



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

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

June 12, 2015

Jeffrey Corriher, Administrator
Bridgeview Estates
1828 Bridgeview Boulevard
Twin Falls, ID 83301-3051

Provider #: 135113

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

Dear Mr. Corriher:

On **June 4, 2015**, a Facility Fire Safety and Construction survey was conducted at **Bridgeview Estates** 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

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Correct" (listed on 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 **June 25, 2015**. Failure to submit an acceptable PoC by **June 25, 2015**, may result in the imposition of civil monetary penalties by **July 15, 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 **July 9, 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 **July 9, 2015**.

A change in the seriousness of the deficiencies on **July 9, 2015**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **July 9, 2015**, includes the following:

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Denial of payment for new admissions effective **September 4, 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 **December 4, 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 **June 4, 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 **June 25, 2015**. If your request for informal dispute resolution is received after **June 25, 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: 06/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135113	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE NF BLDG B. WING _____	(X3) DATE SURVEY COMPLETED 06/04/2015
NAME OF PROVIDER OR SUPPLIER BRIDGEVIEW ESTATES		STREET ADDRESS, CITY, STATE, ZIP CODE 1828 BRIDGEVIEW BOULEVARD TWIN FALLS, ID 83301		
(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)	(X6) COMPLETION DATE
K 000	<p>INITIAL COMMENTS</p> <p>The facility is a single story, type V (III) building constructed in 1992 with an addition in 1996. The building is fully sprinklered and has exits to grade. A two hour wall separates the Skilled Nursing Facility from Assisted Living Facility and independent apartments. Currently the facility is licensed for 116 SNF/NF beds.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on June 4, 2015. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.</p> <p>The Survey was conducted by:</p> <p>Nathan Elkins Health Facility Surveyor Fire Life Safety & Construction</p>	K 000	<p style="text-align: center;"><i>RECEIVED</i></p> <p style="text-align: center;"><i>JUN 26 2015</i></p> <p style="text-align: center;"><i>FACILITY STANDARDS</i></p> <p><i>Preparation and/or execution of the plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies</i></p>	<i>6/25/15</i>
K 018 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 1/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p>	K 018	<p>K018</p> <p>The identified door of the housekeeping closet was fixed on 6/17/15 replacing the defective hinge. The door now latches appropriately.</p> <p>The identified door of the Canyon Springs Dining Room was repaired with a new latch on 6/17/15 The door now latches appropriately.</p>	

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

TITLE

(X6) DATE

[Signature]

Executive Director

6-24-15

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 018	Continued From page 1 This Standard is not met as evidenced by: Based on observation and operational testing, it was determined that the facility did not ensure that corridor doors were smoke resisting. Corridor doors that do not resist the passage of smoke can allow smoke and fire gases to enter the corridor in the event of a fire. This deficient practice affected one of eight smoke compartments, 15 residents, staff and visitors on the date of survey. The facility is licensed for 116 SNF/NF beds with a census of 61 on the day of survey Finding Include: 1.) During the facility tour on June 4, 2015 between 8:30 AM and 12:00 PM, observation and operational testing of the door leading to the Canyon Springs dining room would not close and latch properly when released from the magnetic hold open device. When asked, the maintenance supervisor stated they were unaware of the door not closing and latching properly. 2.) During the facility tour on June 4, 2015 between 8:30 AM and 12:00 PM, observation and operational testing of the door leading to the housekeeping closet would not close and latch properly. When asked, the maintenance supervisor stated they were unaware of the door not closing and latching properly Actual NFPA reference:	K 018	Facility Maintenance Staff checked all corridor doors on 6/24/15 to ensure there were no more problem doors. Facility Maintenance Staff will conduct & log monthly inspections of corridor doors. Maintenance Director will inspect 10 doors monthly for 3 months, then quarterly thereafter to ensure proper latching; any issues identified will be brought to our quality assurance and performance improvement meeting.	

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K 018	Continued From page 2 19.3.6.3 Corridor Doors. 19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¼ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted.	K 018		
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to assure that all smoke barriers would provide protection against passage of smoke between smoke compartments. Openings in smoke barriers can allow smoke and fire gasses to enter other smoke compartments in the event of a fire. This deficient practice affected two of eight smoke compartments, 20 residents, staff and visitors on the day of survey. The facility has	K 025	K025 The identified smoke barrier in Section 4A was repaired on 6/17/15. The smoke barrier is intact and functions appropriately. Facility Maintenance Staff checked all smoke barriers on 6/17/15 to ensure the smoke barriers were intact. Facility Maintenance Staff will conduct & log monthly inspections of the smoke barriers. Maintenance Director will inspect all corridor smoke barriers monthly for 3 months, then quarterly	6/25/15

