



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

C.L. "BUTCH" OTTER – Governor  
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N., R.H.I.T., Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0009  
PHONE 208-334-6626  
FAX 208-364-1888

**CERTIFIED MAIL: 7012 1010 0002 0836 4087**

July 17, 2014

Gary Liesner, Administrator  
Ivy Court  
2200 Ironwood Place  
Coeur D'Alene, ID 83814-2610

Provider #: 135053

**RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER  
LETTER**

Dear Mr. Liesner:

On **July 9, 2014**, a Facility Fire Safety and Construction survey was conducted at **Ivy Court** 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 and a similar State Form 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

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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 both Statement of Deficiencies and Plan of Correction, Form CMS-2567 and State Form, in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **July 30, 2014**. Failure to submit an acceptable PoC by **July 30, 2014**, may result in the imposition of civil monetary penalties by **August 19, 2014**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.
- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567 and the state licensure survey report, State Form.

All references to federal regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **August 13, 2014**, (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 **August 13, 2014**. A change in the seriousness of the deficiencies on **August 13, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by

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**August 13, 2014**, includes the following:

Denial of payment for new admissions effective **October 9, 2014**.  
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 **January 9, 2015**, if substantial compliance is not achieved by that time.

**Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.**

If you believe these deficiencies have been corrected, you may contact Mark P. Grimes, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **July 9, 2014**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFa>

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[ilities/tabid/434/Default.aspx](#)

Go to the middle of the page to Information Letters section and click on State and select the following:

BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process  
2001-10 IDR Request Form

This request must be received by **July 30, 2014**. If your request for informal dispute resolution is received after **July 30, 2014**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,



Mark P. Grimes, Supervisor  
Facility Fire Safety and Construction

MPG/lj  
Enclosures

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

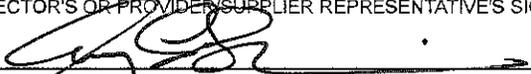
Printed: 07/16/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135053</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b> - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/09/2014</b>
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NAME OF PROVIDER OR SUPPLIER <b>IVY COURT</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2200 IRONWOOD PLACE COEUR D'ALENE, ID 83814</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	<p><b>INITIAL COMMENTS</b></p> <p>The facility is a single story, Type V (111) construction with a complete automatic fire extinguishment and fire alarm system. Smoke detection covers the corridors and open areas. The facility was built in 1973 and is currently licensed for 80 SNF/NF beds.</p> <p>The following deficiencies were cited at the above facility during the annual fire/life safety code survey conducted on July 9, 2014. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, and in accordance with 42 CFR 483.70</p> <p>The survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	K 000	<p>Submission of this plan of correction does not constitute an admission by the provider of any fact or conclusion set forth in this statement of deficiency. This plan of correction is being submitted because it is required by law.</p>	
K 012 SS=F	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that smoke and fire barrier continuity was maintained properly. Failure to ensure that compartment barriers are maintained would allow smoke and dangerous gases to pass freely between compartments compromising egress. This deficient practice affected 78 residents, staff and visitors in 2 of 2 smoke compartments on the date of the survey. The facility is licensed for 80 SNF/NF beds and had a</p>	K 012	<p style="text-align: center;"><b>RECEIVED</b> <b>JUL 30 2014</b> <b>FACILITY STANDARDS</b></p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>NHA</b>	(X6) DATE <b>7/29/14</b>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 012	<p>Continued From page 1 census of 78 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on July 9, 2014 between 9:15 AM and 11:30 AM, observation of the sprinkler system ceiling escutcheons revealed that these integral components were missing from the dining hall closet, resident room 63 and Social Services Director office. It was further observed that the escutcheons in resident room 35 and a second escutcheon in the Social Services Director's office had dropped below the ceiling by approximately 1 inch. When asked, the Maintenance Director stated he was not aware any of the escutcheons were missing or had been dislodged.</p> <p>Actual NFPA standard: NFPA 101 8.2.3.2.4.2* Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows: (1) The space between the penetrating item and the fire barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire</p>	K 012	<p>It is the policy of Ivy Court to ensure sprinkler escutcheons are in place and secure.</p> <p>To enhance currently compliant operations and under the direction of the administrator, our fire service vendor will replace and repair cited escutcheons.</p> <p>Although all residents, staff and visitors are potentially affected by the cited practice; no adverse effects have been noted. An audit of all center sprinkler heads has revealed no other missing or dislodged escutcheons. To ensure ongoing compliance, the maintenance director will complete monthly audits. Any deficiencies will be corrected immediately, and the findings of the audits will be submitted at the QUAPI committee meetings for further review or corrective action.</p>	8/11

