



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK – ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
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

February 15, 2017

Mason Hunter, Administrator
Coeur d'Alene of Cascadia
2514 North Seventh Street
Coeur d'Alene, ID 83814-3720

Provider #: 135052

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

Dear Mr. Hunter:

On **February 7, 2017**, a Facility Fire Safety and Construction survey was conducted at **Coeur d'Alene of Cascadia** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. Please provide **ONLY ONE** completion date for each federal and state tag in column (X5) Completion Date to signify when

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you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office. If a State Form with deficiencies was issued, it should be signed, dated and returned along with the CMS-2567 Form.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **February 28, 2017**. Failure to submit an acceptable PoC by **February 28, 2017**, may result in the imposition of civil monetary penalties by **March 20, 2017**.

Your PoC must contain the following:

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

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **March 14, 2017**, (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 **March 14, 2017**. A change in the seriousness of the deficiencies on **March 14, 2017**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **March 14, 2017**, includes the following:

Denial of payment for new admissions effective **May 7, 2017**.
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 **August 7, 2017**, if substantial compliance is not achieved by that time.

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

If you believe these deficiencies have been corrected, you may contact Nate Elkins, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, option 3; Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **February 7, 2017**, 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:

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<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/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 **February 28, 2017**. If your request for informal dispute resolution is received after **February 28, 2017**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626, option 3.

Sincerely,



Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosures

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

PRINTED: 02/14/2017
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 02/07/2017
NAME OF PROVIDER OR SUPPLIER COEUR D'ALENE OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814	
(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) 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 special focus Fire/Life Safety survey conducted on February 7, 2017. The facility was surveyed under the LIFE SAFETY CODE, 2012 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	Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies, the plan of correction is prepared and submitted solely because of the requirements under state and federal law.	
K 211 SS=F	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This STANDARD is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure that fire rated assemblies were inspected in accordance with NFPA 80. Failure to inspect and test fire rated doors could result in a lack of system performance as designed. This deficient practice affected 22 residents, staff and visitors on the date of the survey. The facility is licensed for 117	K 211	FACILITY STANDARDS Maintenance Director to perform inspection for fire rated assemblies All residents have the potential to be affected Maintenance Director established monthly inspections for all fire rated assemblies Maintenance director to report inspection findings to QAPI committee monthly X 3 months for review and further comment as indicated	DOC 3/14/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *NHA* (X8) DATE *2/27/17*

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 211	<p>Continued From page 1 SNF/NF beds and had a census of 22 on the day of the survey.</p> <p>Findings include:</p> <p>During review of provided facility annual inspection records conducted on February 7, 2017 from approximately 9:30 AM to 10:30 AM, no record was available demonstrating an initial inspection and testing of fire rated assemblies had been conducted. Further observation revealed the facility was equipped with fire rated assemblies which ranged between twenty (20) minutes to ninety (90) minutes fire resistance. When asked about the missing initial testing documentation, the Plant Operations Manager stated he was aware of the requirements of testing of fire rated assemblies, but was unsure as to which assemblies in the facility were required to be tested and how to document those results.</p> <p>Actual NFPA standard:</p> <p>NFPA 101</p> <p>19.2 Means of Egress Requirements 19.2.2.2 Doors. 19.2.2.2.1 Doors complying with 7.2.1 shall be permitted.</p> <p>7.2.1 Door Openings. 7.2.1.15 Inspection of Door Openings. 7.2.1.15.1* Where required by Chapters 11 through 43, the following door assemblies shall be inspected and tested not less than annually in accordance with 7.2.1.15.2 through 7.2.1.15.8: (1) Door leaves equipped with panic hardware or fire exit hardware in accordance with 7.2.1.7</p>	K 211	<i>Page intentionally left blank</i>	

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K 211	Continued From page 2 (2) Door assemblies in exit enclosures (3) Electrically controlled egress doors (4) Door assemblies with special locking arrangements subject to 7.2.1.6 7.2.1.15.2 Fire-rated door assemblies shall be inspected and tested in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Smoke door assemblies shall be inspected and tested in accordance with NFPA 105, Standard for Smoke Door Assemblies and Other Opening Protectives. NFPA 80 5.2* Inspections. 5.2.1* Fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ.	K 211		
K 232 SS=F	NFPA 101 Aisle, Corridor, or Ramp Width Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure that means of egress were maintained free of obstructions in the event of a fire or other emergency. Failure to provide planning and training for the relocation of wheeled equipment, could hinder egress of residents during a fire or other emergency. This deficient	K 232	K 232 Update to emergency plan to define location for placement of wheeled equipment in the event of an emergency All residents have the potential to be affected Maintenance Director/Admin to inservice staff related to updated emergency plan related to defined location for placement of wheeled equipment in the event of an emergency	

