



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK – ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Eker Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

September 30, 2015

Bradley Hruza, Administrator
Valley Vista Care Center of St. Maries
820 Elm Street
St Maries, ID 83861-2119

Provider #: 135075

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

Dear Mr. Hruza:

On **September 21, 2015**, a Facility Fire Safety and Construction survey was conducted at **Valley Vista Care Center of St Maries** 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 one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. Please provide **ONLY ONE** completion date for each federal and state tag in column (X5) Completion Date to signify when

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you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office. If a State Form with deficiencies was issued, it should be signed, dated and returned along with the CMS-2567 Form.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **October 13, 2015**. Failure to submit an acceptable PoC by **October 13, 2015**, may result in the imposition of civil monetary penalties by **November 2, 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 **October 26, 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 **October 26, 2015**. A change in the seriousness of the deficiencies on **October 26, 2015**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **October 26, 2015**, includes the following:

Denial of payment for new admissions effective **December 21, 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 **March 21, 2016**, 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 **September 21, 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:

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<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

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

BFS Letters (06/30/11)

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

This request must be received by **October 13, 2015**. If your request for informal dispute resolution is received after **October 13, 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: 09/29/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE NF STRUCTURE - BUILDING AND APARTMENT B. WING _____	(X3) DATE SURVEY COMPLETED 09/21/2015
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NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CTR OF ST MARIES	STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	<p>INITIAL COMMENTS</p> <p>The original construction of the facility was a single story, Type V(111) building with a two story addition and renovation completed in 1997. Included were updated sprinkler and fire alarm systems. In 2000 the Behavior Care Unit addition was completed. Currently the building is licensed for 74 SNF/NF beds.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on September 21, 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>Nate Elkins Health Facility Surveyor Facility Fire Safety & Construction</p>	K 000	<p style="text-align: center;">RECEIVED OCT 13 2015 FACILITY STANDARDS</p>	
K 012 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure the smoke and fire resistive integrity of the building. Failure to ensure the smoke and fire resistive properties of the facility could allow smoke and dangerous gases to pass freely and add to the rapid development of fire in exposed wall cavities. This deficient practice affected staff and visitors on the date of the survey. The facility is licensed for 74 SNF/NF</p>	K 012	<p>K 012 The holes in the wall were patched and sealed on 09/22/2015. The rest of the building was inspected to ensure compliance. Inspections for holes in walls or ceilings will be added to the facility maintenance department's weekly checklist. Staff was educated that business office on ground floor falls under the same Fire Life Safety regulations as the skilled nursing facility on the second</p>	09/22/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Brad Huy* TITLE *NHA* (X6) DATE *10-09-2015*

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 012	<p>Continued From page 1 beds and had a census of 63 on the day of the survey.</p> <p>Findings include:</p> <p>1.) During the facility tour conducted on September 21, 2015 at approximately 10:30 AM, observation of the ground floor server room revealed a 3" circular hole cut into the wall exposing the interior wall cavity.</p> <p>2.) During the facility tour conducted on September 21, 2015 at approximately 10:30 AM, observation of the ground floor records room revealed a 8" x 6" rectangular hole cut into the wall exposing the interior wall cavity.</p> <p>When asked, about the holes cut into the walls, the Maintenance Supervisor stated the facility was aware of the holes but were unaware of the code requirements.</p> <p>Actual NFPA standard:</p> <p>19.1.6.2 Health care occupancies shall be limited to the types of building construction shown in Table 19.1.6.2. (See 8.2.1.) Exception*: Any building of Type I(443), Type I(332), Type II(222), or Type II(111) construction shall be permitted to include roofing systems involving combustible supports, decking, or roofing, provided that the following criteria are met: (a) The roof covering meets Class C requirements in accordance with NFPA 256, Standard Methods of Fire Tests of Roof Coverings. (b) The roof is separated from all occupied portions of the building by a noncombustible floor</p>	K 012	<p>floor of the facility. Staff was in-serviced on 10/05/2015 regarding smoke and fire resistive barriers.</p>	

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K 012	Continued From page 2 assembly that includes not less than 2 1/2 in. (6.4 cm) of concrete or gypsum fill. (c) The attic or other space is either unoccupied or protected throughout by an approved automatic sprinkler system. 8.2.1* Construction. Buildings or structures occupied or used in accordance with the individual occupancy chapters (Chapters 12 through 42) shall meet the minimum construction requirements of those chapters. NFPA 220, Standard on Types of Building Construction, shall be used to determine the requirements for the construction classification. Where the building or facility includes additions or connected structures of different construction types, the rating and classification of the structure shall be based on either of the following: (1) Separate buildings if a 2-hour or greater vertically-aligned fire barrier wall in accordance with NFPA 221, Standard for Fire Walls and Fire Barrier Walls, exists between the portions of the building Exception: The requirement of 8.2.1(1) shall not apply to previously approved separations between buildings. (2) The least fire-resistive type of construction of the connected portions, if no such separation is provided.	K 012		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with 3/4 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	K 029	K 029 A self-closing device was installed on the records room door on 09/22/2015. Educated staff that the ground floor business office falls under the same Fire Life Safety regulations as the skilled nursing facility on the second	09/22/2015

