October 14, 2016

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 October 5, 2016, 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 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 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 9, 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 9, 2016**. A change in the seriousness of the deficiencies on **November 9, 2016**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **November 9, 2016**, includes the following:
Denial of payment for new admissions effective **January 5, 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 5, 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 5, 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:

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
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided 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.
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

<table>
<thead>
<tr>
<th>PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER</th>
<th>MULTIPLE CONSTRUCTION</th>
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</thead>
<tbody>
<tr>
<td>135075</td>
<td>A. BUILDING 02 - ENTIRE NF STRUCTURE - BUILDING AND APARTMENT</td>
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<td>B. WING</td>
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**STATEMENT OF DEFICIENCIES**

**ID PREFIX**

<table>
<thead>
<tr>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
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<td>PROVIDER'S PLAN OF CORRECTION</td>
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<td>(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
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<tr>
<th>ID PREFIX TAG</th>
<th>AFFECTED RESIDENTS</th>
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<tr>
<td></td>
<td>Sixty seven residents were affected by the annual sprinkler testing lapsing and the non-factory paint on the sprinkler heads.</td>
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</table>

**SYSTEMIC CHANGES**

Maintenance staff was educated on the requirement for compliance with sprinkler heads. Staff was in-serviced on 10/25/2016 regarding the NFPA standard for sprinklers and sprinkler inspections.

**MONITORING**

Facility maintenance staff will add checking sprinkler heads for noncompliance to their quarterly rounds. Facility maintenance director will track annual inspection dates internally to maintain compliance. Going forward, maintenance director or

**Findings include:**

1. During record review conducted on October 5, 2016, from approximately 9:30 AM to 10:30 AM, documentation for the annual sprinkler inspection could not be located. The last inspection was dated April 2015. When asked, the Maintenance Supervisor stated the facility was not aware the annual sprinkler inspection was past due.

2. During the facility tour on October 5, 2016, from approximately 10:30 AM to 1:30 PM, observation of sprinkler pendants found the following locations had a single sprinkler head with non-factory applied paint or overspray:
   - Resident Rooms 210 and 244
   - Resident Room Bathrooms 203, 231, 233 and 244

Based on the quantity found in multiple locations, the condition was deemed widespread and further documentation was unnecessary. When asked, the Maintenance Supervisor stated the facility was unaware of the painted sprinkler heads.

**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,
**Summary Statement of Deficiencies**

**K062**
Continued From page 2

- **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.

**K064**

**NFPA 101 LIFE SAFETY CODE STANDARD**

- Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6
- This STANDARD is not met as evidenced by:
  - Based on observation and interview, the facility failed to ensure that fire extinguishers were installed per NFPA 10. Failure to install fire extinguishers at the proper height could hinder emergency response by staff. This deficient practice affected 67 residents, staff and visitors on the day of the survey.
  - The facility is licensed for 74 SNF/NF beds and had a census of 67 on the day of the survey.

Findings include:

During the facility tour on October 5, 2016, from approximately 10:30 AM to 1:30 PM, examination of fire extinguishers installed in the following areas found that the height measured from the floor to the top of the extinguishers exceeded sixty inches (60"):
- Administrative Hallway (65")
- Across from the Reception desk in the 200 hallway (65")
- Across from the Nurse's station (68 1/2")

**Corrective Action**

- On 10/06/2016 all fire extinguishers were audited for appropriate height and those that were out of compliance were lowered to meet the requirement.

**Affected Residents**

Sixty seven residents were affected by the noncompliant height of the fire extinguishers.

**Systemic Changes**

Staff were educated on the appropriate height for fire extinguishers. Staff was in-serviced on 10/25/2016 regarding NFPA standards for
### Summary Statement of Deficiencies

Each deficiency must be preceded by full regulatory or LSC identifying information.

#### K 064
- **Location:** Mechanical/Electrical Room (65")
- **Details:** Based on the quantity found in multiple locations, the condition was deemed widespread and further documentation was unnecessary.
- **Actual NFPA Standard:**
  - **NFPA 10 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 31/2 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 072
- **Location:** NFPA 101 LIFE SAFETY CODE STANDARD
- **Details:** 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 thereeto, egress therefrom, or visibility thereof shall be in accordance with 7.1.10, 16.2.1, 19.2.1
- **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

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**Corrective Action**

- **K 064**
  - A delayed egress lock was installed on the door to the Administrative hallway on 10/21/2016.
  - A delayed egress lock was installed on the Laundry/Kitchen door on 12/01/2016.

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**Facility Standards**

- **Received Dec. 2, 2016**
  - L. Chaney

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**Form CMS-2587**

- **Previous Versions Obsolete**
- **Event ID:** ZY7K21
- **Facility ID:** MDS001620
- **If continuation sheet Page 4 of 6**
Continued From page 4

for full instant use could hinder the safe evacuation of residents during an emergency. 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 67 on the day of the survey.

Findings include:

During the facility tour on October 5, 2016 from approximately 10:30 AM to 1:30 PM, observation and operational testing revealed the following exit doors were equipped with controlled access and could not be opened without special knowledge.

- Administrative hallway
- Laundry/Kitchen hallway

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 ensured that the controlled access component would drop in the event of a power outage or activation of the fire alarm system allowing egress.

Actual NFPA standard:

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.
7.2.1.5 Locks, Latches, and Alarm Devices.

Sixty seven residents were affected by the controlled access to an egress exit.

SYSTEMIC CHANGES
Staff was in-serviced on 10/25/2016 regarding the means of egress requirements and the delayed egress lock installed on the Administrative hallway door. Staff was in-serviced on 12/01/2016 regarding the delayed egress lock installed on the Laundry/Kitchen the exit door.

MONITORING
Weekly delayed egress door operational inspections will be expanded to include the Administrative hallway door and the Laundry/Kitchen door.
<table>
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<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
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<td>Continued From page 5 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</td>
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<td></td>
<td>10/05/2016</td>
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