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K 025	Continued From page 3 a capacity for 116 SNF/NF beds with a census of 61 on the date of survey. Findings include: During the facility tour on June 4, 2015 at approximately 11:00 AM, observation of the smoke barrier above the suspended ceiling tiles in section 4A revealed a 2' x 1' rectangular hole cut into the sheetrock. When asked, the maintenance supervisor stated he was unaware of the large hole cut through the sheetrock. Actual NFPA reference: LSC 101, 19.3.7.3. Smoke barriers shall provide at least a one half hour fire resistance rating. 8.3.1* General. Where required by Chapters 12 through 42, smoke barriers shall be provided to subdivide building spaces for the purpose of restricting the movement of smoke.	K 025	thereafter to ensure smoke barrier integrity; any issues identified will be brought to our quality assurance and performance improvement meeting.	
K 046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This Standard is not met as evidenced by: Based on record review and interview the facility failed to provide annual emergency lighting system testing documentation. Failure to test emergency lighting systems could inhibit egress of residents during an emergency. This deficient practice affected all patients, staff and visitors on the day of survey. The facility is licensed for 116 SNF/NF beds with a census of 61 on the date of survey. Findings include:	K 046	K046 An annual 90-minute emergency lighting test with appropriate documentation was completed 6/23/15. The emergency lighting system is working appropriately. Facility Maintenance Staff verified all monthly and annual emergency lighting tests were completed in a timely manner.	6/25/15

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K 046	Continued From page 4 During record review on June 4, 2015 at approximately 8:00 AM, it was observed the facility was unable to provide the annual emergency lighting system testing documentation for When asked, the maintenance supervisor stated the facility was conducting the required tests but was unaware the records were not in the facility book. Actual NFPA reference: NFPA 101, 19.2.9.1 Emergency lighting shall be provided in accordance with Section 7.9. 7.9. 3 A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 11/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction	K 046	Facility Maintenance Staff will enter a monthly reminder in the TELS system regarding the emergency lighting system. Maintenance Director bring the monthly TELS reminder to our quality assurance and performance improvement meeting.	
K 130 SS=F	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This Standard is not met as evidenced by: Based on observation, operational testing, and interview the facility failed to maintain the intended function of the exit doors. Failure to maintain the intended function of the exit doors could allow unauthorized exit of residents from the facility and could hinder proper accountability during an emergency. This deficient practice	K 130	K130 The power supply to the delayed egress door was professionally replaced prior to 6/17/15. Facility Maintenance Staff verified the repair of the delayed egress system provided the irreversible process maintaining locked status	6/25/15

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K 130	<p>Continued From page 5</p> <p>affected all residents, staff, and visitors on the day of survey. The facility is licensed for 116 SNF/NF beds with a census of 61 on the date of survey.</p> <p>Findings include:</p> <p>During the facility tour on June 4, 2015 between 8:00 AM and 12:00 PM, observation and operational testing of the delayed egress doors revealed that all the doors would not release the lock within 15 seconds, instead the locks released immediately upon application of force. When questioned, the maintenance supervisor stated they were aware that the delayed egress system was not operational.</p> <p>Actual NFPA reference: 7.2.1.6 Special Locking Arrangements. 7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed-egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met. (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6. (b) The doors shall unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to</p>	K 130	<p>for 15 seconds followed by an immediate release of the locking mechanism.</p> <p>Additionally staff was in-serviced on fire watch protocols in the event the delayed egress system malfunctions again.</p> <p>K130</p> <p>Facility Maintenance Staff will check the delayed egress on external doors monthly.</p> <p>Maintenance Director will audit the delayed egress on all external doors every month for 3 months, then quarterly thereafter. The results will be brought to the quality assurance and performance improvement meeting monthly for review and discussion on any potential issues.</p>	6/25/15

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K 130	Continued From page 6 the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) * On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS	K 130		
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure electrical wiring and proper clearance around electric circuit breakers was in accordance with the National Electrical Code. This deficient practice affected two of eight smoke compartments, staff and visitors on the date of survey. The facility is licensed for 116 SNF/NF beds with a census of 61 the day of survey. Findings include: 1.) During the facility tour on June 4, 2015 between 8:30 AM and 12:00 PM, observation of	K 147	K147 The cords in the Business Office and Central Supply office were immediately removed and devices were plugged directly into the wall outlets. Items were immediately removed from in front of the electrical panels in the Hot Water Heater/Furnace Room and the area taped off barring placement of anything in that direct space.	6/25/15

