November 13, 2018

David Farnes, 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 Mr. Farnes:

On November 1, 2018, 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 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 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 November 26, 2018. Failure to submit an acceptable PoC by November 26, 2018, may result in the imposition of civil monetary penalties by December 18, 2018.

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 may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by December 6, 2018, (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 January 30, 2019. A change in the seriousness of the deficiencies on December 16, 2018, may result in a change in the remedy.
The remedy, which will be recommended if substantial compliance has not been achieved by December 6, 2018, includes the following:

Denial of payment for new admissions effective February 1, 2019.
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 May 1, 2019, 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 November 1, 2018, 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 **November 26, 2018**. If your request for informal dispute resolution is received after **November 26, 2018**, 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

Enclosures
K 000 INITIAL COMMENTS

The facility is a type V (111), single story structure with a partial basement originally constructed in 1958. The basement is accessed by staff only, utilizing a keypad entry system. This area houses the maintenance shop, fire suppression system riser and access to the facility mechanical spaces. Additional freight access is accomplished by a freight elevator from the service corridor off the main Kitchen. The facility is fully sprinklered with an interconnected, addressable fire alarm and smoke detection system installed in 2013. The building is currently licensed for 127 SNF/NF beds and had a census of 56 on the date of the survey.

The following deficiencies were cited during the annual fire/life safety survey conducted on October 31 and November 1, 2018. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Chapter 19, Existing Healthcare Occupancies, in accordance with 42 CFR 483.70 and 483.80.

The Survey was conducted by:

Sam Burbank
Health Facility Surveyor
Facility Fire Safety and Construction

K 100 GENERAL REQUIREMENTS - OTHER

This plan of correction is prepared and submitted as required by law. By submitting this plan of correction, Prestige Care and Rehabilitation-The Orchards does not admit that the deficiencies listed on this form exist, nor does the center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiencies. The center reserves the rights to challenge in legal and/or regulatory administrative proceedings the deficiencies statements, facts, and conclusions that form the basis for the deficiencies.

Residents affected: All
What corrective action(s) will be accomplished for those residents

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.

Form CMS-2567(02-99) Previous Versions Obsolete
| K 100 | Continued From page 1 by: Based on record review and interview, the facility failed to demonstrate implementation of a water management program for waterborne pathogens such as Legionella, in accordance with 42 CFR 483.80. Failure to implement a water management program with consideration for the ASHRAE 188 standard and utilizing those parameters as defined in the CDC toolkit, has the potential to limit relevant facility awareness and expose residents to Legionella and other water source bacterium based on inconclusive data. This deficient practice affected 56 residents, staff and visitors on the date of the survey. Findings include: During review of provided policies and procedures for water management conducted on 10/31/18 from 10:30 AM to 12:00 PM, records demonstrated the facility had a policy established July of 2018 to develop a water management program to identify and mitigate the risks associated with waterborne pathogens, yet no documentation or establishment of risk assessment, control measures or testing protocols was evident. Interview of the Infection Control nurse stated she was not aware of the facility policy or any program that had been established, but that her time in the position was only limited to the past two weeks. Further interview of both the Administrator and the Maintenance Director did not establish any water management program had been established prior to the survey date. CFR standard: 42 CFR 483.80 | K 100

found to have been affected by the deficient practice: The facility has created and implemented a water management program for waterborne pathogens such as legionella.

How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken: Staff Development coordinator has been in-serviced on the importance of a well-maintained water management program. Program will be assessed for accuracy and function monthly at the facility QAPI meeting.

What measures will be put in to place or what systemic changes will be made to ensure that the deficient practice does not recur: The facility has created a water management program committee, and will review program monthly.

How the corrective action will be monitored: Results of water management program assessments will be reported to the facility QAPI team.

Who will be responsible to ensure correction(s):
K 100 Continued From page 2

Additional reference:
Center for Medicaid/Medicare Services S&C 17-30

K 111 Building Rehabilitation
SS=F CFR(s): NFPA 101

Building Rehabilitation
Repair, Renovation, Modification, or Reconstruction
Any building undergoing repair, renovation, modification, or reconstruction complies with both of the following:
* Requirements of Chapter 18 and 19
* Requirements of the applicable Sections 43.3, 43.4, 43.5, and 43.6
18.1.1.4.3, 19.1.1.4.3, 43.1.2.1
Change of Use or Change of Occupancy
Any building undergoing change of use or change of occupancy classification complies with the requirements of Section 43.7, unless permitted by 18.1.1.4.2 or 19.1.1.4.2
18.1.1.4.2 (4.6.7 and 4.6.11), 19.1.1.4.2 (4.6.7 and 4.6.11), 43.1.2.2 (43.7)

Additions
Any building undergoing an addition shall comply with the requirements of Section 43.8. If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a 2-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors with at least a 1-1/2-hour fire resistance rating. Additions comply with the requirements of Section 43.8.
18.1.1.4.1 (4.6.7 and 4.6.11), 18.1.1.4.1.1 (8.3), 18.1.1.4.1.2, 18.1.1.4.1.3, 19.1.1.4.1 (4.6.7 and 4.6.11), 19.1.1.4.1.1 (8.3), 19.1.1.4.1.2, 19.1.1.4.1.3, 43.1.2.3 (43.8)
This REQUIREMENT is not met as evidenced by...
Based on record review, observation and interview, the facility failed to ensure that ongoing rehabilitation projects were conducted in accordance with NFPA 101. Failure to provide alternative, or interim life safety measures during rehabilitation or construction projects, has the potential to expose residents to risks associated with such work. This deficient practice affected 56 residents, staff and visitors on the date of the survey.

Findings include:

1) During review of provided policies and procedures conducted on 10/31/18 from 8:45 - 10:00 AM, no records were available demonstrating the facility had an interim life safety measure (ILSM) policy for ongoing rehabilitation and construction projects.

2) During the facility tour conducted on 10/31/18 from 10:00 AM - 12:00 PM, observation of the Therapy wing of the facility revealed equipment had been moved into the corridor. When asked about this condition, the Administrator in Training (AIT) stated the facility was starting a flooring replacement for the entire facility. When subsequently asked if the facility had an ILSM in place for this project, both the AIT and the Maintenance Director stated they were unaware of the requirements for an ILSM.

Actual NFPA standard:

NFPA 101
19.1.1.1 General.
19.1.1.3 General. The provisions of Chapter 4, General, shall apply.

interim safety measures during building restoration projects.

**How the corrective action will be monitored:**
Facility will report any interim life safety measures put into place to the facility management team.

**Who will be responsible to ensure correction(s):**
Administrator.
### Provider/Supplier/CUA Identification Number:
135103

### Multiple Construction
**A. Building 01 - Entire Building**

### Date Survey Completed
11/01/2018

### Name of Provider or Supplier
Prestige Care & Rehabilitation - The 01

### Street Address, City, State, Zip Code
1014 Burrell Avenue, Lewiston, ID 83501

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix</th>
<th>TAG</th>
<th>Description</th>
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<tbody>
<tr>
<td>K 111</td>
<td>Continued From page 4</td>
<td>19.1.1.4</td>
<td>Additions, Conversions, Modernization, Renovation and Construction Operations. 19.1.1.4.3 Rehabilitation. 19.1.1.4.3.1 For purposes of the provisions of this chapter, the following shall apply: (1) A major rehabilitation shall involve the modification of more than 50 percent, or more than 4500 ft² (420 m²), of the area of the smoke compartment. (2) A minor rehabilitation shall involve the modification of not more than 50 percent, and not more than 4500 ft² (420 m²), of the area of the smoke compartment. 19.1.1.4.4 Construction, Repair, and Improvement Operations. See 4.6.10.</td>
</tr>
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</table>

Chapter 4

4.6.7 Building Rehabilitation. 4.6.7.1 Rehabilitation work on existing buildings shall be classified as one of the following work categories in accordance with 43.2.2.1: (1) Repair... (2) Renovation (3) Modification (4) Reconstruction (5) Change of use or occupancy classification (6) Addition 4.6.7.2 Rehabilitation work on existing buildings shall comply with Chapter 43.

4.6.10 Construction, Repair, and Improvement Operations. 4.6.10.1* Buildings, or portions of buildings, shall be permitted to be occupied during construction, repair, alterations, or additions only where required means of egress and required fire protection features are in place and continuously maintained for the portion occupied or where
Chapter 43

43.2 Special Definitions.
43.2.2.1.2 Renovation. The replacement in kind, strengthening, or upgrading of building elements, materials, equipment, or fixtures, that does not result in a reconfiguration of the building spaces within.

43.4 Renovations.
43.4.1 General Requirements.
43.4.1.1 A renovation, as defined in 43.2.2.1.2, in other than historic buildings shall comply with the requirements of Section 43.4.

43.4.1.4 The work shall not make the building less conforming with other sections of this Code, or with any previous approved alternative arrangements, than it was before the renovation was undertaken, unless otherwise specified in 43.4.1.5.

Refer also to K-232

K 232
Aisle, Corridor, or Ramp Width
CFR(s): NFPA 101

Aisle, Corridor or Ramp Width
2012 EXISTING
The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5.

Residents affected: All
What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:
Facility has removed therapy equipment to ensure that egress
### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLA Identification Number:**

135103

**Multiple Construction**
- A. Building 01 - Entire Building
- B. Wing

**Date Survey Completed:**

11/01/2018

**Name of Provider or Supplier:**

Prestige Care & Rehabilitation - The O

**Street Address, City, State, Zip Code:**

1014 Burrell Avenue
Lewiston, ID 83501

### Summary Statement of Deficiencies

Each deficiency must be preceded by full regulatory or LSC identifying information.

