



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSSELL S. BARRON – 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

November 6, 2017

Candice Durham, 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. Durham:

On **October 24, 2017**, 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. 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 **November 19, 2017**. Failure to submit an acceptable PoC by **November 19, 2017**, may result in the imposition of civil monetary penalties by **December 9, 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 may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by , (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 . A change in the seriousness of the deficiencies on , may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by ,

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

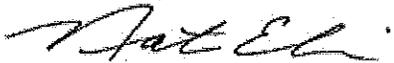
BFS Letters (06/30/11)

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

This request must be received by **November 19, 2017**. If your request for informal dispute resolution is received after **November 19, 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

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includes the following:

Denial of payment for new admissions effective .
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 , 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 **October 24, 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:

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

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

PRINTED: 11/06/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135103	(X2) MULTIPLE CONSTRUCTION: A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/24/2017
NAME OF PROVIDER OR SUPPLIER PRESTIGE CARE & REHABILITATION - THE ORCHARDS			STREET ADDRESS, CITY, STATE, ZIP CODE 1014 BURRELL AVENUE 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 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 at the above facility during the annual fire/life safety code survey conducted on October 24, 2017. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Chapter 19, Existing Healthcare Occupancies, in accordance with 42 CFR 483.70, 483.80 and 42 CFR 483.65. The Survey was conducted by: Linda Chaney Health Facility Surveyor Facility Fire Safety and Construction NFPA 101 General Requirements - Other	K 000	K 100-F <i>What corrective action will be accomplished for those residents found to have been affected by the deficient practice</i> <i>The facility has completed and implemented a water management plan, which includes a risk assessment and testing protocols for the prevention of waterborne pathogens such as Legionella</i> <i>How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</i> <i>All facility residents have the potential to be affected by the deficient practice</i> <i>What measures will be put in to place or what systemic changes you will make to ensure that the deficient practice does not recur</i> <i>The facility has completed and implemented a water</i>	
K 100 SS=F	General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This STANDARD is not met as evidenced by: Based on record review, and interview, the facility failed to develop and implement a water management plan. Failure to develop and implement a facility specific water management plan could increase risk of growth and spread of	K 100		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Cecilia Santana* TITLE *Administrator* (X6) DATE *11/17/17*

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 100	Continued From page 1 Legionella and other opportunistic pathogens in building water systems. This deficient practice could potentially affect all residents, visitors and staff on the date of the survey. The facility is licensed for 127 SNF/NF residents and had a census of 55 on the day of the survey.	K 100	<i>management plan, which includes a risk assessment and testing protocols for the prevention of waterborne pathogens such as Legionella</i>	
K 325 SS=F	Findings include: During the review of facility records on October 24, 2017, from approximately 8:30 AM to 12:00 PM, no records were available demonstrating the facility had completed or implemented a water management plan, which included a risk assessment and testing protocols for the prevention of waterborne pathogens such as Legionella. When asked about the missing documentation, the interim Maintenance Director stated he was not aware of the requirement for such a plan. CFR standard: 42 CFR 483.65 § 483.65 Infection control. The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. Additional reference: Center for Medicaid/Medicare Services S & C letter 17-30 NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR)	K-325	<i>How will the corrective action be monitored to ensure the deficient practice will not recur Facility Maintenance Director will review the water management plan at the Monthly QAPI Committee x's 3 months then quarterly x3, to ensure compliance and assist with further plan of action of needed Date the deficient practice correction will be completed 12/01/17</i>	

12/1/17

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K 325	Continued From page 2 Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 This STANDARD is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure Alcohol Based Hand Rub Dispensers (ABHR) were maintained in accordance with NFPA 101. Failure to test and document the operation of ABHR dispensers in accordance with the manufacturer's care and use instructions each time a new refill is installed could result in inadvertently spilling flammable liquids, increasing the risk of fires. This deficient practice affected all residents, staff and visitors on the date of the survey. The facility is licensed for 127 SNF/NF residents and had a census of 55 on the day of the survey.	K 325	<i>K 325-F</i> <i>What corrective action will be accomplished for those residents found to have been affected by the deficient practice</i> <i>All alcohol based hand rub dispensers were immediately tested in accordance with manufacturer's care and use instructions</i> <i>How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</i> <i>All residents have the potential to be affected by the deficient practice; the facility has conducted audit of all alcohol based hand rub dispensers to ensure patency and no spillage of flammable liquid</i>	

