



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 3050 0001 2128 2613

August 29, 2014

Cole Clarke, Administrator
Coeur d'Alene Health Care & Rehabilitation Center
2514 North Seventh Street
Coeur d'Alene, ID 83814-3720

Provider #: 135052

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

Dear Mr. Clarke:

On **August 19, 2014**, a Facility Fire Safety and Construction survey was conducted at **Coeur d'Alene Health Care & Rehabilitation Center** 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 September 11, 2014**. Failure to submit an acceptable PoC by **September 11, 2014**, may result in the imposition of civil monetary penalties by **September 30, 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 **September 23, 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 **September 23, 2014**. A change in the seriousness of the deficiencies on **September 23, 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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September 23, 2014, includes the following:

Denial of payment for new admissions effective **November 19, 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 **February 19, 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 **August 19, 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 **September 11, 2014**. If your request for informal dispute resolution is received after **September 11, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135052	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - PINWOOD CARE CENTER B. WING _____	(X3) DATE SURVEY COMPLETED 08/19/2014
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NAME OF PROVIDER OR SUPPLIER COEUR D'ALENE HEALTH CARE & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	INITIAL COMMENTS The facility is a single story, type V (111) construction built in 1961. It is fully sprinklered with a complete fire alarm/smoke detection system that includes resident rooms. Currently the facility is licensed for 117 SNF/NF beds. The following deficiencies were cited during the annual Fire/Life Safety survey conducted on August 19, 2014. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy and in accordance with CFR 42, 483.70. The Survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	K 000		
K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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 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 no residents, staff and visitors in 1 of 6 smoke compartments on the date of the survey. The facility is licensed for 117 SNF/NF beds and had a census of 32 on the day of the survey.	K 012	1. No residents are known to have been affected by this practice. Escutcheons in rooms 504, 506, and 510 and at the S.E. exit will be adjusted by a sprinkler contractor to make contact with the ceiling. 2. All residents have the potential to be affected. 3. A monthly inspection of all escutcheons in the building will be conducted and entered into the TELS system. 4. Monthly completion of the TELS inspections will be monitored for compliance by the Executive Director/ designee for compliance.	10/23/2014

RECEIVED
SEP 15 2014
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Cel Clarke</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>9/11/14</i>
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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.

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135052	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - PINWOOD CARE CENTER B. WING _____	(X3) DATE SURVEY COMPLETED 08/19/2014
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K 012	<p>Continued From page 1</p> <p>Findings include:</p> <p>During the facility tour conducted on August 19, 2014 between 2:00 PM and 4:00 PM, observation by the surveyor and the Maintenance Supervisor of the sprinkler system ceiling escutcheons in the renovated 500 wing, revealed that these integral components were separated from the ceilings in rooms 504, 506, and 510 leaving a gap of 1/4 inch to 3/8 inch between the sprinkler and the surrounding ceiling area.</p> <p>Further observation of this wing found that the sprinkler escutcheon at the southeast exit was also dislodged from the ceiling revealing an approximately 1/4 inch to 1/2 inch gap between the sprinkler and the surrounding ceiling. When asked, the Maintenance Supervisor stated he was not aware of these escutcheons being dislodged from the ceiling area.</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</p>	K 012		
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K 012	Continued From page 2 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. (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.	K 012		

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K 012	Continued From page 3 b. It shall be protected by an approved device that is designed for the specific purpose. (3) Where designs take transmission of vibrations into consideration, any vibration isolation shall meet one of the following conditions: a. It shall be made on either side of the smoke partitions. b. It shall be made by an approved device that is designed for the specific purpose.	K 012		
K 022 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that exit signs clearly identified exits. Failure to ensure that exits are identified clearly would hinder the safe evacuation of occupants during an emergency. This deficient practice affected 28 residents, staff and visitors in 2 of 6 smoke compartments on the date of the survey. The facility is licensed for 117 SNF/NF beds and had a census of 32 on the day of the survey.	K 022	K022 1. No residents are known to have been affected by this practice. Exit signs will be installed by Reliable Electric, Inc above the doors in the 400 wing and the outside exit in the Activities room. The exit signs above the entrance to the Activities room and 110 wing smoke barrier doors will be replaced with illuminated exit signs. All batteries in the backup exit lighting have been checked and replaced as necessary. 2. All residents had the potential to be affected by this practice. 3. The Maintenance director will conduct a monthly inspection of the exit lighting and document in the TELS system. 4. Results of inspections will be reported monthly in QAPI for three months to ensure compliance.	09/23/2014
	Findings include:			

