



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

October 14, 2016

David Green, 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. Green:

On **October 4, 2016**, 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

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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 27, 2016**. Failure to submit an acceptable PoC by **October 27, 2016**, may result in the imposition of civil monetary penalties by **November 16, 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 **November 8, 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 **November 8, 2016**. A change in the seriousness of the deficiencies on **November 8, 2016**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **November 8, 2016**, includes the following:

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Denial of payment for new admissions effective **January 4, 2017**.
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 **April 4, 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 Nate Elkins, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, option 3; 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 **October 4, 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>

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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 **October 27, 2016**. If your request for informal dispute resolution is received after **October 27, 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

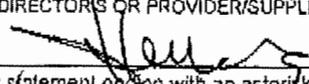
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/13/2016
FORM APPROVED
OMB NO. 0938-0301

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135055	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/04/2016
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NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF SANDPOINT	STREET ADDRESS, CITY, STATE, ZIP CODE 220 SOUTH DIVISION SANDPOINT, ID 83864
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The facility is a single story, Type V(111) 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 October 4, 2016. 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: Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction	K 000	Preparation and execution of this POC 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 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure smoke resistive properties of smoke barriers were maintained. Failure to ensure smoke barriers resist the passage of smoke would allow smoke and dangerous gases	K 025	CORRECTIVE ACTION The penetrations in the communications/mechanical room have been filled with spray foam and a ceiling tile was replaced to ensure that all penetrations are sealed.	11/07/2016

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE NHA	(X6) DATE 10/25/16
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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>to pass freely between smoke compartments. This deficient practice affected 16 residents, staff and visitors on the date of the survey. The facility is licensed for 73 SNF/NF beds and had a census of 62 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour on October 4, 2016 from approximately 10:30 AM to 2:00 PM, observation of the communications/mechanical room off of the kitchen found multiple penetrations in the ceiling and walls. The penetrations ranged in size from 1' x 2' to 2" x 4". When asked the Maintenance Supervisor stated the facility was unaware of the penetrations.</p> <p>Actual NFPA standard:</p> <p>19.3.7.3 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.</p> <p>8.3.2* Continuity. Smoke barriers required by this Code shall be</p>	K 025	<p>AFFECTED RESIDENTS</p> <p>This deficient practice had the potential to affect 16 Residents, Staff and visitors.</p> <p>SYSTEMATIC CHANGES</p> <p>All rooms in the Facility have been inspected by the Maintenance Supervisor to ensure compliance. In-Service provided to staff on 10/24/16 educating them on reporting any penetrations that may need repair.</p> <p>MONITORING</p> <p>The maintenance Supervisor or designee will do documented weekly rounds x 4, q 2 weeks x's 2 and monthly x 3 and report to the QA Committee to ensure on-going compliance.</p> <p>Audits will begin 11/07/2016</p>	

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K 025	Continued From page 2 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 NFPA 101 LIFE SAFETY CODE STANDARD	K 025		
K 062 SS=F	Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, § 7.5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that sprinklers were maintained free of paint. Failure to keep sprinklers clear of paint could result in lack of system performance during a fire. This deficient practice affected 62 residents, staff and visitors on the date of the survey. The facility is licensed for 73 SNF/NF beds and had a census of 62 on the day of the survey. Findings include: During the facility tour on October 4, 2016 from approximately 10:30 AM to 2:00 PM, observation of sprinkler pendants found the following locations had sprinklers with non-factory applied	K 062	CORRECTIVE ACTION Simplex Grinnell came to the Facility On 10/20/16 to assess the sprinkler heads on the hallway across from the lodge nurses station, Resident rooms 202, 203, 206, 212, 301 and the hallway between resident rooms 204 and 206 and replacement heads have been ordered to replace all sprinkler heads that have non factory applied paint on them.	11/07/2016

