November 17, 2016

Troy Thayne, Administrator
Bell Mountain Village & Care Center
620 N. 6th St.
Bellevue, ID 83313-5174

Provider #: 135069

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Mr. Thayne:

On November 8, 2016, a Facility Fire Safety and Construction survey was conducted at Bell Mountain Village & Care Center 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 **November 30, 2016**. Failure to submit an acceptable PoC by **November 30, 2016**, may result in the imposition of civil monetary penalties by **December 20, 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 **December 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 **December 13, 2016**. A change in the seriousness of the deficiencies on **December 13, 2016**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **December 13, 2016**, includes the following:
Denial of payment for new admissions effective **February 8, 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 **May 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 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 **November 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:


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 **November 30, 2016**. If your request for informal dispute resolution is received after **November 30, 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
K 000 INITIAL COMMENTS

The facility is comprised of two (2) SNF/NF small house model buildings, identical in design. Construction of the two SNF/NF buildings was completed in January, 2016. The buildings are defined as buildings A and C which house residential sleeping rooms. Building B houses the physical therapy occupancy which serves the SNF/NF residents, administrative offices and an assisted living facility separated by two-hour construction.

All buildings are type II (000) construction equipped with automatic sprinkler protection, corridor smoke detection. Type 2 Emergency Electrical Systems with automatic transfer switching is provided for building A and C. Building B EES provides emergency power for the Assisted Living, Physical Therapy and Administrative offices. Both buildings A and C have commercial kitchens which are separated by one-hour construction. The facility was built in 2016 and is licensed for 32 SNF/NF beds.

The following deficiencies were cited during the annual Fire/Life Safety survey conducted on November 8, 2016. The facility was surveyed under the LIFE SAFETY CODE 2012 Edition, Existing Health Care Occupancy in accordance with 42 CFR 483.70.

The survey was conducted by:

Sam Burbank
Health Facility Surveyor
Facility Fire Safety and Construction
NFPA 101 Cooking Facilities

K 324
NFPA 101 Cooking Facilities

AFFECTED RESIDENTS

All residents could be affective by this citation

CORRECTIVE ACTION

The facility had the hood inspected and cleaned on 12/7/2016.

SYSTEMATIC CHANGES

The Vice President of Operations entered the semi-annual hood inspection and cleaning into the maintenance tracking system. The system will alert the maintenance technician of the upcoming due date for the inspection to ensure ongoing compliance.

Monitoring

The semi-annual kitchen hood cleaning and inspection reports will be presented to Q.A.P.I. the following month of the inspection to ensure compliance.

The Maintenance Technician is responsible for compliance.
K324 Continued From page 1

Cooking Facilities

Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:

* residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2
* cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or
* cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.

Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor.

18.3.2.5.1 through 16.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2

This STANDARD is not met as evidenced by:

Based on record review and interview, the facility failed to ensure a semi-annual inspection of the Kitchen hood was conducted in accordance with NFPA 96. Failure to conduct semi-annual inspections of cooking ventilation systems could increase the risk of fires due to excessive build-up of grease laden vapors. This deficient practice affected staff and vendors of the main Kitchen on the date of the survey. The facility is licensed for 32 SNF/NF beds and had a census of 21 on the day of the survey.
During review of provided hood Inspection records conducted on November 8, 2016 from approximately 9:00 AM to 10:00 AM, Inspection records provided for the Kitchen cooking ventilation system, no records were available demonstrating a hood Inspection had been completed since December of 2015. Interview of the Maintenance Supervisor revealed the time lapse between Inspections was due to a change in vendors. Further evaluation revealed the facility's system served moderate volume cooking operations requiring semi-annual Inspections of the hood exhaust system.

Actual NFPA standard:

**NFPA 96**

### 11.4 Inspection for Grease Buildup

The entire exhaust system shall be inspected for grease buildup by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction and in accordance with Table 11.4.