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix Tag</th>
<th>Summary of Deficiencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>K232</td>
<td>Continued From page 6</td>
<td>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that egress corridors were maintained free of obstructions in accordance with NFPA 101. Failure to prevent reduction of exit access corridors of eight (8) feet in width to less than four (4) feet, has the potential to hinder emergency egress during a fire or other event requiring evacuation. This deficient practice affected staff and visitors of the Therapy wing on the date of the survey. Findings include: During the facility tour conducted on 10/31/18 from 10:00 AM to 12:00 PM, observation of the Therapy wing revealed the facility had moved multiple pieces of equipment into the corridor and reduced the clear width to less than 48 inches in the following locations: In the exit corridor outside the Beauty Shop, measurement of the distance from the opposing wall to a set of physical therapy parallel bars, which measured approximately 84 inches in length and 50 inches wide, revealed only 42 inches remained of the 8 foot corridor width. In the exit corridor outside of Medical Records, measurement of the distance from the wall to a multi-station weight exercise machine, revealed only 19 inches remained of the 8 foot corridor width. Interview of the AIT and the Maintenance Director established that both were aware of the reduction of the corridor width. Actual NFPA standard: Corridors are maintained free of obstructions in accordance with NFPA 101. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken: Facility will audit all additional corridors to ensure that egress corridors are maintained free of obstructions. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Facility has added a weekly task to TELS to audit all corridors to ensure egress is not obstructed. Maintenance director has been in-serviced to the requirement. Staff will be in-serviced on importance of maintaining egress free of obstruction. How the corrective action will be monitored: Maintenance director will report all findings to QAPI committee. Who will be responsible to ensure correction(s): Maintenance director.</td>
</tr>
</tbody>
</table>
### Summary Statement of Deficiencies

19.2.3.4* Any required aisle, corridor, or ramp shall be not less than 48 in. (1220 mm) in clear width where serving as means of egress from patient sleeping rooms, unless otherwise permitted by one of the following:

1. Aisles, corridors, and ramps in adjunct areas not intended for the housing, treatment, or use of inpatients shall be not less than 44 in. (1120 mm) in clear and unobstructed width.

2. Where corridor width is at least 6 ft (1830 mm), noncontinuous projections not more than 6 in. (150 mm) from the corridor wall, above the handrail height, shall be permitted.

3. Exit access within a room or suite of rooms complying with the requirements of 19.2.5 shall be permitted.

4. Projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met:
   a. The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in. (1525 mm).
   b. The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency.
   c. The wheeled equipment is limited to the following:
      i. Equipment in use and carts in use
      ii. Medical emergency equipment not in use
      iii. Patient lift and transport equipment

5. Where the corridor width is at least 8 ft (2440 mm), projections into the required width shall be permitted for fixed furniture, provided that all of the following conditions are met:
   a. The fixed furniture is securely attached to the floor or to the wall.
   b. The fixed furniture does not reduce the clear width necessary for egress.
K 232 Continued From page 8

unobstructed corridor width to less than 6 ft (1830 mm), except as permitted by 19.2.3.4(2).
(c) The fixed furniture is located only on one side of the corridor.
(d) The fixed furniture is grouped such that each grouping does not exceed an area of 50 ft² (4.6 m²).
(e) The fixed furniture groupings addressed in 19.2.3.4(5)(d) are separated from each other by a distance of at least 10 ft (3050 mm).
(f) *The fixed furniture is located so as to not obstruct access to building service and fire protection equipment.
(g) Corridors throughout the smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the fixed furniture spaces are arranged and located to allow direct supervision by the facility staff from a nurses’ station or similar space.
(h) The smoke compartment is protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.8.

Residents affected: All

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:
20 yard dumpster has been removed to ensure exit discharge is maintained free of obstruction.

How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken:
Facility will audit all exit discharges to ensure adequate egress is
<table>
<thead>
<tr>
<th>ID TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>K 271</td>
<td>Continued From page 9 NFPA 101. Failure to ensure facility exit discharge is maintained free of obstructions that impede clear access to the public way, has the potential to hinder response of personnel in the safe evacuation of residents during an emergency. This deficient practice affected 16 residents, staff and visitors on the date of the survey. Findings include: During the facility tour conducted on 10/31/18 from 1:00 - 4:00 PM observation of the exit discharge that leads southwest from the 300 hall to the public way, revealed a twenty-yard dumpster parked in the ambulance/fire lane, blocking termination at the public way. Actual NFPA standard: 19.2.7 Discharge from Exits. Discharge from exits shall be arranged in accordance with Section 7.7. 7.7 Exit Termination. Exits shall terminate directly, at a public way or at an exterior exit discharge, unless otherwise provided in 7.7.1.2 through 7.7.1.4.</td>
<td>K 271 achievable in accordance with NFPA 101. What measures will be put in to place or what systemic changes will be made to ensure that the deficient practice does not recur: Maintenance director has been in-serviced to the regulation of maintaining exit discharges free of obstruction. In the case of a building restoration project, external contractors will be advised of regulations and staff will work with contractors to develop a plan that does not involve obstructing an exit discharge. How the corrective action will be monitored: Maintenance director will report findings to facility QAPI committee. Who will be responsible to ensure correction(s): Maintenance director.</td>
<td>11/01/2018</td>
</tr>
<tr>
<td>K 291</td>
<td>Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on record review, observation and operational testing, the facility failed to ensure testing for battery powered emergency lighting was conducted in accordance with NFPA 101.</td>
<td>K 291</td>
<td>11/01/19</td>
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Residents affected: All

What corrective action(s) will be accomplished for those residents
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<td>K 291</td>
<td>Continued From page 10</td>
<td>Failure to test emergency lighting for 30 seconds monthly and 90 minutes annually, has the potential to hinder resident evacuation during an emergency. This deficient practice affected 56 residents, staff and visitors on the date of the survey. Findings include: During review of facility maintenance and inspection testing logs conducted on 10/31/18 from 8:45 - 10:00 AM, records were provided for monthly emergency light testing, however the documentation provided for the year 2018, did not indicate any testing had been conducted for the months prior to the survey date. During the facility tour conducted on 10/31/18 from 10:30 AM to 3:00 PM, observation of the corridors revealed the facility was equipped with battery backup emergency exit lighting at each smoke barrier door. Operational testing of the emergency exit light at the door outside the Beauty Salon established the battery for the light was dead. Actual NFPA standard: NFPA 101 19.2 Means of Egress Requirements. 19.2.1 General. Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7, unless otherwise modified by 19.2.2 through 19.2.11. 7.9 Emergency Lighting. 7.9.3 Periodic Testing of Emergency Lighting Equipment.</td>
<td>K 291</td>
<td>found to have been affected by the deficient practice: Exit light at the door outside of the beauty salon will be replaced. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken: Facility will conduct a 90-minute functional test of all battery-backup emergency lighting. What measures will be put in to place or what systemic changes will be made to ensure that the deficient practice does not recur: Maintenance director has been in-serviced on the regulation for a monthly 30 second functional test as well as an annual 90 minute functional test of emergency lighting. Maintenance director will conduct a monthly functional test for 30 seconds monthly, and an annual functional test for 90 minutes on emergency lighting. How the corrective action will be monitored: Maintenance director will report all findings to QAPI committee. Who will be responsible to ensure correction(s):</td>
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(K) 291 Continued From page 11

7.9.3.1.1 Testing of required emergency lighting systems shall be permitted to be conducted as follows:

(1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, except as otherwise permitted by 7.9.3.1.1(2).

(2)*The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction.

(3) Functional testing shall be conducted annually for a minimum of 11.2 hours if the emergency lighting system is battery powered.

(4) The emergency lighting equipment shall be fully operational for the duration of the tests required by 7.9.3.1.1(1) and (3).

(5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction.

(K) 293 Exit Signage

SS=D CFR(s): NFPA 101

Exit Signage

2012 EXISTING

Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1

(Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.)

This REQUIREMENT is not met as evidenced by:

Based on observation and operational testing, the facility failed to ensure that exit signs were maintained in accordance with NFPA 101. Failure to ensure internally illuminated exit signs are operational as designed, has the potential to hinder egress of residents during a fire or other

Residents affected: All

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

Exit sign at the door outside of the beauty salon will be replaced.

How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken:
Facility will audit all exit signage to ensure that they meet requirement in accordance with NFPA 101.

What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur:
Maintenance director has been in-serviced on the regulation for proper exit sign lighting, installation, and directional indication. Maintenance director will audit all exit signs monthly.

How the corrective action will be monitored:
Maintenance director will report all findings to QAPI committee.

Who will be responsible to ensure correction(s):
Maintenance director.

Residents affected: All

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:
<table>
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<tbody>
<tr>
<td>K 325</td>
<td>Continued From page 13 fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room.</td>
</tr>
</tbody>
</table>

- Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30.
- Dispensers are not installed within 1 inch of an ignition source.
- Dispensers over carpeted floors are in sprinklered smoke compartments.
- ABHR does not exceed 95 percent alcohol.
- Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11).
- ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485.

This REQUIREMENT is not met as evidenced by:

Based on record review, observation, and interview, the facility failed to ensure manually operated Alcohol Based Hand Rub Dispensers (ABHR), were maintained in accordance with NFPA 101. Failure to install, test and document operation of ABHR dispensers under manufacturer's recommendations and in accordance with the standard, has the potential of increasing the risk of fires from flammable liquids. This deficient practice affected 56 residents, staff and visitors on the date of the survey.

