



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 3610**

September 26, 2014

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

Provider #: 135103

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

Dear Ms. Butler:

On **September 18, 2014**, a Facility Fire Safety and Construction survey was conducted at **Prestige Care & Rehabilitation - The Orchards** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

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

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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 **October 9, 2014**. Failure to submit an acceptable PoC by **October 9, 2014**, may result in the imposition of civil monetary penalties by **October 29, 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 **October 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 **October 23, 2014**. A change in the seriousness of the deficiencies on **October 23, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **October 23, 2014**, includes the following:

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Denial of payment for new admissions effective **December 18, 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 **March 18, 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 **September 18, 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/NursingFacilities/tabid/434/Default.aspx>

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

BFS Letters (06/30/11)

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

This request must be received by **October 9, 2014**. If your request for informal dispute resolution is received after **October 9, 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,

A handwritten signature in black ink, appearing to read 'MPG', with a long, sweeping horizontal line extending to the right.

Mark P. Grimes, Supervisor  
Facility Fire Safety and Construction

MPG/lj  
Enclosures

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

Printed: 09/25/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135103</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/18/2014</b>
NAME OF PROVIDER OR SUPPLIER <b>PRESTIGE CARE &amp; REHABILITATION - THE O</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1014 BURRELL AVENUE LEWISTON, ID 83501</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS  The facility is a single story type V (111) structure completed in 1958, with an addition of comparable construction. The facility is sprinklered with a new fire alarm and smoke detection system installed in 2013. The building has a partial basement which is used for storage and maintenance. The building is currently licensed for 127 beds.  The following deficiencies were cited during the annual fire/life safety survey conducted on September 18, 2014. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.  The Survey was conducted by:  Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	K 000	This plan of correction is being submitted in compliance with specific regulatory requirements and preparation and/or execution of this plan does not constitute admission or agreement by the provider of the facts alleged or conclusions set forth on the statement of deficiencies.  <i>RECEIVED OCT 15 2014 FACILITY STANDARDS</i>	
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	K 022	1. No residents were affected 2. No residents were identified at risk 3. Systemic Changes include: a. Facility floor plan reviewed for areas that exit signs were needed b. Exit signs will be replaced or installed if not currently in place c. Conflicting signs removed and signage added that reads "Emergency Exit Only. Alarm Will Sound."	11/25/14

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

*Rebecca Butler*

TITLE

*LNHA*

(X6) DATE

*10/14/14*

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.

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K 022	<p>Continued From page 1</p> <p>failed to ensure that exits were clearly identified by appropriate means. Failure to ensure that exits are identified would hinder the safe evacuation of occupants during an emergency. This deficient practice affected 61 residents, staff and visitors in 7 of 7 smoke compartments on the date of the survey. The facility is licensed for 127 SNF/NF beds and had a census of 61 on the day of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on September 18, 2014 from 1:30 PM to 4:30 PM, observation by the surveyor and the Maintenance Director of the corridor facing south from the Medical Records office found the exit sign installed at the main Dining hall was blocked from view by installed lighting. During further observation of this corridor, when the smoke compartment doors located between the Employee Breakroom and the Lobby were activated, the sign was not visible at all and no sign was installed in the header above the doors. When asked, the Maintenance Director stated he had never noticed the absence of signs at this location.</p> <p>2) During the facility tour conducted on September 18, 2014 from 1:30 PM to 4:30 PM, observation by the surveyor and the Maintenance Director of the corridor facing west found the exit sign installed above the exit access was equipped with an illuminated arrow indicating the direction of egress travel was into the Oxygen storage closet.</p> <p>3) During the facility tour conducted on September 18, 2014 from 1:30 PM to 4:30 PM, observation by the surveyor and the Maintenance</p>	K 022	This page intentionally left blank		

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K 022	<p>Continued From page 2</p> <p>Director of the corridor facing west when standing between resident rooms 228 and 225, found that when the smoke compartment doors at this location were activated, no exit sign was visible and no sign was installed in the header above the doors. Further observation of these doors found they were solid wood without vision glass.</p> <p>4) During the facility tour conducted on September 18, 2014 from 1:30 PM to 4:30 PM, observation by the surveyor and the Maintenance Director of the exit access located in the Gym found the intended direction of egress travel indicated by the escape plan would be directly ahead when facing north, but the illuminated directional arrows on the installed exit sign indicated that escape would be either to the left or right into dead-end walls.</p> <p>5) During the facility tour conducted on September 18, 2014 from 1:30 PM to 4:30 PM, observation by the surveyor and the Maintenance Director of the corridor facing north in the 300 wing found that based on the exit access, egress travel would be straight, but the illuminated directional arrows on the exit sign indicated the direction of egress travel was either left or right. This direction of egress travel places occupants into either room 326 or 327 which are not equipped with exterior doors.</p> <p>6) During the facility tour conducted on September 18, 2014 from 1:30 PM to 4:30 PM, further observation of the designated facility exits by the surveyor and the Maintenance Director could not reveal a clearly identified exit at any of the exterior doors by means of appropriate signs. When interviewed, the Maintenance Director stated he had not noticed the confusing nature of the exit signs installed prior to the survey.</p>	K 022	This page intentionally left blank	