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K 147	<p>Continued From page 7 the Business Manager's office revealed a microwave and a refrigerator plugged into a Relocatable Power Tap (RPT).</p> <p>2.) During the facility tour on June 4, 2015 between 8:30 AM and 12:00 PM, observation of the Central Supply office revealed a refrigerator plugged into a Relocatable Power Tap (RPT).</p> <p>3.) During the facility tour on June 4, 2015 between 8:30 AM and 12:00 PM, observation of the Hot Water heater/Furnace Room revealed a tool box and a wheeled cart blocking the electrical breaker panels.</p> <p>When questioned, the maintenance supervisor stated they were unaware of the deficient practices.</p> <p>Item# 1-2 Actual NFPA reference: NFPA 70 National Electrical Code 1999 Edition 400-8. Uses Not Permitted Unless specifically permitted in Section 400-7, flexible cords and cables shall not be used for the following:</p> <ol style="list-style-type: none"> 1. As a substitute for the fixed wiring of a structure 2. Where run through holes in walls, structural ceilings suspended ceilings, dropped ceilings, or floors 3. Where run through doorways, windows, or similar openings 4. Where attached to building surfaces Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of Section 364-8. 5. Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors 	K 147	<p>Facility wide inspection was done on 6/24/15 and no other Relocatable Power Taps in offices were found to have appliances plugged into them. Staff was also in-serviced on electrical safety and acceptable Relocatable Power Tap usage.</p> <p>Facility wide inspection was done on 6/24/15 of all electrical panels to ensure nothing was placed in front of any other electrical panels.</p> <p>Facility will educate residents and family member upon admission.</p> <p>Facility will educate staff on regulations regarding the use of Relocatable Power Taps.</p> <p>Facility Maintenance staff will monitor all facility electrical panels to ensure proper placement of items in relation to panels.</p> <p>Maintenance Director will inspect 10 rooms monthly for 3 months, then quarterly thereafter to ensure</p>	

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K 147	<p>Continued From page 8</p> <p>6. Where installed in raceways, except as otherwise permitted in this Code See UL listings: XBYS Guide Information XBZN2 Guide information</p> <p>Item #3 Actual NFPA reference: NFPA 70.110.26 Spaces About Electrical Equipment.</p> <p>Sufficient access and working space shall be provided and maintained about all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons.</p> <p>(2) Width of Working Space. The width of the working space in front of the electric equipment shall be the width of the equipment or 750 mm (30 in.), whichever is greater. In all cases, the work space shall permit at least a 90 degree opening of equipment doors or hinged panels</p>	K 147	<p>that appliances are not plugged into Relocatable Power Taps and that Relocatable Power Taps are not used in resident rooms; any issues identified will be brought to our quality assurance and performance improvement meeting.</p> <p>Maintenance Director will inspect all electrical panels monthly for 3 months then quarterly thereafter for proper item placement with regard to the electrical panels. Any issues identified will be brought monthly to the quality assurance and performance improvement meeting.</p>	

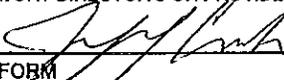
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135113	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE NF BLDG B. WING _____	(X3) DATE SURVEY COMPLETED 06/04/2015
NAME OF PROVIDER OR SUPPLIER BRIDGEVIEW ESTATES		STREET ADDRESS, CITY, STATE, ZIP CODE 1828 BRIDGEVIEW BOULEVARD TWIN FALLS, ID 83301		
(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) COMPLETE DATE
C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>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.</p> <p>The facility is a single story, type V (III) building constructed in 1992 with an addition in 1996. The building is fully sprinklered and has exits to grade. A two hour wall separates the facility from Assisted Living and independent apartments. Currently the facility is licensed for 116 SNF/NF beds.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on June 4, 2015. The facility was surveyed under NFPA 101 Life Safety Code and IDAPA 16.03.02, Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities.</p> <p>The survey was conducted by:</p> <p>Nathan Elkins Health Facility Surveyor Fire Life Safety & Construction</p>	C 000	<p><i>Preparation and/or execution of the plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies</i></p> <p>RECEIVED JUN 26 2015 FACILITY STANDARDS</p>	
C 226	<p>02.106 FIRE AND LIFE SAFETY</p> <p>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:</p> <p>1. K018 - Corridor Doors</p> <p>2. K025 - Smoke Barriers</p>	C 226	<p>C226</p> <p>Refer to Facility POC in regards to tags: K018, K025, K046, K130, K147</p>	6/29/15

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

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

TITLE

(X6) DATE



Executive Director

6-24-15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135113	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE NF BLDG B. WING _____	(X3) DATE SURVEY COMPLETED 06/04/2015
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C 226	Continued From Page 1 3. K046 - Emergency Lighting 4. K130 - Delayed Egress Doors 5. K147 - Electrical	C 226		

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