December 12, 2019

Brandi Jeffries, 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. Jeffries:

On December 2, 2019, 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 (XS) 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). 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 **December 26, 2019.** Failure to submit an acceptable PoC by **December 26, 2019,** may result in the imposition of civil monetary penalties by **January 16, 2020.**

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 **January 6, 2020,** (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 **March 1, 2020.** A change in the seriousness of the deficiencies on **January 16, 2020,** may result in a change in the remedy.
The remedy, which will be recommended if substantial compliance has not been achieved by January 6, 2020, includes the following:

Denial of payment for new admissions effective March 2, 2020.
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 June 2, 2020, 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 December 2, 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:

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 **December 26, 2019**. If your request for informal dispute resolution is received after **December 26, 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
Enclosures
The facility is a type V (111), single story structure with a partial basement originally constructed in 1958. The partial basement is staff-access only, utilizing a keypad entry system. This area houses the maintenance shop, fire suppression system riser and access to the facility mechanical spaces. The facility is located within a municipal fire district, with both county and state EMS services available. The building is fully sprinklered with an interconnected, fire alarm and smoke detection system and backup emergency power is provided with an on-site, spark-ignited Emergency Power Supply System (EPSS) generator. Currently the facility is licensed for 127 SNF/NF beds with a census of 60 on the date of the survey.

The following deficiencies were cited during the annual fire/life safety survey conducted on December 2, 2019. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Chapter 19, Existing Healthcare Occupancies, in accordance with 42 CFR 483.70.

The Survey was conducted by:

Sam Burbank
Health Facility Surveyor
Facility Fire Safety and Construction

<table>
<thead>
<tr>
<th>ID TAG</th>
<th>INITIAL COMMENTS</th>
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<tbody>
<tr>
<td>K 000</td>
<td>The plan of correction is prepared and submitted as required by law. By submitting this plan of correction, Prestige Care and Rehabilitation-The Orchards 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 deficiencies. The center reserves the rights to challenge in legal and/or regulatory administrative proceedings the deficiencies statements, facts, and conclusions that form the basis for the deficiencies.</td>
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</table>

Residents affected: All

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

K 345
Fire Alarm System - Testing and Maintenance

SS=F CFR(s): NFPA 101

Fire Alarm System - Testing and Maintenance
A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.

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.
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>PROVIDERS PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>K 345</td>
<td>Continued From page 1 available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72</td>
<td>A sensitivity report from the FACP will be completed.</td>
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<td>This REQUIREMENT is not met as evidenced by. Based on record review and interview, the facility failed to ensure fire alarm systems were maintained in accordance with NFPA 72. Failure to ensure fire alarm systems are maintained and tested as required, has the potential to hinder system response during a fire event. This deficient practice affected 60 residents and staff on the date of the survey.</td>
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<td>Findings include: During the review of provided fire alarm inspection and testing reports, no record was available demonstrating the documentation of a sensitivity testing of the fire alarm. Interview of the Maintenance Director at approximately 10:00 A.M., established he was not aware of the requirement for documenting addressable fire alarm system sensitivity testing.</td>
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<td>Actual NFPA standard: NFPA 72 Chapter 14 Inspection, Testing, and Maintenance</td>
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<td>14.1 Application. 14.1.1 The inspection, testing, and maintenance of systems, their initiating devices, and notification appliances shall comply with the requirements of this chapter.</td>
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<td>14.4.5.3 In other than one- and two-family dwellings, sensitivity of smoke detectors and single- and multiple-station smoke alarms shall be tested in accordance with 14.4.5.3.1 through 14.4.5.3.7.</td>
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</table>
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER’S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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<tr>
<td>K345</td>
<td>Continued From page 2</td>
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<td>14.4.5.3.1 Sensitivity shall be checked within 1 year after installation. 14.4.5.3.2 Sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with 14.4.5.3.3. 14.4.5.3.3 After the second required calibration test, if sensitivity tests indicate that the device has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years.</td>
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<tr>
<td>K353</td>
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<td>Sprinkler System - Maintenance and Testing</td>
<td>CFR(s): NFPA 101</td>
<td>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</td>
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<td>b) Who provided system test</td>
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<td>c) Water system supply source</td>
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</table>
| | | | 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 REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure fire suppression systems were maintained in accordance with NFPA 25. Failure to maintain fire suppression systems free from Residents affected: All!

