December 4, 2017

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 November 22, 2017, 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 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 **December 18, 2017.** Failure to submit an acceptable PoC by **December 18, 2017,** may result in the imposition of civil monetary penalties by **January 6, 2018.**

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 may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **December 26, 2017,** (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 26, 2017.** A change in the seriousness of the deficiencies on **December 26, 2017,** may result in a change in the remedy.
The remedy, which will be recommended if substantial compliance has not been achieved by December 26, 2017, includes the following:

Denial of payment for new admissions effective February 22, 2018.
24 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 22, 2018, 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 22, 2017, 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 24 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 **December 18, 2017**. If your request for informal dispute resolution is received after **December 18, 2017**, 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
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(R1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135098

(State of the Deficiencies and Plan of Correction)

K000 INITIAL COMMENTS

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.

The following deficiencies were cited at the above facility during the annual fire/life safety code survey conducted on November 21 - 22, 2017. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Chapter 19, Existing Healthcare Occupancies, in accordance with 42 CFR 483.70, 42 CFR 483.80 and 42 CFR 483.65.

The survey was conducted by:

Linda Chaney
Health Facility Surveyor
Facility Fire Safety & Construction

General Requirements - Other
CFR(s): NFPA 101

K100 Residents:
The water management plan was present at the facility. The plan will be updated to contain the missing elements to attain compliance for our residents.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:

135098

(X2) MULTIPLE CONSTRUCTION
A. BUILDING 02 - ENTIRE BUILDING
B. WING ________________

(X3) DATE SURVEY COMPLETED: 11/22/2017

NAME OF PROVIDER OR SUPPLIER:

VALLEY VIEW NURSING & REHABILITATION

STREET ADDRESS, CITY, STATE, ZIP CODE:

1140 NORTH ALLUMBAUGH STREET
BOISE, ID 83704

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

K 100

Other Residents:

The water management plan was present at the facility. The plan will be updated to contain the missing elements to attain compliance for our residents.

Measures:

The Water management plan was updated to address the missing elements. It will also be updated yearly to ensure continued compliance.

Corrective Actions:

The water management plan will be reviewed each quarter in a facility monthly QAPI meeting to ensure its compliance.

Findings include:

During the review of facility records on November 21, 2017, from approximately 8:30 AM to 2:30 PM, the water management plan was missing required elements. Including, the facility risk assessment, control measures, and testing protocols. When asked, the Administrator stated the facility was not aware of the specific requirements for the water management plan.

Actual Standard:

42 CFR § 483.80 Infection control.

The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

Additional Reference:

Means of Egress - General
Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11.
18.2.1, 19.2.1, 7.1.10.1
This REQUIREMENT is not met as evidenced by:
Based on observation and interview, the facility failed to ensure that means of egress were provided in accordance with NFPA 101. Failure to maintain means of egress free of obstructions has the potential to hinder evacuation of residents during an emergency. This deficient practice has the potential to affect residents, staff and visitors utilizing the exit access corridor across from the first floor dining room on the date of the survey. The facility is licensed for 120 SNF/NF beds and had a census of 91 on the day of the survey.

Findings include:

During the facility tour conducted on November 22, 2017 from 8:30 AM to 11:30 AM, observation of the exit access corridor across from the first floor dining room revealed it was being used for miscellaneous storage, obstructing full use of the exit egress. When asked, the Maintenance Supervisor stated the facility is short on storage space, and since the doors were not blocked, they figured it would be okay to store items along the wall between the two exit doors.

Actual NFPA standard:
K 211 Continued From page 3

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, unless otherwise modified by 19.2.2 through 19.2.11.

7.1.10 Means of Egress Reliability.
7.1.10.1* 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.

K 222 Egress Doors

Egress Doors
Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements:

**CLINICAL NEEDS OR SECURITY THREAT LOCKING**
Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times.

**SPECIAL NEEDS LOCKING ARRANGEMENTS**
Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are

Residents:
No specific resident were affected by this issue.

Other Residents:
Residents using the therapy area have the potential be affected by this issue.

Measures:
The magnet will be removed to ensure compliance with this citation. Maintenance department will check doors monthly to ensure compliance, if issues are encountered, they will arrange for their repair to return to compliance.
Corrective Measures:
Maintenance department will check the doors monthly for compliance. Maintenance will report to QAPI monthly regarding compliance.
### Summary Statement of Deficiencies

Continued From page 5

During the facility tour on November 22, 2017, observation and operational testing of the exit door at the physical therapy suite revealed the door was magnetically controlled and required a code to activate the lock. When asked about the locking arrangement, the Maintenance Supervisor stated he was not aware of the requirement.

