



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

October 13, 2016

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 **October 3, 2016**, 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 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 be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to

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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 **October 26, 2016**. Failure to submit an acceptable PoC by **October 26, 2016**, may result in the imposition of civil monetary penalties by **November 15, 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 **November 7, 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 **November 7, 2016**. A change in the seriousness of the deficiencies on **November 7, 2016**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **November 7, 2016**, includes the following:

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Denial of payment for new admissions effective **January 3, 2017**.  
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 **April 3, 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 Nate Elkins, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, option 3; 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 **October 3, 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>

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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 **October 26, 2016**. If your request for informal dispute resolution is received after **October 26, 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,



Nate Elkins, Supervisor  
Facility Fire Safety and Construction

NE/lj  
Enclosures

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

PRINTED: 10/13/2016  
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  10/03/2016
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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 ( III ) 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 October 3, 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 & Construction	K 000		
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 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	K 029	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 this plan does not constitute agreement by the facility that the surveyor's findings and/or conclusions are accurate, or that the findings constitute a deficiency or that the scope and severity regarding any of the deficiencies cited are correctly applied.	

RECEIVED  
OCT 25 2016  
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>Jafer M. Zaharia</i>	TITLE  Executive Director	(X6) DATE  10-24-16
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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 029	<p>Continued From page 1</p> <p>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 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>During the facility tour on October 3, 2016 from approximately 10:30 AM to 5:00 PM, observation and operational testing of the following hazardous areas revealed the doors were not equipped with a self-closure:</p> <ol style="list-style-type: none"> <li>1.) Maintenance Office which contained chemicals and combustibles.</li> <li>2.) Electric Room #2</li> <li>3.) Communications/Mechanical &amp; Electrical Room</li> <li>4.) Records storage closet which was greater than 50 sq. ft. and contained combustibles.</li> </ol> <p>When asked, the Maintenance Supervisor stated the facility was not aware the doors needed to be on a self-closure.</p> <p>Actual NFPA standard:</p> <p>NFPA 101, 3.3.13.2 Area, Hazardous. An area of a structure or building that poses a degree of hazard greater than that normal to the general occupancy of the building or structure, such as areas used for the storage or use of combustibles or flammables; toxic, noxious, or corrosive materials; or heat-producing appliances.</p> <p>19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a</p>	K 029	<p><b>K029</b></p> <p><b>SPECIFIC DEFICIENCY</b></p> <p>4 Hazardous area doors were not equipped with a self-closing mechanism.</p> <ol style="list-style-type: none"> <li>1. <b>Maintenance Office door</b> now has a self-closing mechanism - installed on 10/3/16.</li> <li>2. <b>Electric Room #2 door</b> now has a self-closing mechanism - installed on 10/3/16.</li> <li>3. <b>Communications/Mechanical &amp; Electrical room door</b> now has a self-closing mechanism - installed on 10/3/16.</li> <li>4. <b>Records storage closet door</b> now has a self-closing mechanism – installed on 10/13/16.</li> </ol> <p><b>OTHER RESIDENTS, STAFF &amp; VISITORS AFFECTED</b></p> <p>1. Audit of all other hazardous area doors requiring self-closure has been completed and no other doors are missing the self-closing mechanism.</p> <p><b>SYSTEMIC CHANGES</b></p> <p>1. Continued monitoring of all hazardous area automatic self-closing door mechanisms throughout the facility via the Preventative Maintenance Program.</p>		

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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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K 029	Continued From page 2 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:  (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	<b>MONITOR</b> Maintenance Director or designee will audit Weekly x 4 weeks then monthly x 3 months. Audits will begin 10/24/16.  <b>DATE OF COMPLIANCE:</b>	10/24/16
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  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, observation and interview, the facility failed to maintain sprinkler systems in reliable operating condition. Failure to	K 062		

