



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

May 16, 2018

Rick Myers, Administrator
Life Care Center of Sandpoint
1125 North Division Street
Sandpoint, ID 83864-2148

Provider #: 135127

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

Dear Mr. Myers:

On **May 8, 2018**, a Facility Fire Safety and Construction survey was conducted at **Life Care Center of Sandpoint** 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 **May 29, 2018**. Failure to submit an acceptable PoC by **May 29, 2018**, may result in the imposition of civil monetary penalties by **June 18, 2018**.

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 **June 12, 2018**, (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 **June 12, 2018**. A change in the seriousness of the deficiencies on **June 12, 2018**, 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 **June 12, 2018**, includes the following:

Denial of payment for new admissions effective **August 8, 2018**.
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 **November 8, 2018**, 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 **May 8, 2018**, 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:

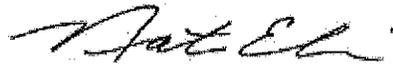
BFS Letters (06/30/11)

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

This request must be received by **May 29, 2018**. If your request for informal dispute resolution is received after **May 29, 2018**, 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

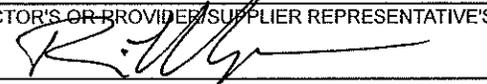
NE/lj
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 05/08/2018
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT	STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	<p>INITIAL COMMENTS</p> <p>The facility is a single story, Type V (111) structure that was originally completed in October of 1997. The building is protected throughout by an automatic fire suppression system in accordance with NFPA 13, along with an interconnected fire alarm/smoke detection system and is equipped with a diesel powered, EES (Emergency Electrical System) generator. Currently the facility is licensed for 124 SNF/NF beds, with a census of 89 on the date of the survey.</p> <p>The following deficiencies were cited during the annual Fire/Life safety survey conducted on May 8, 2018. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.</p> <p>The Survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	K 000	<p style="text-align: center;">RECEIVED</p> <p style="text-align: center;">MAY 25 2018</p> <p style="text-align: center;">FACILITY STANDARDS</p>	
K 100 SS=F	<p>General Requirements - Other CFR(s): NFPA 101</p> <p>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 REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to demonstrate implementation of a water management program for waterborne pathogens</p>	K 100	<p>Facility map has been updated to identify boilers, chiller, and fire suppression system. Facility Water Management Risk Assessment tool has also been updated. Added to Tels schedule for appropriate water testing. Appropriate vendor has been contacted and testing will be complete on soonest available date, no later than 6-30-18. (cont'd)</p>	6/30/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE EXECUTIVE DIRECTOR	(X6) DATE 5-23-18
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 100	Continued From page 1 such as Legionella, in accordance with 42 CFR 483.80. Failure to conduct a facility based risk assessment that includes all known components of the facility complex water system, limits the facility's ability to implement correct control measures and testing protocols based on insufficient data. This deficient practice affected 89 residents, staff and visitors on the date of the survey. Findings include: During review of provided water management documentation conducted on 5/8/18 from approximately 9:30 - 10:00 AM, documentation failed to identify known components of the complex water system in the facility risk assessment. These components included: Facility boiler(s). Facility chiller. Facility fire suppression system. CFR standard: 42 CFR 483.80 § 483.80 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	K 100	Maintenance staff educated that the facility boilers, chiller, and fire suppression system are "closed loop" systems and still require appropriate annual monitoring for Legionella. Maintenance Director, or designee, will verify that testing has been completed on an annual basis.	6/30/18	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing	K 353	Spreadsheet created to provide accurate documentation for weekly inspection of dry system gauges. Inspections will be added to Tels System.	6/30/18	

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K 353	Continued From page 3 2) During the facility tour conducted on 5/8/18 from 1:00 - 3:00 PM, observation of the spare sprinkler pendants at the main riser revealed only nine (9) spare pendants. Actual NFPA standard: NFPA 25 5.2.4 Gauges. 5.2.4.2 Gauges on dry, preaction, and deluge systems shall be inspected weekly to ensure that normal air and water pressures are being maintained. 5.4.1.5 The stock of spare sprinklers shall include all types and ratings installed and shall be as follows: (1) For protected facilities having under 300 sprinklers - no fewer than 6 sprinklers (2) For protected facilities having 300 to 1000 sprinklers - no fewer than 12 sprinklers (3) For protected facilities having over 1000 sprinklers - no fewer than 24 sprinklers	K 353	An additional 3 sprinkler heads have been ordered. A monthly audit system has been initiated and added to the Tels System. Maintenance staff have been educated on appropriate number of spare sprinkler heads to have in inventory and to notify the Maintenance Director if there are less than 12. Maintenance Director, or designee, will verify that there are 12 spare sprinkler heads in inventory weekly for three weeks and monthly for three months.	6/30/18 6/30/18 6/30/18
K 918 SS=F	Electrical Systems - Essential Electric System CFR(s): NFPA 101 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	K 918	Annual test for the diesel powered generator's fuel is scheduled for 5-29-18. Testing schedule added to Tels System and in-house calendar. Maintenance staff educated that the fuel in the diesel powered generator is to be tested annually. Maintenance Director, or designee, will verify that the test has been completed on an annual basis.	6/30/18 6/30/18 6/30/18

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

Printed: 05/16/2018
FORM APPROVED
OMB NO. 0938-0391

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K 918	<p>Continued From page 4</p> <p>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, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.</p> <p>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure the EES (Essential Electrical System) generator was maintained in accordance with NFPA 110. Failure to annually test the fuel for diesel powered generators has the potential of hindering system performance during a power loss or other emergency. This deficient practice affected 89 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During review of annual inspection and maintenance records conducted on 5/8/18 from approximately 9:30 AM to 12:00 PM, records provided for the annual generator inspection did</p>	K 918		

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K 918	Continued From page 5 not indicate any testing was completed for the fuel supply. When asked, the Maintenance Director stated he was aware of the fuel testing requirement for diesel-fired systems, but the test had not yet been conducted. Actual NFPA standard: NFPA 110 8.3.8 A fuel quality test shall be performed at least annually using tests approved by ASTM standards.	K 918		

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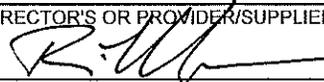
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E 000	<p>Initial Comments</p> <p>The facility is a single story, Type V (111) structure that was originally completed in October of 1997. The building is protected throughout by an automatic fire suppression system in accordance with NFPA 13, along with an interconnected fire alarm/smoke detection system and is equipped with a diesel powered, EES (Emergency Electrical System) generator. The facility is located in a municipal fire district with additional county emergency support services. Currently the facility is licensed for 124 SNF/NF beds, with a census of 89 on the date of the survey.</p> <p>The facility was found to be in substantial compliance during the emergency preparedness survey conducted on May 8, 2018. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.</p> <p>The Survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	E 000	<p>RECEIVED</p> <p>MAY 25 2018</p> <p>FACILITY STANDARDS</p>	
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