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Maintenance director will remove data cabling from fire suppression pipe.

How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken: Maintenance director will assure no other cabling is attached to sprinkler pipe.

What measures will be put in to place or what systemic changes will be made to ensure that the deficient practice does not recur: Maintenance department will audit sprinkler pipe throughout the facility.
### PROVIDER/SPONSOR/CUA IDENTIFICATION NUMBER:

135103

### MULTIPLE CONSTRUCTION

<table>
<thead>
<tr>
<th>A. BUILDING 01 - ENTIRE BUILDING</th>
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<th>WING</th>
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### DATE SURVEY COMPLETED

12/02/2019

### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

**K 353** Continued From page 3

non-system installations including data cabling, has the potential to increase stress on system supports and increase the potential for damage to system piping from non-associated trades and vendor equipment using fire suppression system piping to support other loads. This deficient practice affected staff in the partial basement on the date of the survey.

Findings include:

- During the facility tour conducted on 12/2/19 from 12:30 - 3:30 PM, observation of the lower basement fire suppression system piping, revealed data cabling had been installed and attached to the piping along the section leading into the main riser area. Interview of the Maintenance director at approximately 2:00 PM, established he was unaware of the installation.

- Actual NFPA standard:
  - **NFPA 25**
    - 5.2.2* Pipe and Fittings. Sprinkler pipe and fittings shall be inspected annually from the floor level.
    - 5.2.2.2 Sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe.

**K 374** Subdivision of Building Spaces - Smoke Barriers

**SS=D**

Subdivision of Building Spaces - Smoke Barrier Doors

**2012 EXISTING**

Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors must be self-closing or automatically closable upon actuation of a smoke detection device.

- **Residents affected:** All

**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**

Maintenance department will adjust timing on the door closing device to ensure proper closure and latch of both doors. Maintenance department will audit sprinkler pipe throughout the facility once per week x 3 weeks, and monthly thereafter to ensure compliance. Results will be reported to QAPI committee.

**How the corrective action will be monitored:**

Maintenance department will audit sprinkler pipe throughout the facility once per week x 3 weeks, and monthly thereafter to ensure compliance. Results will be reported to QAPI committee.

**Who will be responsible to ensure correction(s):**

Maintenance department.

**COMPLETION DATE:**

1/6/20
<table>
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<tr>
<th>ID</th>
<th>Summary Statement of Deficiencies</th>
<th>K 374</th>
<th>Provider's Plan of Correction</th>
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<tbody>
<tr>
<td>K 374</td>
<td>Continued from page 4</td>
<td>are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9</td>
<td>This REQUIREMENT is not met as evidenced by: Based on observation and operational testing, the facility failed to ensure smoke compartment cross-corridor doors would fully close and resist the passage of smoke when activated. Failure to ensure the smoke-resistive properties of cross-corridor doors, has the potential to allow fire, smoke and dangerous gases to pass between smoke compartments during a fire event. This deficient practice affected 23 residents and staff in 2 of 7 smoke compartments on the date of the survey. Findings include: During the facility tour conducted on 12/2/19 from 12:30 - 2:00 PM, observation and operational testing of the cross-corridor smoke barrier doors located in the 200 hall to 300 hall connecting hallway, revealed the doors were obstructed by a metal astragal, that prevented them from fully self-closing. Further observation revealed this obstruction created a gap between the two (2) leading edges of the doors that measured approximately 3/8 inches wide. Actual NFPA standard: 19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.5 and shall have a minimum 1.2-hour fire resistance</td>
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</tbody>
</table>
### Statement of Deficiencies and Plan of Correction

**Provider/Supplier:** Prestige Care & Rehabilitation - The O1

**Street Address:** 1014 Burrell Avenue, Lewiston, ID 83501

**Provider Identification Number:** 135103

**Date Survey Completed:** 12/02/2019

**ID Prefix Tag:** K374

### Summary Statement of Deficiencies

**Rating:** 1/6/2017 BY021 If continuation sheet Page 6 of 16

**Reminder:** Each deficiency must be preceded by full regulatory or LSC identifying information.

**Regulatory Requirement:**

This requirement is not met as evidenced by:

<table>
<thead>
<tr>
<th>Building Area</th>
<th>Requirement Violation</th>
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<tbody>
<tr>
<td>A. Building 01 - Entire Building</td>
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<td>B. Wing ________ _</td>
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### How the Facility Will Identify Other Residents Having the Potential to Be Affected by the Deficient Practice and What Corrective Action(s) Will Be Taken:

Therapy staff will be in-serviced on the rules and regulations surrounding the use of RPTs. Therapy staff will be in-serviced on the rules and regulations surrounding the use of RPTs.

