



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

July 3, 2018

Jacob Moore, 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. Moore:

On **June 19, 2018**, 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 **July 16, 2018**. Failure to submit an acceptable PoC by **July 16, 2018**, may result in the imposition of civil monetary penalties by **August 5, 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 **July 24, 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 **July 24, 2018**. A change in the seriousness of the deficiencies on **July 24, 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 **July 24, 2018**, includes the following:

Denial of payment for new admissions effective **September 19, 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 **December 19, 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 **June 19, 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:

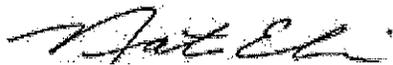
BFS Letters (06/30/11)

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

This request must be received by **July 16, 2018**. If your request for informal dispute resolution is received after **July 16, 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

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

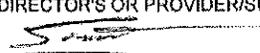
PRINTED: 07/13/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  06/19/2018
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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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(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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E 000	<p>Initial Comments</p> <p>The facility is a single-story, type V (111) construction built in 1961. The building is fully sprinklered with a complete fire alarm/smoke detection system that includes resident rooms. There are multiple exits to grade. The facility is currently licensed for 117 beds, and had a census of 42 on the dates of the survey.</p> <p>The facility was found to be in substantial compliance during the initial Emergency Preparedness Survey conducted on June 18 - 19, 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>Linda Chaney Health Facility Surveyor Facility Fire Safety &amp; Construction</p>	E 000	<p><b>RECEIVED</b></p> <p>JUL 16 2018</p> <p><b>FACILITY STANDARDS</b></p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE CEO - CO4 Cascadia	(X6) DATE 7/16/18
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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.

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:  135052	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - PINWOOD CARE CENTER  B. WING _____	(X3) DATE SURVEY COMPLETED  06/19/2018
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)
K 000	<p>INITIAL COMMENTS</p> <p>The facility is a single-story, type V (111) construction built in 1961. The building is fully sprinklered with a complete fire alarm/smoke detection system that includes resident rooms. There are multiple exits to grade. The facility is currently licensed for 117 beds, and had a census of 42 on the dates of the survey.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on June 18 - 19, 2018. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Chapter 19, Existing Healthcare Occupancies, in accordance with 42 CFR 483.70, 42 CFR 483.80 and 42 CFR 483.65.</p> <p>The survey was conducted by:</p> <p>Linda Chaney Health Facility Surveyor Facility Fire Safety and Construction</p> <p>K 232 Aisle, Corridor, or Ramp Width SS=F CFR(s): NFPA 101</p> <p>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 REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain corridor exit access free of</p>	K 000	<p><i>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Coeur d'Alene Health of Cascadia does not admit that the deficiencies listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.</i></p> <p>K 232 <u>K 232 – NFPA 101 Aisle, Corridor or Ramp Width</u></p> <p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</i> No residents were found to have been affected by this deficient practice.</p> <p><i>How will you identify other residents having the potential to be affected by the same practice and what anticipated corrective action will be taken?</i> All residents have the potential to be effected by this deficiency.</p>

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

TITLE

(X8) DATE

*[Signature]*

*Coeur d'Alene Cascadia*

*7/16/18*

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 232

Continued From page 1  
obstructions. Failure to maintain exit access width in the path of travel, could hinder the safe evacuation of residents during a fire or other emergency. This deficient practice affected 42 residents, staff and visitors on the dates of the survey.

Findings include:

During the facility tour on June 18, 2018, from approximately 3:00 PM to 5:00 PM, observation of the exit access corridors revealed the intercom speakers projecting from the corridor wall 7 inches, tapering down to 4 inches at a height of approximately 71 inches from the floor and were located throughout the facility. When asked, the Maintenance Director stated the facility was unaware of the requirement for non-continuous projections.

Actual NFPA Standard:

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), non-continuous 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 be permitted.
- (4) Projections into the required width shall be

K 232

*Measure that will be put into place to ensure that this deficiency does not reoccur.*

All intercom speakers projecting greater than 7 inches from the wall will be replaced with speakers not more than 6 inches from the corridor wall.