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K 062	Continued From page 3 test and maintain sprinklers could result in inadequate sprinkler system operation during a fire event. This deficient practice affected 78 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.  Findings include:  1.) During record review on October 3, 2016, from approximately 9:45 AM to 10:30 AM, the following deficiencies were noted on the Annual Sprinkler Inspection dated July 28, 2016: a.) All 2 dry valve risers are missing sign indicating locations of low points and axillary drains. b.) There are 27 dry barrel heads dated 1996 and 2009. They are exposed to harsh environments and need to be replaced or tested every 5 years per NFPA 25. c.) Wet system #1 shut off valve does not hold. d.) 2 dry barrel heads in freezers exposed to harsh environments are older than 5 years and due for testing or replacement. e.) Tyco DPV-1 Valve #1 has bad 1/4" pop off valve that leaks and needs to be replaced. The facility failed to correct the deficiencies and could not produce a plan of correction for the deficiencies. When asked, the Administrator and Maintenance Supervisor stated that they were both new to their positions, and unaware of the deficiencies.  2.) During the facility tour on October 3, 2016, from approximately 10:30 AM to 5:00 PM, observation of the cabinet which holds spare sprinklers for replacement on the premises, revealed the facility did not maintain a minimum	K 062	<b>K062</b>  <b>SPECIFIC DEFICIENCY</b> I. Annual Sprinkler Inspection issues, missing signage, wet system pressure issues, valve leakage, barrel heads that are requiring replacement.  a. All 2 dry valve risers are missing signs indicating locations of low points and axillary drains. <b>REMEDY</b> – Fire Sprinkler Contractor to create and install general information signs for dry system risers.  <b>DATE OF COMPLIANCE:</b> 11/11/16  b. 27 dry barrel heads dated 1996 and 2009 need to be replaced or tested every 5 years. <b>REMEDY</b> – Fire Sprinkler Contractor to special order and replace the aforementioned (27) dry barrel heads.  <b>DATE OF COMPLIANCE:</b> 12/9/16  c. Wet System # 1 shut off valve does not hold. <b>REMEDY</b> – Fire Sprinkler Contractor to install new 3" inch butterfly valve to replace current central valve that does not hold.  <b>DATE OF COMPLIANCE:</b> 11/11/16	



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K 062	Continued From page 5 will not be exposed to moisture, dust, corrosion, or a temperature exceeding 100°F (38°C). Exception: Where dry sprinklers of different lengths are installed, spare dry sprinklers shall not be required, provided that a means of returning the system to service is furnished. 2-4.1.5 The stock of spare sprinklers shall be as follows: (a) For protected facilities having under 300 sprinklers -no fewer than 6 sprinklers (b) For protected facilities having 300 to 1000 sprinklers -no fewer than 12 sprinklers (c) For protected facilities having over 1000 sprinklers -no fewer than 24 sprinklers NFPA 101 LIFE SAFETY CODE STANDARD	K 062	<b>MONITOR</b> Maintenance Director or designee will visually audit monthly sprinkler system and parts inventory x 3 months with audit forms submitted to the Executive Director and reported to CQI with findings. Audits to begin 10/26/16.	
K 144 SS=F	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) This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the generator of the Emergency Power Supply System (EPSS) was inspected weekly and tested monthly in accordance with NFPA 110. Failure to inspect and test EPSS generators could result in a lack of system reliability during a power loss. This deficient practice affected 78 residents, staff and visitors on the date of the survey. The facility is licensed for 120 SNF/NF residents and had a census of 78 on the day of the survey.  Findings include:  1) During review of the the facility generator inspection and testing records conducted on	K 144		

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K 144	<p>Continued From page 6</p> <p>October 3, 2016 from 9:45 AM to 10:30 AM, records indicated weekly inspections had not been completed since June 18, 2016.</p> <p>2) During review of the the facility generator inspection and testing records conducted on October 3, 2016 from 9:45 AM to 10:30 AM, records indicated monthly load tests had not been completed since May 31, 2016.</p> <p>The Maintenance Supervisor stated the facility was not aware of the required weekly inspections and monthly load tests, due to a recent change in maintenance staffing.</p> <p>Actual NFPA standard:</p> <p>NFPA 99</p> <p>3-4.4.1 Maintenance and Testing of Essential Electrical System. 3-4.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches. (a) Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-4.3.1. Maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6. (b) Inspection and Testing. 1. * Test Criteria. Generator sets shall be tested twelve (12) times a year with testing intervals between not less than 20 days or exceeding 40 days. Generator sets serving emergency and equipment systems shall be in accordance with</p>	K 144	<p><b>K144</b></p> <p><b>SPECIFIC DEFICIENCY</b> 1.Facility did not have a current record of the required <i>weekly</i> generator inspections and testing records or the required <i>monthly</i> generator load test records.</p> <p><b>SYSTEMIC CHANGES</b> A weekly inspection tracking form and a monthly load-test tracking form have been created and implemented for tracking of the required inspections and testing. Maintenance Director or designee will inspect the generator weekly and document appropriately and test the generator monthly with the appropriate loads required and document the results.</p> <p><b>MONITOR</b> Maintenance Director or designee will complete the required weekly and monthly tests with documentation and submit copies to the Executive Director for auditing x 3 months. Executive Director to report to CQI with findings. Audits to begin 10/7/16.</p> <p><b>DATE OF COMPLIANCE: 10/7/16</b></p>	