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K 232	Continued From page 3 practice affected 22 residents, staff and visitors on the date of the survey. The facility is licensed for 117 SNF/NF beds and had a census of 22 on the day of the survey. Findings include: During review of the facility fire safety plan conducted on February 7, 2017 from approximately 9:30 AM to 10:30 AM, no information as to the location was contained in the plan. Further review of staff inservice training did not provide information as to training conducted on the relocation of the wheeled equipment during a fire or other emergency. Interview of the nursing staff at the main nurse's station revealed no specific location as to where wheeled equipment was to be moved had been identified, only to "a resident room". Actual NFPA standard: NFPA 101 19.2.3.4* Any required aisle, corridor, or ramp shall be not less than 48 in. (1220 mm) in clear width where serving as means of egress from patient sleeping rooms, unless otherwise permitted by one of the following: (1) Aisles, corridors, and ramps in adjunct areas not intended for the housing, treatment, or use of inpatients shall be not less than 44 in. (1120 mm) in clear and unobstructed width. (2)*Where corridor width is at least 6 ft (1830 mm), noncontinuous projections not more than 6 in. (150 mm) from the corridor wall, above the handrail height, shall be permitted. (3) Exit access within a room or suite of rooms complying with the requirements of 19.2.5 shall	K 232	Maintenance Director/Admin to perform monthly audits of staff knowledge of updated emergency plan related to defined location of wheeled equipment in the event of an emergency Maintenance Director/Admin to report findings to QAPI committee monthly x 3 months for review and further comment as indicated	DOC 3/14/17

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K 232	Continued From page 4 be permitted. (4) Projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in.(1525 mm). (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c)*The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment (5)*Where the corridor width is at least 8 ft (2440 mm), projections into the required width shall be permitted for fixed furniture, provided that all of the following conditions are met: (a) The fixed furniture is securely attached to the floor or to the wall. (b) The fixed furniture does not reduce the clear unobstructed corridor width to less than 6 ft (1830 mm), except as permitted by 19.2.3.4(2). (c) The fixed furniture is located only on one side of the corridor. (d) The fixed furniture is grouped such that each grouping does not exceed an area of 50 ft2 (4.6 m2). (e) The fixed furniture groupings addressed in 19.2.3.4(5)(d) are separated from each other by a distance of at least 10 ft (3050 mm). (f)*The fixed furniture is located so as to not obstruct access to building service and fire protection equipment. (g) Corridors throughout the smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance	K 232	Page intentionally left blank		

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K 232	Continued From page 5 with 19.3.4, or the fixed furniture spaces are arranged and located to allow direct supervision by the facility staff from a nurses' station or similar space. (h) The smoke compartment is protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.8.	K 232		
K 291 SS=E	<p>NFPA 101 Emergency Lighting</p> <p>Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9.18.2.9.1, 19.2.9.1 This STANDARD is not met as evidenced by: Based on record review, observation, operational testing and interview, the facility failed to ensure that battery powered emergency lighting was tested in accordance with NFPA 101. Failure to test emergency lights for thirty seconds monthly and ninety minutes annually could result in equipment failure during a power outage. This deficient practice affected 8 residents, staff and visitors in the 100 hall and the northeast 500 wing dining on the date of the survey. The facility is licensed for 117 SNF/NF beds and had a census of 22 on the day of the survey.</p> <p>Findings include:</p> <p>1) During review of the facility inspection and testing documentation conducted on February 7, 2017 from approximately 9:30 AM to 10:30 AM, no records were provided indicating battery powered emergency lighting was tested for thirty seconds monthly and ninety minutes annually. When asked about any documentation, the Plant Operations Manager stated the facility did not have any emergency lighting that was not</p>	K 291	<p>K 291</p> <p>Maintenance Director to perform following: 1) Initiate testing records for exit lights powered by backup battery. 2) Replace 100 hall and 500 hall exit lights. 5) Test exit lights identified with backup battery power</p> <p>All residents have the potential to be affected</p> <p>Maintenance Director to test Battery backup powered emergency exit lights monthly for 30 seconds and annually for 90 minutes</p> <p>Maintenance director to report findings to QAPI monthly X 3 months for review and further comment as indicated</p>	<p>00C 3/14/17</p>