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K 029	<p>Continued From page 3</p> <p>field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This Standard is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure that hazardous areas were protected with self-closing doors. Failure to provide self-closing doors for hazardous areas would allow smoke and dangerous gases to pass freely into corridors and hinder egress during a fire event. This deficient practice affected staff and visitors on the date of the survey. The facility is licensed for 74 SNF/NF beds and had a census of 63 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour on September 21, 2015 at approximately 11:00 AM, observation and operational testing of the ground floor Billing Office/Records storage room revealed the door to the storage room was not equipped with a self-closure. The room measured over 50 square feet and stored combustible supplies. When asked, the Maintenance Supervisor stated the facility was unaware the door needed to be on a self closure.</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.</p>	K 029	<p>floor. Inspections of ground floor offices to assure operable self-closing devices are on all doors will be added to the facility maintenance department's monthly checklist. Staff was in-serviced on 10/05/2015 regarding self-closing door requirements for rooms storing combustible materials.</p>	

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K 029	Continued From page 4 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: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft ² (9.3 m ²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft ² (4.6 m ²), including repair shops, used for storage of 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 034 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Stairways and smokeproof towers used as exits are in accordance with 7.2. 19.2.2.3, 19.2.2.4 This Standard is not met as evidenced by: Based on observation and interview the facility failed to provide proper signage on delayed egress doors. Failure to maintain the special locking requirements could confuse and hinder occupants from exiting through the door. This deficient practice affected residents utilizing the second floor activities areas/dining area, staff,	K 034	K 034 Delayed egress signage was posted on delayed egress door on 09/21/2015. Weekly delayed egress door operational inspections will be expanded to assure proper signage on the doors is also in place. Staff was in-serviced on 10/05/2015 regarding signage requirements on all delayed egress doors.	09/22/2015

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K 034	<p>Continued From page 5 and visitors on the date of survey. The facility is licensed for 74 SNF/NF beds with a census of 63 on the day of survey</p> <p>During the facility tour on September 21, 2015 at approximately 2:00 PM, observation of the second floor delayed egress door serving the stairway across from the dining facility revealed that the required sign was readily visible warning occupants of the function for the delayed egress door. When asked, the Maintenance Supervisor stated the facility was unaware of the sign requirement.</p> <p>Actual NFPA reference:</p> <p>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 the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be</p>	K 034		

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K 034	Continued From page 6 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 034		
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that fire extinguishers were installed in accordance with NFPA 10. Failure to ensure fire extinguishers were installed at the correct height and readily accessible could inhibit their use during a fire event. This deficient practice affected kitchen staff on the date of the survey. The facility is licensed for 74 SNF/NF beds with a census of 63 on the day of the survey. Findings include:	K 064	K 064 The fire extinguisher was relocated and rehung at the appropriate height. Daily facility maintenance department rounds will include checks to be certain no obstructions to fire extinguisher access exist. Staff was educated about height restrictions and obstructing accessibility of fire extinguishers. Staff was in-serviced on 10/05/2015 regarding height restrictions and requirements for fire extinguishers.	09/22/2015

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K 064	Continued From page 7 During the facility tour on September 21, 2015 at approximately 1:30 PM, observation of the kitchen revealed a "K"-Style fire extinguisher was installed at height of 67 inches above the floor. Upon further investigation it was revealed the access to the extinguisher was impeded by a sink and trash can. This was determined when a kitchen staff member was asked to retrieve the extinguisher from the bracket and was unable to complete the task. When asked, the Maintenance Supervisor stated the facility was unaware of the extinguisher requirements. Actual NFPA standard: NFPA 10 Standard for Portable Fire Extinguishers 1-6.3 Fire extinguishers shall be conspicuously located where they will be readily accessible and immediately available in the event of fire. Preferably they shall be located along normal paths of travel, including exits from areas. 1-6.10 Fire extinguishers having a gross weight not exceeding 40 lb (18.14 kg) shall be installed so that the top of the fire extinguisher is not more than 5 ft (1.53 m) above the floor. Fire extinguishers having a gross weight greater than 40 lb (18.14 kg) (except wheeled types) shall be so installed that the top of the fire extinguisher is not more than 3 1/2 ft (1.07 m) above the floor. In no case shall the clearance between the bottom of the fire extinguisher and the floor be less than 4 in. (10.2 cm).	K 064		
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility	K 072	K 072 All objects were removed from the hallway on 09/21/2015. Signs are posted in the hallway to remind staff to keep hallways clear to maintain	09/22/2015

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NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CTR OF ST MARIES		STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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 072	<p>Continued From page 8 of exits. 7.1.10</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that means of egress was maintained free from obstructions. Failure to provide exit access free of obstructions could prevent the safe evacuation during an emergency. This deficient practice affected staff and visitors on the date of survey. The facility is licensed for 74 SNF/NF beds with a census of 63 on the day of survey.</p> <p>Findings Include:</p> <p>During the facility tour on September 21, 2015, at approximately 10:00 AM, observation of the ground floor rear exit corridor revealed the corridor was obstructed by two carts carrying numerous metal fold-up chairs, two floor vacuums, and two floor wax machines. When asked, the Maintenance Supervisor stated a new company was contracted and used it to store the items. The items were removed prior to the exit conference.</p> <p>Actual NFPA Standard: NFPA 101, 7.1.10 Means of Egress Reliability. 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.</p>	K 072	<p>an open means of egress. Daily facility maintenance department rounds will assure hallways remain clear and maintain proper means of egress. Educated staff that the ground floor business office falls under the same Fire Life Safety regulations as the skilled nursing facility on the second floor does. Staff was in-serviced on 10/05/2015 regarding maintaining means of egress.</p>	