). Receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface.	K 147		
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