### Residents Affected:

All residents having the potential to be affected by the deficient practice.

### What Measures Will Be Put in to Place or What Systemic Changes Will Be Made to Prevent the Use of RPTs After the Corrective Action(s) Are Accomplished:

RPT was removed and remaining RPT was plugged directly into the wall outlet.

### How the Facility Will Identify Other Residents Having the Potential to Be Affected by the Same Deficient Practice and What Corrective Action(s) Will Be Taken:

Therapy staff will be in-serviced on the rules and regulations surrounding the use of RPTs.

### What Corrective Action(s) Will Be Accomplished for Those Residents Found to Have Been Affected by the Deficient Practice:

RPT was removed and remaining RPT was plugged directly into the wall outlet.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:</th>
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<tr>
<td>12/02/2019</td>
<td>12/02/2019</td>
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**STREET ADDRESS, CITY, STATE, ZIP CODE**

PRESTIGE CARE & REHABILITATION - THE 01

1014 BURRELL AVENUE

LEWISTON, ID 83501

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<thead>
<tr>
<th>ID</th>
<th>PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
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<tbody>
<tr>
<td>K511</td>
<td>Continued From page 6</td>
<td>Based on observation, the facility failed to ensure safe electrical installations were maintained in accordance with NFPA 70 and approved, listed assemblies. Use of relocatable power taps (RPT) when connected in series (daisy-chained), has the potential to expose residents to the risk of arc fires and electric shock. This deficient practice affected staff on the date of the survey. Findings include: During the facility tour conducted on 12/2/19 from 10:00 AM - 12:00 PM, observation of the Physical Therapy office revealed a RPT daisy-chained into another RPT. Actual NFPA standard: NFPA 70 110.3 Examination, Identification, Installation, and Use of Equipment. (A) Examination. In judging equipment, considerations such as the following shall be evaluated: (1) Suitability for installation and use in conformity with the provisions of this Code Informational Note: Suitability of equipment use may be identified by a description marked on or provided with a product to identify the suitability of the product for a specific purpose, environment, or application. Special conditions of use or other limitations and other pertinent information may be marked on the equipment, included in the product instructions, or included in the appropriate listing and labeling information. Suitability of equipment may be evidenced by listing or labeling. (2) Mechanical strength and durability, including, for parts designed to enclose and protect other</td>
<td>K511</td>
<td>Continued From page 6</td>
<td>be made to ensure that the deficient practice does not recur: Maintenance director will audit RPT use weekly x 4 weeks and monthly thereafter. How the corrective action will be monitored: Results will be reported to QAPI committee. Who will be responsible to ensure correction(s): Maintenance director.</td>
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</tbody>
</table>
Summary Statement of Deficiencies:

K 511 Continued From page 7:

1. Equipment; the adequacy of the protection thus provided
2. Wire-bending and connection space
3. Electrical insulation
4. Heating effects under normal conditions of use and also under abnormal conditions likely to arise in service
5. Arcing effects
6. Classification by type, size, voltage, current capacity, and specific use
7. Other factors that contribute to the practical safeguarding of persons using or likely to come in contact with the equipment.
8. Installation and Use. Listed or labeled equipment shall be installed and used in accordance with any instructions included in the listing or labeling.

Further reference: UL 1363 XBYS

K 712 Fire Drills:

SS=F 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, the facility failed to ensure fire drills were performed for each shift each quarter. Failure to conduct quarterly fire drills has the potential to hinder staff response.

Residents affected: All

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

An additional fire drill for night shift has been scheduled for this, fourth quarter of 2019.

How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken:

Maintenance director is aware of the required frequency of fire drills. Maintenance director will ensure that
K 712 Continued From page 8  
During fire events: This deficient practice affected 60 residents and staff on the date of the survey.