*How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur?*

All intercom speakers will be inspected to ensure that no speakers are protruding greater than 6 inches above away from the wall.

*Individual Responsible:* Plant Manager

*Date of Completion:* 7/24/2018

*per rink  
change  
7-25-18  
JC*

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K 232	Continued From page 2 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 ft <sup>2</sup> (4.6 m <sup>2</sup> ). (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 with 19.3.4, or the fixed furniture spaces are arranged and located to	K 232			

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K 232	Continued From page 3 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 521 SS=F	HVAC CFR(s): NFPA 101  HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2  This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to maintain installed smoke/fire dampers. Failure to maintain and inspect smoke/fire dampers could allow the spread of smoke/fire from the space of fire origin to other compartments. This deficient practice has the potential to affect all residents, staff, and visitors on the dates of the survey.  Findings include:  During the review of facility inspection records on June 18, 2018, from approximately 8:30 AM to 3:00 PM, no records were available to indicate inspection and testing of smoke/fire dampers. When asked, the Maintenance Director stated the facility was aware of the requirement and was in	K 521	<b><u>K 521 – NFPA 101 HVAC</u></b> <i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</i> No residents were found to have been effected by this deficiency.  <i>How will you identify other residents having the potential to be affected by the same practice and what anticipated corrective action will be taken?</i> All residents have the potential to be effected by this deficiency.  <i>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</i> Coeur d'Alene Health of Cascadia will call and reserve the earliest possible date to have inspection and testing of smoke/fire dampers completed per the availability of the inspection company.	

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K 521	Continued From page 4 the process of scheduling the testing and inspection of the smoke/fire dampers.  Actual NFPA standard:  NFPA 101 19.5.2 Heating, Ventilating, and Air-Conditioning. 19.5.2.1 Heating, ventilating, and air-conditioning shall comply with the provisions of Section 9.2 and shall be installed in accordance with the manufacturer's specifications, unless otherwise modified by 19.5.2.2.  9.2 Heating, Ventilating, and Air-Conditioning. 9.2.1 Air-Conditioning, Heating, Ventilating Ductwork, and Related Equipment. Air-conditioning, heating, ventilating ductwork, and related equipment shall be in accordance with NFPA 90 A, Standard for the Installation of Air-Conditioning and Ventilating Systems, or NFPA 90B, Standard for the Installation of Warm Air Heating and Air-Conditioning Systems, as applicable, unless such installations are approved existing installations, which shall be permitted to be continued in service.  NFPA 90 A 5.4.8.1 Fire dampers and ceiling dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. 5.4.8.2 Smoke dampers shall be maintained in accordance with NFPA 105, Standard for Smoke Door Assemblies and Other Opening Protectives.  NFPA 80 19.4.1 Each damper shall be tested and inspected 1 year after installation.	K 521	<i>How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur?</i> Inspection and testing of smoke/fire dampers will be tested every 4 years per the regulatory guidelines.  <i>Individual Responsible:</i> Plant Manager  <i>Date of Completion: <del>07/24/2018</del></i> <i>8/27/2018 JC</i>	
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K 521	Continued From page 5 19.4.1.1 The test and inspection frequency shall then be every 4 years, except in hospitals, where the frequency shall be every 6 years.  NFPA 105 6.5.2* Each damper shall be tested and inspected one year after installation. The test and inspection frequency shall then be every 4 years, except in hospitals, where the frequency shall be every 6 years.	K 521	
K 911 SS=F	Electrical Systems - Other CFR(s): NFPA 101  Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems 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, Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the Essential Electrical System (EES) generator was equipped with a remote manual stop station in accordance with NFPA 110. Failure to provide a remote stop, potentially hinders the ability of staff to shut down the generator if required. This deficient practice affected 42 residents, staff and visitors on the dates of the survey.  Findings include:  During the facility tour conducted on June 18, 2018 from approximately 3:00 PM to 5:00 PM, a remote manual stop station for the EES generator	K 911	<b><u>K 911 – NFPA 101 Electrical Systems</u></b> <i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</i> No residents were found to have been effected by this deficiency.  <i>How will you identify other residents having the potential to be affected by the same practice and what anticipated corrective action will be taken?</i> All residents have the potential to be effected by this deficiency.  <i>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</i> Coeur d'Alene Health of Cascadia will call and reserve the earliest possible date to have a remote manual stop station for the EES generator installed per the availability of the installation company.

