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 4063**

July 17, 2014

Bryan Lindsay, Administrator
Life Care Center of Coeur d'Alene
500 West Aqua Avenue
Coeur d'Alene, ID 83815-7764

Provider #: 135122

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

Dear Mr. Lindsay:

On **July 9, 2014**, a Facility Fire Safety and Construction survey was conducted at **Life Care Center of Coeur d'Alene** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies 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

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

**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

cilities/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

Printed: 07/17/2014
FORM APPROVED
OMB NO. 0938-0391

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 135122 | | 07/09/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LIFE CARE CENTER OF COEUR D'ALENE | 500 WEST AQUA AVENUE<br>COEUR D ALENE, ID 83815 |

| (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 000 | INITIAL COMMENTS<br><br>The facility is a Type V ( 111 ) construction with a 94,000 square foot building that is fully sprinklered with smoke detection coverage including resident sleeping rooms. The building was built in 1995-96 and currently licensed for 120 SNF beds.<br><br>The following deficiencies were cited during the annual fire/life safety survey conducted on July 9, 2014. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.<br><br>The Survey was conducted by:<br><br>Sam Burbank<br>Health Facility Surveyor<br>Facility Fire Safety and Construction | K 000 | This plan of correction is submitted as required under Federal and State regulations and statutes applicable to long term care providers. This plan of correction does not constitute an admission of liability on the part of the facility and, such liability is hereby specifically denied. The submission of the plan does not constitute agreement by the facility that the surveyor's findings and/or conclusions are accurate, that the findings constitute a deficiency or that the scope and severity regarding any of the deficiencies cited are correctly applied. | 8-6-14 |
| K 018<br>SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3<br><br>Roller latches are prohibited by CMS regulations in all health care facilities. | K 018 | RECEIVED<br>JUL 30 2014<br>FACILITY STANDARDS | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Ryan Lindsay | Executive Director | 7-30-14 |

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.

Printed: 07/17/2014
FORM APPROVED
OMB NO. 0938-0391

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 135122 | | 07/09/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LIFE CARE CENTER OF COEUR D'ALENE | 500 WEST AQUA AVENUE<br>COEUR D ALENE, ID 83815 |

| (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 018 | Continued From page 1<br><br>This Standard is not met as evidenced by:<br>Based on observation and operational testing, the facility failed to ensure resident room doors positively latched when closed. Failure to ensure corridor/room doors close completely would allow smoke and dangerous gases to pass freely unhindered and compromise egress during a fire event. This deficient practice affected 4 residents, staff and visitors in 1 of 8 smoke compartments on the date of the survey. The facility is licensed for 120 SNF/NF beds and had a census of 80 on the day of the survey.<br><br>Findings include:<br><br>During the facility tour conducted on July 9, 2014 from 1:00 PM to 4:00 PM, observation and operational testing of resident room doors 309 and 319 demonstrated to the surveyor and the Maintenance Director the doors would not fully close and latch without substantial effort. Further investigation demonstrated that both doors were dragging on the frame and threshold.<br><br>Actual NFPA standard:<br><br>19.3.6.3 Corridor Doors.<br>19.3.6.3.1*<br>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. | K 018 | **K018**<br><br>SPECIFIC DEFICIENCY<br>Resident room doors 309 and 319 did not fully close without substantial effort. The impediments of these doors were modified on 7/11/14 to ensure proper closure without substantial effort<br><br>OTHER RESIDENTS AFFECTED<br>Audit of all other resident room doors in the facility were completed and no other doors needed any substantial effort to stay closed.<br><br>SYSTEMIC CHANGES<br>Continued monitoring through facility Preventive Maintenance Program of resident room doors to assess proper ability to close and shut without substantial effort.<br><br>MONITOR<br>Maintenance director or designee will audit resident room doors weekly x 4 weeks then monthly x 3. Audits will begin 8/6/14. ED will bring audits to CQI to report on findings.<br><br>DATE OF COMPLIANCE: 8/6/14 | |

