



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
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June 7, 2017

Tiffany Goin, Administrator
Life Care Center of Lewiston
325 Warner Drive
Lewiston, ID 83501-4437

Provider #: 135128

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Ms. Goin:

On **June 1, 2017**, a Facility Fire Safety and Construction survey was conducted at **Life Care Center Of Lewiston** 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 an isolated 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 **June 20, 2017**. Failure to submit an acceptable PoC by **June 20, 2017**, may result in the imposition of civil monetary penalties by **July 10, 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 **July 6, 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 **July 6, 2017**. A change in the seriousness of the deficiencies on **July 6, 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 **July 6, 2017**, includes the following:

Denial of payment for new admissions effective **September 1, 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 **December 1, 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 **June 1, 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 **June 20, 2017**. If your request for informal dispute resolution is received after **June 20, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135128	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 06/01/2017
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF LEWISTON			STREET ADDRESS, CITY, STATE, ZIP CODE 325 WARNER DRIVE LEWISTON, ID 83501	
(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 55,000 square foot single story type V(111) building constructed in 1997. It is fully sprinklered and has smoke detection throughout. Currently the facility is licensed for 121 SNF/NF beds. The following deficiencies were cited during the annual fire/life safety survey conducted on June 1, 2017. The facility was surveyed under the LIFE SAFETY CODE, 2012 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	RECEIVED JUN 21 2017 FACILITY STANDARDS K - 161 SPECIFIC RESIDENTS No residents were directly affected by this practice. OTHER RESIDENTS All residents are at risk from this deficient practice. SYSTEMATIC CHANGES The identified wall penetration has been sealed by the Maintenance Director. An audit will be conducted of all fire barrier walls to ensure no other penetrations exist. When work is performed by external contractor, maintenance department will review prior to them leaving premises to ensure no holes exist between fire compartments.	
K 161 SS=D	NFPA 101 Building Construction Type and Height Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed	K 161		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

William J. ... Executive Director 6/19/17

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 161	<p>Continued From page 1</p> <p>non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111)</p> <p>7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered</p> <p>Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5)</p> <p>Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure the smoke and fire resistive properties of the structure were maintained. Failure to repair holes in fire resistive assemblies could allow fires to grow beyond incipient stages and pass between compartments. This deficient practice affected 16 residents, staff and visitors on the date of the survey. The facility is licensed for 121 SNF/NF beds and had a census of 87 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on June 1, 2017 from approximately 1:00 PM to 1:45 PM, an above the ceiling inspection, at the northeast corridor door to the Grand Dining room from the 100 hall, revealed an approximately two inch by six inch hole cut through the 1-hour fire barrier</p>	K 161	<p>MONITOR</p> <p>Maintenance Director or designee will ensure all future construction that penetrates a fire wall is sealed prior to contractor leaving facility.</p> <p>Maintenance Director or designee will audit fire barrier walls to ensure no wall penetrations monthly for three months. Results will be reported to monthly QA committee.</p> <p>DATE OF COMPLIANCE</p>	7/4/17

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K 161	Continued From page 2 ceiling. When viewed, this hole exposed the attic space above. Interview of the Maintenance Director revealed he was not aware of the hole in the 1-hour separation prior to the date of the survey. Actual NFPA standard: 19.1.6 Minimum Construction Requirements. 19.1.6.1 Health care occupancies shall be limited to the building construction types specified in Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7. (See 8.2.1.) 8.2 Construction and Compartmentation. 8.2.1 Construction. 8.2.1.1 Buildings or structures occupied or used in accordance with the individual occupancy chapters, Chapters 11 through 43, shall meet the minimum construction requirements of those chapters.	K 161		
K 321 SS=D	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1	K 321	K - 321 SPECIFIC RESIDENTS No residents were directly affected by this practice. OTHER RESIDENTS All residents are at risk from this deficient practice. SYSTEMATIC CHANGES The door in the laundry room has been repaired to close and latch when activated. An audit will be conducted to ensure all self-closing doors latch when activated. MONITOR Maintenance Director will audit self-closing monthly for three months. Results will be reported to monthly QA committee. DATE OF COMPLIANCE	7/6/17