Findings include:

1) During review of facility maintenance and inspection records conducted on 10/31/18 from approximately 8:30 - 10:30 AM, maintenance records provided for the facility failed to indicate what procedures were performed during the refill process for ABHR dispensers. When interviewed on the ABHR dispenser refilling procedure, the Maintenance Director stated he was not sure what procedure for documentation was necessary.

Facility has created and implemented a program for ABHR dispensers to be functionally tested at time of each refill. Houskepers will maintain a log sheet of inspection to be documented each time the dispenser is refilled. Housekeepers will check the physical integrity of the dispenser, physical integrity of the ABHR container, as well as test the dispenser for proper function.

How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken:

- Facility will conduct a functional test on all ABHR dispensers to ensure proper function.

What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur:

- Maintenance director has been inserviced on the regulation for functional testing of ABHR dispensers at time of refill. Maintenance director will audit dispensers monthly to ensure compliance.

How the corrective action will be monitored:

- Facility has created and implemented a program for ABHR dispensers to be functionally tested at time of each refill. Houskepers will maintain a log sheet of inspection to be documented each time the dispenser is refilled. Housekeepers will check the physical integrity of the dispenser, physical integrity of the ABHR container, as well as test the dispenser for proper function.
## K 325

Continued From page 14

for the testing of ABHR dispensers.

2) During the facility tour conducted on 10/31/18 from 11:00 AM - 3:00 PM, observation of the facility revealed manually activated ABHR dispensers installed throughout the building.

Actual NFPA standard:

NFPA 101

19.3.2.6* Alcohol-Based Hand-Rub Dispensers. Alcohol-based hand-rub dispensers shall be protected in accordance with 8.7.3.1, unless all of the following conditions are met:

1. Where dispensers are installed in a corridor, the corridor shall have a minimum width of 6 ft (1830 mm).
2. The maximum individual dispenser fluid capacity shall be as follows:
   a. 0.32 gal (1.2 L) for dispensers in rooms, corridors, and areas open to corridors
   b. 0.53 gal (2.0 L) for dispensers in suites of rooms

3. Where aerosol containers are used, the maximum capacity of the aerosol dispenser shall be 18 oz. (0.51 kg) and shall be limited to Level 1 aerosols as defined in NFPA30B, Code for the Manufacture and Storage of Aerosol Products.
4. Dispensers shall be separated from each other by horizontal spacing of not less than 48 in. (1220 mm).
5. Not more than an aggregate 10 gal (37.8 L) of alcohol-based hand-rub solution or 1135 oz (32.2 kg) of Level 1 aerosols, or a combination of liquids and Level 1 aerosols not to exceed, in

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>K 325</td>
<td>Maintenance director will report all findings to QAPI committee.</td>
<td>K 325</td>
<td>Maintenance director.</td>
</tr>
</tbody>
</table>

Maintenance director will report all findings to QAPI committee.

Who will be responsible to ensure correction(s):

Maintenance director.
K 325 Continued From page 15

total, the equivalent of 10 gal
(37.8 L) or 1135 oz (32.2 kg), shall be in use
outside of a storage cabinet in a single smoke
compartment, except as otherwise provided in
19.3.2.6(6).

(6) One dispenser complying with 19.3.2.6 (2) or
(3) per room and located in that room shall not be
included in the aggregated quantity addressed in
19.3.2.6(5).

(7) Storage of quantities greater than 5 gal (18.9
L) in a single smoke compartment shall meet the
requirements of NFPA 30, Flammable and
Combustible Liquids Code.

(8) Dispensers shall not be installed in the
following locations:
(a) Above an ignition source within a 1 in. (25
mm) horizontal distance from each side of the
ignition source
(b) To the side of an ignition source within a 1 in.
(25mm) horizontal distance from the ignition
source
(c) Beneath an ignition source within a 1 in. (25
mm) vertical distance from the ignition source

(9) Dispensers installed directly over carpeted
floors shall be permitted only in sprinklered
smoke compartments.

(10) The alcohol-based hand-rub solution shall
not exceed 95 percent alcohol content by volume.

(11) Operation of the dispenser shall comply with
the following criteria:
(a) The dispenser shall not release its contents
except when the dispenser is activated, either
manually or automatically by touch-free
activation.
(b) Any activation of the dispenser shall occur
only when an object is placed within 4 in. (100
mm) of the sensing device.
(c) An object placed within the activation zone
and left in place shall not cause more than one
activation.
### Summary of Deficiencies

(d) The dispenser shall not dispense more solution than the amount required for hand hygiene consistent with label instructions.

(e) The dispenser shall be designed, constructed, and operated in a manner that ensures that accidental or malicious activation of the dispensing device is minimized.

(f) The dispenser shall be tested in accordance with the manufacturer's care and use instructions each time a new refill is installed.

**K 355 Portable Fire Extinguishers**

**SS=DF**

- Portable Fire Extinguishers
- Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers.
- 18.3.5.12, 19.3.5.12, NFPA 10
- This REQUIREMENT is not met as evidenced by:
  - Based on observation, the facility failed to ensure fire extinguishers were installed in accordance with NFPA 10. Failure to install signs for special fire extinguishers in kitchens could hinder staff response during a fire. This deficient practice affected staff and visitors of the main Kitchen on the date of the survey.

Findings include:

- During the facility tour conducted on 10/31/18 from approximately 10:00 AM to 3:30 PM, observation of installed portable fire extinguishers revealed the K-style fire extinguisher was not signed according to its use after activation of the UL 300 hood suppression system.

- Further observation of this sign and the fire-type use placard on the fire extinguisher itself,

### Residents Affected

- **Residents affected:** All

### What Corrective Action(s) will be Accomplished

- **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**
  - Facility has ordered signage to be installed at the area of the k-class extinguisher to indicate usage only after activation of UL300 hood suppression system. Kitchen staff will be in-serviced on this operation. Inaccurate signage that incorrectly identified types of extinguisher usage was removed.

### How the Facility will Identify Other Residents having the Potential to be Affected by the Same Deficient Practice and What Corrective Action(s) will be Taken

- **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken:**
  - Maintenance director will audit the facility to ensure that no additional special fire extinguishers are installed without proper signage and indication.

### What Measures will be Put in place or what Systemic Changes will be implemented

- **What measures will be put in place or what systemic changes will be implemented:**
  - Further correction to be completed.

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*Printed: 11/08/2018*  
*Form Approved*: OMB NO. 0938-0391

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**K 325**

Continued From page 16

- (d) The dispenser shall not dispense more solution than the amount required for hand hygiene consistent with label instructions.
- (e) The dispenser shall be designed, constructed, and operated in a manner that ensures that accidental or malicious activation of the dispensing device is minimized.
- (f) The dispenser shall be tested in accordance with the manufacturer's care and use instructions each time a new refill is installed.

**K 325**

**K 355**

**SS=DF**

- Portable Fire Extinguishers
- Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers.
- 18.3.5.12, 19.3.5.12, NFPA 10
- This REQUIREMENT is not met as evidenced by:
  - Based on observation, the facility failed to ensure fire extinguishers were installed in accordance with NFPA 10. Failure to install signs for special fire extinguishers in kitchens could hinder staff response during a fire. This deficient practice affected staff and visitors of the main Kitchen on the date of the survey.

Findings include:

- During the facility tour conducted on 10/31/18 from approximately 10:00 AM to 3:30 PM, observation of installed portable fire extinguishers revealed the K-style fire extinguisher was not signed according to its use after activation of the UL 300 hood suppression system.

- Further observation of this sign and the fire-type use placard on the fire extinguisher itself,
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:</th>
<th>MULTIPLE CONSTRUCTION</th>
<th>DATE SURVEY COMPLETED</th>
</tr>
</thead>
<tbody>
<tr>
<td>135103</td>
<td>A. BUILDING 01 - ENTIRE BUILDING</td>
<td>11/01/2018</td>
</tr>
</tbody>
</table>

**PRESTIGE CARE & REHABILITATION - THE 01 STREET ADDRESS, CITY, STATE, ZIP CODE**

1014 BURRELL AVENUE
LEWISTON, ID 83501

**SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)**

<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>(X5) COMPLETION DATE</th>
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<tr>
<td>K 355</td>
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</table>

Revealed the extinguisher was only rated for type A (trash, wood, paper) and type K (grease) fires, however the sign mounted above the extinguisher identified the extinguisher was also to be used for Electrical (Type C) and flammable liquids (Type B) fires and did not reference the activation of the fire protection system prior to use of the extinguisher.

Actual NFPA standard:
NFPA 10

5.5.5* Class K Cooking Media Fires. Fire extinguishers provided for the protection of cooking appliances that use combustible cooking media (vegetable or animal oils and fats) shall be listed and labeled for Class K fires.

5.5.5.3* A placard shall be conspicuously placed near the extinguisher that states that the fire protection system shall be actuated prior to using the fire extinguisher.

**PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)**

<table>
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<tr>
<th>ID PREFIX TAG</th>
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</table>

Maintenance director has been in-serviced on the regulation for proper signage and indication of special use extinguishers. Maintenance director will audit signage at K-class extinguisher monthly to ensure compliance.