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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K 012	Continued From page 2 barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (3) * Insulation and coverings for pipes and ducts shall not pass through the fire barrier unless one of the following conditions is met: a. The material shall be capable of maintaining the fire resistance of the fire barrier. b. The material shall be protected by an approved device that is designed for the specific purpose. (4) Where designs take transmission of vibration into consideration, any vibration isolation shall meet one of the following conditions: a. It shall be made on either side of the fire barrier. b. It shall be made by an approved device that is designed for the specific purpose. 8.2.4.4.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through smoke partitions shall be protected as follows: (1) The space between the penetrating item and the smoke partition shall meet one of the following conditions: a. It shall be filled with a material that is capable of limiting the transfer of smoke. b. It shall be protected by an approved device that is designed for the specific purpose. (2) Where the penetrating item uses a sleeve to penetrate the smoke partition, the sleeve shall be solidly set in the smoke partition, and the space between the item and the sleeve shall meet one of the following conditions: a. It shall be filled with a material that is capable of limiting the transfer of smoke. b. It shall be protected by an approved device that is designed for the specific purpose. (3) Where designs take transmission of	K 012		



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K 018	Continued From page 4 residents in the north wing, staff and visitors in 1 of 2 smoke compartments on the date of the survey. The facility is licensed for 80 SNF/NF beds and had a census of 78 on the day of the survey.  Findings include:  During the facility tour conducted on July 9, 2014 between 9:30 AM and 11:30 AM, operational testing of doors to resident room numbers 30, 33, 35 and 63 revealed they would not close and latch. Interview of the Maintenance Director revealed he was aware resident room doors needed to close and latch.  Actual NFPA standard:  NFPA 101 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.2. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: Existing roller latches demonstrated to keep the door closed against a force of 5 lbf (22 N) shall be permitted to be kept in service.	K 018		
K 022 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Access to exits is marked by approved, readily	K 022		

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K 022	<p>Continued From page 5</p> <p>visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that exit signage clearly identified the exits to the facility. Failure to ensure exits are clearly identified would hinder egress during an emergency. This deficient practice affected 7 residents, 5 staff and visitors in the physical therapy wing of the facility on the date of the survey. The facility is licensed for 80 SNF/NF beds and had a census of 78 on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on July 9, 2014 between 10:00 AM and 11:00 AM, observation of the exit sign from the physical therapy wing leading into the north corridor of the main facility indicated egress was accomplished by turning into the walls rather than the exit access as designed and listed on the facility evacuation plan. Interview of the Maintenance Director indicated that he was not aware this sign was not correctly oriented.</p> <p>Actual NFPA standard: NFPA 101</p>	K 022	<p>It is the policy of Ivy Court to ensure exit signs are present and appropriate.</p> <p>To enhance currently compliant operations and under the direction of the administrator, the arrows pointing from the exit sign have been removed.</p> <p>Although all residents, staff and visitors are potentially affected by the cited practice; no adverse effects have been noted. An audit of all center exit signs reveals no other exit signs providing inaccurate orientation. To ensure ongoing compliance, the maintenance director will ensure any newly placed exit signs clearly identify exits to the center.. Any deficiencies will be corrected immediately, and the findings of the audits will be submitted at the QUAPI committee meetings for further review or corrective action.</p>	8/11

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K 022	Continued From page 6 <b>7.10 MARKING OF MEANS OF EGRESS</b> 7.10.1.4* Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. Sign placement shall be such that no point in an exit access corridor is in excess of 100 ft (30 m) from the nearest externally illuminated sign and is not in excess of the marked rating for internally illuminated signs. Exception: Signs in exit access corridors in existing buildings shall not be required to meet the placement distance requirements.	K 022		
K 027 SS=F	<b>NFPA 101 LIFE SAFETY CODE STANDARD</b> Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7  This Standard is not met as evidenced by: Based on observation and operational testing, the facility failed to ensure smoke barrier doors would close when activated by the smoke detection system. Failure to ensure that smoke compartment doors close completely would allow the passage of smoke and dangerous gases to travel freely and negate the opportunity to defend in place. This deficient practice affected 78 residents, staff and visitors in 2 of 2 smoke compartments on the date of the survey. The	K 027	It is the policy of Ivy Court to provide corridor doors that have no impediment to closing.  To enhance currently compliant operations and under the direction of the administrator, the doors cited during the survey (main smoke barrier doors) have been repaired and now close completely.  All smoke compartments are potentially affected by the cited deficiency. All smoke barrier doors have been checked and all now close completely. The administrator will complete facility rounds weekly for 30 days then twice monthly for 60 days to ensure all compartment doors close completely. Any future deficiencies will be corrected immediately, and the findings of the audits will be submitted at the QUAPI committee meetings for further review or correction.	8/11

