



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

September 14, 2016

Candice Hale, Administrator
Prestige Care & Rehabilitation-- The Orchards
1014 Burrell Avenue
Lewiston, ID 83501-5589

Provider #: 135103

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Ms. Hale:

On **September 7, 2016**, a Facility Fire Safety and Construction survey was conducted at **Prestige Care & Rehabilitation - The Orchards** 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 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 27, 2016**. Failure to submit an acceptable PoC by **September 27, 2016**, may result in the imposition of civil monetary penalties by **October 17, 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. If a State Form was issued as well, it should also be signed, dated and returned.

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 **October 12, 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 **October 12, 2016**. A change in the seriousness of the deficiencies on **October 12, 2016**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **October 12, 2016**, includes the following:

- Denial of payment for new admissions effective **December 7, 2016**. 42 CFR §488.417(a)

Candice Hale, Administrator
September 14, 2016
Page 3 of 4

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 **March 7, 2017**, 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 **September 7, 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:

<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:

Candice Hale, Administrator
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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 27, 2016**. If your request for informal dispute resolution is received after **September 27, 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, option 3.

Sincerely,

A handwritten signature in black ink, appearing to read "Nate Elkins". The signature is fluid and cursive, with a long horizontal stroke at the end.

Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosures

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

PRINTED: 09/14/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135103	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 09/07/2016
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NAME OF PROVIDER OR SUPPLIER PRESTIGE CARE & REHABILITATION - THE ORCHARDS	STREET ADDRESS, CITY, STATE, ZIP CODE 1014 BURRELL AVENUE LEWISTON, ID 83501
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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 single story type V (111) structure completed in 1958, with an addition of comparable construction. The facility is sprinklered with a new fire alarm and smoke detection system installed in 2013. The building has a partial basement which is used for storage and maintenance. The building is currently licensed for 127 beds. The following deficiencies were cited during the annual fire/life safety survey conducted on September 7, 2016. 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: Linda Chaney Health Facility Surveyor Facility Fire Safety and Construction Nate Elkins Supervisor Facility Fire Safety and Construction	K 000		
K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1o-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,	K 027	<p style="text-align: center;">RECEIVED SEP 29 2016 FACILITY STANDARDS</p> <p>K 027-E <i>What corrective action will be accomplished for those residents found to have been affected by the deficient practice</i> <i>The smoke doors between resident rooms 224 and 226 have been repaired; there is no longer a 1/2 inch gap and the doors latch when the magnetic hold is released; the smoke doors near Office 101 have been repaired; there is no longer a 1/4 inch gap between the leading edges of the doors; the smoke doors by west wing "short hallway" have been repaired; there is no longer a 1/4 inch gap between the leading edges of the doors</i></p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Candice Durham ADMINISTRATOR 9/26/16

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 027	<p>Continued From page 1 19.3.7.7 This STANDARD is not met as evidenced by: Based on observation, operational testing, and interview the facility failed to maintain doors that protect corridor openings. Failure to maintain corridor doors could allow smoke and dangerous gases to pass freely between smoke compartments. This deficient practice affected 20 residents, staff, and visitors on the date of survey. The facility is licensed for 127 SNF/NF beds with a census of 53 on the day of survey.</p> <p>Findings include:</p> <p>During the facility tour on September 7, 2016 from approximately 8:30 AM to 2:30 PM, observation and operational testing of the cross corridor doors revealed the following:</p> <ol style="list-style-type: none"> 1.) Smoke doors between resident rooms 224 and 226, when released from the magnetic hold open device, failed to seal when closed. There was an aprox. 1/2" gap between the leading edges of the doors and one door did not latch properly. 2.) Smoke doors near Office 101, when released from the magnetic hold open device, failed to seal when closed. There was an aprox. 1/4" gap between the leading edges of the doors. 3.) Smoke doors by west wing "short hallway", when released from the magnetic hold open device, failed to seal when closed. There was an aprox. 1/4" gap between the leading edges of the doors. <p>When asked, the Maintenance Supervisor stated the facility was unaware the doors did not resist the passage of smoke.</p> <p>Actual NFPA standard:</p>	K 027	<p><i>How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</i></p> <p><i>All residents living within the smoke compartments between the stated smoke doors have the potential to be affected by the deficient practice; the facility conducted an audit of all smoke compartment doors to ensure residents living within the boundaries of other smoke compartment doors were not at risk</i></p> <p><i>What measures will be put in to place or what systemic changes you will make to ensure that the deficient practice does not recur</i></p> <p><i>Facility Maintenance Director will conduct weekly checks x3 months on all smoke doors in facility to ensure the facility is maintaining doors that protect corridor openings</i></p>	
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K 027	Continued From page 2 19.3.7.5 Openings in smoke barriers shall be protected by fire-rated glazing; by wired glass panels and steel frames; by substantial doors, such as 13/4-in. (4.4-cm) thick, solid-bonded wood core doors; or by construction that resists fire for not less than 20 minutes. Nonrated factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door shall be permitted. Exception: Doors shall be permitted to have fixed fire window assemblies in accordance with 8.2.3.2.2. 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* 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	<i>How will the corrective action be monitored to ensure the deficient practice will not recur</i> Facility Maintenance Director will review smoke door audits at the Monthly QAPI Committee x's 3 months then quarterly x3, to ensure compliance and assist with further plan of action of needed <i>Date the deficient practice correction will be completed</i> 9/30/16		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with 0 hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are	K 029	<i>K 029-D</i> <i>What corrective action will be accomplished for those residents found to have been affected by the deficient practice</i> <i>The kitchen, laundry, bio-hazard room, and oxygen storage room doors to hazardous areas have been repaired: they now self-close and latch</i>	9/30/16	