Printed: 07/17/2014
FORM APPROVED
OMB NO. 0938-0391

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 135122 | A. BUILDING 01 - ENTIRE BUILDING<br>B. WING | 07/09/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LIFE CARE CENTER OF COEUR D'ALENE | 500 WEST AQUA AVENUE<br>COEUR D ALENE, ID 83815 |

| (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 018 | Continued From page 2<br>Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors.<br>Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.<br>Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. | K 018 | | |
| K 029<br>SS=F | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>One hour fire rated construction (with ¾ 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<br><br>This Standard is not met as evidenced by:<br>Based on observation, operational testing and interview, the facility failed to ensure hazardous areas were protected by doors which would self-close and latch. Failure to ensure the protection of hazardous areas would allow smoke and dangerous gases to pass freely into corridors | K 029 | **K029**<br><br>SPECIFIC DEFICIENCY<br>1.The doors leading into the dining room were remedied on 7/11/14 and now are able to close on their own.<br>2. The tape on the latch strip plates was removed on 7/11/14.<br><br>OTHER RESIDENTS AFFECTED<br>1.Audit of all other automatic closing fire doors in the facility were completed and no other doors needed adjustment.<br>2. No other areas were found to have tape over the latches. | |

Printed: 07/17/2014
FORM APPROVED
OMB NO. 0938-0391

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 135122 | | 07/09/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LIFE CARE CENTER OF COEUR D'ALENE | 500 WEST AQUA AVENUE<br>COEUR D ALENE, ID 83815 |

| (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 | Continued From page 3<br>compromising egress during a fire event. This deficient practice affected all residents, staff and visitors occupying the dining room, activity room abutting the 200 wing, admissions area, 19 residents, staff and visitors in 2 of 8 smoke compartments on the date of the survey. The facility is licensed for 120 SNF/NF beds and had a census of 80 on the day of the survey.<br><br>Findings include:<br><br>1) During the facility tour conducted on July 9, 2014 from 1:00 PM to 4:00 PM, observation and operational testing of the two doors leading from the main dining hall into the kitchen revealed they would not close. Testing of the first door leading into the kitchen found it to stop approximately 2 to 3 inches from completely closing. Testing of the second door found that once activated, it would stop twelve to eighteen inches from closing. Further testing revealed that the first door would force the second door open when activated. When interviewed, the Maintenance Director stated he was aware that these doors were required to self-close.<br>2) During the facility tour conducted on July 9, 2014 from 1:00 PM to 4:00 PM, observation of the doors from the corridor into the electrical room and the corridor into the adjacent janitor's closet in the 300 wing revealed that the latch strike plates had been taped over. Further investigation of these rooms revealed they both contained over 50 sf of combustible storage. When interviewed, the Maintenance Director stated the strike plates had been taped by painters working in the facility.<br><br>Actual NFPA standard:<br><br>NFPA 101 | K 029 | SYSTEMIC CHANGES<br>1.Continued monitoring through facility Preventive Maintenance Program of automatic closing fire doors to assess proper ability to close independently.<br>2. Any contractors who work will have their work area inspected after they leave to ensure no obstructions are left that would prevent automatic closing of doors.<br><br>MONITOR<br>Maintenance director or designee will audit fire doors and latches weekly x 4 weeks then monthly x 3. Audits will begin 8/6/14. ED will bring audits to CQI to report on findings.<br><br>DATE OF COMPLIANCE: 8/6/14 | |

Printed: 07/17/2014
FORM APPROVED
OMB NO. 0938-0391

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 135122 | | 07/09/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LIFE CARE CENTER OF COEUR D'ALENE | 500 WEST AQUA AVENUE<br>COEUR D ALENE, ID 83815 |

| (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 | Continued From page 4<br>3.3.13.2 Area, Hazardous.<br>An area of a structure or building that poses a degree of hazard greater than that normal to the general occupancy of the building or structure, such as areas used for the storage or use of combustibles or flammables; toxic, noxious, or corrosive materials; or heat-producing appliances.<br>19.3.2 Protection from Hazards.<br>19.3.2.1 Hazardous Areas.<br>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:<br>(1) Boiler and fuel-fired heater rooms<br>(2) Central/bulk laundries larger than 100 ft2 (9.3 m2)<br>(3) Paint shops<br>(4) Repair shops<br>(5) Soiled linen rooms<br>(6) Trash collection rooms<br>(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<br>(8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard.<br>Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more | K 029 | | |

