



IDAHO DEPARTMENT OF
HEALTH & WELFARE

.BRAD LITTLE – Governor
DAVE JEPPESEN – 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 5, 2019

Eric Miller, 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. Miller:

On **June 25, 2019**, 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 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).

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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 18, 2019**. Failure to submit an acceptable PoC by **July 18, 2019**, may result in the imposition of civil monetary penalties by **August 9, 2019**.

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 30, 2019**, (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 **September 23, 2019**. A change in the seriousness of the deficiencies on **August 9, 2019**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **July 30, 2019**, includes the following:

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Denial of payment for new admissions effective **September 25, 2019**.
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 25, 2019**, 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 25, 2019**, 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>

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

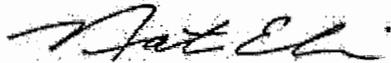
BFS Letters (06/30/11)

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

This request must be received by **July 18, 2019**. If your request for informal dispute resolution is received after **July 18, 2019**, 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
Enclosure

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

PRINTED: 07/06/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135052	(X2) MULTIPLE CONSTRUCTION: A. BUILDING 01 - PINWOOD CARE CENTER B. WING _____	(X3) DATE SURVEY COMPLETED 06/25/2019
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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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K.000 INITIAL COMMENTS

K.000

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 Essential Electrical System is supplied by a natural gas powered, on-site automatic generator with an annunciator and emergency stop. The facility is currently licensed for 117 beds and had a census of 48 on the dates of the survey.

The following deficiencies were cited during the annual fire/life safety survey conducted on June 24 - 25, 2019. 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:

Linda Chaney
Health Facility Surveyor
Facility Fire Safety & Construction

K.291 Emergency Lighting
SS=F CFR(s): NFPA 101

Emergency Lighting
Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9.18.2.9.1, 19.2.9.1

This REQUIREMENT is not met as evidenced by:

Based on record review, interview, and operational testing, the facility failed to provide operational emergency lighting and monthly emergency lighting test documentation. Failure to maintain and test emergency lighting could hinder

This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Coeur d'Alene Health and Rehabilitation of Cascadia does not admit that the deficiencies listed on the CMS Form 2567 exist, nor does the Facility admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.

K.291 Resident Specific
Emergency light by resident room #102 has been repaired. Testing of all emergency lights has been implemented throughout the facility monthly for every emergency light for at least 30 seconds and for at least 1-1/2 hours annually on the battery-powered lights and will maintain written records of these tests according to NFPA standards.

Other Residents
Emergency light by resident room #102 has been repaired. Testing of all emergency lights throughout the facility has been implemented weekly for the next four weeks to

RECEIVED

JUL 18 2019

FACILITY STANDARDS

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

TITLE

(X6) DATE

Executive Director

07/19/19

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 291	<p>Continued From page 1</p> <p>egress of residents during an emergency. This deficient practice affected 48 residents and staff on the dates of the survey.</p> <p>Findings include:</p> <p>During review of the emergency lighting test logs on June 24, 2019, from approximately 9:00 AM to 2:00 PM, records revealed thirty (30) second monthly testing of the emergency lighting had not been conducted in November or December 2018. Further, operational testing during the facility tour on June 25, 2019, from approximately 11:00 AM - 1:00 PM, revealed the emergency light by resident room #102 was non-operational. During an interview of the Maintenance Director on June 25, 2019, at approximately 11:30 AM, revealed the facility was unaware of the missing monthly testing. He also stated the facility was unaware of the inoperable emergency light.</p> <p>Actual NFPA reference:</p> <p>NFPA 101 19.2.9 Emergency Lighting. 19.2.9.1 Emergency lighting shall be provided in accordance with Section 7.9. 7.9.3 Periodic Testing of Emergency Lighting Equipment. 7.9.3.1 Required emergency lighting systems shall be tested in accordance with one of the three options offered by 7.9.3.1.1, 7.9.3.1.2, or 7.9.3.1.3. 7.9.3.1.1 Testing of required emergency lighting systems shall be permitted to be conducted as follows: (1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30</p>	K 291	<p>implemented weekly for the next four weeks to establish an appropriate baseline after which period the facility will resume monthly tests on every emergency light and written records of these tests will be kept and recorded according to NFPA standards.</p> <p>Facility Systems The Maintenance Director was educated on the requirements for NFPA 7.9.18.2.9.1, and 19.2.9.1. Re-education was provided by Chief Executive Officer to include but not limited to, all emergency lighting must have functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds and at least annually for a minimum of 1-1/2 hours if the emergency lighting system is battery powered.</p> <p>Monitor The Maintenance Director and/or designee will test every emergency light for at least 30 seconds once a week for 4 weeks then twice per month for 2 months to validate all emergency lights are functioning properly and all battery-powered emergency lights shall be tested for 1-1 1/2 hours by 7/26/2019 to ensure compliance with NFPA standards. Starting the week of 7/22/2019 the</p>	

