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 (XS) Completion Date to signify when you allege that each tag will be back in compliance. NOTE: The alleged compliance date must
be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign 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.
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:
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
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 with applicable laws.
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 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 19.2.2.2.8. 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*
### NFPA 101: LIFE SAFETY CODE STANDARD

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 19.7. 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, NFPA 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 protection.

<table>
<thead>
<tr>
<th>Tag</th>
<th>Summary Statement of Deficiencies</th>
<th>K 027</th>
<th>K 056</th>
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</thead>
<tbody>
<tr>
<td></td>
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<tr>
<td></td>
<td>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.</td>
<td>K 027</td>
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<tr>
<td></td>
<td>No residents, staff, or visitors were adversely affected.</td>
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<td>K 056</td>
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<td></td>
<td>Sprinkler head was ordered and installed in the 100 Hall restroom by Patriot Fire Protection our service vendor.</td>
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<td>1.</td>
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<td>The maintenance director was involved in 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 sprinkler head system monthly and report findings to the safety committee.</td>
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<td>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.</td>
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<td>AOC 2/14/16</td>
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### K056 Continued From page 3

**K056**

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**K062 NFPA 101 LIFE SAFETY CODE STANDARD**

SS=F

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.

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**K062**

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.
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.

1. No residents, staff, or visitors were adversely affected.
2. Damper testing was conducted on 8/13/2015 to ensure the dampers operate to manufacturer's specifications.
3. The maintenance director has been in-serviced on scheduling damper testing at four year intervals to ensure dampers meet manufacturer'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.
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.

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.

K068 NFPA 101 LIFE SAFETY CODE STANDARD

Cooking facilities are protected in accordance with 8.2.3, 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 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
K 069 Continued from page 6

Actual NFPA standard:

NFPA 66
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
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
various types of building construction shown in Table
K 130 Continued From page 7

19.1.6.2. (See 8.2.1.)
Exception*: Any building of Types I (443), Type I (332), Type II (222), or Type III (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 236, 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 tile.
(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 smoke tight 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 Continued From page 8

K 144 NFPA 101 LIFE SAFETY CODE STANDARD

1. No residents, staff, or visitors were adversely affected. The Generator was tested the next morning to ensure 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
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 147 NFPA 101 LIFE SAFETY CODE STANDARD
SS=E

1. No residents, staff or visitors were adversely affected. Electrical faceplates have been replaced in rooms 109 and 104 and the physical therapy department.

2. The maintenance director completed an audit of the electrical outlets to ensure there were on other missing or broken faceplates.

3. 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.

4. The ED / designee will conduct random environmental safety rounds, findings will be reported to the monthly QAPI committee to ensure substantial compliance.

5. AOC 2/14/16
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