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K 022	<p>Continued From page 4</p> <p>1) During the facility tour conducted on August 19, 2014 from 1:00 PM to 2:00 PM, observation of the smoke compartment doors located in the 400 wing found there was not an exit sign installed above the doors indicating the path of egress to the south. Further investigation found that when activated, the doors obstructed the view of the exit sign installed outside room 409 which indicated the path of egress travel. When asked, the Maintenance Supervisor stated he had not noticed this condition existed prior to the survey.</p> <p>2) During the facility tour conducted on August 19, 2014 from 1:00 PM to 2:00 PM, observation of the exit sign installed above the Activities Room door revealed it was a plastic, non-illuminated sign. Further investigation found that the exit access door from the Activities Room directly to the exterior was not signed. Upon interview of the Maintenance Supervisor, he stated he had not noticed the lack of proper signs prior to the date of the survey.</p> <p>3) During the facility tour conducted on August 19, 2014 from 2:30 PM to 3:30 PM, observation of the exit sign installed above the smoke compartment doors located in the 100 wing facing south, found that it was a plastic, non-illuminated sign installed above the doors. When asked, the Maintenance Supervisor stated he was not aware these doors had not been properly signed.</p> <p>Actual NFPA standard:</p> <p>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</p>	K 022		

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K 022	Continued From page 5 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	NFPA 101 LIFE SAFETY CODE STANDARD 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 interview, the facility failed to ensure that smoke compartment doors would fully close when activated. Failure to ensure that smoke compartment doors fully close would allow smoke and dangerous gases to pass freely between smoke compartments hindering egress and the ability to defend in place. This deficient practice affected 31 residents in 2 of 6 smoke compartments on the date of the survey. The facility is licensed for 117 SNF/NF beds and had a census of 32 on the day of the survey. Findings include: During the facility tour conducted on August 19, 2014 from 11:15 AM to 12:00 PM, observation	K 027	K027 1. No residents are known to have been affected by this practice. The doors were adjusted by "Door Technologies Inc" to close properly and a new door closer installed. 2. All residents had the potential to be affected by this practice. 3. The Maintenance director will conduct a monthly inspection of smoke doors for complete closure and document in the TELS system. 4. Results of inspections will be reported monthly in QAPI for three months to ensure compliance.	09/23/2014

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K 027	Continued From page 6 and operational testing of the smoke compartment doors between resident rooms 207 and 208 found they would not close completely leaving an approximately 3/4 inch to 1 inch wide by eighteen inch long gap between the astragal installed on the doors and the opposing door face when activated. Interview of the Maintenance Director revealed that he was not aware the doors had such a substantial separation. Actual NFPA standard: 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 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 This Standard is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure hazardous areas were protected with self-closing doors.	K 029	K029 1. No residents are known to have been affected by this practice. A door closer will be installed on the Beauty Salon, Central Supply, soiled linen room, and Medical Records doors. The HVAC will be rebalanced in Dietary, and a new door closer installed to allow the door to fully shut. 2. All residents had the potential to be affected by this practice. 3. The Maintenance director will conduct a monthly inspection of doors for complete closure and document in the TELS system. 4. Results of inspections will be reported monthly in QAPI for three months to ensure compliance.	09/23/2014