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K 029	<p>Continued From page 3 permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure that hazardous areas were protected with self-closing doors. Failure to provide self-closing doors 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 10 residents, staff and visitors on the date of the survey. The facility is licensed for 127 SNF/NF beds with a census of 53 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour on September 7, 2016 from approximately 8:30 AM to 2:30 PM, observation and operational testing of the following doors to hazardous areas revealed they did not self-close or latch.</p> <ol style="list-style-type: none"> 1.) Kitchen 2.) Laundry 3.) Bio-Hazard Room 4.) Oxygen Storage <p>When asked, the Maintenance Supervisor stated the facility was not aware the doors were not closing properly.</p> <p>Actual NFPA standard:</p> <p>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</p>	K 029	<p><i>How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</i></p> <p><i>All residents have the potential to be affected by the deficient practice; the facility has conducted audit of all doors to hazardous areas to ensure self-closure and latching for the safety of all residents in the event of a fire emergency</i></p> <p><i>What measures will be put in to place or what systemic changes you will make to ensure that the deficient practice does not recur</i></p> <p><i>Facility Maintenance Director will conduct weekly checks x3 months on all doors leading to hazardous areas to ensure the facility is maintaining doors that prevent smoke and dangerous gases to pass freely into corridors and hinder the egress of occupants during a fire event</i></p>	
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K 029	Continued From page 4 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: (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. NFPA 101 LIFE SAFETY CODE STANDARD	K 029	<i>How will the corrective action be monitored to ensure the deficient practice will not recur</i> Facility Maintenance Director will review audits of doors leading to hazardous areas at the Monthly QAPI Committee x's 3 months then quarterly x3, to ensure compliance and assist with further plan of action of needed <i>Date the deficient practice correction will be completed</i> 9/30/16	
K 066 SS=D	Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.	K 066	<i>K 066-D</i> <i>What corrective action will be accomplished for those residents found to have been affected by the deficient practice</i> <i>The smoking area is now equipped with a metal container with a self-closing cover</i>	9/30/16

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K 066	<p>Continued From page 5</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide metal containers with self-closing devices in designated smoking areas. The deficient practice affected residents that utilize the smoking area, staff and visitors on the day of survey. The facility is licensed for 127 SNF/NF beds with a census of 53 on the date of survey.</p> <p>Findings include:</p> <p>During the facility tour on September 7, 2016 from approximately 8:30 AM to 2:30 PM, observation revealed the residents designated smoking area was not equipped with a metal container with a self-closing cover. When asked, the Maintenance Supervisor stated the facility was not aware the smoking areas required a self-closing metal container.</p> <p>Actual NFPA standard:</p> <p>19.7.4* Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO</p>	K 066	<p><i>How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</i></p> <p><i>All resident who smoke have the potential to be affected by the deficient practice; currently, the facility is home to 14 residents who smoke and/or use the smoking patio</i></p> <p><i>What measures will be put in to place or what systemic changes you will make to ensure that the deficient practice does not recur</i></p> <p><i>Facility Maintenance Director will conduct weekly checks x3 months to ensure the metal container with self-closing cover is located in the smoking area and in good repair</i></p>	