**RESIDENTS AFFECTED**

All

**WHAT CORRECTIVE ACTION(S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:**

Conduit and metal light switch box in Therapy room closet was repaired to be secured. Extension cord at the window air conditioner in Business office was removed. Oxygen concentrator in room 308 was plugged directly into wall receptacle. Counter...
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>K511</td>
<td>Continued From page 18</td>
<td></td>
<td>accordance with NFPA 70 and equipment listing. Failure to provide safe electrical installations has been historically linked to the increased potential of arc fires. This deficient practice affected 10 residents, staff and visitors on the date of the survey. Findings include: During the facility tour conducted on 10/31/18 from approximately 8:30 AM to 3:30 PM, observation of electrical installations in the facility revealed the following: 1) Observation of the interior of the Therapy room closet was revealed a conduit and metal light switch box installed that was unsecured to a wall or other fixed location of the structure and loosely hanging from the ceiling of the room. Interview of the Maintenance Director revealed he was aware these installations were required to be secured and not loosely hanging. 2) Observation of the Business Office revealed the window air conditioning unit was supplied power from a homemade extension cord. 3) Observation of resident room 308 revealed an oxygen concentrator using a relocatable power tap (RPT) to supply power. 4) Observation of the interior of the clean side of the main Laundry revealed a countertop in front of the electrical shutoff panel, measuring 39 inches deep when measured from the wall and blocking access to the panel. 5) Observation of the dining room on the 200 east hall revealed a RPT plugged into a multiple plug adapter (MPA). in laundry that was installed in front of the electrical panel was removed. Multi-plug adapter in the dining room of the 200 hall was removed. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken: Maintenance director will audit the facility to identify any deficient practices as it relates to electrical safety. Any deficiencies will be promptly corrected. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur: Maintenance director has been in-serviced on electrical safety best practices. Maintenance director will audit facility monthly to ensure compliance with electrical safety standards. How the corrective action will be monitored: Maintenance director will report all findings to QAPI committee. Who will be responsible to ensure correction(s):</td>
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<tr>
<td>ID</td>
<td>PREFIX</td>
<td>TAG</td>
<td>SUMMARY STATEMENT OF DEFICIENCIES</td>
<td>ID</td>
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<td>PROVIDER'S PLAN OF CORRECTION</td>
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<tr>
<td>K 511</td>
<td>Continued From page 19</td>
<td></td>
<td>Actual NFPA standard</td>
<td></td>
<td></td>
<td>Maintenance director.</td>
<td></td>
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</tbody>
</table>
### (X3) DATE SURVEY COMPLETED
11/01/2018

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
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<tbody>
<tr>
<td>K 511</td>
<td>Continued From page 20</td>
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</tr>
</tbody>
</table>

(7) Classification by type, size, voltage, current capacity, and specific use

(8) Other factors that contribute to the practical safeguarding of persons using or likely to come in contact with the equipment

(B) Installation and Use. Listed or labeled equipment shall be installed and used in accordance with any instructions included in the listing or labeling.

110.12 Mechanical Execution of Work. Electrical equipment shall be installed in a neat and workmanlike manner.

(A) Unused Openings. Unused cable or raceway openings in boxes, raceways, auxiliary gutters, cabinets, cutout boxes, meter socket enclosures, equipment cases, or housings shall be effectively closed to afford protection substantially equivalent to the wall of the equipment. Where metallic plugs or plates are used with nonmetallic enclosures, they shall be recessed at least 6 mm (¼ in.) from the outer surface of the enclosure.

(B) Subsurface Enclosures. Conductors shall be racked to provide ready and safe access in underground and subsurface enclosures into which persons enter for installation and maintenance.

(C) Integrity of Electrical Equipment and Connections. Internal parts of electrical equipment, including busbars, wiring terminals, insulators, and other surfaces, shall not be damaged or contaminated by foreign materials such as paint, plaster, cleaners, abrasives, or corrosive residues. There shall be no damaged parts that may adversely affect safe operation or mechanical strength of the equipment such as parts that are broken; bent; cut; or deteriorated by corrosion, chemical action, or overheating.

II. 600 Volts, Nominal, or Less
### Statement of Deficiencies and Plan of Correction

#### (X1) Provider/Supplier/CUA Identification Number:
135103

#### (X2) Multiple Construction
A. Building 01 - Entire Building
B. Wing ________

Printed: 11/08/2018
Form Approved OMB No. 0938-0391

#### (X3) Date Survey Completed
11/01/2018

### Name of Provider or Supplier
Prestige Care & Rehabilitation - The 01
1014 Burrell Avenue
Lewiston, ID 83501

### Summary Statement of Deficiencies

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix TAG</th>
<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</th>
<th>ID Prefix TAG</th>
<th>Provider’s Plan of Correction (Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency)</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>K 511</td>
<td>Continued From page 21</td>
<td>110.26 Spaces About Electrical Equipment. Access and working space shall be provided and maintained about all electrical equipment to permit ready and safe operation and maintenance of such equipment. (A) Working Space. Working space for equipment operating at 600 volts, nominal, or less to ground and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A)(1), (A)(2), and (A)(3) or as required or permitted elsewhere in this Code. (1) Depth of Working Space. The depth of the working space in the direction of live parts shall not be less than that specified in Table 110.26(A)(1) unless the requirements of 110.26(A)(1)(a), (A)(1)(b), or (A)(1)(c) are met. Distances shall be measured from the exposed live parts or from the enclosure or opening if the live parts are enclosed.... Additional Reference: Table 110.26(A)(1) Working Spaces Additional reference: UL 1363 XBYS.GuidInfo Relocatable Power Taps</td>
<td>K 511</td>
<td>Facilities will have fire/smoke dampers tested for functionality.</td>
<td>11/04/19</td>
</tr>
<tr>
<td>K 521</td>
<td>HVAC</td>
<td>Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2</td>
<td>K 521</td>
<td>Maintenance director will ensure that an inspection of all fire/smoke dampers occurs in accordance with NFPA 80.</td>
<td></td>
</tr>
</tbody>
</table>

Residents affected: All

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:
Facility will have fire/smoke dampers tested for functionality.

How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken:
Maintenance director will ensure that an inspection of all fire/smoke dampers occurs in accordance with NFPA 80.
<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>ID</th>
<th>(X5) COMPLETION DATE</th>
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<tbody>
<tr>
<td>K 521</td>
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<td>K 521</td>
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</tbody>
</table>

**Summary Statement of Deficiencies:**

Based on record review, the facility failed to perform maintenance on fire dampers in accordance with NFPA 101 and 90 A. Failure to conduct inspections and maintenance of fire dampers has the potential to allow fire, smoke and dangerous gases to pass between compartments and affect the safety of clients during a fire. This deficient practice affected 56 residents, staff and visitors on the date of the survey.

**Findings Include:**

- During review of the facility inspection and maintenance records conducted on 10/31/18 from 8:45 - 10:30 AM, documentation demonstrating the date of previous inspections and maintenance of fire dampers was not available.

**Actual NFPA Standard:**

- **NFPA 101**
  19.5.2 Heating, Ventilating, and Air-Conditioning.
  19.5.2.1 Heating, ventilating, and air-conditioning shall comply with the provisions of Section 9.2 and shall be installed in accordance with the manufacturer’s specifications, unless otherwise modified by 19.5.2.2.

- **9.2 Heating, Ventilating, and Air-Conditioning.**
  Air-conditioning, heating, ventilating ductwork, and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems, or NFPA 90B, Standard for the Installation of Warm...
### K 521

**Summary Statement of Deficiencies**

<table>
<thead>
<tr>
<th>K 521</th>
<th>Continued From page 23</th>
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</thead>
<tbody>
<tr>
<td><strong>Air Heating and Air-Conditioning Systems, as applicable,</strong> unless such installations are approved existing installations, which shall be permitted to be continued in service.</td>
<td></td>
</tr>
<tr>
<td><strong>NFPA 90A</strong></td>
<td></td>
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<tr>
<td>5.4.8 Maintenance.</td>
<td></td>
</tr>
<tr>
<td>5.4.8.1 Fire dampers and ceiling dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives.</td>
<td></td>
</tr>
<tr>
<td><strong>NFPA 80</strong></td>
<td></td>
</tr>
<tr>
<td>19.4 Periodic Inspection and Testing.</td>
<td></td>
</tr>
<tr>
<td>19.4.1 Each damper shall be tested and inspected 1 year after installation.</td>
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<tr>
<td>19.4.1.1 The test and inspection frequency shall then be every 4 years, except in hospitals, where the frequency shall be every 6 years.</td>
<td></td>
</tr>
</tbody>
</table>

**Residents affected:** All

**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**

Facility elevator has been taken out of service for all use.

**How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken:**

Maintenance director will audit elevator doors at both floors to ensure that they are locked and secured at all times.
<table>
<thead>
<tr>
<th>ID Tag</th>
<th>Summary Statement of Deficiencies</th>
<th>Provider's Plan of Correction</th>
</tr>
</thead>
<tbody>
<tr>
<td>K 531</td>
<td>Continued From page 24 detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure the maintenance of elevator systems was conducted in accordance with NFPA 101 and ASME A17.3. Failure to ensure elevator doors are secured closed when the elevator car is not present on the floor of use, has the potential to allow access to open elevator shafts and the risk of contact with energized equipment or falls. This deficient practice affected staff and visitors in the mechanical/maintenance basement level of the facility on the date of the survey. Findings include: During the facility tour conducted on 10/31/18 from 12:30 - 3:30 PM, observation and operational testing of the outer access door to the freight elevator from the basement level, established the door would not remain secured and locked when the elevator car was stationary on the floor above. Further observation revealed the open door exposed a drop of approximately five feet into the bottom of the open shaft and all related equipment and materials. Asked about the condition of the door and the open shaft, the Maintenance Director stated he was not aware the door would not latch and remain secured when the elevator car was not present on this level. Actual NFPA standard: NFPA 101 19.5.3 Elevators, Escalators, and Conveyors.</td>
<td>What measures will be put in to place or what systemic changes will be made to ensure that the deficient practice does not recur: Staff have been in-serviced to the fact that the elevator is now out of service. Signage at the elevator has been posted indicating “out of service”. How the corrective action will be monitored: Maintenance director will audit elevator access doors weekly to ensure that they remain locked and secured. Signage indicating that the elevator is out of service will also be inspected at this time. Who will be responsible to ensure correction(s): Maintenance director.</td>
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<tr>
<td>K 531</td>
<td>Continued From page 25</td>
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<tr>
<td>Elevators, escalators and conveyors shall comply with the provisions of Section 9.4.</td>
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</table>

9.4.2.2 Except as modified herein, existing elevators, escalators, dumbwaiters, and moving walks shall be in accordance with the requirements of ASME A17.3, Safety Code for Existing Elevators and Escalators.