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K 029	<p>Continued From page 7</p> <p>Failure to protect hazardous areas would allow smoke and dangerous gases to pass freely into corridors hindering egress in a fire. This deficient practice affected 31 residents, staff and visitors in 3 of 6 smoke compartments on the date of the survey. The facility is licensed for 117 SNF/NF beds and had a census of 32 on the day of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on August 19, 2014 from 11:15 AM to 12:00 PM, observation of the Housekeeping storage room adjacent to the Beauty Salon revealed the door was not equipped with a self-closing device. Further observation of this area found it stored a volume greater than the general occupancy of both combustible chemicals and treated mopheads for the Housekeeping staff. When asked, the Maintenance Supervisor stated he was not aware this area contained such a large volume of combustible supplies.</p> <p>2) During the facility tour conducted on August 19, 2014 from 11:15 AM to 12:00 PM, observation and operational testing of the corridor door to Central Supply adjacent to room 205 found the door was not equipped with a self-closing device. When asked, the Maintenance Director stated he was aware this door was required to be self-closing.</p> <p>3) During the facility tour conducted on August 19, 2014 from 11:15 AM to 12:00 PM, observation and operational testing by the surveyor and Maintenance Supervisor of the corridor door to the soiled linen room adjacent to Nurse's station #2 found that it would not self close.</p>	K 029		

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K 029	<p>Continued From page 8</p> <p>4) During the facility tour conducted on August 19, 2014 from 11:15 AM to 12:00 PM, observation and operational testing of the corridor door to the Medical Records storage adjacent to room 206 found it was not equipped with a self-closing device. When asked, the Maintenance Supervisor stated he was not aware this door required a self-closing device.</p> <p>5) During the facility tour conducted on August 19, 2014 from 11:15 AM to 12:00 PM, observation and operational testing of the southwest entry into the Kitchen from the corridor found the door would not self-close and left a gap of 1 to 2 inches when activated. When interviewed, the Maintenance Supervisor stated the door was having problems due to the air pressure of the exhaust hood.</p> <p>Actual NFPA standard:</p> <p>3.3.13.2 Area, Hazardous. An area of a structure or building that poses a degree of hazard greater than that normal to the general occupancy of the building or structure, such as areas used for the storage or use of combustibles or flammables; toxic, noxious, or corrosive materials; or heat-producing appliances.</p> <p>19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a 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</p>	K 029		

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NAME OF PROVIDER OR SUPPLIER COEUR D'ALENE HEALTH CARE & REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814		
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K 029	Continued From page 9 self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. 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.	K 029		
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This Standard is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure that delayed egress locks would operate as designed. Failure to maintain delayed egress locks could prevent occupants from safely evacuating during an emergency. This deficient practice affected all	K 038	K038 1. No residents are known to have been affected by this practice. The door was adjusted to activate when pressure is applied to the hardware. 2. All residents had the potential to be affected by this practice. 3. The Maintenance director will conduct a monthly inspection of all delayed egress doors for proper functioning of the panic hardware and document in the TELS system. 4. Results of inspections will be reported monthly in QAPI for three months to ensure compliance.	09/23/2014

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K 038	<p>Continued From page 10</p> <p>residents, staff and visitors using the south exit adjacent to the Therapy Gym in the 100 wing. The facility is licensed for 117 SNF/NF beds and had a census of 32 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on August 19, 2014 from 3:30 PM to 4:00 PM, observation of operational testing by the Maintenance Supervisor, of the delayed egress door exiting the 100 wing to the south, found it would not activate when pressure was applied to the panic hardware. Further testing revealed the door lock dropped when activated by the keypad, ruling out an Immediate Jeopardy. Interview of the Maintenance Supervisor indicated he was not aware this door was not operating with an activated delay as designed.</p> <p>Actual NFPA standard:</p> <p>19.2.1 General. Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7. Exception: As modified by 19.2.2 through 19.2.11.</p> <p>7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed-egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met. (a) The doors shall unlock upon actuation of an</p>	K 038	

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K 038	Continued From page 11 approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6. (b) The doors shall unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) * On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS	K 038		
K 046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This Standard is not met as evidenced by: Based on record review and interview, the facility failed to ensure 90 minute annual emergency light testing was performed. Not performing battery powered emergency light testing for 90	K 046		