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K 022	Continued From page 3  7) During the facility tour conducted on September 18, 2014 from 1:30 PM to 4:30 PM, observation of the exterior door adjacent to the vending machines and the exterior door adjacent to the Housekeeping closet in the 300 wing found that these doors were not intended to be used as a designated exit to a public way and were not equipped with appropriate signs indicating they were not an exit.  8) During the facility tour conducted on September 18, 2014 from 1:30 PM to 4:30 PM, observation of the exterior exits found the exit at the 200 wing and the 300 wing found that they were equipped with signs attached to the door jambs which read "Stop; Not an Exit; Use as an exit only in an emergency". When interviewed, the Maintenance Director stated these conflicting signs were installed to prevent residents from exiting without staff knowledge.  Actual NFPA standard:  Findings 1 - 6  7.10.1.2* Exits. Exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign readily visible from any direction of exit access.  Finding 7  7.10.8 Special Signs. 7.10.8.1* No Exit. Any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as	K 022	This page intentionally left blank	

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K 022	Continued From page 4 follows: NO EXIT Such sign shall have the word NO in letters 2 in. (5 cm) high with a stroke width of 3/8 in. (1 cm) and the word EXIT in letters 1 in. (2.5 cm) high, with the word EXIT below the word NO. Exception: This requirement shall not apply to approved existing signs.  Finding 8  7.7.3 The exit discharge shall be arranged and marked to make clear the direction of egress to a public way. Stairs shall be arranged so as to make clear the direction of egress to a public way. Stairs that continue more than one-half story beyond the level of exit discharge shall be interrupted at the level of exit discharge by partitions, doors, or other effective means.	K 022		
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	K 029	1. No residents were affected 2. No residents were identified at risk 3. Systemic Changes include: a. Facility floor plan was reviewed for rooms that meet self-closing device requirement b. Self closing devices installed on all doors that meet self-closing requirement	11/25/14

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K 029	<p>Continued From page 5</p> <p>interview, the facility failed to ensure the protection of hazardous areas with required self-closing doors. Failure to protect hazardous areas would allow smoke and dangerous gases to pass freely into corridors hindering egress during a fire event. This deficient practice affected 45 residents, staff and visitors in 3 of 7 smoke compartments on the date of the survey. The facility is licensed for 127 SNF/NF beds and had a census of 61 on the day of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on September 18, 2014 from 1:30 PM to 4:30 PM, observation and operational testing of the Durable Equipment storage room located adjacent to the Physical Therapy waiting area found it was approximately twelve feet by twelve feet (144 square feet) and the door was not equipped with a self-closing device. Interview of the Maintenance Director indicated he was not aware this door was required to self-close.</p> <p>2) During the facility tour conducted on September 18, 2014 from 1:30 PM to 4:30 PM, observation by the surveyor and the Maintenance Director of the soiled linen closet between room 324 and 326; the soiled linen storage between room 305 and 303 found these closets were equipped with self-closing devices, but when tested they would not completely close. Further inspection revealed that when closed, these doors left a gap of approximately 1-1/2 inch wide between the doors. Interview of the Maintenance Director found he was not aware the doors were not completely closing as required.</p> <p>3) During the facility tour conducted on September 18, 2014 from 1:30 PM to 4:30 PM,</p>	K 029	This page intentionally left blank	

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K 029	<p>Continued From page 6</p> <p>observation by the surveyor and the Maintenance Director of the Oxygen storage closets located across from room 201; between rooms 317 and 319 and the Oxygen storage room adjacent to the Therapy Manager's office found they were not equipped to self-close. Interview of the Maintenance Director indicated he was aware these doors were required to self-close.</p> <p>4) During the facility tour conducted on September 18, 2014 from 1:30 PM to 4:30 PM, observation by the surveyor and the Maintenance Director of the doors to both the Medical Records office and the Medical Records storage located adjacent to the office were not equipped with a self-closing device. Further investigation found that the Medical Records office measured twenty six feet by sixteen feet (416 square feet) and the storage area for Medical Records measured ten feet by ten feet (100 square feet). When asked, the Maintenance Director stated he was not aware these rooms required self-closing doors.</p> <p>5) During the facility tour conducted on September 18, 2014 from 1:30 PM to 4:30 PM, observation by the surveyor and the Maintenance Director of the Housekeeping closet abutting room 302 found it contained over ten gallons of combustible liquid and an assortment of combustible paper and supplies, i.e.: paper towels and cleaning rags. When asked the Maintenance Director stated he was not sure why this door was not equipped with a self-closing device.</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</p>	K 029	This page intentionally left blank		