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K 321	<p>Continued From page 3</p> <p>Area Automatic Sprinkler Separation N/A</p> <p>a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)</p> <p>This Standard is not met as evidenced by: Based on observation and operational testing, the facility failed to ensure corridor doors entering hazardous areas would fully close and latch when activated. Failure to protect hazardous areas could allow smoke, fires and dangerous gases to pass into corridors, hindering egress during a fire. This deficient practice affected staff and visitors on the date of the survey. The facility is licensed for 121 SNF/NF beds and had a census of 87 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on June 1, 2017 from approximately 10:00 AM to 11:00 AM, observation and operational testing of the self-closing doors entering the Laundry from the corridor, revealed 1 of 2 doors would not fully close and latch when activated.</p> <p>Actual NFPA standard:</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</p>	K 321		

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K 353	<p>Continued From page 5</p> <p>1) During review of facility maintenance and inspection records conducted on June 1, 2017 from approximately 8:15 AM to 10:00 AM, inspection records for the facility fire suppression system indicated "N/A" by the vendor in the report section asking if dry system pendants were ten (10) years of age or older.</p> <p>2) During the facility tour conducted on June 1, 2017 from approximately 11:00 AM to 2:00 PM, observation of dry barrel pendants in both the walk-in refrigerator and the walk-in freezer located in the main Kitchen, revealed these sprinklers were dated 2006, indicating they were over ten years old.</p> <p>3) During the facility tour conducted on June 1, 2017 from approximately 11:00 AM to 2:00 PM, observation of the Medical Records storage room in the 100 hall revealed approximately 16 inches of clearance from the bottom of the sprinkler pendant to the top of stored cardboard boxes of medical records. Interview of the Maintenance Director indicated he was aware of the requirement for clearance to storage from the bottom of the sprinkler.</p> <p>Actual NFPA standard:</p> <p>NFPA 25</p> <p>5.2.1.2* The minimum clearance required by the installation standard shall be maintained below all sprinkler deflectors.</p> <p>5.3.1.1.1.6* Dry sprinklers that have been in service for 10 years shall be replaced or representative samples shall be tested and then</p>	K 353	<p>MONITOR</p> <p>Maintenance Director will schedule and maintain documentation of all dry system inspections and any negative findings will be reported to the monthly QA committee.</p> <p>Maintenance Director will audit storage rooms to ensure compliance weekly for 4 weeks and then monthly for three months. Results will be reported to monthly QA committee.</p> <p>DATE OF COMPLIANCE</p>	7/6/17

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K 353	Continued From page 6 retested at 10-year intervals. NFPA 13 8.5.6* Clearance to Storage. 8.5.6.1* Unless the requirements of 8.5.6.2, 8.5.6.3, 8.5.6.4, or 8.5.6.5 are met, the clearance between the deflector and the top of storage shall be 18 in. (457 mm) or greater.	K 353		
K 374 SS=D	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure smoke barrier doors would resist the passage of smoke. Failure to maintain smoke seals on smoke barrier doors could allow smoke and dangerous gases to pass between smoke compartments, hindering egress of residents during a fire. This deficient practice affected 15 residents, staff and visitors on the date of the survey. The facility is licensed for 121 SNF/NF beds and had a census of 87 on the day of the survey.	K 374	K - 374 SPECIFIC RESIDENTS No residents were directly affected by this practice. OTHER RESIDENTS All residents are at risk from this deficient practice. SYSTEMATIC CHANGES Maintenance has repaired identified door with smoke gasket material to meet NFPA Standard. All smoke barrier doors will be inspected to ensure smoke gasket material is in place. MONITOR Maintenance Director or designee will conduct inspections of door smoke gaskets monthly for three months. Any door with missing material will be replaced. Results will be reported to monthly QA committee. DATE OF COMPLIANCE	7/6/17

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

Printed: 06/06/2017
FORM APPROVED
OMB NO. 0938-0391

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K 374	<p>Continued From page 7</p> <p>Findings include:</p> <p>During the facility tour conducted on June 1, 2017 from approximately 11:00 AM to 11:45 AM, observation and operational testing of the smoke barrier doors in the 200 hall revealed 1 of 2 leaves (north side) in the door assembly was missing approximately 15 inches of the installed smoke gasket material. Interview of the Maintenance Director revealed he was not aware of the missing gasket.</p> <p>Actual NFPA standard:</p> <p>NFPA 101</p> <p>8.5.4.4* Doors in smoke barriers shall be self-closing or automatic-closing in accordance with 7.2.1.8 and shall comply with the provisions of 7.2.1.</p> <p>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.</p> <p>NFPA 105</p> <p>Chapter 5 Maintenance</p> <p>5.2.1.3 Hardware and gaskets shall be inspected annually, and any parts found to be damaged or inoperative shall be replaced.</p>	K 374		