### 11.6 Cleaning of Exhaust Systems

11.6.1 Upon Inspection, if the exhaust system is found to be contaminated with deposits from grease-laden vapors, the contaminated portions of the exhaust system shall be cleared by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction.
**DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
**CENTERS FOR MEDICARE & MEDICAID SERVICES**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
</tr>
</thead>
</table>
Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.  
a) Date sprinkler system last checked  
b) Who provided system test  
c) Water system supply source | K 353 | NFPA Sprinkler System - Maintenance and Testing  
Affected Residents  
All residents could be affected by this citation.  
Corrective Action  
The facility has entered into a new contract with a sprinkler inspection company named, SHILO. The facility is on a quarterly inspection schedule with the company.  
Systematic Changes  
The Vice President of Operations added the Quarterly inspection of the sprinkler system into our on-line maintenance tracking system. The system will alert the maintenance technician of the upcoming due date for the inspection.  
Monitoring  
The Maintenance Technician will present the quarterly Sprinkler System test to the Q.A.P.I. committee on a quarterly basis.  
The maintenance technician is responsible for compliance. |

**NAME OF PROVIDER OR SUPPLIER**  
BELL MOUNTAIN VILLAGE & CARE CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**  
620 NORTH SIXTH STREET  
BELLEVUE, ID 83313

**STATEMENT OF DEFICIENCIES**

K 353 Continued From page 3

K 353  
NFPA 101 Sprinkler System - Maintenance and Testing

K 353  
NFPA Sprinkler System - Maintenance and Testing

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>COMPLIANCE DATE</th>
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<tbody>
<tr>
<td>K 353</td>
<td></td>
<td></td>
<td>11/08/2016</td>
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<tr>
<td>K 353</td>
<td></td>
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<td>11/08/2016</td>
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</tbody>
</table>

**FINDINGS INCLUDE:**

1) During review of facility fire suppression system inspection records provided on November 8, 2018 from approximately 9:30 AM to 11:00 AM,
<table>
<thead>
<tr>
<th>K 353 Continued From page 4</th>
<th>K 353</th>
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<tbody>
<tr>
<td>records provided indicated the quarterly</td>
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<tr>
<td>Inspections for second and third quarter of 2016</td>
<td></td>
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<tr>
<td>were not conducted for either of the SNF/NF</td>
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<td>residence buildings.</td>
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<td>2) During the facility tour conducted on November</td>
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<tr>
<td>8, 2016 from approximately 1:00 PM to 3:00 PM,</td>
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<tr>
<td>observation of the fire suppression system risers</td>
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<td>in both buildings did not reveal any inspection</td>
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<tr>
<td>tags affixed to the risers indicating a quarterly</td>
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<tr>
<td>inspection was conducted during the second and</td>
<td></td>
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<td>third quarter of 2016.</td>
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<tr>
<td>Actual NFPA standard:</td>
<td></td>
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<tr>
<td>NFPA 25</td>
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<tr>
<td>6.3.3 Waterflow Alarm Devices.</td>
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<tr>
<td>6.3.3.1 Mechanical waterflow alarm devices</td>
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<tr>
<td>including, but not limited to, water motor gongs,</td>
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<tr>
<td>shall be tested quarterly.</td>
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<td>K 522 HVAC - Any Heating Device</td>
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<tr>
<td>HVAC - Any Heating Device</td>
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<tr>
<td>Any heating device, other than a central heating</td>
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<tr>
<td>plant, is designed and installed so combustible</td>
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<tr>
<td>materials cannot be ignited by device, and has a</td>
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<td>safety feature to stop fuel and shut down</td>
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<tr>
<td>equipment if there is excessive temperature or</td>
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<tr>
<td>Ignition failure. If fuel fired, the device also:</td>
<td></td>
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<tr>
<td>* Is chimney or vent connected</td>
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<td>* Takes air for combustion from outside</td>
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<tr>
<td>* Provides for a combustion system separate from</td>
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<tr>
<td>occupied area atmosphere</td>
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<td>18.5.2.2, 18.5.2.2</td>
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<tr>
<td>This STANDARD is not met as evidenced by:</td>
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<tr>
<td>Based on observation and Interview, the facility</td>
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<td>failed to ensure that wall mounted heaters were</td>
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<tr>
<td>maintained free of obstructions. Electric wall</td>
<td></td>
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<tr>
<td>K 522 HVAC - Any Heating Device</td>
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<tr>
<td>Affected Residents</td>
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<td>All residents could be affected by this</td>
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<tr>
<td>citation.</td>
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<td>Corrective Action</td>
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<tr>
<td>The dresser in room 15C was moved</td>
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<tr>
<td>away from the heater.</td>
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<tr>
<td>The exercise ball was moved away from</td>
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<tr>
<td>the heater in the therapy room.</td>
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<tr>
<td>The five gallon bucket in front of the</td>
<td></td>
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<tr>
<td>heater in the kitchen of the</td>
<td></td>
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<tr>
<td>Hemmingway building was moved.</td>
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</table>
**Summary Statement of Deficiencies**