Findings include:

During review of provided fire drill records conducted on 12/2/19 from 8:30 - 10:00 AM, records failed to demonstrate the facility conducted a fire drill on the graveyard shift during the first quarter of 2019.

Actual NFPA standard:

19.7.1 Evacuation and Relocation Plan and Fire Drills.

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 741 Smoking Regulations  
SS=D CFR(s): NFPA 101

Smoking Regulations  
Smoking regulations shall be adopted and shall include not less than the following provisions:

1. Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking.

2. In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required.

3. Smoking by patients classified as not

Residents affected: All

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

Self-closing metal container was ordered for staff smoking area.
### Summary Statement of Deficiencies

#### (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

**ID** | **PREFIX** | **TAG** | **CONTINUATION FROM PAGE 9**
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K 741 | Continued From page 9 responsible shall be prohibited.

1. The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision.

2. Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.

3. Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.

4. This REQUIREMENT is not met as evidenced by:

   - Based on observation and record review, the facility failed to ensure smoking was conducted in accordance with NFPA 101 and facility policy.
   - Failure to ensure smoking procedures are in accordance with safe practices as defined in NFPA 101 and as supported by facility policy, has the potential to increase the risk of exposing residents to fires from unextinguished smoking materials. This deficient practice affected residents and staff using designated smoking areas on the date of the survey.

   Findings include:

   - During the facility tour conducted on 12/2/19 from 10:00 AM - 12:00 PM, observation of the resident smoking area revealed 1 of 2 provided trash cans had been used for both combustible trash, i.e. empty cigarette cartons and mixed paper trash, and the disposal of cigarette ashtrays.
   - Further observation of the staff smoking area revealed the area was not equipped with a self-closing metal trash can for the disposal of smoking materials and staff were using the trash can for the disposal of combustible trash along with the dumping of ashtrays.

#### How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken:

- **Training** will occur with all staff on the requirement of ashtray disposal and combustible waste disposal requirements. Receptacles at the staff and resident smoking area will be labeled for correct use.

#### What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur:

- Maintenance department and housekeeping department will audit both staff and resident smoking area daily for proper use of trash receptacles and ashtray disposal.

#### How the corrective action will be monitored:

- Maintenance director will report all findings to QAPI committee.

#### Who will be responsible to ensure correction(s):

- Maintenance director.
Review of the provided smoking policy conducted on 12/2/19 from 3:00 - 3:30 PM revealed the policy stated in sections 3 to 5, that smoking areas would be provided with separate trash receptacles for the disposal of combustible materials such as "trash" and "metal containers with self-closing covers to be used solely for the disposal of cigarette butts and ashes".

Actual NFPA standard:

19.7.4* Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions:

1. Smoking shall be prohibited in any room, ward, or individual enclosed space where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking.
2. In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required.
3. Smoking by patients classified as not responsible shall be prohibited.
4. The requirement of 19.7.4(3) shall not apply where the patient is under direct supervision.
5. Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.
6. Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.

Residents affected: All
**SUMMARY STATEMENT OF DEFICIENCIES**

**K 922 Continued From page 11**

Gas Equipment - Other

List in the REMARKS section any NFPA 99 Chapter 11 Gas Equipment 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.

**Findings include:**

During the facility tour conducted on 12/2/19 from 12:30 - 3:00 PM, observation of the front door and the southwest door entrance door to the facility, revealed signs posted at these two (2) entrances that read: "No Smoking", but failed to indicate the use and storage of the facility's housed oxygen. Subsequent review of the smoking policies and procedures of the facility conducted on 12/2/19 from 3:00 - 3:30 PM, revealed the verbiage used in the posted signs matched that of a non-smoking campus as described in Item #1 of the policy, however, the facility allowed and provided dedicated smoking areas for both residents and staff.

**Actual NFPA standard:**

<table>
<thead>
<tr>
<th>K 922</th>
<th>PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER: 135103</th>
<th>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION</th>
<th>MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING</th>
<th>DATE SURVEY COMPLETED 12/02/2019</th>
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</thead>
</table>

**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**

Signage has been ordered for all facility entrances that state "no smoking, oxygen in use" this signage will be conspicuously displayed at every facility entrance. Signage for both designated smoking areas have been ordered and will be conspicuously displayed at each designated smoking area.

