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 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
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September 30, 2015

Brian Sawyer, Administrator
Valley Vista Care Center of Sandpoint
220 South Division
Sandpoint, ID 83864-1759

Provider #: 135055

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

Dear Mr. Sawyer:

On **September 22, 2015**, a Facility Fire Safety and Construction survey was conducted at **Valley Vista Care Center of Sandpoint** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

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

you allege that each tag will be back in compliance. **NOTE**: The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). 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 27, 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 27, 2015**. A change in the seriousness of the deficiencies on **October 27, 2015**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **October 27, 2015**, includes the following:

Denial of payment for new admissions effective **December 22, 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 22, 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 22, 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

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

ATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	135055		09/22/2015

AME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEY VISTA CARE CENTER OF SANDPOINT	220 SOUTH DIVISION SANDPOINT, ID 83864

(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	K 000		
	The facility is a single story, Type V(111) structure. The building is protected throughout by automatic fire extinguishing and fire alarm systems. The building was originally constructed in 1959 with an addition in 1985. There have been several minor additions and remodels with a major remodeling completed in 2001. The facility currently is licensed for 73 SNF/NF beds. The following deficiencies were cited during the annual fire/life safety survey conducted on September 22, 2015. The facility was surveyed under the Life Safety Code 2000 Edition, Existing Health Care Occupancy and in accordance with 42 CFR 483.70. The Survey was conducted by: Nate Elkins Health Facility Surveyor Facility Fire Safety & Construction		Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies rendered by the reviewing agency. The Plan of Correction is prepared and executed solely because the provisions of federal and state law require it..	
K 012 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD 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	K 012		
	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			

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	10-27-15

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing 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 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

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K 012	Continued From page 1 exposed wall cavities. This deficient practice affected 8 residents, staff and visitors on the date of the survey. The facility is licensed for 73 SNF/NF beds and had a census of 64 on the day of the survey. Findings include: 1.) During the facility tour on September 22, 2015 at approximately 10:30 AM, observation of the Billing Office revealed a 3" circular hole cut into the wall exposing the interior wall cavity. 2.) During the facility tour on September 22, 2015 at approximately 10:45 AM, observation of the breakroom in the 100 hallway revealed two 1 inch circular holes and a one 2 inch circular hole cut into the wall exposing the interior wall cavity. When asked, about the holes cut into the walls, the Environment Director stated the facility was aware of the holes but were unaware of the code requirements. Actual NFPA standard: 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	K 012	... . .K 012 The 3 inch circular hole into the wall cavity of the Business office cited in # 1 and the 2-1 inch circular holes and 1- 2 inch circular hole cut into the wall cavity of the Employee break room cited in#2 had the potential to affect 8 Residents 0f 64 census. . Both walls with the holes cited in #1 and#2 were repaired immediately before inspection was completed on Sept-22-2015. All walls were inspected by the Environmental Dir and no other holes or compromised areas were found in the facility. . Future wall compromises will be monitored/ repaired if needed by Environmental Dir or designee upon discovery. . Environmental Dir or designee will inspect weekly during rounds and report findings monthly for three months to the QA committee	9/22/15

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K 012	Continued From page 2 Coverings. (b) The roof is separated from all occupied portions of the building by a noncombustible floor assembly that includes not less than 21/2 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 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as	K 018		

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K 018	Continued From page 3 those constructed of 1¾ 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 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation, operational testing and interview the facility failed to maintain doors that protect corridor openings. Failure to maintain corridor doors could allow smoke and dangerous gases to pass freely between smoke compartments. This deficient practice affected 16 residents, staff, and visitors on the date of survey. The facility is licensed for 73 SNF/NF beds with a census of 64 on the day of survey. Findings include: 1.) During the facility tour on September 22, 2014 at approximately 10:00 AM, observation and operational testing of the Clean Utilities room door in the 300 hallway found a hoyer lift and a sit/stand lift impeding the closing of the door. This was corrected on spot by the Environment	K 018	K018 The door in the 300 hall being impeded X 2 from closing had the potential to affect 16 residents of 64 census. The impediment "Hoyer" was immediately moved by the Environmental Dir to the designated assigned space. The Environmental Dir created signage both on the floor and on the door ensuring unobstructed closure space. A sign was also posted on the door stating "this door to remain closed at all times". The door leading from the 400 corridor into the TV/activities room was provided with a latch All doors and rooms were inspected for compliance by the Environmental Dir for possible need of code required door closers. The Environmental Dir or designee will observe compliance on a daily basis and report to the QA committee monthly for three months.	9/24/15 9/24/15

