



IDAHO DEPARTMENT OF
HEALTH & WELFARE

G.L. "BUTCH" OTTER - Governor
RICHARD M. ARMSTRONG - Director

DEBRA RANSOM, R.N., F.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

February 17, 2015

Tobi Lucero, Administrator
Bell Mountain Village & Care Center
706 South Main Street
Hailey, ID 83333-8400

Provider #: 135069

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

Dear Ms. Lucero:

On **February 5, 2015**, a Facility Fire Safety and Construction survey was conducted at **Bell Mountain Village & Care Center** 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 and a similar State Form 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

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page 2). After each deficiency has been answered and dated, the administrator should sign both Statement of Deficiencies and Plan of Correction, Form CMS-2567 and State Form, in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **March 2, 2015**. Failure to submit an acceptable PoC by **March 2, 2015**, may result in the imposition of civil monetary penalties by **March 22, 2015**.

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 and the state licensure survey report, State Form.

All references to federal regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **March 12, 2015**, (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 12, 2015**. A change in the seriousness of the deficiencies on **March 12, 2015**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **March 12, 2015**, includes the following:

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Denial of payment for new admissions effective **May 5, 2015**.
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 **August 5, 2015**, 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 Mark P. Grimes, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, 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 **February 5, 2015**, 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 **March 2, 2015**. If your request for informal dispute resolution is received after **March 2, 2015**, 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.

Sincerely,



Mark P. Grimes, Supervisor
Facility Fire Safety and Construction

MPG/lj
Enclosures

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

Printed: 02/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135069	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE BLDG B. WING _____	(X3) DATE SURVEY COMPLETED 02/05/2015
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NAME OF PROVIDER OR SUPPLIER BELL MOUNTAIN VILLAGE & CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 706 SOUTH MAIN STREET HAILEY, ID 83333
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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
K 000	INITIAL COMMENTS The facility is a single story Type V (111) building that is equipped with an automatic fire sprinkler system and fire alarm/smoke detection system. There is a non-conforming physicians' clinic attached to the building with a two-hour fire wall separation. The facility was built in 1982 and is licensed for 25 SNF/NF beds. The following deficiencies were cited during the annual fire/life safety survey conducted on February 5, 2015. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR, 483.70. The Survey was conducted by: Nathan Elkins Health Facility Surveyor Fire Life Safety & Construction	K 000		
K 029 SS-E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This Standard is not met as evidenced by: Based on observation and operational testing it	K 029		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Nathan Elkins* TITLE *Surveyor* (X6) DATE *3/3/15*

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 029	<p>Continued From page 1</p> <p>was determined that the facility did not ensure doors closed and latched properly to hazardous rooms. This deficiency can allow smoke and fire gases to spread beyond the hazardous area in the event of a fire occurring in the room. This deficiency affected one of three smoke compartments, five residents, staff, and visitors on the day of survey.</p> <p>Findings include:</p> <p>During observation on February 5, 2015 at approximately 1:30 PM, revealed that the self closing doors to the oxygen storage room would not close and latch properly. The facility is licensed for 25 SNF/INF beds</p> <p>Actual NFPA standard: NFPA 101, 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:</p> <ol style="list-style-type: none"> (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft² (9.3 m²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft² (4.6 m²), including repair shops, used for storage of 	K 029	<p>K-029 02 storage room latch</p> <p>The upper and lower hinges on door was loose, causing the door to sag. Hinges were tightened on 2/6/15 by maintenance.</p>	2/6/2015

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K 029	Continued From page 2 combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard.	K 029		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at 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. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This Standard is not met as evidenced by: Based on record review and interview it was determined that the facility did not conduct fire drills one per shift per quarter. Failure to adequately conduct drills for all shifts can result in staff not being trained to act appropriately in an emergency. The facility had a census of twenty two residents on the day of survey. This deficiency affected all residents, staff and visitors on the day of the survey Findings include: During record review on February 5, 2015 at approximately 10:00 AM, the facility was unable to provide documentation for conducting an AM drill during the third quarter and PM drill during the fourth quarter. When questioned about the documentation for the drills the Maintenance	K 050	K-050 Fire drills Maintenance will run fire drills per CMS guidelines. 1 per quarter per shift and will have sign in sheets for all employees to sign. That they was in serviced and the fire drill was complete. Fire drill done on 2/26/15.	2/26/2015

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K 050	Continued From page 3 Supervisor stated that he was aware of the missing drills. The facility is licensed for 25 SNF/NF beds. Actual NFPA standard: NFPA 101 19.7.1.2 Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. 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. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building.	K 050		
K 051 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6	K 051	K-051 Fire Alarm Systems panel Documentation was not posted that the panel had been inspected and tested by Delta Fire system. The building received the documentation from Delta Fire systems on 2/5/15 prior to exiting with survey.	2/5/2015