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K 046	<p>Continued From page 12</p> <p>minutes annually would not prove sufficient battery strength and could result in equipment failure during prolonged electrical outages created by a fire or other emergency. This deficient practice affected 32 residents, staff and visitors on the date of the survey. The facility is licensed for 117 SNF/NF beds and had a census of 32 on the day of the survey.</p> <p>Findings include:</p> <p>During record review conducted on August 19, 2014 from 8:45 AM to 11:00 AM, the facility failed to provide a record demonstrating the battery powered emergency lighting was being tested for 90 minutes annually. Interview of the Maintenance Supervisor revealed that he had not been performing this testing as required.</p> <p>Actual NFPA standard:</p> <p>19.2.9.1 Emergency lighting shall be provided in accordance with Section 7.9.</p> <p>7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment</p>	K 046	<p>K046</p> <ol style="list-style-type: none"> No residents are known to have been affected by this practice. The annual 90 minute inspection of the battery powered emergency lighting will be conducted. All residents had the potential to be affected by this practice. Maintenance will conduct annual 90 minute inspections and document them in the TELS system. Inspection results will be reported in QAPI annually to ensure compliance. 	09/23/2014

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K 046	Continued From page 13 that automatically performs a test for not less than 30 seconds and diagnostic routine not less than once every 30 days and indicates failures by a status indicator shall be exempt from the 30-day functional test, provided that a visual inspection is performed at 30-day intervals.	K 046		
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that combustible overhangs greater than four feet in depth were protected with sprinklers as required in NFPA 13. Failure to provide suppression of combustible overhangs would result in an uncontrolled fire spreading into the facility. This deficient practice affected all residents, staff and visitors in using the southeast exit of the 500 wing on the date of the survey. The facility is licensed for 117 SNF/NF beds and had a census of 32 on the day of the survey. Findings include:	K 056	K056 1. No residents are known to have been affected by this practice. Sprinkler protection will be extended to include the external 500 wing exit overhang. 2. All residents had the potential to be affected by this practice. 3. The Maintenance will inspect the entire building exterior to determine if there are any other exterior areas needing sprinkler protection and make recommendations to the Executive Director. 4. Inspection results will be reported in QAPI to ensure compliance.	10/23/2014

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K 056	<p>Continued From page 14</p> <p>During the facility tour conducted on August 19, 2014 from 2:00 PM to 2:30 PM, observation and evaluation of the overhang coverage of the 500 wing exit found it to be constructed of combustible material and measured approximately fifty eight inches by ninety six inches. Interview of the Maintenance Supervisor found he was not aware that overhangs four feet in depth or greater required sprinkler protection.</p> <p>Actual NFPA standard:</p> <p>NFPA 13 1-6 Level of Protection. 1-6.1 A building, where protected by an automatic sprinkler system installation, shall be provided with sprinklers in all areas. Exception: This requirement shall not apply where specific sections of this standard permit the omission of sprinklers.</p> <p>5-13.8* Exterior Roofs or Canopies. 5-13.8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 ft (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.</p>	K 056		
K 062 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p>	K 062		
	This Standard is not met as evidenced by:			