**How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken:**

Maintenance director will perform posting of signage.

**What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur:**

To ensure that signage is still present, maintenance director will audit all entrances and both smoking areas weekly for 4 weeks, and monthly thereafter.

**How the corrective action will be monitored:**

...
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER: 135103

(X2) MULTIPLE CONSTRUCTION

A. BUILDING 01 - ENTIRE BUILDING

B. WING ________ 

(X3) DATE SURVEY COMPLETED 12/02/2019

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<th>(X5) COMPLETION DATE</th>
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</thead>
</table>
| K 923     |     | Continued From page 13 cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by:

Based on observation and interview, the facility failed to ensure storage of medical gas cylinders such as oxygen, were maintained in accordance with NFPA 99. Failure to segregate storage of empty cylinders from full cylinders, has the potential to inadvertently use the incorrect cylinder during an emergency requiring supplemental oxygen. This deficient practice affected those residents requiring supplemental oxygen treatment and staff on the dates of the survey.

Findings include:

During the facility tour, conducted on 12/2/19 from 12:30 - 3:00 PM, the following observations were made of stored oxygen in the facility:

1) The Salon was observed to have one (1) found to have been affected by the deficient practice:

The oxygen cylinder stored in the salon was immediately removed. Improperly stored oxygen cylinders in the storage room were in use by contracted hospice services. Hospice agency was instructed to remove and return all oxygen cylinders, and moving forward, the agency was instructed to use the facility’s housed oxygen cylinders. Hospice agency removed oxygen cylinders from the building.

**How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken:**

The contracted salon operator is no longer providing services at the facility. Maintenance director has created an in-service training to perform with the new contracted salon operator for proper oxygen use and storage.

**What measures will be put in to place or what systemic changes will be made to ensure that the deficient practice does not recur:**
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<tbody>
<tr>
<td>K922</td>
<td>Continued From page 12</td>
<td>NFPA 99</td>
<td>11.5.3.2 Signs. 11.5.3.2.1 In health care facilities where smoking is not prohibited, precautionary signs readable from a distance of 1.5 m (5 ft) shall be conspicuously displayed wherever supplemental oxygen is in use and in aisles and walkways leading to such an area. 11.5.3.2.2 The signs shall be attached to adjacent doorways or to building walls or be supported by other appropriate means. 11.5.3.2.3 In health care facilities where smoking is prohibited and signs are prominently (strategically) placed at all major entrances, secondary signs with no smoking language shall not be required. 11.5.3.2.4 The nonsmoking policies shall be strictly enforced.</td>
<td>K922</td>
<td>Maintenance director will report all findings to QAPI committee. <strong>Who will be responsible to ensure correction(s):</strong> Maintenance director.</td>
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</table>

| K923 | Gas Equipment - Cylinder and Container Storage | Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet. Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet. Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet. In a single smoke compartment, individual | K923 | Residents affected: All **What corrective action(s) will be accomplished for those residents:** |

ORM CMS-2567(02-99) Previous Versions Obsolete
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<tr>
<td>K 923</td>
<td>Continued From page 14 unsecured oxygen cylinder stored in room. 2) Observation of the oxygen storage and transfill room in the southwest end of the 200 hall, revealed four (4) cylinders, 6 cu. ft. in size and two (2) cylinders, 9 cu. ft. in size, identified by the Maintenance Director during interview at this time as &quot;Full&quot;, stored in a rack with one (1) cylinder, 9 cu. ft. in size, identified as &quot;Empty&quot;. Further observation revealed all seven (7) cylinders were stored on the side of the space marked as &quot;Empty&quot;. Actual NFPA standard: NFPA 99 5.1.3.3.2* Design and Construction. Locations for central supply systems and the storage of positive-pressure gases shall meet the following requirements: (1) They shall be constructed with access to move cylinders, equipment, and so forth, in and out of the location on hand trucks complying with 11.4.3.1.1. (2) They shall be secured with lockable doors or gates or otherwise secured. (3) If outdoors, they shall be provided with an enclosure (wall or fencing) constructed of noncombustible materials with a minimum of two entry/exits. (4) If indoors, they shall be constructed and use interior finishes of noncombustible or limited-combustible materials such that all walls, floors, ceilings, and doors are of a minimum 1-hour fire resistance rating. (5)*They shall be compliant with NFPA 70, National Electrical Code, for ordinary locations. (6) They shall be heated by indirect means (e.g., steam, hot water) if heat is required.</td>
<td>K 923</td>
<td>All staff will be trained on proper transportation and storage of oxygen cylinders. How the corrective action will be monitored: Maintenance director will audit oxygen storage daily for 2 weeks, and weekly thereafter. Results will be reported to QAPI committee. Who will be responsible to ensure correction(s): Maintenance director.</td>
<td>12/02/2019</td>
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### SUMMARY STATEMENT OF DEFICIENCIES