<table>
<thead>
<tr>
<th>K 712</th>
<th>Fire Drills</th>
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<tbody>
<tr>
<td>CFR(s): NFPA 101</td>
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</tbody>
</table>

Fire Drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.

19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by:

Based on record review and interview, the facility failed to ensure fire drills were conducted in accordance with NFPA 101. Failure to perform fire drills quarterly for each shift has the potential to hinder staff response in the event of a fire. This deficient practice affected 82 residents, staff and visitors on the date of the survey.

Findings include:

1) During review of provided facility maintenance

Residents affected: All

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:
Facility will conduct an extra NOC shift fire drill during the 4th quarter of 2018.

How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken:
Maintenance director will conduct fire drills in accordance with NFPA 101.

What measures will be put in to place or what systemic changes will be made to ensure that the deficient practice does not recur:
Maintenance director has been in-serviced on the regulation of fire drill procedures and frequency. Maintenance director will perform fire drills in accordance with NFPA 101.

How the corrective action will be monitored:
Maintenance director will report all findings to QAPI committee.
records conducted on 10/31/18 from 8:45 - 10:30 AM, no records were provided demonstrating fire drills were performed during the third quarter and the NOC (graveyard shift) in the second quarter of 2018.

2) Interview of the Maintenance Director revealed he was aware of the missing fire drills.

Actual NFPA standard:

19.7* Operating Features.
19.7.1 Evacuation and Relocation Plan and Fire Drills.

19.7.1.6 Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions.

K 754 Soiled Linen and Trash Containers

Soiled Linen and Trash Containers

Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square foot. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended.

Containers used solely for recycling are permitted to be excluded from the above requirements where each container is less than or equal to 96 gallons unless attended, and containers for combustibles are labeled and listed as meeting

Residents affected: All

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:
The 50 gallon bins in the storage closets outside room 303 and 316 were removed.

How the facility will identify other residents having the potential to be affected by the same deficient
K 754  Continued From page 27

FM Approval Standard 6921 or equivalent.
18.7.5.7, 19.7.5.7

This REQUIREMENT is not met as evidenced by:
Based on observation and interview, the facility failed to ensure that highly combustible material was stored in accordance with NFPA 101. Failure to provide protection of hazardous storage such as trash and soiled linens, could result in smoke and dangerous gases passing into corridors and affect the safe egress of residents during a fire. This deficient practice affected 30 residents, staff and visitors in 2 of 8 smoke compartments on the date of the survey.

Findings include:

During the facility tour conducted on 10/31/18 from 1:30 - 3:30 PM, observation of the storage closet outside room 303 and 316, revealed both closets were not constructed as hazardous areas, with 1-hour construction and self-closing doors, and were used for the purpose of storing two (2) 50 gallon bins of soiled linens and one (1) 30 gallon bin of trash.

When asked about the storage arrangements, the Maintenance Director stated he was not aware of the storage requirements for combustible trash and linens.

Actual NFPA standard:

NFPA 101

19.7.5.7 Soiled Linen and Trash Receptacles. 19.7.5.7.1 Soiled linen or trash collection receptacles shall not exceed 32 gal (121 L) in capacity and shall meet all of the following requirements:

practice and what corrective action(s) will be taken:
Maintenance director will audit the facility to ensure that there are no additional storage bins housed inside closets that are not constructed as hazardous areas. Any deficient practices identified will be immediately remedied.

What measures will be put in to place or what systemic changes will be made to ensure that the deficient practice does not recur:
Maintenance director has been inserviced on the regulation for storage of combustible materials and hazardous area construction. Maintenance director will audit, monthly, all storage closets that are not constructed as hazardous areas to ensure that the storage of combustible materials occur.

How the corrective action will be monitored:
Maintenance director will report all findings to QAPI committee.

Who will be responsible to ensure correction(s):
Maintenance director.
<table>
<thead>
<tr>
<th>ID Prefix</th>
<th>Tag</th>
<th>Summary Statement of Deficiencies</th>
<th>ID Prefix</th>
<th>Tag</th>
<th>Provider's Plan of Correction</th>
</tr>
</thead>
<tbody>
<tr>
<td>K 754</td>
<td>Continued From page 28&lt;br&gt;1) The average density of container capacity in a room or space shall not exceed 0.5 gal/ft² (20.4 L/m²).&lt;br&gt;2) A capacity of 32 gal (121 L) shall not be exceeded within any 64 ft² (6 m²) area.&lt;br&gt;3) Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) shall be located in a room protected as a hazardous area when not attended.&lt;br&gt;4) Container size and density shall not be limited in hazardous areas.</td>
<td>K 754</td>
<td>Residents affected: All&lt;br&gt;What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:&lt;br&gt;Facility will conduct a load test on facility standby generator.</td>
<td>K 918</td>
<td>Residents affected: All&lt;br&gt;What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:&lt;br&gt;Facility will conduct a load test on facility standby generator.</td>
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</tbody>
</table>
K 918 Continued From page 29

readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.

6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)

This REQUIREMENT is not met as evidenced by:

Based on record review and interview, the facility failed to ensure the EES (Essential Electrical System) generator was maintained in accordance with NFPA 110. Failure to test for load monthly has the potential of hindering system performance during a power loss or other emergency. This deficient practice affected 56 residents, staff and visitors on the date of the survey.

Findings include:

During review of annual inspection and maintenance records conducted on 10/31/18 from approximately 8:30 - 10:30 AM, records provided for the monthly generator testing revealed one (1) monthly test was documented for the prior year to date of the survey.

When asked, the Maintenance Engineer stated he was not aware of the missing documentation for monthly load testing.

Actual NFPA standard:

NFPA 110

8.4 Operational Inspection and Testing.
8.4.1* EPSSs, including all appurtenant components, shall be inspected weekly and

Maintenance director has been in-serviced on the regulation of maintenance and inspection of emergency generator. Maintenance director will maintain documentation of weekly, monthly, and annual tests and inspections in accordance with NFPA 110.

How the corrective action will be monitored:
Maintenance director will maintain generator testing documentation and report any findings to facility QAPI committee.

Who will be responsible to ensure correction(s):
Maintenance director.
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<th>ID</th>
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<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tbody>
<tr>
<td>K 918</td>
<td>Continued From page 30</td>
<td>exercised under load at least monthly.</td>
<td>K 918</td>
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<tr>
<td>K 923</td>
<td>SS=D</td>
<td>Gas Equipment - Cylinder and Container Storage CFR(s): NFPA 101</td>
<td>K 923</td>
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<td></td>
<td></td>
<td>Greater than or equal to 3,000 cubic feet</td>
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<td>Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3.</td>
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<td>&gt;300 but &lt;3,000 cubic feet</td>
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<td></td>
<td>Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of non-combustible construction having a minimum 1/2 hr. fire protection rating.</td>
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<td>Less than or equal to 300 cubic feet</td>
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<td>In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign reachable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum “CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING.”</td>
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<td></td>
<td>Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)</td>
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Residents affected: All

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:
The facility has relocated the oxygen storage to be housed in an area that is constructed as a hazardous area.

How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken:
Maintenance director will audit the facility to ensure that there is no storage of oxidizing gases outside of the designated area.

What measures will be put in to place or what systemic changes will be made to ensure that the deficient practice does not recur:
Maintenance director will perform weekly audits to ensure that oxygen tanks are stored only within the designated area.

How the corrective action will be monitored:
Maintenance director will report all findings to QAPI committee.
### Summary Statement of Deficiencies

**K 923 Continued From page 31**

This REQUIREMENT is not met as evidenced by:

Based on observation and operational testing, the facility failed to ensure medical gas storage was in accordance with NFPA 99. Failure to store pressurized medical gas cylinders in an area designed and constructed for that purpose, has the potential to expose residents to the risks of fires and explosions without the required life safety protections in place. This deficient practice affected 14 residents, staff and visitors on the date of the survey.

Findings include:

During the facility tour conducted on 10/31/18 from 12:45 - 3:30 PM, observation of a closet located between rooms 317 and 319 revealed it was signed for oxygen storage. Further observation of the space and operational testing of the doors revealed the space was not vented to the exterior of the building by static or mechanical ventilation and the doors into the space were neither rated, or would self-close as required under the 1-hour standard.

Actual NFPA standard:

NFPA 99

5.1.3.3.2 Design and Construction. Locations for central supply systems and the storage of positive-pressure gases shall meet the following requirements:

1. They shall be constructed with access to move cylinders, equipment, and so forth, in and out of the location on hand trucks complying with 11.4.3.1.1.