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K 062	<p>Continued From page 15</p> <p>Based on record review, observation and interview, the facility failed to ensure that sprinkler pendants were properly maintained for adequate suppression coverage. Failure to ensure sprinklers are maintained as required in NFPA 25 would prevent adequate suppression coverage during a fire. This deficient practice affected 32 residents, staff and visitors in 6 of 6 smoke compartments on the date of the survey. The facility is licensed for 117 SNF/NF beds and had a census of 32 on the day of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on August 19, 2014 from 11:00 AM to 4:00 PM, observation by the surveyor and the Maintenance Supervisor of the sprinkler pendants in the Ponderosa dining room; both Therapy gyms; Administration hallway and abutting corridor soffit; found eight sprinkler pendants recessed into the ceiling exposing approximately 1/4 inch or less of the pendant. Further investigation demonstrated these pendant glass temperature bulbs were not exposed to the room or corridors and the deflector was flush or recessed above the ceiling. Interview of the Maintenance Supervisor indicated he was aware this did not provide sufficient coverage of the occupied spaces. Due to the number of pendants found, further investigation was not deemed necessary.</p> <p>2) During record review of the facility conducted on August 19, 2014 from 8:45 AM to 11:00 AM, the facility failed to provide records of quarterly fire sprinkler system inspections. Interview of the Maintenance Supervisor found he had not been testing the sprinkler flow alarm on a quarterly basis and was aware the contracted fire sprinkler inspection company was also not performing this</p>	K 062	<p>K062</p> <ol style="list-style-type: none"> No residents are known to have been affected by this practice. The eight sprinkler pendants will be adjusted to be in compliance by a qualified technician. A quarterly inspection of the fire sprinkler system will be conducted including testing the sprinkler flow alarm. A five year internal inspection will be conducted and documented. All residents had the potential to be affected by this practice. The Maintenance will include Pendant inspection as part of his monthly required TELS inspections. Maintenance director will be trained to complete fire sprinkler inspections and enter inspection schedule in the TELS system. Inspection results will be reported In QAPI to ensure compliance. 	10/23/2014

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K 062	Continued From page 16 inspection. 3) During record review of the facility conducted on August 19, 2014 from 8:45 AM to 11:00 AM, the facility failed to provide records demonstrating when the last 5-year internal inspection had been completed. Interview of the Maintenance Supervisor indicated he was not aware when this inspection had been completed. Inspection of the main riser failed to reveal when this inspection had last been performed. Actual NFPA standard: 4.6.12 Maintenance and Testing. 4.6.12.1 Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be continuously maintained in accordance with applicable NFPA requirements or as directed by the authority having jurisdiction.	K 062		
K 072 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD 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	K 072		
	This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that exit access was maintained			

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K 072	<p>Continued From page 17</p> <p>free of obstacles. Failure to ensure that exits remain unobstructed would prevent the safe evacuation of occupants during an emergency. This deficient practice affected all residents, staff and visitors using the north corridor exit off the Ponderosa dining room. The facility is licensed for 117 SNF/NF beds and had a census of 32 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on August 19, 2014 from 12:30 PM to 4:00 PM, observation by the surveyor and the Maintenance Supervisor of the north exit corridor off the Ponderosa dining room found it was blocked with a laundry cart; (3) dietary services carts; (2) folding tables; and a housekeeping cart. These items were observed to be stored in this location at 12:30 PM; 1:00 PM; 2:00 PM and 3:00 PM. When interviewed, the Maintenance Supervisor indicated that this exit was normally kept clear of obstructions.</p> <p>Actual NFPA standard:</p> <p>7.1.10 Means of Egress Reliability. 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.</p>	K 072	<p>K072</p> <ol style="list-style-type: none"> No residents are known to have been affected by this practice. All items blocking the hallway have been removed. All residents had the potential to be affected by this practice. Staff has been in-serviced to keep the hallway clear. The Maintenance, Housekeeping, and Dietary managers will monitor the hallway daily to ensure that it is kept clear. Inspection results will be reported in QAPI for three months to ensure compliance. 	09/23/2014

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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 built in 1961. It is fully sprinklered with a complete fire alarm/smoke detection system that includes resident rooms. Currently the facility is licensed for 117 SNF/NF beds.</p> <p>The following deficiencies were cited during the annual Fire/Life Safety survey conducted on August 19, 2014. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with CFR 42, 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		
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 "K" tags on CMS 2567:</p>	C 226	<p>C226</p> <p>Please refer to the applicable K-tag for POC and dates of compliance.</p>	

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SEP 15 2014
FACILITY STANDARDS

Idaho form
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE C.C. Cloude TITLE Executive Director (X6) DATE 9/11/14

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C 226	Continued From Page 1 K 012 Building construction continuity K 022 Exit signs K 027 Smoke barrier doors K 029 Hazardous areas K 038 Delayed egress locks K 046 Emergency light testing K 056 Sprinklered overhangs K 062 Sprinkler maintenance K 072 Obstructed egress	C 226		