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K 029	Continued From page 7 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.  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: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft <sup>2</sup> (9.3 m <sup>2</sup> ) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft <sup>2</sup> (4.6 m <sup>2</sup> ), 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	This page intentionally left blank	
K 038	NFPA 101 LIFE SAFETY CODE STANDARD	K 038		

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K 038 SS=F	<p>Continued From page 8</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>This Standard is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to maintain doors with readily accessible means of exit access. Failure to allow rapid means of exit access has the potential to impede escape in the event of a fire or other emergency. This deficient practice affected 61 residents, staff and visitors in 7 of 7 smoke compartments on the date of the survey. The facility is licensed for 127 SNF/NF beds and had a census of 61 on the day of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on September 18, 2014 from 1:30 PM to 4:30 PM, observation of the doors to the shared bathroom between room 222/224 found throw bolts installed at the top of the doors both inside and outside the bathroom. When interviewed, the Maintenance Director stated that all shared bathrooms in the facility had similar installations and that these had been installed to accommodate privacy.</p> <p>2) During the facility tour conducted on September 18, 2014 from 1:30 PM to 4:30 PM, observation and operational testing of the door to the Treatment Room at the Physical Therapy Gym found that access into this area was achieved by a pocket door which had a combination lock installed and the Maintenance</p>	K 038	<ol style="list-style-type: none"> <li>1. No residents were affected</li> <li>2. No residents were identified at risk</li> <li>3. Systematic Changes:               <ol style="list-style-type: none"> <li>a. Facility floor plan reviewed for current throwbolt usage</li> <li>b. Throw bolts and combination locks removed</li> <li>c. Privacy knobs installed, where needed</li> <li>d. Single use locks installed on storage locations, where needed</li> </ol> </li> </ol>	11/25/14

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OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER <b>PRESTIGE CARE &amp; REHABILITATION - THE OI</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1014 BURRELL AVENUE LEWISTON, ID 83501</b>		
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K 038	<p>Continued From page 9</p> <p>Director did not immediately know the combination to this lock. Further investigation found the interior of the room measured approximately eight feet by ten feet (80 square feet) clear area. When interviewed, the Maintenance Director stated the therapy department had installed this lock for security purposes.</p> <p>3) During the facility tour conducted on September 18, 2014 from 1:30 PM to 4:30 PM, observation and operational testing of storage closets in the main corridor beside the Physical Therapy Manager's office; the Oxygen storage closet abutting the Kitchen; the storage closet abutting the Medical Records office; and the Hoyer storage closet located in the 300 wing between rooms 324 and 326, had throw bolts installed on the top of the door on the egress side. Further examination of these storage areas revealed they had approximately five feet by three feet unobstructed space inside. When asked, the Maintenance Director stated these latches were installed to keep equipment and supplies secured.</p> <p>Actual NFPA standard:</p> <p>7.2.1.5.4* A latch or other fastening device on a door shall be provided with a releasing device having an obvious method of operation and that is readily operated under all lighting conditions. The releasing mechanism for any latch shall be located not less than 34 in. (86 cm), and not more than 48 in. (122 cm), above the finished floor. Doors shall be operable with not more than one releasing operation. Exception No. 1*: Egress doors from individual living units and guest rooms of residential</p>	K 038	This page intentionally left blank		

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K 038	Continued From page 10 occupancies shall be permitted to be provided with devices that require not more than one additional releasing operation, provided that such device is operable from the inside without the use of a key or tool and is mounted at a height not exceeding 48 in. (122 cm) above the finished floor. Existing security devices shall be permitted to have two additional releasing operations. Existing security devices other than automatic latching devices shall not be located more than 60 in. (152 cm) above the finished floor. Automatic latching devices shall not be located more than 48 in. (122 cm) above the finished floor. Exception No. 2: The minimum mounting height for the releasing mechanism shall not be applicable to existing installations.	K 038			
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2  This Standard is not met as evidenced by: Based on record review and interview, the facility failed to ensure that all employees were properly trained for procedures in the event of an emergency. Failure to provide sufficient training to staff would result in the staff being unprepared on the proper response during an emergency requiring evacuation or other action. This	K 050	1. No residents were affected 2. No residents were identified at risk 3. Systematic Changes: a. Fire Drills completed and documented on the additional 2 weekend shifts 4. Monitoring: a. TELS system updated to include the necessary additional fire drills on a quarterly basis	9/30/14	