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K 144	<p>Continued From page 7</p> <p>NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6.</p> <p>2. Test Conditions. The scheduled test under load conditions shall include a complete simulated cold start and appropriate automatic and manual transfer of all essential electrical system loads.</p> <p>3. Test Personnel. The scheduled tests shall be conducted by competent personnel. The tests are needed to keep the machines ready to function and, in addition, serve to detect causes of malfunction and to train personnel in operating procedures.</p> <p>NFPA 110 Chapter 6 6-4 Operational Inspection and Testing. 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 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. 6-4.2* Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (a) Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating (b) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer The date and time of day for required testing shall</p>	K 144			

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K 144	Continued From page 8 be decided by the owner, based on facility operations.	K 144			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001390</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: <b>01 - ENTIRE BUILDING</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/03/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>LIFE CARE CENTER OF COEUR D'ALENE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 WEST AQUA AVENUE COEUR D ALENE, ID 83815</b>
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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) COMPLETE DATE
C 000	<p><b>16.03.02 INITIAL COMMENTS</b></p> <p>The facility is a Type V (III) 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.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on October 3, 2016. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70. The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16.03.02.</p> <p>The Survey was conducted by:</p> <p>Linda Chaney Health Facility Surveyor Facility Fire Safety &amp; Construction</p>	C 000		
C 260	<p><b>02.106,07,h Weekly Cleaning of Range Hoods/Filters</b></p> <p>h. All range hoods and filters shall be cleaned at least weekly. This Rule is not met as evidenced by: Based on observation and interview the facility failed to maintain kitchen hood and filter systems. Failure to maintain kitchen hood and filter systems could result in grease and other combustibles building up on the hood and filters potentially causing a fire event. This deficient practice affected 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</p>	C 260		

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FACILITY STANDARDS

Bureau of Facility Standards  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
*Jafar M. Zahraie*  
STATE FORM 6899

TITLE  
*Executive Director*  
ZE0U21

(X6) DATE  
*10-24-16*  
If continuation sheet 1 of 2

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001390</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: <b>01 - ENTIRE BUILDING</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/03/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>LIFE CARE CENTER OF COEUR D'ALENE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 WEST AQUA AVENUE COEUR D ALENE, ID 83815</b>		
(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) COMPLETE DATE
C 260	Continued From page 1 day of the survey.  Findings include:  During the facility tour on October 3, 2016, from approximately 10:30 AM to 5:00 PM, observation of the hood and filters in the kitchen revealed they were dirty and appeared to have a greasy build up on them. When asked, Director Dietary Services stated they were cleaned semi-annually by an outside provider. The facility had a kitchen cleaning schedule, but there was no record of the hood and filter on the cleaning schedule.  Actual Standard:  IDAPA 106.07h All range hoods and filters shall be cleaned at least weekly.	C 260	<b>C260</b>  <b>SPECIFIC DEFICIENCY</b> Facility failed to maintain a clean kitchen hood and filter system.  <b>SYSTEMIC CHANGES</b> A weekly cleaning schedule of the kitchen hood and filter system with the appropriate documentation has been created and implemented.  <b>MONITORING</b> The Maintenance Director or designee will audit the weekly cleaning of the kitchen hood and filter system and the appropriate documentation of the cleaning will be submitted weekly to the Executive Director for review x 3 months.  <b>DATE OF COMPLIANCE: 10/24/16</b>	