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K 027	Continued From page 7 facility is licensed for 80 SNF/NF beds and had a census of 78 on the day of the survey.  Findings include:  During the facility tour conducted on July 9, 2014 between 10:30 AM and 11:30 AM, operational testing demonstrated the main smoke barrier doors located outside the Director of Nursing's office would not close when activated and left an approximate 2-1/2" gap between the facing edge of the doors. This finding was acknowledged by the Maintenance Director.  Actual NFPA standard:  NFPA 101 19.3.7.6* Doors in smoke barriers shall comply with 8.3.4 and shall be self-closing or automatic-closing in accordance with 19.2.2.2.6. Such doors in smoke barriers shall not be required to swing with egress travel. Positive latching hardware shall not be required.	K 027		
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  One hour fire rated construction (with 3/4 hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1	K 029		

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K 029	<p>Continued From page 8</p> <p>This Standard is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure that hazardous areas were protected with doors which would self-close and latch. Failure to ensure hazardous areas are protected with self-closing doors would allow smoke and dangerous gases to pass freely between compartments compromising egress. This deficient practice affected 78 residents, staff and visitors in 2 of 2 smoke compartments on the date of the survey. The facility is licensed for 80 SNF/NF beds and had a census of 78 on the day of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on July 9, 2014 between 9:15 AM and 11:30 AM, observation and operational testing of the door into the Dietary Service Manager's office and storage area from the corridor revealed it would not self-close. Further investigation of this area demonstrated the room contained more than 50 sf of combustible storage.</p> <p>2) During the facility tour conducted on July 9, 2014 between 9:15 AM and 11:30 AM, observation and operational testing of the door into the Laundry from the corridor found it was obstructed by a laundry cart and would not self-close when activated.</p> <p>3) During the facility tour conducted on July 9, 2014 between 9:15 AM and 11:30 AM, observation and operational testing of the door into the Medical Records/Activities room from the main dining hall revealed it would not self-close. Further investigation revealed the self-closure had been removed. When asked, the Maintenance Director stated that the closure had been removed when the Medical Records room</p>	K 029	<p>It is the policy of Ivy Court to provide self-closure doors to hazardous areas.</p> <p>To enhance currently compliant operations and under the direction of the administrator, the doors cited during the survey (DSM office and medical records/activities) have had self-closing devices installed. The laundry staff have been re-educated that blocking open a self-closing door is not allowed.</p> <p>All residents are potentially affected by the cited deficiency. An audit was completed and no other areas of the center, not equipped with self-closing doors, were found to meet the definition of a hazardous area. The maintenance supervisor will audit the center monthly to ensure that no hazardous areas exist without self-closing doors. The laundry supervisor will audit the laundry room doors 5 days/week x 4 weeks, the weekly x 8 weeks to ensure the self-closing doors are not blocked. Any future deficiencies will be corrected immediately, and the findings of the audits will be submitted at the QUAPI committee meetings for further review or correction.</p>	8/11

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NAME OF PROVIDER OR SUPPLIER <b>IVY COURT</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2200 IRONWOOD PLACE COEUR D'ALENE, ID 83814</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	<p>Continued From page 9 began being shared as an Activities room.</p> <p>Actual NFPA standard:</p> <p>NFPA 101            19.3.2 Protection from Hazards.            19.3.2.1 Hazardous Areas.            Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:</p> <ol style="list-style-type: none"> <li>(1) Boiler and fuel-fired heater rooms</li> <li>(2) Central/bulk laundries larger than 100 ft2 (9.3 m2)</li> <li>(3) Paint shops</li> <li>(4) Repair shops</li> <li>(5) Soiled linen rooms</li> <li>(6) Trash collection rooms</li> <li>(7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction</li> <li>(8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard.</li> </ol> <p>Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door</p>	K 029		
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 072		

