



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
FAX 208-364-1888

September 15, 2016

Randal Barnes, Administrator
Valley View Nursing & Rehabilitation
1140 North Allumbaugh Street
Boise, ID 83704-8700

Provider #: 135098

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

Dear Mr. Barnes:

On **September 8, 2016**, a Facility Fire Safety and Construction survey was conducted at **Valley View Nursing & Rehabilitation** 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 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

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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 **September 28, 2016**. Failure to submit an acceptable PoC by **September 28, 2016**, may result in the imposition of civil monetary penalties by **October 18, 2016**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.
- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567. If a State Form was issued as well, it should also be signed, dated and returned.

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

Remedies 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 13, 2016**, (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 13, 2016**. A change in the seriousness of the deficiencies on **October 13, 2016**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **October 13, 2016**, includes the following:

Denial of payment for new admissions effective **December 8, 2016**. 42 CFR §488.417(a)

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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 8, 2017**, 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 8, 2016**, 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:

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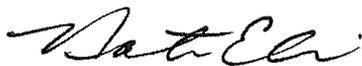
BFS Letters (06/30/11)

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

This request must be received by **September 28, 2016**. If your request for informal dispute resolution is received after **September 28, 2016**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626, option 3.

Sincerely,



Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosures

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

Printed: 09/14/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135098	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 09/08/2016
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NAME OF PROVIDER OR SUPPLIER VALLEY VIEW NURSING & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 1140 NORTH ALLUMBAUGH STREET BOISE, ID 83704
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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 facility is a two story Type II (111) completed in 1985. It underwent a complete renovation in 2009. There is a two-hour fire separation between the nursing facility and the retirement center apartments. The fire alarm system was upgraded in 2009 with addressable smoke detection throughout the building. The fire sprinkler system was upgraded in 2009 with quick response heads throughout the facility. The facility is currently licensed for 120 SNF/NF beds.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on August 8, 2016. 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: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	K 000	<p>This Plan of Correction is submitted as required under Federal and State regulations and statutes applicable to long-term care providers. The Plan of Correction does not constitute an admission of liability on part of the facility, and such liability is specifically denied. The submission of this Plan of Correction does not constitute agreement by the facility that the surveyors findings and/or conclusions constitute a deficiency, or that the scope and severity of the deficiencies cited are correctly applied.</p> <p style="text-align: center;">RECEIVED SEP 29 2016 FACILITY STANDARDS</p>	
K 025 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5</p> <p>This Standard is not met as evidenced by: Based on observation and interview the facility failed to maintain the smoke and fire resistive properties of smoke barriers. Failure to maintain smoke barrier continuity could allow smoke, fire and dangerous gases to pass between compartments, hindering egress during a fire.</p>	K 025	<p>K025</p> <p>Residents:</p> <p>There were no residents directly affected by this practice.</p> <p>Other Residents:</p> <p>Residents on the first and second floor have the potential to be affected by this practice. The 6 inch x 6 inch hole outside of the electrical room was sealed.</p>	10/5/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 9-28-16
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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 025	<p>Continued From page 1</p> <p>This deficient practice affected staff and visitors on the first and second floor on the date of the survey. The facility is licensed for 120 SNF/NF beds and had a census of 83 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on August 8, 2016 from approximately 1:00 PM to 2:00 PM, observation of the electrical/data rooms adjacent to the nurse's station revealed the following unsealed penetrations:</p> <p>1) An above the ceiling inspection outside the first floor electrical room revealed an approximate six inch by six inch hole in the wall of the electrical room, exposing the interior wall cavity. When asked, the Maintenance Supervisor stated he had not been aware of this hole prior to the survey.</p> <p>2) Observation of the first and second floor electrical/data room installations revealed four (4) conduits, tightly filled with data cabling, not sealed to resist smoke or fire. Further observation revealed that two of these were installed in the concrete floor/ceiling separation between the first and second floor; one (1) was through the corridor wall and sealed only with a paper towel and one (1) was through the corridor wall, unsealed and tightly filled with data cabling.</p> <p>When asked about the unsealed penetrations, the Maintenance Supervisor stated he had not been aware these conduits were not sealed prior to the date of the survey.</p> <p>Actual NFPA standard: 19.3.7.3</p>	K 025	<p>The paper towel was removed. Four additional holes were drilled in the floor. The cabling was distributed evenly among the four holes. The conduit was then sealed.</p> <p>Measures:</p> <p>Following contractor work, maintenance department to visually inspect the area to ensure penetrations have been sealed and will document findings. Maintenance staff will conduct a complete 100% audit of all areas within the facility to ensure all penetrations are sealed properly and document findings.</p> <p>Monitor:</p> <p>Maintenance Supervisor or designee to report at the monthly QAPI meeting of issues regarding wall penetrations.</p>	