12/1/17

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K 325	Continued From page 3 Findings include: During the review of facility inspection records on October 24, 2017 from approximately 8:30 AM to 12:00 PM, no records were available indicating ABHR dispensers were tested in accordance with manufacturer's care and use instructions when a new refill is installed. ABHR dispensers were observed throughout the facility and when asked, the Maintenance Director stated the facility was not aware of the requirement to test ABHR dispensers each time a new refill is installed. Actual NFPA standard: NFPA 101 19.3.2.6* Alcohol-Based Hand-Rub Dispensers. Alcohol-based hand-rub dispensers shall be protected in accordance with 8.7.3.1, unless all of the following conditions are met: (1) Where dispensers are installed in a corridor, the corridor shall have a minimum width of 6 ft (1830 mm). (2) The maximum individual dispenser fluid capacity shall be as follows: (a) 0.32 gal (1.2 L) for dispensers in rooms, corridors, and areas open to corridors (b) 0.53 gal (2.0 L) for dispensers in suites of rooms (3) Where aerosol containers are used, the maximum capacity of the aerosol dispenser shall be 18 oz. (0.51 kg) and shall be limited to Level 1 aerosols as defined in NFPA30B, Code for the Manufacture and Storage of Aerosol Products. (4) Dispensers shall be separated from each other by horizontal spacing of not less than 48 in. (1220 mm).	K 325	<i>What measures will be put in to place or what systemic changes you will make to ensure that the deficient practice does not recur</i> <i>Housekeeping staff have been educated regarding the testing of alcohol based hand rub dispensers according to manufacturer's care and use instructions when a new refill is installed and to the documentation required to maintain compliance</i> <i>How will the corrective action be monitored to ensure the deficient practice will not recur</i> <i>Maintenance Director will review in Monthly QAPI Committee x's 3 months then quarterly x3, to ensure compliance and assist with further plan of action of needed</i> <i>Date the deficient practice correction will be completed</i> <i>12/01/17</i>	

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K 325	Continued From page 4 (5) Not more than an aggregate 10 gal (37.8 L) of alcohol-based hand-rub solution or 1135 oz (32.2 kg) of Level 1 aerosols, or a combination of liquids and Level 1 aerosols not to exceed, in total, the equivalent of 10 gal (37.8 L) or 1135 oz (32.2 kg), shall be in use outside of a storage cabinet in a single smoke compartment, except as otherwise provided in 19.3.2.6(6). (6) One dispenser complying with 19.3.2.6 (2) or (3) per room and located in that room shall not be included in the aggregated quantity addressed in 19.3.2.6(5). (7) Storage of quantities greater than 5 gal (18.9 L) in a single smoke compartment shall meet the requirements of NFPA 30, Flammable and Combustible Liquids Code. (8) Dispensers shall not be installed in the following locations: (a) Above an ignition source within a 1 in. (25 mm) horizontal distance from each side of the ignition source (b) To the side of an ignition source within a 1 in. (25 mm) horizontal distance from the ignition source (c) Beneath an ignition source within a 1 in. (25 mm) vertical distance from the ignition source (9) Dispensers installed directly over carpeted floors shall be permitted only in sprinklered smoke compartments. (10) The alcohol-based hand-rub solution shall not exceed 95 percent alcohol content by volume. (11) Operation of the dispenser shall comply with the following criteria: (a) The dispenser shall not release its contents except when the dispenser is activated, either manually or automatically by touch-free activation. (b) Any activation of the dispenser shall occur	K 325		

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K 325	Continued From page 5 only when an object is placed within 4 in. (100 mm) of the sensing device. (c) An object placed within the activation zone and left in place shall not cause more than one activation.	K 325	K 353-D <i>What corrective action will be accomplished for those residents found to have been affected by the deficient practice</i>	
K 353. SS=D	(d) The dispenser shall not dispense more solution than the amount required for hand hygiene consistent with label instructions. (e) The dispenser shall be designed, constructed, and operated in a manner that ensures that accidental or malicious activation of the dispensing device is minimized. (f) The dispenser shall be tested in accordance with the manufacturer's care and use instructions each time a new refill is installed. NFPA 101 Sprinkler System - Maintenance and Testing 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. a) Date sprinkler system last checked b) Who provided system test c) Water system's supply source 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:	K 353	<i>The head wrench for TY313, TY323, and TY3431 sprinkler heads is now in the Spare sprinkler box at the riser room; the two dry barrel sprinkler heads needing to be tested... one at the north entry from admin parking and one at the south entry center courtyard have been tested and documentation of such has been completed</i> <i>How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</i> <i>All residents have the potential to be affected by the deficient practice; facility Maintenance Director has received 1:1 in-service from the Administrator regarding his</i>	12/1/17