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K 050	<p>Continued From page 11</p> <p>deficient practice affected 61 residents, staff and visitors in 7 of 7 smoke compartments on the date of the survey. The facility is licensed for 127 SNF/NF beds and had a census of 61 on the day of the survey.</p> <p>Findings include:</p> <p>1) During record review of the facility conducted on September 18, 2014 from 12:45 PM to 1:30 PM, interview of the Maintenance Director indicated the facility had six (6) staff members who only worked weekend shifts. Review of the facility fire drill records demonstrated only one drill conducted in the first quarter and one drill conducted in the fourth quarter had been performed during a weekend shift that would include this personnel.</p> <p>2) During the exit conference of the facility conducted on September 18, 2014 from 4:45 PM to 5:45 PM, interviews of the Administrator and Nursing staff confirmed that six (6) staff members only worked weekends. Further investigation revealed the staff was not aware this constituted a fourth shift and would require an additional drill per quarter.</p> <p>Actual NFPA standard:</p> <p>19.7.1.2* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. (2100 hours) and</p>	K 050	This page intentionally left blank	

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K 050	Continued From page 12 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building.	K 050		
K 056 SS=F	<b>NFPA 101 LIFE SAFETY CODE STANDARD</b>  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 all areas of the facility were fully sprinklered. Failure to provide sprinkler protection throughout the facility would allow fires to spread beyond incipient stages. This deficient practice affected all residents, staff and visitors required to use the the north exit of the Annex wing on the date of the survey during an emergency or fire event. The facility is licensed for 127 SNF/NF beds and had a census of 61 on the day of the survey.  Findings include:	K 056	1. No residents were identified 2. No residents were at risk 3. Systemic Changes: a. Sprinklers installed to South side of the Annex Dining Room where there is a 55 inches by 45 feet overhang	11/25/14

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K 056	Continued From page 13 During the facility tour conducted on September 18, 2014 from 1:30 PM to 4:30 PM, observation of the overhang at the north exit of the facility directly outside room 326 revealed it was of wooden, combustible construction. Further investigation found it was unsprinklered and measured 55 inches by 45 feet. When asked, the Maintenance Director stated he was aware this area required sprinkler protection. Further interview of the Maintenance Director found he was unsure why the facility had failed to have this area sprinklered when it was brought to their attention during the annual survey conducted on August 14, 2013 and again during the Federal Comparative Survey conducted on September 12, 2013.  Actual NFPA standard:  NFPA 13  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.	K 056		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5  This Standard is not met as evidenced by: Based on observation and interview, the facility	K 062	1. No residents were identified 2. No residents were at risk 3. Systemic Changes: a. Facility floor plan reviewed for sprinklers with paint and mixed heads b. Mixed head and painted sprinkler heads replaced	11/25/14

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K 062	<p>Continued From page 14</p> <p>failed to ensure sprinklers were properly maintained per NFPA 25. Failure to maintain sprinkler systems would allow fires to grow beyond incipient stages, or fail to provide suppression altogether. This deficient practice affected 61 residents, staff and visitors in 7 of 7 smoke compartments on the date of the survey. The facility is licensed for 127 SNF/NF beds and had a census of 61 on the day of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on September 18, 2014 from 1:30 PM to 4:30 PM, multiple sprinkler heads were found to be painted over. Those noted were identified at the following locations:</p> <ul style="list-style-type: none"> <li>(6) in the corridor between the Administrator office and Copy room</li> <li>(1) inside the Medical Records office</li> <li>(1) outside Durable Clean storage</li> <li>(8) in the Physical Therapy Gym</li> <li>(1) in the Activity Director office</li> <li>(1) in the Social Services Director office</li> <li>(1) in the Employee breakroom</li> </ul> <p>When interviewed, the Maintenance Director stated he was aware that these sprinklers were required to be kept free of paint or obstructions. Due to the number and extent of locations in the facility, further documentation was deemed unnecessary.</p> <p>2) During the facility tour conducted on September 18, 2014 from 1:30 PM to 4:30 PM, a mix of sprinkler heads was found in the hall outside room 320 and in the small dining room in the Annex wing. Further examination could not determine the type of response type on the older heads due to the accumulation of paint. When asked, the Maintenance Director stated the</p>	K 062	This page intentionally left blank	