2. They shall be secured with lockable doors or gates or otherwise secured.

### Provider's Plan of Correction

**Who will be responsible to ensure correction(s):**

Maintenance director
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<td>K 923</td>
<td>Continued From page 32</td>
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<td>(3)</td>
<td>If outdoors, they shall be provided with an enclosure (wall or fencing) constructed of noncombustible materials with a minimum of two entry/exits.</td>
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<td>(4)</td>
<td>If indoors, they shall be constructed and use interior finishes of noncombustible or limited-combustible materials such that all walls, floors, ceilings, and doors are of a minimum 1-hour fire resistance rating.</td>
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<td>(5)</td>
<td>*They shall be compliant with NFPA 70, National Electrical Code, for ordinary locations.</td>
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<td>(6)</td>
<td>They shall be heated by indirect means (e.g., steam, hot water) if heat is required.</td>
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<td>(7)</td>
<td>They shall be provided with racks, chains, or other fastenings to secure all cylinders from falling, whether connected, unconnected, full, or empty.</td>
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<td>(8)</td>
<td>*They shall be supplied with electrical power compliant with the requirements for essential electrical systems as described in Chapter 6.</td>
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<tr>
<td>(9)</td>
<td>They shall have racks, shelves, and supports, where provided, constructed of noncombustible materials or limited-combustible materials.</td>
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<td>(10)</td>
<td>They shall protect electrical devices from physical damage.</td>
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9.3.7 Medical Gas Storage or Transfilling.

9.3.7.5 Indoor storage or manifold areas and storage or manifold buildings for medical gases and cryogenic fluids shall be provided with natural ventilation or mechanical exhaust ventilation in accordance with 9.3.7.5.1 through 9.3.7.8.

9.3.7.5.2 Natural Ventilation.

9.3.7.5.2.1 Natural ventilation shall consist of two nonclosable louvered openings, each having an aggregate free opening area of at least 155 cm²/35 L (24 in²/1000 ft³) of the fluid designed to be stored in the space and in no case less than
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<th>(X4) ID PREFIX TAG</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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</table>
| K 923             | Continued From page 33 466 cm² (72 in²).                                                       | K 923       | Residents affected: All 11/14/19  
What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:  
Facility has implemented policy and procedure for staff training of oxygen safety as it related to handling, transportation and use.

How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken:  
Maintenance director will audit the facility to ensure that no unsafe storage, use, or application of oxygen is occurring. Any deficient practices will be immediately remedied.

What measures will be put in to place or what systemic changes will be made to ensure that the deficient practice does not recur:  
Facility will ensure that all staff are trained, upon hire and at least annually, for safe oxygen use, storage, and transportation.

How the corrective action will be monitored: |
| K 926 SS=E        | Gas Equipment - Qualifications and Training CFR(s): NFPA 101                                     | K 926       | |
|                   | Gas Equipment - Qualifications and Training of Personnel  
Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment.  
11.5.2.1 (NFPA 99)  
This REQUIREMENT is not met as evidenced by:  
Based on record review, and interview, the facility failed to ensure continuing education and staff training was provided on the risks associated with the storage, handling and use of medical gases and their cylinders. Failure to provide training of safety and the risks associated with medical gases, potentially increases risks associated, hindering staff response on the use and handling of oxygen. This deficient practice potentially affected oxygen dependent residents, staff and visitors on the date of the survey.

Findings include:  
During review of provided training records on 10/31/18 from 8:30 - 10:30 AM, records provided did not demonstrate continuing training was performed on an annual basis for the risks associated with oxygen and its use.

Interview of 3 of 3 staff members conducted on 11/1/18 from 9:30 - 11:45 AM, revealed none had participated in a facility provided, continuing... |
**K 926 Continued From page 34**

- Education program, on the risks associated with the storage, handling, or use of medical gases such as oxygen.

**Actual NFPA standard:**

- NFPA 99
- 11.5.2 Gases in Cylinders and Liquefied Gases in Containers.
- 11.5.2.1 Qualification and Training of Personnel.
- 11.5.2.1.1* Personnel concerned with the application and maintenance of medical gases and others who handle medical gases and the cylinders that contain the medical gases shall be trained on the risks associated with their handling and use.
- 11.5.2.1.2 Health care facilities shall provide programs of continuing education for their personnel.
- 11.5.2.1.3 Continuing education programs shall include periodic review of safety guidelines and usage requirements for medical gases and their cylinders.

**K 926**

Administrator will audit employee files monthly to ensure that oxygen safety training has occurred, and documentation is present.

**Who will be responsible to ensure correction(s):**

Administrator.
November 13, 2018

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

Provider#: 135103

RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER

Dear Mr. Farnes:

On November 1, 2018, an Emergency Preparedness 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 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. 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.
Your Plan of Correction (PoC) for the deficiencies must be submitted by November 26, 2018. Failure to submit an acceptable PoC by November 26, 2018, may result in the imposition of civil monetary penalties by December 18, 2018.

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 may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by December 6, 2018, (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 . A change in the seriousness of the deficiencies on December 28, 2018, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by December 6, 2018, includes the following:

    Denial of payment for new admissions effective February 1, 2019.
    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 **May 1, 2019,** 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 **November 1, 2018,** 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 **November 26, 2018**. If your request for informal dispute resolution is received after **November 26, 2018**, 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,

[Signature]

Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosures
<table>
<thead>
<tr>
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<tr>
<td>E 018</td>
<td></td>
<td>Continued From page 7 on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location.</td>
<td>E 018</td>
<td></td>
<td>How the corrective action will be monitored: Results of Emergency management committee meetings will be reported to the facility QAPI team</td>
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<td>*[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.</td>
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<td>Who will be responsible to ensure correction(s): Administrator</td>
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<td>*[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records.</td>
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<td>*[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the facility failed to provide a policy for tracking of staff and sheltered residents during an emergency. Lack of a tracking policy for sheltered staff and residents has the potential to hinder continuity of care and essential services during an emergency. This deficient practice has the potential to affect the 56 residents, staff and visitors in the facility on the date of the survey. Findings include: On 10/31/18 from 2:00 - 4:00 PM, review of</td>
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<td>E 018</td>
<td>Continued From page 8</td>
<td>Provided EOP, failed to demonstrate the facility had in place a system to track the location of on-duty staff and residents sheltered in the facility during an emergency.</td>
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<tr>
<td>E 024</td>
<td>Policies/Procedures-Volunteers and Staffing</td>
<td>[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:]</td>
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<td>E 024</td>
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**SUMMARY STATEMENT OF DEFICIENCIES**

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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<tr>
<td>E 024</td>
<td>Continued From page 9 needs during an emergency. This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the facility failed to develop EOP which addressed the use of volunteers during an emergency. Lack of a plan, policy and procedure specific to the use of volunteers, potentially hinders the facility's ability to provide continuity of care during a disaster. This deficient practice had the potential to affect the 56 residents, staff and visitors in the facility on the date of the survey. Findings include: Review of provided emergency plan, policies and procedures conducted on 10/31/18 from 2:00 - 4:00 PM, failed to demonstrate a plan, policy or procedure for the use of volunteers during an emergency. Reference: 42 CFR 483.73 (b) (6)</td>
<td>The facility has created an emergency management committee. Committee will meet monthly How the corrective action will be monitored: Results of Emergency management committee meetings will be reported to the facility QAPI team Who will be responsible to ensure correction(s): Administrator</td>
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</table>

<p>| E 025 | SS=F (b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:[[For Hospices at §418.113(b), PRFTs at §441.184(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b);] Policies and procedures. | Residents affected: All What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Facility will review agreements with other like facilities for resident transfer in case of evacuation. How the facility will identify other residents having the potential to be |</p>
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<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
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<tr>
<td>E025</td>
<td>Continued From page 10</td>
<td>(7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients.</td>
<td>The emergency management committee will review agreements annually to ensure that each agreement has been reviewed and updated if needed.</td>
<td>Administrator</td>
<td></td>
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</table>

| E025 | | affected by the same deficient practice and what corrective action(s) will be taken: | What measures will be put in to place or what systemic changes will be made to ensure that the deficient practice does not recur: | How the corrective action will be monitored: | Who will be responsible to ensure correction(s): |
| | | The facility has created an emergency management committee. Committee will meet monthly | Results of Emergency management committee meetings will be reported to the facility QAPI team | Administrator |  |

Findings include:

On 10/31/18 from 2:00 - 4:00 PM, review of the EOP, failed to indicate current arrangements with
Residents affected: All

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:
Facility has added a policy and procedure titled "Alternate care sites under 1135 waiver" to the disaster preparedness manual which identifies continuation of care and reimbursement for all residents.

How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken:
Facility will in-service emergency management committee on these new additions to the policies and procedures.

What measures will be put in to place or what systemic changes will
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<tr>
<td>E 026</td>
<td>Continued From page 12</td>
<td>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to document their role under an 1135 waiver as declared by the Secretary and the provisions of care as required under this action if identified by emergency management officials. Failure to plan for alternate means of care and the role under an 1135 waiver has the potential to limit facility options during an emergency. This deficient practice potentially affects reimbursement and continuity of care for the 73 residents, staff and visitors housed on the date of the survey along with the available surge needs of the community during a disaster. Findings include: On 10/31/18 from 2:00 - 4:00 PM, review of the provided EOP, did not demonstrate the role of the facility under the declaration of an 1135 waiver, should that condition be enacted by the Secretary. Interview of the AIT revealed she was not aware the facility had not included any policies or procedures on the role assumed by the facility under an 1135 waiver. Reference: 42 CFR 483.73 (b) (8)</td>
</tr>
<tr>
<td>E 030</td>
<td>Names and Contact Information</td>
<td>[c] The facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:</td>
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</table>

**Residents affected:** All
What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:
Facility will add a call list to the disaster preparedness manual that lists contact information for staff, entities providing services under arrangement, resident's physicians, and any regular volunteers.

How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken:
Facility will in-service emergency management committee on these new additions to the policies and procedures.

What measures will be put in to place or what systemic changes will be made to ensure that the deficient practice does not recur:
The facility has created an emergency management committee. Committee will meet monthly. The emergency management committee will review call list(s) for accuracy.