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K 353	Continued From page 6 Based on record review and interview, the facility failed to maintain the fire suppression system in accordance with NFPA 25. Failure to maintain fire suppression systems could hinder system performance during a fire event. This deficient practice affected all residents, staff and visitors on the date of the survey. The facility is licensed for 127 SNF/NF beds and had a census of 55 on the day of the survey. Findings include: During record review on October 24, 2017, from approximately 8:30 AM to 12:00 PM, an annual fire sprinkler inspection document dated May 23, 2017 identified the following deficiencies: a.) No head wrench for TY313, TY323, and TY3431 sprinkler heads in the spare sprinkler box at the riser room. b.) Two (2) dry barrel sprinkler heads needed to be tested or replaced. One at the North Entry/Exit from main parking and one at the South Entry/Exit Center Courtyard. These deficiencies were also identified on the quarterly sprinkler inspections dated January 25, 2017 and August 29, 2017. No documentation that the deficiencies had been corrected could be produced. When asked, the Maintenance Director stated the facility had not yet corrected the deficiencies. Actual NFPA standard: NFPA 25 5.4.1.6* A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. 5.4.1.6.1 One sprinkler wrench shall be provided for each type of sprinkler installed.	K 353	<i>role in compliance with deficient practice</i> <i>What measures will be put in to place or what systemic changes you will make to ensure that the deficient practice does not recur</i> <i>Facility Maintenance Director will conduct weekly checks x3 months to ensure head wrench is available in the spare sprinkler box at the riser room and to ensure all dry barrel sprinkler heads have been tested are replaced</i> <i>How will the corrective action be monitored to ensure the deficient practice will not recur</i> <i>Facility Maintenance Director will review at the Monthly QAPI Committee x's 3 months to ensure compliance and assist with further plan of action of needed</i> <i>Date the deficient practice correction will be completed</i> <i>12/01/17</i>	12/1/17	

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K 353	Continued From page 7 5.3.1.1.2* Where sprinklers are subjected to harsh environments, including corrosive atmospheres and corrosive water supplies, on a 5-year basis, either sprinklers shall be replaced or representative sprinkler samples shall be tested.	K 353			
K 918 SS=F	NFPA 101 Electrical Systems - Essential Electric System Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design	K 918	<i>K 918-F What corrective action will be accomplished for those residents found to have been affected by the deficient practice Facility generator for the EES has been inspected and tested under load to ensure reliability during a power loss How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken All facility residents have the potential to be affected by the deficient practice; the facility Maintenance Director will complete the generator inspection and test weekly, ongoing to ensure reliability during a</i>		

12/1/17

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135103	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2017
NAME OF PROVIDER OR SUPPLIER PRESTIGE CARE & REHABILITATION - THE ORCHARDS			STREET ADDRESS, CITY, STATE, ZIP CODE 1014 BURRELL AVENUE LEWISTON, ID 83501		
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K 918	Continued From page 8 consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the generator for the EES (Essential Electrical System) was maintained in accordance with NFPA 110. Failure to inspect and test EES generators could result in a lack of system reliability during a power loss. This deficient practice affected all residents, staff and visitors on the date of the survey. The facility is licensed for 127 SNF/NF beds and had a census of 55 on the date of the survey. Findings include: 1.) During review of the facility generator inspection and testing records on October 24, 2017, from approximately 8:30 AM to 12:00 PM, the facility failed to provide weekly generator inspection logs for the following weeks: 1/1/17 - 1/7/17, 1/29/17 - 2/4/17, 3/12/17 - 3/18/17, 6/4/17 - 6/10/17, 6/18/17 - 6/24/17, 6/25/17 - 7/1/17, 7/2/17 - 7/8/17, 7/9/17 - 7/15/17, 7/23/17 - 7/29/17, 7/30/17 - 8/5/17, 8/13/17 - 8/19/17, 8/20/17 - 8/26/17, 9/17/17 - 9/23/17, 9/24/17 - 9/30/17 2.) During review of the facility generator inspection and testing records on October 24, 2017, from approximately 8:30 AM to 12:00 PM, the facility failed to provide monthly load tests for the months of December 2016, January 2017, June 2017, and September 2017. When asked, the Maintenance Director stated he thought if they did an annual inspection, they were not required to do monthly load tests. He	K 918	<i>power loss; the facility Maintenance Director will conduct inspection and test under load at least monthly</i> <i>- What measures will be put in to place or what systemic changes you will make to ensure that the deficient practice does not recur</i> <i>Facility Maintenance Director has been provided with 1:1 education from the Administrator regarding his role in inspecting and testing the facility generator weekly to ensure reliability during a power loss</i> <i>How will the corrective action be monitored to ensure the deficient practice will not recur</i> <i>Facility Maintenance Director will review results of weekly checks at the Monthly QAPI Committee x's 3 months to ensure compliance and assist with further plan of action of needed</i>		

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K 918	Continued From page 9 also stated that weekly inspections were sometimes missed when he wasn't there. Actual NFPA standard:	K 918	<i>Date the deficient practice correction will be completed</i> 12/01/17		
	NFPA 110 8.4 Operational Inspection and Testing. 8.4.1* EPSSs, including all appurtenant components, shall be inspected weekly and exercised under load at least monthly. 8.4.2* Diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS nameplate kW rating				12/1/17