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NAME OF PROVIDER OR SUPPLIER COEUR D'ALENE OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 2614 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814	
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K 291	Continued From page 6 Interconnected to the generator. 2) During the facility tour conducted on February 7, 2017 from approximately 1:30 PM to 2:30 PM, observation of installed exit signs revealed five (5) signs equipped with battery powered backup. Further observation and operational testing of these lights revealed the exit sign at the 100 hall by the Therapy gym and the northeast 500 hall dining had dead batteries. Actual NFPA standard: 7.9.3 Periodic Testing of Emergency Lighting Equipment. 7.9.3.1 Required emergency lighting systems shall be tested in accordance with one of the three options offered by 7.9.3.1.1, 7.9.3.1.2, or 7.9.3.1.3. 7.9.3.1.1 Testing of required emergency lighting systems shall be permitted to be conducted as follows: (1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, except as otherwise permitted by 7.9.3.1.1(2). (2)*The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction. (3) Functional testing shall be conducted annually for a minimum of 11.2 hours if the emergency lighting system is battery powered. (4) The emergency lighting equipment shall be fully operational for the duration of the tests required by 7.9.3.1.1(1) and (3). (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the	K 291	<i>Page intentionally left blank</i>	

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K 291	Continued From page 7 authority having jurisdiction.	K 291		
K 353 SS=D	<p>NFPA 101 Sprinkler System - Maintenance and Testing</p> <p>Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.</p> <p>a) Date sprinkler system last checked</p> <p>b) Who provided system test</p> <p>c) Water system supply source</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure fire suppression system pendants were maintained free of obstructions such as paint or corrosion. Failure to maintain fire sprinkler pendants free of obstructions could hinder system performance during a fire event. This deficient practice affected staff and visitors on the date of the survey. The facility is licensed for 117 SNF/NF beds and had a census of 22 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on February 7,</p>	K 353	<p>Maintenance Director to schedule replacement of 3 corroded pendants</p> <p>All residents have the potential to be affected</p> <p>Maintenance Director to establish scheduled inspections of fire sprinkler pendants</p> <p>Maintenance director to perform quarterly inspection of fire sprinkler pendants</p> <p>Maintenance director to report findings to QAPI committee monthly X 3 months for review and further comment as indicated</p>	Doc 3/4/17

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K 353	Continued From page 8 2017 from approximately 10:30 AM to 2:30 PM, observation of the installed fire suppression system sprinkler pendants revealed the following: Housekeeping storage abutting the Administrative wing: Close visual inspection from a ladder of the installed pendant showed signs of corrosion. Dishwashing area of the main Kitchen: Close visual inspection from a ladder of the two (2) pendants over the dishwasher showed signs of corrosion on both pendants. Interview of the Plant Operations Manager revealed he was not aware of these corroded pendants prior to the date of the survey. Actual NFPA standard: NFPA 25 5.2.1 Sprinklers. 5.2.1.1* Sprinklers shall be inspected from the floor level annually. 5.2.1.1.1* Sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., upright, pendent, or sidewall). 5.2.1.1.2 Any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage	K 353	<i>Page intentionally left blank</i>	

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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 02/07/2017
NAME OF PROVIDER OR SUPPLIER COEUR D'ALENE OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814	
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K 353	Continued From page 9 (2) Corrosion (3) Physical damage (4) Loss of fluid in the glass bulb heat responsive element (5)*Loading (6) Painting unless painted by the sprinkler manufacturer	K 353		
K 711 SS=F	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This STANDARD is not met as evidenced by: Based on record review, the facility failed to ensure the fire safety plan contained all nine elements, in accordance with NFPA 101. Failure to provide a written fire safety plan which includes a call to the local fire department could hinder response by emergency personnel in the event of a fire. This deficient practice affected 22 residents, staff and visitors on the date of the survey. The facility is currently licensed for 117 SNF/NF beds and had a census of 22 on the day of the survey. Findings include:	K 711 K 711	Update to evacuation and relocation plan to include an emergency phone call by the facility to the fire department All residents have the potential to be affected Maintenance director/Admin to Inservice staff related to updated evacuation and relocation plan to include an emergency phone call by the facility to the fire department Maintenance director/Admin to perform scheduled audits of staff knowledge of update to evacuation and relocation plan Maintenance director to report findings to QAPI committee monthly X 3 months for review and further comment as indicated	000 3/14/17

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K 711	Continued From page 10 During review of the facility emergency preparedness policies conducted on February 7, 2017 from approximately 9:30 AM to 10:30 AM, review of the Fire Safety Plan provided did not indicate the plan included an emergency phone call by the facility to the fire department in the event of a fire. Actual NFPA standard: 19.7.2.2 Fire Safety Plan. A written health care occupancy fire safety plan shall provide for all of the following: (1) Use of alarms (2) Transmission of alarms to fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire. (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire	K 711		
K 741 SS=D	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language	K 741	K 741 Maintenance director/Admin to perform following: 1) Remove unapproved smoking receptacles from smoking area outside employee breakroom, 2) Update to smoking policy to include language to ensure smoking is conducted in accordance to the	