How the corrective action will be monitored:
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<th>ID</th>
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<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tbody>
<tr>
<td>E 030</td>
<td>Continued From page 14</td>
<td>Results of Emergency management committee meetings will be reported to the facility QAPI team</td>
<td>E 030</td>
<td></td>
<td>Who will be responsible to ensure correction(s): Administrator</td>
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</table>

Based on record review, it was determined the facility failed to document a communication plan which included contact information for resident physicians, other long term care facilities and volunteers. Failure to have a communication plan which includes contact information for those parties assisting in the facility's response and recovery during a disaster, has the potential to hinder both internal and external emergency response efforts. This deficient practice affected 56 residents, staff and visitors on the date of the survey.

Findings include:

On 10/31/18 from 2:00 - 4:00 PM, review of provided EOP, failed to reveal a communication plan that included contact information for resident physicians, long term care facilities and volunteers. Additional review of the page with the...
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:** 135103

**MULTIPLE CONSTRUCTION**

**A. BUILDING**

**B. WING**

**STATE DATE SURVEY COMPLETED:** 11/01/2018

**NAME OF PROVIDER OR SUPPLIER:** PRESTIGE CARE & REHABILITATION - THE 01

**STREET ADDRESS, CITY, STATE, ZIP CODE:** 1014 BURRELL AVENUE, LEWISTON, ID 83501

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<td>E 030</td>
<td>Continued From page 15</td>
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<td>provided information for the facility sister facility in the adjacent state, revealed the documentation area for the facility phone number was left blank.</td>
<td>E 030</td>
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<tr>
<td>E 031</td>
<td>Emergency Officials Contact Information</td>
<td>SS=F</td>
<td>CFR(s): 483.73(c)(2)</td>
<td>E 031</td>
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**Residents affected:** All

**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**

- Facility will add a call list to the disaster preparedness manual that lists local, state, tribal and federal agencies.
- Facility will list a primary and alternate contact for each local, state, tribal and federal agency.

**How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken:**

- Facility will in-service emergency management committee on these new additions to the policies and procedures.

**What measures will be put in to place or what systemic changes will be made to ensure that the deficient practice does not recur:**

- Facility will improve the documentation process to ensure the facility phone number is not left blank. 
  - This REQUIREMENT is not met as evidenced by:
  - Reference:
    - 42 CFR 483.73 (c) (1)
  - (c) The facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:
    - (2) Contact information for the following:
      - (i) Federal, State, tribal, regional, and local emergency preparedness staff.
      - (ii) Other sources of assistance.
  - *(For LTC Facilities at §483.73(c):)* (2) Contact information for the following:
    - (i) Federal, State, tribal, regional, or local emergency preparedness staff.
    - (ii) The State Licensing and Certification Agency.
    - (iii) The Office of the State Long-Term Care Ombudsman.
    - (iv) Other sources of assistance.
  - *(For ICF/IIDs at §483.475(c):)* (2) Contact information for the following:
    - (i) Federal, State, tribal, regional, and local emergency preparedness staff.
    - (ii) Other sources of assistance.
    - (iii) The State Licensing and Certification Agency.
    - (iv) The State Protection and Advocacy Agency.
  - This REQUIREMENT is not met as evidenced by:
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**X1 PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:** 135103

**X2 MULTIPLE CONSTRUCTION**
A. BUILDING
B. WING

**X3 DATE SURVEY COMPLETED:** 11/01/2018

---

**NAME OF PROVIDER OR SUPPLIER:** PRESTIGE CARE & REHABILITATION - THE O
**STREET ADDRESS, CITY, STATE, ZIP CODE:** 1014 BURRELL AVENUE LEWISTON, ID 83501

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**E 031** Continued From page 16

Based on record review, the facility failed to ensure current contact information for emergency management officials and other resources of assistance was provided in the emergency communication plan. Failure to provide information for resources available to the facility has the potential to hinder facility response and continuity of care for the 56 residents, staff and visitors in the facility on the date of the survey.

Findings include:

- On 10/31/18 from 2:00 - 4:00 PM, review of the provided EOP, revealed the failed to include contact information for emergency officials as follows:
  - No phone number(s) for Federal, State, tribal, regional or local emergency preparedness staff.
  - No phone number for the State Licensing and Certification agency.
  - No phone number for the State Long Term Care Ombudsman
  - Other sources of assistance.

**Reference:**
42 CFR 483.73 (c) (2)

**E 034** Information on Occupancy/Needs
**SS=D** CFR(s): 483.73(c)(7)

- [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following:
- (7) [(5) or (6)] A means of providing information about the [facility]'s occupancy, needs, and its ability to provide assistance, to the authority

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**PROVIDER'S PLAN OF CORRECTION**

The facility has created an emergency management committee. Committee will meet monthly. The emergency management committee will review call lists for accuracy and update as needed.

**How the corrective action will be monitored:**
Results of Emergency management committee meetings will be reported to the facility QAPI team

**Who will be responsible to ensure correction(s):**
Administrator

**Residents affected:** All

**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**
Facility will implement a telephone communication policy that identifies a primary and alternate means of
**Summary Statement of Deficiencies**

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<td>E 034</td>
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**Findings include:**

On 10/31/18 from 2:00 - 4:00 PM, review of provided EOP failed to indicate what method the facility would use to share information on its capabilities and abilities to provide assistance when communicating with emergency management officials.

**Reference:**

42 CFR 483.73 (c) (7)

**Provider's Plan of Correction**

Based on record review, the facility failed to provide a communication plan for sharing information on its ability to provide assistance with emergency management officials. Failure to provide a plan to share information with emergency personnel on the facility's abilities to provide assistance during a disaster, has the potential to hinder response assistance and continuation of care for the 56 residents, staff and visitors on the date of the survey.

Communication with local, state, tribal, or federal agencies.

**How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken:**

Facility will in-service emergency management committee on these new additions to the policies and procedures.

**What measures will be put in to place or what systemic changes will be made to ensure that the deficient practice does not recur:**

The facility has created an emergency management committee. Committee will meet monthly.

**How the corrective action will be monitored:**

Results of Emergency management committee meetings will be reported to the facility QAPI team.

**Who will be responsible to ensure correction(s):**

Administrator
### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CUA Identification Number:** 135103

**Multiple Construction:**
- A. Building
- B. Wing

**Date Survey Completed:** 11/01/2018

**Name of Provider or Supplier:** Prestige Care & Rehabilitation - The 01

**Street Address, City, State, Zip Code:** 1014 Burrell Avenue, Lewiston, ID 83501

### Summary Statement of Deficiencies

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<tr>
<td>E036</td>
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</table>
| E036 | EP Training and Testing | | (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.

"[For ICF/IIDs at §483.475(d):]" Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h).

"[For ESRD Facilities at §494.62(d):]" Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually.

### Residents Affected

**Residents affected:** All

**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**

Facility will in-service all staff on disaster preparedness and the disaster preparedness manual annually and upon hire. Staff will complete a post-test after training. Staff will provide training to vendors performing services in the facility under contract. Facility will conduct a full-scale community based exercise annually to test the disaster policies and procedures. Facility will also conduct a second in-house exercise annually to test the disaster policies and procedures.

**How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken:**

Facility will in-service emergency management committee on these new additions to the policies and procedures.

**What measures will be put in to place or what systemic changes will be made:**

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*ORM CMS-2567(02-99) Previous Versions Obsolete*
NAME OF PROVIDER OR SUPPLIER: PRESTIGE CARE & REHABILITATION - THE ONE
STREET ADDRESS, CITY, STATE, ZIP CODE: 1014 BURRELL AVENUE LEWISTON, ID 83501

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<tbody>
<tr>
<td>E 036</td>
<td>Continued From page 19</td>
<td>This REQUIREMENT is not met as evidenced by:</td>
<td>E 036</td>
<td>be made to ensure that the deficient practice does not recur:</td>
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<td>Based on record review and interview, it was determined the facility failed to provide an emergency prep training and testing program. Lack of a facility emergency training and testing program covering the emergency preparedness plan, policies and procedures, has the potential to hinder staff response during a disaster. This deficient practice affected 73 residents, staff and visitors on the date of the survey.</td>
<td></td>
<td>The facility has created an emergency management committee. Committee will meet monthly. Training and post-test will be added to the facility new employee orientation program.</td>
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<td>Findings include:</td>
<td></td>
<td>How the corrective action will be monitored:</td>
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<td>On 10/31/18 from 2:00 - 4:00 PM, review of provided EOP, along with associated inservices, found no documentation demonstrating the facility had a current testing program for staff based on training conducted over the contents of the emergency plan (EP).</td>
<td></td>
<td>The facility has added a task to the TELS program to alert administration when a full scale and in-house exercise is due to ensure that compliance is achieved.</td>
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<td>Interview of 3 of 3 staff members conducted on 11/1/18 from 9:30 - 11:45 AM, established the facility had not yet implemented a testing program for staff on the contents of the EP.</td>
<td></td>
<td>Who will be responsible to ensure correction(s):</td>
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<td></td>
<td>Reference:</td>
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<td>Administrator</td>
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<tr>
<td></td>
<td></td>
<td>42 CFR 483.73 (d)</td>
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Residents affected: All

What corrective action(s) will be accomplished for those residents
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<th>(X4) ID</th>
<th>(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<th>(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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<tbody>
<tr>
<td>E 037</td>
<td>Continued From page 20</td>
<td>E 037</td>
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found to have been affected by the deficient practice:

Facility will in-service all staff on disaster preparedness and the disaster preparedness manual annually and upon hire. Staff will complete a post-test after training. Staff will provide training to vendors performing services in the facility under contract

How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken:

Facility will in-service emergency management committee on these new additions to the policies and procedures.