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K 072	<p>Continued From page 10</p> <p>Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10</p> <p>This Standard is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure that means of egress were free from impediments or obstructions. Failure to ensure egress is kept clear of obstructions or impediments would prevent the safe evacuation of occupants during an emergency. This deficient practice affected no residents, staff and visitors in 1 of 2 smoke compartments on the date of the survey. The facility is licensed for 80 SNF/NF beds and had a census of 78 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on July 9, 2014 between 9:45 AM and 10:30 AM, observation and operational testing of the door leading from the employee break room to the courtyard located on the southeast portion of the facility revealed a window style air conditioning unit had been mounted into the lower portion of the exterior door. When tested, the door would not open fully and only provided approximately eighteen inches of clear width. Further investigation revealed this door was shown as a means of egress from the room on the evacuation plan. When asked, the Maintenance Director stated the unit had been installed in the door since he started with the facility.</p>	K 072	<p>It is the policy of Ivy Court to ensure means of egress are unobstructed.</p> <p>To enhance currently compliant operations and under the direction of the administrator, the break room door has been posted with a "No Exit" sign. The Wanderguard alarm system around the door has been removed.</p> <p>Although all staff are potentially affected by the cited practice; no adverse effects have been noted. A center audit reveals all other means of egress are unobstructed. To ensure ongoing compliance, the maintenance director will perform audits weekly for 3 months to ensure means of egress remain unobstructed. Any deficiencies will be corrected immediately, and the findings of the audits will be submitted at the QUAPI committee meetings for further review or corrective action.</p>	8/11

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K 072	Continued From page 11  Actual NFPA standard:  NFPA 101 7.1.10 Means of Egress Reliability. 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K 072		
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2  This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure electrical equipment was maintained free of obstacles and accessible at all times. Failure to provide sufficient accessible working space in front of electrical panels would hinder access in emergencies and impede safe operations. This deficient practice affected 24 residents, staff and visitors in 1 of 2 smoke compartments on the date of the survey. The facility is licensed for 80 SNF/NF beds and had a census of 78 on the day of the survey.  Findings include:  During the facility tour conducted on July 9, 2014 between 10:00 AM and 10:30 AM, observation of the electrical panel closet located inside the Bistro/Lounge area revealed the electrical main was blocked by a folding table and cleaning equipment. When asked, the Maintenance Director stated he was not aware this area was being used for this storage.	K 147	It is the policy of Ivy Court to ensure electrical panels are unobstructed.  To enhance currently compliant operations and under the direction of the administrator, the area around the electrical panel in the bistro closet has been freed of obstacles and is accessible at all times. Staff were re-educated on keeping electrical panels free from obstruction.  Although all residents may be affected if electrical panels are obstructed, an audit revealed that no other panels within the center were obstructed. To ensure ongoing compliance, the maintenance director will perform audits weekly for 3 months to ensure all electrical panels remain unobstructed. Any deficiencies will be corrected immediately, and the findings of the audits will be submitted at the QAPI committee meetings for further review or corrective action.	8/11

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K 147	Continued From page 12  Actual NFPA Standard: NFPA 70 110.26 Spaces About Electrical Equipment. Sufficient access and working space shall be provided and maintained about all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons. (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), (2), and (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), (b), or (c) are met. Distances shall be measured from the exposed live parts or from the enclosure or opening if the live parts are enclosed.	K 147		

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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2.</p> <p>The facility is a single story, Type V (111) construction with a complete automatic fire extinguishment and fire alarm system. Smoke detection covers the corridors and open areas. The facility was built in 1973 and is currently licensed for 80 SNF/NF beds.</p> <p>The following deficiencies were cited at the above facility during the annual fire/life safety code survey conducted on July 9, 2014. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, in accordance with 42 CFR 483.70 and IDAPA 16.03.02, Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities.</p> <p>The survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	C 000	<p><b>RECEIVED</b> <b>JUL 30 2014</b> <b>FACILITY STANDARDS</b></p>	
C 226	<p>02.106 FIRE AND LIFE SAFETY</p> <p>106. FIRE AND LIFE SAFETY. Buildings on the premises used as facilities shall meet all the requirements of local, state and national codes concerning fire and life safety standards that are applicable to health care facilities.</p> <p>This Rule is not met as evidenced by: Please refer to federal form 2567 following "K"</p>	C 226		

Idaho form

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE



**NHA**

**7/30/14**

Bureau of Facility Standards

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C 226	Continued From Page 1  tags:  K012 Penetrations K018 Corridor doors K022 Exit signage K027 Smoke Barrier Doors K029 Hazardous Areas K072 Obstructed Egress K147 Electrical	C 226	<i>see 7 tags</i>	<i>8/11</i>