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K 018	Continued From page 4 Director. At approximately 2:30 PM, observation and operational testing of the same room door revealed the hoyer lift and the sit/stand lift was once again impeding the door from closing again. When asked, the Environment Director stated the facility was aware the door was being blocked from closing and would provide staff training and proper configuration for storage. 2.) During the facility tour on September 22, 2015 at approximately 1:30 AM, observation of the door leading from the 400 corridor into the television/activities room revealed the door would not latch when closed completely because the latch was missing. When asked, the Environment Director stated the facility was unaware the door needed a latch. Actual NFPA standard: 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 shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments	K 018		

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K 018	Continued From page 5 protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke.	K 018		
K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure smoke barrier doors would close properly when activated by the smoke detection system. Failure to ensure that smoke compartment doors close completely could allow the passage of smoke and dangerous gases to travel freely and negate the opportunity to defend in place. This deficient practice affected 28 residents, staff and visitors on the date of the survey. The facility is licensed for 73 SNF/NF beds with a census of 64 on the day of the survey. Findings include:	K 027	The cross corridor doors near 501/502 leaving a gap during operational testing had the potential to affect 28 residents of 64 census. the door were adjusted to ensure proper closure and compliance. This will be tested weekly by the Environmental Diror designee and reported to the QA committee monthly for three months.	10/22/15

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K 027	Continued From page 6 During the facility tour conducted on September 22, 2015 at approximately 11:30 AM, operational testing of the cross corridor doors near room 501/502 would not close when activated and left an approximate 2 inch gap between the facing edge of the doors. When asked, the Environment Director stated the facility was unaware of the doors not closing properly. Actual NFPA standard: NFPA 101 19.3.7.6* Doors in smoke barriers shall comply with 8.3.4 and shall be self-closing or automatic-closing in accordance with 19.2.2.2.6. Such doors in smoke barriers shall not be required to swing with egress travel. Positive latching hardware shall not be required.	K 027		
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, operational testing and	K 029		

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4) 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 029	Continued From page 7 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 of occupants during a fire event. This deficient practice affected 28 residents, staff and visitors on the date of the survey. The facility is licensed for 73 SNF/NF beds with a census of 64 on the day of the survey. Findings include: 1.) During the facility tour on September 22, 2015 at approximately 11:00 AM, observation and operational testing of the Nurse Supply room in the 500 hallway revealed the room door was not equipped with a self-closure. The room was being utilized as a storage room which measured more than 50 square feet and stored combustible items. 2.) During the facility tour on September 22, 2015 at approximately 1:30 PM, observation and operational testing of the Storage Room at the intersection of the 100 hallway and the 300 hallway revealed the room door was not equipped with a self-closure. The room was being utilized to store combustibles and was measured to be larger than 50 square feet. When asked, the Environment Director stated the facility was unaware of the self-closure requirements. Actual NFPA standard: 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a	K 029	The door into the nurse supply room on the 500 hall and the storage room door on the 100/300 hall intersection were not equipped self closure devises and had the potential to affect 28 residents of 64 census. The nurse supply room on the 500 hall as well the storage room at the 100/300 hall intersection have been equipped with self closure devices All doors in the facility were inspected for the possible need of self closure devices. All doors will be monitored during weekly testing and reported to the QA committee monthly for three months.	9/24/15.

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K 029	Continued From page 8 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: (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 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 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.	K 144		

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K 144	Continued From page 9 This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to load test the generator on a monthly basis. Failure to load test the generator system monthly could lead to the system not operating correctly when required. This deficient practice affected all residents, staff and visitors on the date of survey. The facility is licensed for 73 SNF/NF beds with a census of 64 on the day of survey. Findings include: During the record review process on September 22, 2015 at approximately 9:00 AM, the facility failed to provide monthly load testing documentation for the generator system. When asked, the Environment Director stated the facility was unaware of the requirements for the generator system. 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 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	The monthly Generator testing was not properly documented per code having the potential to affect 64 residents. . The Generator has been and is being tested with proper documentation per code by Environmental Dir or desigee. . Environmental Dir will monitor and be responsible for compliance . . Reports will be made to the QA committee monthly for three months.	9/30/15