Printed: 07/17/2014
FORM APPROVED
OMB NO. 0938-0391

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 135122 | | 07/09/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LIFE CARE CENTER OF COEUR D'ALENE | 500 WEST AQUA AVENUE<br>COEUR D ALENE, ID 83815 |

| (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 | Continued From page 5<br>than 48 in. (122 cm) above the bottom of the door. | K 029 | | |
| K 064<br>SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10<br><br>This Standard is not met as evidenced by:<br>Based on observation and interview, the facility failed to ensure "K" type fire extinguisher signs were properly located. Failure to properly locate signage for "K" type fire extinguishers would result in confusion for adequate suppression during a fire event. This deficient practice affected staff and visitors to the main kitchen on the date of the survey. The facility is licensed for 120 SNF/NF beds and had a census of 80 on the day of the survey.<br><br>Findings include:<br><br>During the facility tour conducted on July 9, 2014 from 1:00 PM to 4:00 PM, observation of the placard for the "K" type fire extinguisher in the main kitchen found it to be inconspicuously placed on the adjacent wall and above a fire blanket. When asked about this location, the Maintenance Director stated the extinguisher had been relocated and the placard had not been moved with the extinguisher.<br><br>Actual NFPA standard:<br><br>NFPA 10<br>2-3.2* | K 064 | **K064**<br><br>SPECIFIC DEFICIENCY<br>A new sign was ordered to accompany the "K" type extinguisher and placed next to the extinguisher in the kitchen on 8/6/14.<br><br>OTHER RESIDENTS<br>No other "K" type fire extinguishers are found in the facility.<br><br>SYSTEMIC CHANGES<br>Any time a fire extinguisher is moved in its permanent location, the sign will accompany the extinguisher.<br><br>MONITOR<br>Maintenance director or designee will audit monthly for 3 months that the sign is in place in the kitchen.<br><br>DATE OF COMPLIANCE: 8/6/14 | |

Printed: 07/17/2014.
FORM APPROVED
OMB NO. 0938-0391

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 135122 | | 07/09/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LIFE CARE CENTER OF COEUR D'ALENE | 500 WEST AQUA AVENUE<br>COEUR D ALENE, ID 83815 |

| (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) | (X9) COMPLETION DATE |
|---|---|---|---|---|
| K 064 | Continued From page 6<br>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.<br>Exception: Extinguishers installed specifically for these hazards prior to June 30, 1998.<br>2-3.2.1<br>A placard shall be conspicuously placed near the extinguisher that states that the fire protection system shall be activated prior to using the fire extinguisher. | K 064 | | |
| K 076<br>SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.<br><br>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.<br><br>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4<br><br>This Standard is not met as evidenced by:<br>Based on observation and interview, the facility failed to ensure medical gases were properly secured per NFPA 99. Failure to secure medical gas cylinders would result in the exposure of residents, staff and visitors to an explosion and fire. This deficient practice affected 14 residents, staff and visitors in 1 of 8 smoke compartments on the date of survey. The facility is licensed for 120 SNF/NF beds and had a census of 80 on the day of the survey. | K 076 | **K076**<br><br>SPECIFIC DEFICIENCY<br>Oxygen "E" tanks were put back in chained area for safe storage.<br><br>OTHER RESIDENTS<br>Other oxygen storage areas were checked and no "E" tanks were found to be stored improperly.<br><br>SYSTEMIC CHANGES<br>A sign was placed in the oxygen storage room to remind staff to store oxygen in the designated chained area. Tape was put on the floor to indicate where the tanks should be stored.<br><br>MONITOR<br>Maintenance director will audit the appropriate storage of "E" tanks weekly x 4 weeks then monthly x 3. Audits will begin 8/6/14. ED will bring audits to CQI to report on findings.<br><br>DATE OF COMPLIANCE: 8/6/14 | |