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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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K291 Continued From page 2
seconds, except as otherwise permitted by 7.9.3.1.1(2).
(2)*The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction.
(3) Functional testing shall be conducted annually for a minimum of 1-1?2 hours if the emergency lighting system is battery powered.
(4) The emergency lighting equipment shall be fully operational for the duration of the tests required by 7.9.3.1.1(1) and (3).
(5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction.
7.9.3.1.2 Testing of required emergency lighting systems shall be permitted to be conducted as follows:
(1) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall be provided.
(2) Not less than once every 30 days, self-testing/self-diagnostic battery-operated emergency lighting equipment shall automatically perform a test with a duration of a minimum of 30 seconds and a diagnostic routine.
(3) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall indicate failures by a status indicator.
(4) A visual inspection shall be performed at intervals not exceeding 30 days.
(5) Functional testing shall be conducted annually for a minimum of 1-1?2 hours.
(6) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall be fully operational for the duration of the 1-1?2-hour test.
(7) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction.
7.9.3.1.3 Testing of required emergency lighting

K 291 review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate, Chief Executive Officer will review all tools during clinical meeting.

Date of compliance

July 30, 2019

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K 291	Continued From page 3 systems shall be permitted to be conducted as follows: (1) Computer-based, self-testing/self-diagnostic battery-operated emergency lighting equipment shall be provided. (2) Not less than once every 30 days, emergency lighting equipment shall automatically perform a test with a duration of a minimum of 30 seconds and a diagnostic routine. (3) The emergency lighting equipment shall automatically perform annually a test for a minimum of 1-122 hours. (4) The emergency lighting equipment shall be fully operational for the duration of the tests required by 7.9.3.1.3(2) and (3). (5) The computer-based system shall be capable of providing a report of the history of tests and failures at all times.	K 291	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide documentation of required fire	K 712	<p>K712</p> <p>Resident Specific Facility is conducting fire-drills at least quarterly on each shift including the transmission of a fire alarm signal and simulation of emergency fire conditions at expected and unexpected times under varying conditions on each shift according to NFPA standards.</p> <p>Other Residents Facility is conducting fire-drills at least quarterly on each shift including the transmission of a fire alarm signal and simulation of emergency fire conditions at expected and unexpected times under varying conditions on each shift according to NFPA standards.</p>

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K 712 Continued From page 4
drills, one per shift per quarter. Failure to perform fire drills on each shift quarterly could result in confusion and hinder the safe evacuation of residents during a fire event. This deficient practice affected all residents, staff and visitors on the dates of the survey.

Findings include:

During record review on June 24, 2019 from approximately 9:00 AM to 2:00 PM, review of the fire drill reports revealed the facility was missing fire drill documentation for third shift, second, third and fourth quarters of 2018. When asked during document review on June 24, 2019 at approximately 10:45 AM, the Maintenance Director stated he was new to his position and was unaware fire drills had not been performed during those time frames.

Actual NFPA standard:

19.7.1.6 Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions.

K 761 Maintenance, Inspection & Testing - Doors
SS=F CFR(s): NFPA 101

Maintenance, Inspection & Testing - Doors
Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility

K 712 † Facility Systems

The Maintenance Director was educated on the requirements for NFPA 19.7.1.4 through 19.7.1.7 by the Chief Executive Officer to include but not limited to having fire drills including the transmission of a fire alarm signal and simulation of emergency fire conditions to be held at expected and unexpected times under varying conditions, at least quarterly on each shift according to NFPA standards.

Monitor

The Maintenance Director and/or designee will conduct a fire drill at expected and unexpected times on each shift within 30 days and every quarter from that point forward.

Starting the week of 7/22/2019 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee.