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K 051	Continued From page 4 This Standard is not met as evidenced by: Based on record review and staff interview, it was determined that the facility had not ensured that the fire alarm system was tested/maintained annually as required. This deficient practice could leave no warning of an emergency to the twenty two residents, staff, and visitors on the day of survey. Findings Include: During record review on February 5, 2016 at approximately 10:00 AM, revealed the facility failed to provide documentation of the annual testing and inspection of the fire alarm system. The last inspection of the system was conducted in 2013. The maintenance supervisor stated that an annual alarm test was completed but was unable to locate the documents. The facility is licensed for 25 SNF/NF beds. Actual NFPA 101 reference: 9.6.1.4 A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm Code, unless an existing installation, which shall be permitted to be continued in use, subject to the approval of the	K 051		

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K 051	Continued From page 5 authority having jurisdiction.	K 051		
K 064 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>This Standard is not met as evidenced by: Based on observation and record review it was determined that the facility did not ensure that portable fire extinguishers were being inspected in accordance with NFPA 10. Monthly inspections help ensure extinguisher reliability in the event of a fire requiring the use of an extinguisher. This deficiency affected twenty two residents, staff members and visitors on the day of the survey</p> <p>Findings include:</p> <p>Observation on February 5, 2015, between 10:30 AM and 3:30 PM revealed that the portable fire extinguishers located throughout the facility were not inspected monthly for the months of December 2014 and January 2015. The facility is licensed for 25 SNF/NF beds.</p> <p>Actual NFPA Standard:</p> <p>NFPA 10 Standard for Portable Fire Extinguishers 1998 Edition</p> <p>4-3 Inspection. 4-3.1* Frequency. Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals. Fire extinguishers shall be</p>	K 064	<p>K-064 Fire extinguishers not signed off</p> <p>Maintenance will inspect and initial extinguishers monthly and once annually by Delta Fire system. These will be signed off on the fire extinguishers tags as they are completed.</p>	2/26/2015

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K 064	Continued From page 6 inspected at more frequent intervals when circumstances require.	K 064		
K 144 SS=F	NFPA 101: LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This Standard is not met as evidenced by: Based on record review and interview the facility failed to maintain generator weekly inspection logs. Failure to inspect and document weekly inspections of the generator system could lead to the system not operating correctly when required. This deficient practice affected twenty two residents, all staff and visitors on the day of survey. Findings include: During the record review process on February 5, 2015 at approximately 10:00 AM, the facility failed to provide weekly generator inspection logs. The facility is licensed for 25 SNF/NF beds. Actual NFPA Standard: NFPA 110, 6.4.1. Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly. Exception: If the generator set is used for standby power or for peak load shaving, such use	K 144	K-144 Generator Maintenance will do weekly inspections with the generator and inspecting all components to the generator, maintenance will also complete a once a month load test for 30 minutes. These will be documented and logged in the Fire life and safety book.	2/26/2015

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K 144	Continued From page 7 shall be recorded and shall be permitted to be substituted for scheduled operations and testing of the generator set, provided the appropriate data are recorded.	K 144		

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C 000	16.03.02 INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The facility is a single story Type V (111) building that is equipped with an automatic fire sprinkler system and fire alarm/smoke detection system. There is a non-conforming physicians' clinic attached to the building with a two-hour fire wall separation. The facility was built in 1982 and is licensed for 25 SNF/NF beds. The following deficiencies were cited during the annual fire/life safety survey conducted on February 5, 2015. The facility was surveyed under IDAPA 16.03.02, Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities. The surveyor conducting the survey was: Nathan Elkins Health Facility Surveyor Fire Life Safety & Construction	C 000		
C 226	02.106 FIRE AND LIFE SAFETY 106. FIRE AND LIFE SAFETY. Buildings on the premises used as facilities shall meet all the requirements of local, state and national codes concerning fire and life safety standards that are applicable to health care facilities. This RULE: is not met as evidenced by: Refer to the following Federal "K" tags on the CMS - 2567: 1. K029 Hazardous Areas	C 226	<i>Refer to Federal 2567</i>	

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

Nathan Elkins

TITLE

NHA

(X6) DATE

3/3/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135069	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE BLDG B. WING _____	(X3) DATE SURVEY COMPLETED 02/06/2015
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C 226	Continued From Page 1 2. K050 Fire Drills 3. K064 Portable Fire Extinguishers 4. K144 Monthly Generator Inspections	C 226		

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.