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K 066	Continued From page 6 SMOKING or shall be posted with the international symbol for no smoking. Exception: In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (2) Smoking by patients classified as not responsible shall be prohibited. Exception: The requirement of 19.7.4(2) shall not apply where the patient is under direct supervision. (3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.	K 066	<i>How will the corrective action be monitored to ensure the deficient practice will not recur</i> Facility Maintenance Director will review at the Monthly QAPI Committee x's 3 months to ensure compliance and assist with further plan of action of needed <i>Date the deficient practice correction will be completed</i> 9/30/16	9/30/16
K 070 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices shall be prohibited in all health care occupancies. Except it shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F (100 degrees C). 18.7.8, 19.7.8 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to prohibit portable space heaters in sleeping areas. Portable space heaters in sleeping areas is considered a significant risk due to the history of fires caused by space heaters. This deficient practice affected 6 residents, staff, and visitors on the day of survey. The facility is licensed for 127 SNF/NF beds with a census of 53 on the date of survey.	K 070	<i>K 070-D</i> <i>What corrective action will be accomplished for those residents found to have been affected by the deficient practice</i> <i>The portable space heater has been removed from room 215, the Dietary Manger's Office</i>	

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K 070	Continued From page 7 Findings include: During the facility tour on September 7, 2016 from approximately 8:30 AM to 2:30 PM, observation revealed a portable space heater located in room 215, Dietary Manager's office. This office was located inside a resident sleeping area. When asked, the Maintenance Supervisor stated the facility was unaware the portable heater was in the facility. Actual NFPA standard: 19.7.8 Portable Space-Heating Devices. Portable space-heating devices shall be prohibited in all health care occupancies. Exception: Portable space-heating devices shall be permitted to be used in nonsleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C). NFPA 101 LIFE SAFETY CODE STANDARD 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. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10, 18.2.1, 19.2.1 This STANDARD is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure 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 an emergency. This deficient practice affected 2 residents, staff and visitors utilizing the	K 070	<i>How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</i> <i>All residents residing within the sleeping area of room 215, the Dietary Manger's Office have the potential to be affected by the deficient practice; the Administrator provided 1:1 in-service to the Dietary Manager regarding her role in resident life safety as it relates to the use of portable space heaters in a resident sleeping area; Maintenance Director has completed a facility-wide audit of all rooms / offices in resident sleeping areas to validate no other portable space heaters found in a resident sleeping area</i> <i>What measures will be put in to place or what systemic changes you will make to ensure that the deficient practice does not recur</i>	
K 072 SS=D		K 072		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135103	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED 09/07/2016
NAME OF PROVIDER OR SUPPLIER PRESTIGE CARE & REHABILITATION - THE ORCHARDS		STREET ADDRESS, CITY, STATE, ZIP CODE 1014 BURRELL AVENUE LEWISTON, ID 83501		
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K 072	<p>Continued From page 8</p> <p>physical therapy room on the date of the survey. The facility is licensed for 127 SNF/NF beds and had a census of 53 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour on September 7, 2016 from aprox. 8:30 AM to 2:30 PM, observation of the exit door at the physical therapy room found that the door was equipped with a keypad for a controlled access locking arrangement. Operational testing of the door revealed that special knowledge was needed (code) to operate the exit door. When asked why the controlled access had been installed, the Maintenance Supervisor stated it had always been that way, and the facility was unaware that it was not allowed.</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</p>	K 072	<p><i>Facility Maintenance</i></p> <p><i>Director will conduct weekly checks x3 months of all rooms / offices in resident sleep areas to ensure no portable space heaters are in use; the Administrator will in-service all office staff regarding their role in resident life safety as it relates to the use of portable space heaters in a resident sleeping area</i></p> <p><i>How will the corrective action be monitored to ensure the deficient practice will not recur</i></p> <p>Facility Maintenance Director will review results of weekly checks at the Monthly QAPI Committee x's 3 months to ensure compliance and assist with further plan of action of needed</p> <p><i>Date the deficient practice correction will be completed</i></p> <p>9/30/16</p>	9/30/16

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K 072	Continued From page 9 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. 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 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. (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. (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. (d) Activation of the building fire-protective	K 072	<i>K 072-D</i> <i>What corrective action will be accomplished for those residents found to have been affected by the deficient practice</i> <i>The exit door in the physical therapy room is no longer equipped with a keypad for controlled access locking arrangement; there is no longer a code required to operate the exit door; there is no longer any special knowledge required to exit this egress in emergency event</i> <i>How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</i> <i>All residents that utilize the physical therapy room and all staff that work in the physical therapy room, have the potential to be affected by the deficient practice</i>	
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K 072	Continued From page 10 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. (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.	K 072	<i>What measures will be put in to place or what systemic changes you will make to ensure that the deficient practice does not recur</i> <i>Facility Maintenance</i> <i>Director has removed the keypad and evaluated all exits for safe egress; no other exit door was found to have keypad code or require any special knowledge to utilize</i> <i>How will the corrective action be monitored to ensure the deficient practice will not recur</i> <i>Facility Maintenance</i> <i>Director will review exit door requirements with the facility QAPI Committee to ensure compliance and assist with further plan of action of needed</i> <i>Date the deficient practice correction will be completed</i> <i>9/30/16</i>	9/30/16