K 761 **Date of compliance**

July 30, 2019

K761

Resident Specific

Fire doors assemblies have been inspected and tested in accordance with NFPA 80, standards for Fire

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K 761	<p>Continued From page 5 maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure fire and smoke rated assemblies were inspected in accordance with NFPA 80 and NFPA 105. Failure to inspect and test fire and smoke rated doors could result in a lack of compartmentalization. This deficient practice affected 48 residents and staff on the dates of the survey.</p> <p>Findings include:</p> <p>During review of provided facility annual inspection records conducted on June 24, 2019, from approximately 9:00 AM to 2:00 PM, documentation for an annual inspection and operational testing of fire and smoke rated assemblies could not be produced. Additionally, observation during the facility tour on June 25, 2019, from approximately 11:00 AM - 1:00 PM, revealed fire and smoke rated doors and assemblies throughout the building. When asked during document review on June 24, 2019 at approximately 11:30 AM, if fire and smoke rated doors and assemblies were inspected and tested annually, the Maintenance Director stated the facility was not aware they were required to document the inspection and testing of the rated doors.</p>	K 761	<p>Doors and Other Openings Protectives Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, and will be routinely inspected as part of the facility maintenance program and written records of inspection and testing are maintained and available for review according to NFPA standards.</p> <p>Other Residents Fire doors assemblies have been inspected and tested in accordance with NFPA 80, standards for Fire Doors and Other Openings Protectives Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, and will be routinely inspected as part of the facility maintenance program and written records of inspection and testing are maintained and available for review according to NFPA standards.</p> <p>Facility Systems The Maintenance Director was educated on the requirements for NFPA 80 by the Chief Executive Officer to include but not limited to fire doors assemblies are inspected and tested annually in accordance with NFPA 80, standards for fire doors and other openings protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the</p>

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K 761	Continued From page 6 Actual NFPA standard: NFPA 101 19.2.2.2 Doors. 19.2.2.2.1 Doors complying with 7.2.1 shall be permitted. 7.2.1 Door Openings. 7.2.1.15 Inspection of Door Openings. 7.2.1.15.1* Where required by Chapters 11 through 43, the following door assemblies shall be inspected and tested not less than annually in accordance with 7.2.1.15.2 through 7.2.1.15.8: (1) Door leaves equipped with panic hardware or fire exit hardware in accordance with 7.2.1.7 (2) Door assemblies in exit enclosures (3) Electrically controlled egress doors (4) Door assemblies with special locking arrangements subject to 7.2.1.6 7.2.1.15.2 Fire-rated door assemblies shall be inspected and tested in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Smoke door assemblies shall be inspected and tested in accordance with NFPA 105, Standard for Smoke Door Assemblies and Other Opening Protectives. NFPA 80 5.2* Inspections. 5.2.1* Fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 105 5.2 Specific Requirements. 5.2.1* Inspections.	K 761	facility maintenance program and will keep written records of these inspections and testing available for review. Monitor The Maintenance Director and/or designee will test all fire doors and assemblies once a week for 4 weeks and twice a month for 8 weeks. Starting the week of 7/22/2019 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate. Chief Executive Officer will review all tools during clinical meeting. Date of compliance July 30, 2019		

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K 761	Continued From page 7 5.2.1.1 Smoke door assemblies shall be inspected annually. 5.2.1.2 Doors shall be operated to confirm full closure. 5.2.1.3 Hardware and gaskets shall be inspected annually, and any parts found to be damaged or inoperative shall be replaced.	K 761		
K 918 SS=F	Electrical Systems - Essential Electric Syste 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 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	K 918	K918 Resident Specific Facility is inspecting generator sets weekly, and monthly load tests of 30 minutes in 20-40 day intervals and has conducted a three-year four-hour load test according to NFPA guidelines. Other Residents Facility is inspecting generator sets weekly, and monthly load tests of 30 minutes in 20-40 day intervals and has conducted a three-year four-hour load test according to NFPA guidelines. Facility Systems The Maintenance Director was educated on the requirements for NFPA 110 and 111 by the Chief Executive Officer to include but not limited to conducting weekly inspections of the facility generator sets and exercised monthly in 20-40 day intervals underload and once every 36 months for 4	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
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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 06/25/2019
NAME OF PROVIDER OR SUPPLIER COEUR D'ALENE OF CASCADIA		STREET ADDRESS, CITY, STATE, ZIP CODE 2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814		
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K 918	<p>Continued From page 8</p> <p>separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT 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 48 residents and staff on the dates of the survey.</p> <p>Findings include:</p> <p>1.) During review of the facility generator inspection and testing records on June 24, 2019, from approximately 9:00 AM to 2:00 PM, the facility failed to provide the following weekly generator inspection logs: a.) 7/1/18 - 7/7/18, 7/8/18 - 7/14/18, 7/15/18 - 7/21/18 b.) The entire months of August, October and December 2018 c.) 9/2/18 - 9/8/18 d.) 11/4/18 - 11/10/18, 11/11/18 - 11/17/18 e.) 12/30/18 - 1/5/19 f.) 2/3/19 - 2/9/19</p> <p>2.) During review of the facility generator inspection and testing records on June 24, 2019, from approximately 9:00 AM to 2:00 PM, the facility failed to provide documentation of monthly load tests for October, November and December 2018.</p>	K 918	<p>continuous hours to ensure complete functionality and proper backup of the facility's power system.</p> <p>Monitor</p> <p>The Maintenance Director and/or designee will conduct weekly inspections of the generator sets and will exercise the generator under load monthly in 20-40 day intervals and will exercise the generator once every 36 months for 4 continuous hours. Starting the week of 7/22/2019 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee.</p> <p>Date of compliance</p> <p>July 30, 2019</p>	