What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur:

The facility has created an emergency management committee. Committee will meet monthly. Training and post-test will be added to the facility new employee orientation program.

How the corrective action will be monitored:

Administrator will audit employee files to ensure compliance.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:** 135103

**MULTIPLE CONSTRUCTION**

A. BUILDING ______________

B. WING ______________

**DATE SURVEY COMPLETED:** 11/01/2018

---

**NAME OF PROVIDER OR SUPPLIER:** PRESTIGE CARE & REHABILITATION - THE 01

**STREET ADDRESS, CITY, STATE, ZIP CODE:** 1014 BURRELL AVENUE LEWISTON, ID 83501

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**SUMMARY STATEMENT OF DEFICIENCIES**

**(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY, OR LSC IDENTIFYING INFORMATION)**

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<td>E 037</td>
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(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.

(ii) After initial training, provide emergency preparedness training at least annually.

(iii) Demonstrate staff knowledge of emergency procedures.

(iv) Maintain documentation of all emergency preparedness training.

*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:

(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.

(ii) Provide emergency preparedness training at least annually.

(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.

(iv) Maintain documentation of all training.

*[For CORFs at §485.68(d):] (1) Training. The CORF must do all of the following:

(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.

(ii) Provide emergency preparedness training at least annually.

(iii) Maintain documentation of the training.

(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding

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**Who will be responsible to ensure correction(s):**

Administrator

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*CGY921*
### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CUA Identification Number:** 135103  

**Multiple Construction:**
- A. Building __________________
- B. Wing ____________________

**Date Survey Completed:** 11/01/2018

**Name of Provider or Supplier:** Prestige Care & Rehabilitation - The O

**Street Address, City, State, Zip Code:**
- 1014 Burrell Avenue
- Lewiston, ID 83501

### Summary Statement of Deficiencies

**E 037** Continued From page 22

- The CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.

  *For CAHs at § 485.625(d):* (1) Training program. The CAH must do all of the following:
  - (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
  - (ii) Provide emergency preparedness training at least annually.
  - (iii) Maintain documentation of the training.
  - (iv) Demonstrate staff knowledge of emergency procedures.

  *For CMHCs at § 485.920(d):* (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually.

This REQUIREMENT is not met as evidenced by:

- Based on record review and interview, it was determined the facility failed to provide an emergency prep training program. Lack of a...
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER: 135103

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(X3) DATE SURVEY COMPLETED 11/01/2018

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE
PRESTIGE CARE & REHABILITATION - THE OI 1014 BURRELL AVENUE LEWISTON, ID 83501

(X4) ID PREFIX TAG

E 037 Continued From page 23
training program on the EOP for the facility, has the potential to hinder staff response during a disaster. This deficient practice affected 56 residents, staff and visitors on the date of the survey.

Findings include:

On 10/31/18 from 2:00 - 4:00 PM, review of provided EOP and inservices, revealed no substantiating documentation demonstrating the facility had a training program for staff based on the contents of the plan.

Interview of 4 of 4 staff members on 11/1/18 from 9:30 - 11:45 AM revealed no specific training was conducted on the EOP or its contents.

Reference:

42 CFR 483.73 (d) (1)

E 039 EP Testing Requirements

SS=D CFR(s): 483.73(d)(2)

(2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following:

"[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:]"

(i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual,

Residents affected: All

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

Facility will in-service all staff on disaster preparedness and the disaster preparedness manual annually and upon hire. Staff will complete a post-test after training. Staff will provide training to vendors performing...
## Statement of Deficiencies and Plan of Correction

### (X1) Provider/Supplier/CUA Identification Number:
135103

### (X2) Multiple Construction
- A. Building: 
- B. Wing: 

### (X3) Date Survey Completed
11/01/2018

### Name of Provider or Supplier
PRESTIGE CARE & REHABILITATION - THE O

### Street Address, City, State, Zip Code
1014 BURRELL AVENUE
LEWISTON, ID 83501

### Summary Statement of Deficiencies

#### E 039

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- facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event.
- (ii) Conduct an additional exercise that may include, but is not limited to the following:
  - (A) A second full-scale exercise that is community-based or individual.
  - (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
- (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.

* For RNHCIs at §403.748 and OPOs at §486.360 (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following:
  - (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
  - (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.

This REQUIREMENT is not met as evidenced by the certification statement, and if continued will result in a deficiency. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken:

- Facility will conduct a full-scale community based exercise annually to test the disaster policies and procedures. Facility will also conduct a second in-house exercise annually to test the disaster policies and procedures. Facility will create an after action report following each exercise to identify any updates that may be needed to the policies and procedures.

### Provider's Plan of Correction

- Facility will conduct a full-scale community based exercise annually to test the disaster policies and procedures. Facility will also conduct a second in-house exercise annually to test the disaster policies and procedures. Facility will create an after action report following each exercise to identify any updates that may be needed to the policies and procedures.

- How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken:
  - Facility will in-service emergency management committee on these new additions to the policies and procedures.

- What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur:
  - The facility has created an emergency management committee. Committee will meet monthly. Training and post-test will be added to the facility new employee orientation program.
**E 039 Continued From page 25**

Based on record review and interview, it was determined the facility failed to complete two full-scale exercises which tested the EOP and the overall readiness of the facility. Failure to participate in full-scale or tabletop exercise events has the potential to reduce the facility's effectiveness in providing continuity of care to residents during an emergency. This deficient practice affected 56 residents, staff and visitors on the date of the survey.

Findings include:

On 10/31/18 from 2:00 - 4:00 PM, review of provided EOP inservice and training documentation, established only one (1) of two (2) full-scale exercises, testing the effectiveness of the emergency preparedness plan, policies and procedures had been conducted.

Interview of the Administrator, AIT and Maintenance Director, confirmed the facility had yet to complete these exercises.

Reference:

42 CFR 483.73 (d) (1)

Hospital CAH and LTC Emergency Power CFR(s): 483.73(e)

(e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section.

§483.73(e), §405.625(e)

(e) Emergency and standby power systems. The

**How the corrective action will be monitored:**

The facility has added a task to the TELS program to alert administration when a full scale and in-house exercise is due to ensure that compliance is achieved.

**Who will be responsible to ensure correction(s):**

Administrator

**Residents affected:** All

**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**

Facility will conduct a load test of the emergency standby generator. Facility will maintain and inspect generator weekly, monthly and annually according to NFPA 110
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER’S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>E 041</td>
<td>Continued From page 26</td>
<td></td>
<td>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken: Maintenance director has been in-serviced on emergency generator testing and maintenance requirements according to NFPA 110.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur: The facility has ensured that the facility TELS task list includes all required weekly, monthly and annual inspections and maintenance tasks.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>How the corrective action will be monitored: Maintenance director will monitor documentation of all weekly, monthly, and annual generator maintenance and testing to ensure compliance.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Who will be responsible to ensure correction(s): Maintenance director</td>
</tr>
</tbody>
</table>

How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken:

Maintenance director has been in-serviced on emergency generator testing and maintenance requirements according to NFPA 110.

What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur:

The facility has ensured that the facility TELS task list includes all required weekly, monthly and annual inspections and maintenance tasks.

How the corrective action will be monitored:

Maintenance director will monitor documentation of all weekly, monthly, and annual generator maintenance and testing to ensure compliance.

Who will be responsible to ensure correction(s):

Maintenance director

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The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the standards from the OMB.
### Statement of Deficiencies and Plan of Correction

<table>
<thead>
<tr>
<th>(X1) Provider/Supplier/CUA Identification Number:</th>
<th>(X2) Multiple Construction</th>
<th>(X3) Date Survey Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>135103</td>
<td></td>
<td>11/01/2018</td>
</tr>
</tbody>
</table>

**Name of Provider or Supplier:** Prestige Care & Rehabilitation - The Oi  
**Street Address, City, State, Zip Code:** 1014 Burrell Avenue, Lewiston, ID 83501

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix Tag</th>
<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</th>
<th>ID</th>
<th>Prefix Tag</th>
<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency)</th>
<th>Completion Date</th>
</tr>
</thead>
</table>
| E 041  |             | Continued From page 27 material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes.  
(ii) Technical Interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011.  
(iii) TIA 12-3 to NFPA 99, issued August 9, 2012.  
(iv) TIA 12-4 to NFPA 99, issued March 7, 2013.  
(v) TIA 12-5 to NFPA 99, issued August 1, 2013.  
(vi) TIA 12-6 to NFPA 99, issued March 3, 2014.  
(viii) TIA 12-1 to NFPA 101, issued August 11, 2011.  
(x) TIA 12-3 to NFPA 101, issued October 22, 2013.  
(xi) TIA 12-4 to NFPA 101, issued October 22, 2013.  
(xii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009. This REQUIREMENT is not met as evidenced by: | E 041  |             |                                                                 |
Based on record review, the facility failed to ensure the emergency and standby power systems were maintained and provided subsistence as required under the rule. Failure to ensure emergency generators are maintained and tested in accordance with NFPA 99 and NFPA 110, hinders the facility ability to provide continuity of care during an emergency to the 56 residents, staff and visitors on the date of the survey.

Findings include:

During review of the facility maintenance and inspection records and facility emergency plan, policies and procedures conducted on 10/31/18 from 11:00 AM - 4:00 PM, records provided for the emergency generators revealed missing documentation for monthly load testing in accordance with NFPA 110 (Reference K-918 on CMS 2567).

Reference:

42 CFR 483.73 (e) (1)

Additional reference CMS 2567 K-tag 918