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K 741	Continued From page 11 that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This STANDARD is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure that smoking regulations were provided in accordance with NFPA 101. Failure to provide and adhere to facility policies limiting residents' exposure to the hazards associated with smoking, could result in fires from improper disposal of smoking materials and/or in the presence of combustible liquids or gases. This deficient practice affected staff and visitors on the date of the survey. The facility is licensed for 117 SNF/NF beds and had a census of 22 on the day of the survey. Findings include: 1) During the facility tour conducted on February 7, 2017 from approximately 10:30 AM to 2:30 PM, observation of the area outside the employee breakroom revealed a coffee can filled with cigarette butts. Further observation of this area revealed the absence of a metal trash receptacle with a self-closing lid for emptying the coffee can. Interview of the Plant Operations Manager	K 741	provisions provided in the Life Safety Code, and 3) update smoking policy to include designated smoking area for employees All residents have the potential to be affected Maintenance director/admin to in-service staff related to updated smoking policy and designated smoking areas Maintenance director/admin to perform scheduled inspection of designated smoking areas and smoking receptacles Maintenance director/admin to report findings to QAPI committee monthly X 3 months for review and further comment as indicated	02/14/17

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K 741	<p>Continued From page 12 revealed this area was being used as a smoking area by the night shift staff.</p> <p>2) During review of the provided facility smoking policy conducted on February 7, 2017 from approximately 2:30 PM to 3:15 PM, no information was contained in the policy to ensure smoking was conducted in accordance to the provisions provided in the Life Safety Code such as in the absence of flammable liquids, combustible gases or oxygen, however did include the provision for designated smoking areas.</p> <p>3) Interview of the Administrator, Plant Operations Manager and the Business Office manager conducted on February 7, 2017 at approximately 3:15 PM revealed the designated smoking area allowed by the facility was at the back of the building by the emergency generator.</p> <p>Actual NFPA standard:</p> <p>19.7.4* Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions:</p> <p>(1) Smoking shall be prohibited in any room, ward, or individual enclosed space where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking.</p> <p>(2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required.</p> <p>(3) Smoking by patients classified as not</p>	K 741	<i>Page Intentionally left blank</i>		

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K 741	Continued From page 13 responsible shall be prohibited. (4) The requirement of 19.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.	K 741	<i>Page intentionally left blank</i>		

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER
COEUR D'ALENE OF CASCADIA

STREET ADDRESS, CITY, STATE, ZIP CODE
**2514 NORTH SEVENTH STREET
COEUR D'ALENE, ID 83814**

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C 000	<p>16.03.02 INITIAL COMMENTS</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 special focus Fire/Life Safety survey conducted on February 7, 2017. The facility was surveyed under the LIFE SAFETY CODE, 2012 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	<p>Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies, the plan of correction is prepared and submitted solely because of the requirements under state and federal law.</p> <p>C226</p> <p>K 211</p> <p>Maintenance Director to perform inspection for fire rated assemblies</p> <p>All residents have the potential to be affected</p> <p>Maintenance Director established monthly inspections for all fire rated assemblies</p>	
C 226	<p>02.106 Meet Fire and Life Safety Standards</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 "K" tags on CMS 2567</p> <p>K-200 Fire rated assemblies K-291 Emergency lighting K-353 Fire suppression system maintenance K-711 Fire Safety and evacuation</p>	C 226	<p>Maintenance director to report inspection findings to QAPI committee monthly X 3 months for review and further comment as indicated</p> <p>K 291</p> <p>Maintenance Director to perform following: 1) Initiate testing records for exit lights powered by backup battery. 2) Replace 100 hall and 500 hall exit lights. 5) Test exit lights identified with backup battery power</p> <p>All residents have the potential to be affected</p>	Doc 3/14/17

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Bureau of Facility Standards

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C 260	<p>Continued From page 2</p> <p>IDAPA 16.03.02.07 (h)</p> <p>07. Maintenance of Equipment. The facility shall establish routine test, check and maintenance procedures for all equipment.</p> <p>h. All range hoods and filters shall be cleaned at least weekly.</p>	C 260	<p>smoking is conducted in accordance to the provisions provided in the Life Safety Code, and 3) update smoking policy to include designated smoking area for employees</p> <p>All residents have the potential to be affected</p> <p>Maintenance director/admin to in-service staff related to updated smoking policy and designated smoking areas</p> <p>Maintenance director/admin to perform scheduled inspection of designated smoking areas and smoking receptacles</p> <p>Maintenance director/admin to report findings to QAPI committee monthly X 3 months for review and further comment as indicated</p> <p>C 260</p> <p>Dietary staff to clean hood filters</p> <p>Dietary staff have the potential to be affected.</p> <p>Dietary supervisor to add weekly cleaning of hood filters to scheduled sanitation logs</p> <p>Dietary supervisor to perform monthly audit of hood filter cleaning</p> <p>Dietary supervisor, to report findings to QAPI committee monthly X 3 months for review and further comment as indicated</p>	<p><i>DDC</i> 3/14/17</p> <p><i>DDC</i> 3/14/17</p>