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</table>

11.6.5 Special Precautions - Storage of Cylinders and Containers.

11.6.5.1 Storage shall be planned so that cylinders can be used in the order in which they are received from the supplier.

11.6.5.2 If empty and full cylinders are stored within the same enclosure, empty cylinders shall be segregated from full cylinders.

11.6.5.3 Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed in a rapid manner.
The facility is a type V (111), single story structure with a partial basement originally constructed in 1958. The partial basement is staff-access only, utilizing a keypad entry system. This area houses the maintenance shop, fire suppression system riser and access to the facility mechanical spaces. The facility is located within a municipal fire district, with both county and state EMS services available. The building is fully sprinklered with an interconnected, fire alarm and smoke detection system and backup emergency power is provided with an on-site, spark-ignited Emergency Power Supply System (EPSS) generator. Currently the facility is licensed for 127 SNF/NF beds with a census of 60 on the date of the survey.

The following deficiencies were cited during the annual fire/life safety survey conducted on December 2, 2019. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Chapter 19, Existing Healthcare Occupancies, in accordance with 42 CFR 483.70.

The Survey was conducted by:

Sam Burbank
Health Facility Surveyor
Facility Fire Safety and Construction

Fire Alarm System - Testing and Maintenance
CFR(s): NFPA 101

A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily
January 8, 2020

Brandi Jeffries, Administrator
Prestige Care & Rehabilitation - The Orchards
1014 Burrell Avenue
Lewiston, ID 83501-5589

Provider #: 135103

RE: PLAN OF CORRECTION ACCEPTANCE

Dear Ms. Jeffries:

On December 2, 2019, a Facility Fire Safety and Construction survey was conducted at your facility. You have alleged that the deficiencies cited on that survey will be corrected. We are accepting your Plan of Correction.

If you have any questions, please contact Nate Elkins, Supervisor, Facility Fire Safety and Construction at (208) 334-6626, option 3.

Sincerely,

Nate Elkins, Supervisor
Facility Fire Safety and Construction
December 12, 2019

Brandi Jeffries, Administrator
Prestige Care & Rehabilitation - The Orchards
1014 Burrell Avenue
Lewiston, ID 83501-5589

Provider #: 135103

RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER

Dear Ms. Jeffries:

On December 2, 2019, an Emergency Preparedness survey was conducted at Prestige Care & Rehabilitation - The Orchards 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

Enclosure
**Prestige Care & Rehabilitation - The O**  
1014 BURRELL AVENUE  
LEWISTON, ID 83501

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<td>E 000</td>
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<td><strong>Initial Comments</strong></td>
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The facility is a type V (111), single story structure with a partial basement originally constructed in 1958. The partial basement is staff-access only, utilizing a keypad entry system. This area houses the maintenance shop, fire suppression system riser and access to the facility mechanical spaces. The facility is located within a municipal fire district, with both county and state EMS services available. The building is fully sprinklered with an interconnected, fire alarm and smoke detection system and backup emergency power is provided with an on-site, spark-ignited Emergency Power Supply System (EPSS) generator. Currently the facility is licensed for 127 SNF/NF beds with a census of 60 on the date of the survey.

The facility was found to be in substantial compliance during the Emergency Preparedness Survey conducted on December 2, 2019. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.

The Survey was conducted by:

Sam Burbank  
Health Facility Surveyor  
Facility Fire Safety and Construction

---

**RECEIVED**  
JAN - 3 2020  
FACILITY STANDARDS

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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 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.