Printed: 07/17/2014
FORM APPROVED
OMB NO. 0938-0391

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 135122 | | 07/09/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LIFE CARE CENTER OF COEUR D'ALENE | 500 WEST AQUA AVENUE<br>COEUR D ALENE, ID 83815 |

| (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 076 | Continued From page 7<br><br>Findings include:<br><br>During the facility tour conducted on July 9, 2014 from 1:00 PM to 4:00 PM, inspection of the oxygen transfilling room adjacent to the 100 wing tub room revealed (2) "E" cylinders of oxygen that were not protected by chaining, placement in a rack or use of a cylinder stand/cart. When asked, the facility Maintenance Director stated he was not aware these cylinders were not secured.<br><br>Actual NFPA standard:<br><br>NFPA 99,4-3<br>4-3.1.1* Source - Level 1.<br>4-3.1.1.1 Cylinder and Container Management. Cylinders in service and in storage shall be individually secured and located to prevent falling or being knocked over.<br>(a) * Cylinders or supply containers shall be constructed, tested, and maintained in accordance with the U.S. Department of Transportation specifications and regulations.<br>(b) Cylinder contents shall be identified by attached labels or stencils naming the components and giving their proportions. Labels and stencils shall be lettered in accordance with CGA Pamphlet C-4, Standard Method of Marking Portable Compressed Gas Containers to Identify the Material Contained.<br>(c) Contents of cylinders and containers shall be identified by reading the labels prior to use. Labels shall not be defaced, altered, or removed. | K 076 | | |

PRINTED: 07/15/2014
FORM APPROVED

Bureau of Facility Standards

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 135122 | | 07/09/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LIFE CARE CENTER OF COEUR D'ALENE | 500 WEST AQUA AVENUE<br>COEUR D ALENE, ID 83815 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 000 | 16.03.02 INITIAL COMMENTS<br><br>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.<br>The facility is a Type V ( 111 ) construction with a 94,000 square foot building that is fully sprinklered with smoke detection coverage including resident sleeping rooms. The building was built in 1995-96 and currently licensed for 120 SNF beds.<br><br>The following deficiencies were cited during the annual fire/life safety survey conducted on July 9, 2014. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70 and IDAPA 16.03.02 Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities.<br><br>The Survey was conducted by:<br><br>Sam Burbank<br>Health Facility Surveyor<br>Facility Fire Safety and Construction | C 000 | This plan of correction is submitted as required under Federal and State regulations and statutes applicable to long term care providers. This plan of correction does not constitute an admission of liability on the part of the facility and, such liability is hereby specifically denied. The submission of the plan does not constitute agreement by the facility that the surveyor's findings and/or conclusions are accurate, that the findings constitute a deficiency or that the scope and severity regarding any of the deficiencies cited are correctly applied. | 8-6-14 |
| C 226 | 02.106 FIRE AND LIFE SAFETY<br><br>106. FIRE AND LIFE SAFETY.<br>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.<br><br>This Rule is not met as evidenced by:<br>Please refer to federal form 2567 following "K" tags | C 226 | Please see Plan of Correction on the Federal Life Safety Survey 2567 form<br><br>RECEIVED<br>JUL 30 2014<br>FACILITY STANDARDS | |

Idaho form

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Bryan Lundson | TITLE: Executive Director | (X6) DATE: 7-30-14

PRINTED: 07/15/2014
FORM APPROVED

Bureau of Facility Standards

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 135122 | A. BUILDING 01 - ENTIRE BUILDING<br>B. WING _____ | 07/09/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LIFE CARE CENTER OF COEUR D'ALENE | 500 WEST AQUA AVENUE<br>COEUR D ALENE, ID 83815 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 226 | Continued From Page 1<br><br>K018 Corridor Doors<br>K029 Hazardous Areas<br>K064 Fire Extinguishers<br>K076 Medical Gases | C 226 | | |