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K 025	Continued From page 2 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour. Exception No. 1: Where an atrium is used, smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with Exception No. 2 to 8.2.5.6(1). Not less than two separate smoke compartments shall be provided on each floor. Exception No. 2*: Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.3 has been provided for smoke compartments adjacent to the smoke barrier. 8.3.2* Continuity. Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces. Exception: A smoke barrier required for an occupied space below an interstitial space shall not be required to extend through the interstitial space, provided that the construction assembly forming the bottom of the interstitial space provides resistance to the passage of smoke equal to that provided by the smoke barrier.	K 025		
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This Standard is not met as evidenced by: Based on observation and interview, the facility	K 038	K038	10/5/16

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K 038	<p>Continued From page 3</p> <p>failed to ensure signs for delayed egress doors were in accordance with NFPA 101. Failure to provide signs with a contrasting background could hinder egress during an emergency. This deficient practice affected 22 residents, staff and visitors on the date of the survey. The facility is licensed for 120 SNF/NF beds and had a census of 83 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on August 8, 2016 from approximately 11:30 AM to 2:00 PM, observation of exit doors in halls 1 and 2 revealed these doors were equipped with delayed egress locking arrangements. Further observation revealed the signs for the operation of these doors did not have a contrasting background. When asked, the Maintenance Supervisor stated he had not noticed the background was not contrasting prior to the date of the survey.</p> <p>Actual NFPA standard:</p> <p>19.2 MEANS OF EGRESS REQUIREMENTS 19.2.1 General. Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7. Exception: As modified by 19.2.2 through 19.2.11.</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</p>	K 038	<p>Residents:</p> <p>Signs for the two doors were replaced with signs of a contrasting background to correct this practice for the 22 affected residents.</p> <p>Other Residents:</p> <p>Signs on the other exit doors were contrasting, therefore no other residents have the potential to be affected.</p> <p>Measures:</p> <p>Maintenance Supervisor or designee will conduct a monthly audit of the signs on exit doors to ensure the facility remains in compliance with the contrasting backgrounds.</p> <p>Monitor:</p> <p>Maintenance Supervisor or designee will report at the monthly QAPI meeting on the compliance of the facility regarding contrasting signs on exit doors.</p>	

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K 038	Continued From page 4 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 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 038		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that electrical panel installations	K 147	K147	10/5/16

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K 147	<p>Continued From page 5</p> <p>were maintained free of obstacles. Failure to maintain clearance to electrical panels could hinder access during an emergency. This deficient practice affected staff and visitors on the date of the survey. The facility is licensed for 120 SNF/NF beds and had a census of 83 on the day of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on August 8, 2016 from approximately 10:00 AM to 2:00 PM, observation of the electrical room in the dining hall revealed the electrical shutoff was blocked with Activities storage.</p> <p>2) During the facility tour conducted on August 8, 2016 from approximately 10:00 AM to 2:00 PM, observation of the electrical room across from the first floor nurse's station revealed the access to the electrical panel was blocked with a floor scrubber, vacuum and cartons of wheelchair parts.</p> <p>When asked about the access to the electrical being obstructed, the Maintenance Supervisor stated he was not aware of this storage, but knew of the access requirement.</p> <p>Actual NFPA standard:</p> <p>110.26 Spaces About Electrical Equipment. 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. (A) Working Space. Working space for</p>	K 147	<p>Residents:</p> <p>No residents were affected by this cited practice.</p> <p>Other Residents:</p> <p>In an emergency this cited practice could affect other residents in the facility.</p> <p>Measures:</p> <p>Facility staff will be inserviced on the requirement to maintain clearance to all electrical panels.</p> <p>Maintenance staff will monitor clearance on their daily rounds. If deficient practice is discovered, they will correct immediately.</p> <p>Monitor:</p> <p>Maintenance Supervisor or designee will report at the monthly QAPI meeting on the compliance of the facility regarding clearance to electrical panels.</p>	

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K 147	Continued From page 6 equipment operating at 600 volts, nominal, or less to ground and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A)(1), (2), and (3) or as required or permitted elsewhere in this Code. (1) Depth of Working Space. The depth of the working space in the direction of live parts shall not be less than that specified in Table 110.26(A)(1) unless the requirements of 110.26(A)(1)(a), (b), or (c) are met. Distances shall be measured from the exposed live parts or from the enclosure or opening if the live parts are enclosed.	K 147		
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