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K 918	<p>Continued From page 9</p> <p>3.) During review of the facility generator inspection and testing records on June 24, 2019, from approximately 9:00 AM to 2:00 PM, the facility failed to provide documentation for a three-year, four-hour load test.</p> <p>When asked during document review on June 24, 2019 at approximately 1:30 PM, the Maintenance Director stated he was new to his position and was unaware of the missing inspections and load test documentation.</p> <p>Actual NFPA standard:</p> <p>NFPA 110</p> <p>8.4 Operational Inspection and Testing.</p> <p>8.4.1* EPSSs, including all appurtenant components, shall be inspected weekly and exercised under load at least monthly.</p> <p>8.4.9* Level 1 EPSS shall be tested at least once within every 36 months.</p> <p>8.4.9.1 Level 1 EPSS shall be tested continuously for the duration of its assigned class (see Section 4.2).</p> <p>8.4.9.2 Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 continuous hours.</p> <p>8.4.9.3 The test shall be initiated by operating at least one transfer switch test function and then by operating the test function of all remaining ATSS, or initiated by opening all switches or breakers supplying normal power to all ATSS that are part of the EPSS being tested.</p> <p>8.4.9.4 A power interruption to non-EPSS loads shall not be required.</p> <p>8.4.9.5 The minimum load for this test shall be as specified in 8.4.9.5.1, 8.4.9.5.2, or 8.4.9.5.3.</p> <p>8.4.9.5.1 For a diesel-powered EPS, loading shall</p>	K 918	

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K 918	Continued From page 10 be not less than 30 percent of the nameplate kW rating of the EPS. A supplemental load bank shall be permitted to be used to meet or exceed the 30 percent requirement. 8.4.9.5.2 For a diesel-powered EPS, loading shall be that which maintains the minimum exhaust gas temperatures as recommended by the manufacturer. 8.4.9.5.3 For spark-ignited EPSs, loading shall be the available EPSS load. 8.4.9.6 The test required in 8.4.9 shall be permitted to be combined with one of the monthly tests required by 8.4.2 and one of the annual tests required by 8.4.2.3 as a single test. 8.4.9.7 Where the test required in 8.4.9 is combined with the annual load bank test, the first 3 hours shall be at not less than the minimum loading required by 8.4.9.5 and the remaining hour shall be at not less than 75 percent of the nameplate kW rating of the EPS.	K 918		



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – 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 5, 2019

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

Provider #: 135052

RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER

Dear Mr. Miller:

On **June 25, 2019**, an Emergency Preparedness survey was conducted at Coeur d'Alene of Cascadia by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. Your facility was found to be in substantial compliance with Federal regulations during this survey.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, which states that the facility complies with the requirements of CFR 42, 483.70(a) of the federal requirements. This form is for your records only and does not need to be returned.

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

Sincerely,

Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosure

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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 Essential Electrical System is supplied by a natural gas powered, on-site automatic generator with an annunciator and emergency stop. The facility is currently licensed for 117 beds and had a census of 48 on the dates of the survey.</p> <p>The facility was found to be in substantial compliance during the annual Emergency Preparedness Survey conducted on June 24 - 25, 2019. 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 & Construction</p>	E 000			

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

TITLE

(X6) DATE

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.