Findings include:

During the facility tour conducted on November 8, 2016 from approximately 1:00 PM to 3:00 PM, observation of installed wall heaters revealed the following deficiencies:

- The Cadet wall heater in resident room 15C in the Hemmingway building had a dresser in front of it with approximately ten inches of clearance from the heater.
- The Cadet wall heater in the therapy room of the Galena building was blocked by an exercise ball stored against it.
- The Cadet wall heater in the therapy room of the Hemmingway building had a desk with approximately six inches clearance from the heater.
- The Kitchen storage area of the Hemmingway building had a five-gallon bucket against the Cadet wall heater.

**Actual NFPA Standard:**

NFPA 101

4.5 Fundamental Requirements.

4.5.6 Maintenance. Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of...

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**K 522**

The facility inspected all areas of the facilities to ensure that no other heaters were blocked.

All staff members were in-serviced on December 5th at the all staff meeting.

**Systematic Changes**

The facility has implemented weekly environment focused rounds to ensure that wall heaters are not obstructed.

**Monitoring**

The weekly focused rounds will be presented in the Q.A.P.I. meeting on a monthly basis to ensure compliance with this citation.

**The Maintenance Technician and/or designee is responsible for compliance.**
summary statement of deficiencies

### K 522

- C522 Protection, or other feature shall thereafter be maintained, unless the Code exempts such maintenance.

- 19.5.2.2 Any heating device, other than a central heating plant, shall be designed and installed so that combustible material cannot be ignited by the device or its appurtenances, and the following requirements also shall apply:
  - (1) If fuel-fired, such heating devices shall comply with the following:
    - (a) They shall be chimney connected or vent connected.
    - (b) They shall take air for combustion directly from the outside.
    - (c) They shall be designed and installed to provide for complete separation of the combustion system from the atmosphere of the occupied area.
  - (2) Any heating device shall have safety features to immediately stop the flow of fuel and shut down the equipment in case of either excessive temperature or ignition failure.

### K 918

- Electrical Systems - Essential Electric System

- Affected Residents
  All residents could be affected by this citation.

- Corrective Action
  The Vice President of Operations instructed the Maintenance Technician on 12/7/2016 about the weekly generator inspection and the monthly load test.

- Systematic Changes
  The Vice President of Operations added the weekly generator checks and monthly load test in the electronic maintenance system. The system will alert the Maintenance Technician of the upcoming tests that are due.

- Monitoring
  The Maintenance Technician will report the weekly generator inspections and monthly load test to the Q.A.P.I. on a monthly basis to ensure compliance with this citation.

- If the Maintenance Technician is responsible for compliance.
### K 918 Continued From page 7

Under load conditions, the emergency power supply system (EPSS) is exercised once every 36 months for 4 continuous hours. Scheduled tests under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable.

Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.5.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)

This STANDARD is not met as evidenced by:

Based on record review and interview, the facility failed to ensure Emergency Power Supply Systems (EPSS) were maintained in accordance to NFPA 110. Failure to inspect and test generators could hinder early detection of system problems and the performance of the equipment during an emergency. This deficient practice affected 21 residents, staff and visitors on the date of the survey. The facility is licensed for 32 SNF/NF beds and had a census of 21 on the day of the survey.

Findings include:

During review of the EPSS inspection and monthly load testing documentation provided on November 8, 2016, from approximately 9:00 AM
8.4.2* Diesel generator sets in service shall be exercised at least once a month, for a minimum of 30 minutes, using one of the following methods:

1. Loading with maintenance the minimum exhaust gas temperature as recommended by the manufacturer.

2. Under operating temperature conditions and at not less than 30 percent of the EPS nameplate kw rating.

When asked about the missing documentation, the Maintenance Supervisor stated the missing reports were due to a change in staffing prior to the survey. Furthermore, monthly road test documentation was not available for the month of October 2016 and tests documented for December 2015 and February 2016 did not document any load acquired.