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

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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		
(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 911	Continued From page 6 could not be located. When asked, the Maintenance Director stated the facility was not equipped with a remote stop station.  Actual NFPA standard:  NFPA 110  5.6.5.6* All installations shall have a remote manual stop station of a type to prevent inadvertent or unintentional operation located outside the room housing the prime mover, where so installed, or elsewhere on the premises where the prime mover is located outside the building. 5.6.5.6.1 The remote manual stop station shall be labeled. NFPA 99 6.4.1.1.16.2 Safety indications and shutdowns shall be in accordance with Table 6.4.1.1.16.2. (SEE TABLE)	K 911	<i>How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur?</i> Proper installation will be confirmed to IDT by Plant Manager once installation and testing have been completed.  <i>Individual Responsible:</i> Plant Manager  <i>Date of Completion:</i> <del>7/24/2017</del> 8/27/2018 NE	
K 926 SS=D	Gas Equipment - Qualifications and Training CFR(s): NFPA 101  Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on record review, and interview, the facility failed to ensure staff were properly trained on the risks associated with the storage, use and	K 926	<u><b>K 926 – NFPA 101 Gas Equipment – Qualifications and Training/Utilities – Gas and Electric</b></u> <i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</i> No residents were found to have been effected by this deficiency.  <i>How will you identify other residents having the potential to be affected by the same practice and what anticipated corrective action will be taken?</i> All residents have the potential to be effected by this deficiency.	

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  06/19/2018
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K 926	Continued From page 7 handling of medical gases. Failure to provide an initial and on-going education program which includes periodic review of safety guidelines and usage requirements for medical gases and their cylinders, could result in a life threatening or catastrophic accident. This deficient practice could potentially affect 8 residents using oxygen on the dates of the survey.  Findings include:  During the review of facility training records conducted on June 18, 2018 from approximately 8:30 AM to 3:00 PM, no records were available indicating that the facility maintained an ongoing continuing education program for staff which includes periodic review of safety guidelines and usage requirements for medical gases and their cylinders. When asked, the Maintenance Supervisor stated the facility was not aware of the requirement for medical gas training.  Actual NFPA Standard:  NFPA 101 19.3.2.4 Medical Gas. Medical gas storage and administration areas shall be in accordance with Section 8.7 and the provisions of NFPA 99, Health Care Facilities Code, applicable to administration, maintenance, and testing.  NFPA 99 11.5.2 Gases in Cylinders and Liquefied Gases in Containers. 11.5.2.1 Qualification and Training of Personnel. 11.5.2.1.1* Personnel concerned with the application and maintenance of medical gases and others who handle medical gases and the cylinders that contain the medical gases shall be	K 926	<i>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</i> Staff will be re-educated on proper medical gas handling at next All Staff Meeting to be held on 7/20/2018.  On-going education will be provided through utilization of Relias online training for appropriate staff.  <i>How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur?</i> Staff Development Coordinator will maintain records that ongoing training has been done, both in-person and online as deemed appropriate.  <i>Individual Responsible:</i> Plant Manager  <i>Date of Completion: 7/24/2018</i>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 926	Continued From page 8 trained on the risks associated with their handling and use. 11.5.2.1.2 Health care facilities shall provide programs of continuing education for their personnel. 11.5.2.1.3 Continuing education programs shall include periodic review of safety guidelines and usage requirements for medical gases and their cylinders.	K 926		
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