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K 062	Continued From page 15 facility had some sprinkler heads replaced, but was unsure why a mix of styles had been used at these locations.  Actual NFPA standard:  Finding 1 NFPA 25 2-2.1 Sprinklers. 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. Exception No. 1*: Sprinklers installed in concealed spaces such as above suspended ceilings shall not require inspection. Exception No. 2: Sprinklers installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown.	K 062		
K 075 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5	K 075	1. No residents were affected 2. No residents were at risk 3. Systemic Changes: a. Two receptacles removed from shower room abutting room 221 b. Staff in-serviced on proper storing of soiled and trash receptacles c. Single use storeroom locks and self-closures installed, where needed 4. Monitoring: a. Maintenance or designee will audit shower rooms weekly x 4 weeks and monthly x 3months to ensure compliance with receptacles	11/25/14

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K 075	<p>Continued From page 16</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure highly combustible materials were stored in a safe manner. Failure to provide proper protection of hazardous material would result in smoke and dangerous gases passing freely through corridors during a fire, hindering egress capabilities. This deficient practice affected 6 residents in 1 of 7 smoke compartments on the date of the survey. The facility is licensed for 127 SNF/NF beds and had a census of 61 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on September 18, 2014 from 1:30 PM to 4:30 PM, observation of the Shower Room abutting room 221 found (3) fifty gallon soiled linen/trash storage receptacles stored inside. Further investigation found the door to the shower was not equipped with a self-closing device. When asked, the Maintenance Director stated this area was not normally used to store soiled linen and trash receptacles.</p> <p>Actual NFPA standard:</p> <p>19.7.5.5 Soiled linen or trash collection receptacles shall not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gal/ft<sup>2</sup> (20.4 L/m<sup>2</sup>). A capacity of 32 gal (121 L) shall not be exceeded within any 64-ft<sup>2</sup> (5.9-m<sup>2</sup>) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) shall be located in a room protected as a hazardous area</p>	K 075	This page intentionally left blank	

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K 075	Continued From page 17 when not attended. Exception: Container size and density shall not be limited in hazardous areas.	K 075		
K 147 SS=F	<b>NFPA 101 LIFE SAFETY CODE STANDARD</b> 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 31 residents, staff and visitors in 1 of 7 smoke compartments on the date of the survey. The facility is licensed for 127 SNF/NF beds and had a census of 61 on the day of the survey.  Findings include:  During the facility tour conducted on September 18, 2014 from 1:30 PM to 4:30 PM, observation of the interior of the housekeeping closet in the 300 wing found the electrical panel was blocked by haphazard storage of supplies and a floor scrubber. When asked, the Maintenance Director stated he was aware this area was to be kept clear for access.  Actual NFPA standard:  NFPA 70 110.26 Spaces About Electrical Equipment. Sufficient access and working space shall be provided and maintained about all electric	K 147	1. No residents were affected 2. No residents were at risk 3. Systemic Changes: a. Area around electrical panel cleared b. Staff in-serviced on keeping areas around electrical and service panels clear c. Signs placed on all electrical and service panels stating "DO NOT BLOCK"	10/23/14

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K 147	Continued From page 18 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.	K 147	This page intentionally left blank		

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NAME OF PROVIDER OR SUPPLIER <b>PRESTIGE CARE &amp; REHABILITATION - THE ORCHARD</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1014 BURRELL AVENUE LEWISTON, ID 83501</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 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) structure completed in 1958, with an addition of comparable construction. The facility is sprinklered with a new fire alarm and smoke detection system installed in 2013. The building has a partial basement which is used for storage and maintenance. The building is currently licensed for 127 beds.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on September 18, 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.</p> <p>The Survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	C 000	This page intentionally left blank	
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:</p>	C 226		

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OCT 15 2014  
FACILITY STANDARDS

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

*Rebecca Butler*

TITLE

*LNHA*

(X6) DATE

*10/14/14*

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135103</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - ENTIRE BUILDING</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/18/2014</b>
NAME OF PROVIDER OR SUPPLIER <b>PRESTIGE CARE &amp; REHABILITATION - THE ORCHA</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1014 BURRELL AVENUE LEWISTON, ID 83501</b>		
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C 226	Continued From Page 1  Please refer to the following tags on CMS 2567:  K 022 Exit access signs K 029 Hazardous areas K 038 Exit obstructions K 050 Fire Drills K 056 Sprinklered overhangs K 062 Sprinkler Maintenance K 075 Soiled linen/trash receptacles K 147 Electrical equipment access	C 226	Please refer to the corrective actions on CMS 2567.	