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K 062	<p>Continued From page 3 paint or overspray: Director of Therapy Office Medical Records Medical Records Bath Hallway across from the "Lodge" Nurse's Station Resident room 202 and adjoining bath Resident Rooms 203, 206, 212, and 301 Hallway between resident rooms 204 and 206</p> <p>Based on the quantity found in multiple locations, the condition was deemed widespread and further documentation was unnecessary.</p> <p>When asked, the Maintenance Supervisor stated the facility was unaware of the painted sprinkler heads.</p> <p>Actual NFPA standard: NFPA 25 2-2 Inspection. 2-2.1 Sprinklers. 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. Exception No. 1*: Sprinklers installed in concealed spaces such as above suspended ceilings shall not require inspection. Exception No. 2: Sprinklers installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown.</p>	K 062	<p>AFFECTED RESIDENTS</p> <p>This deficient practice had the potential to effect all Residents, staff and visitors.</p> <p>SYSTEMIC CHANGES</p> <p>The maintenance supervisor inspected all the Facilities sprinkler heads to ensure they do not have Non factory paint or over spray.</p> <p>The maintenance Supervisor or Designee will be involved in planning and inspect all future painting projects in the Facility to ensure no sprinkler heads get painted.</p> <p>MONITORING</p> <p>The maintenance supervisor or designee will do documented weekly rounds x4 weeks, q 2 weeks x 2 and monthly x3 and report to the QA Committee to ensure on-going compliance. Audits will begin 11/07/2016</p>	
K 072	NFPA 101 LIFE SAFETY CODE STANDARD	K 072		

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K 072 SS=C	<p>Continued From page 4</p> <p>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. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1 10. 18.2.1, 19.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure that exit doors were arranged to be readily opened from the egress side and not require special knowledge. Failure to maintain means of egress for full instant use could hinder the safe evacuation of residents during an emergency. This deficient practice affected 19 residents, staff and visitors on the date of the survey. The facility is licensed for 73 SNF/NF beds and had a census of 62 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour on October 4, 2016 from approximately 10:30 AM to 2:00 PM, observation and operational testing revealed the exit door at the 200 Hallway was equipped with controlled access and could not be opened without special knowledge. (keypad code)</p> <p>When asked why the doors were controlled access, the Administrator and Maintenance Manager stated the facility installed them for security and were unaware that controlled access exit doors were not allowed. They further stated that the controlled access component would drop in the event of a power outage or activation of the fire alarm system allowing egress.</p> <p>Actual NFPA standard:</p>	K 072	<p>CORRECTIVE ACTION</p> <p>The key pad was removed from the 200 hall exit door so it no longer has controlled access.</p> <p>AFFECTED RESIDENTS</p> <p>This deficient practice had the potential to effect 19 residents, staff and visitors.</p> <p>SYSTEMATIC CHANGES</p> <p>Effective 10/24/2016 the maintenance Supervisor and Administrator will be directly involved in any changes/alterations to all exit doors in the Facility to ensure on-going compliance.</p> <p>MONITORING</p> <p>The maintenance supervisor or designee will observe documented compliance weekly x4, q 2 weeks x's 2 and monthly x3 and report to the QA committee</p> <p style="text-align: right;">Audits will begin 11/07/2016</p>	11/07/2016

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K 072	<p>Continued From page 5</p> <p>NFPA 101 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>7.2.1.5 Locks, Latches, and Alarm Devices. 7.2.1.5.1 Doors shall be arranged to be opened readily from the egress side whenever the building is occupied. Locks, if provided, shall not require the use of a key, a tool, or special knowledge or effort for operation from the egress side. Exception No. 1: This requirement shall not apply where otherwise provided in Chapters 18 through 23. Exception No. 2: Exterior doors shall be permitted to have key-operated locks from the egress side, provided that the following criteria are met: (a) Permission to use this exception is provided in Chapters 12 through 42 for the specific occupancy. (b) On or adjacent to the door, there is a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high on a contrasting background that reads as follows: THIS DOOR TO REMAIN UNLOCKED WHEN THE BUILDING IS OCCUPIED</p>	K 072		