Findings include:

- During the facility tour on November 22, 2017, observation and operational testing of the exit door at the physical therapy suite revealed the door was magnetically controlled and required a code to activate the lock. When asked about the locking arrangement, the Maintenance Supervisor stated he was not aware of the requirement.

**Actual NFPA standard:**

19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side, unless otherwise permitted by one of the following:

1. Locks complying with 19.2.2.2.5 shall be permitted.
2. Delayed-egress locks complying with 7.2.1.6.1 shall be permitted.
3. Access-controlled egress doors complying with 7.2.1.6.2 shall be permitted.
4. Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted.
5. Approved existing door-locking installations shall be permitted.
**K 521 HVAC**

**CFR(s):** NFPA 101

**HVAC**
Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2

This REQUIREMENT is not met as evidenced by:

Based on record review, and interview, the facility failed to maintain installed smoke/fire dampers. Failure to maintain and inspect smoke/fire dampers could allow the spread of smoke/fire from the space of fire origin to other compartments. This deficient practice has the potential to affect all residents, staff, and visitors on the date of survey. The facility is licensed for 120 SNF/NF beds with a census of 91 on the day of survey.

Findings include:

During the review of facility inspection records on November 21, 2017, from approximately 8:30 AM to 2:30 PM, no records were available indicating smoke/fire dampers had been inspected or tested within the last four years. When asked, the Maintenance Supervisor stated the facility believed the smoke/fire dampers had been inspected and tested, but was unable to produce any current or historical documentation to substantiate the claim.

Actual NFPA standard:

**K 521**

**Residents:**
No specific residents were affected by this issue.

**Other Residents:**
The residents in the facility have the potential to be affected by this issue.

**Measures:**
Smoke/fire dampers were inspected/tested.

**Corrective Actions:**
Maintenance department to add damper testing/inspection to preventative maintenance schedule. Inspections will be reported in monthly QAPI meeting.
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<tr>
<th>ID PREFIX TAG</th>
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| K 521 | Continued From page 7  
NFPA 101  
19.5.2 Heating, Ventilating, and Air-Conditioning.  
19.5.2.1 Heating, ventilating, and air-conditioning shall comply with the provisions of Section 9.2 and shall be installed in accordance with the manufacturer's specifications, unless otherwise modified by 19.5.2.2.  
Air-conditioning, heating, ventilating ductwork, and related equipment shall be in accordance with  
NFPA 90 A, Standard for the Installation of Air-Conditioning and Ventilating Systems, or  
NFPA 90B, Standard for the Installation of Warm Air Heating and Air-Conditioning Systems, as applicable, unless such installations are approved existing installations, which shall be permitted to be continued in service.  
NFPA 90 A  
5.4.8.1 Fire dampers and ceiling dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives.  
5.4.8.2 Smoke dampers shall be maintained in accordance with NFPA 105, Standard for Smoke Door Assemblies and Other Opening Protectives.  
NFPA 80  
19.4.1 Each damper shall be tested and inspected 1 year after installation.  
19.4.1.1 The test and inspection frequency shall then be every 4 years, except in hospitals, where the frequency shall be every 6 years.  
NFPA 105  
6.5.2* Each damper shall be tested and inspected | K 521 | | | |

FORM CMS-2567(C2-99) Previous Versions Obsolete  
Event ID: ZD8C21  
Facility ID: MDS001810  
If continuation sheet Page 8 of 10
### Summary Statement of Deficiencies

#### K 521

Continued From page 8

One year after installation. The test and inspection frequency shall then be every 4 years, except in hospitals, where the frequency shall be every 6 years.

#### K 926

Gas Equipment - Qualifications and Training

**CFR(s): NFPA 101**

Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment.

11.5.2.1 (NFPA99)

This REQUIREMENT is not met as evidenced by:

- Based on record review, and interview, the facility failed to ensure staff were properly trained on the risks associated with the handling and use of medical gases. Failure to provide an education program which includes periodic review of safety guidelines and usage requirements for medical gases and their cylinders, could result in a life threatening or catastrophic accident. This deficient practice could potentially affect 23 residents using oxygen at the date of the survey.

#### Corrective Actions:

SDC will report trainings completed at the monthly QAPI meetings.

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**Residents:**

No specific residents were noted in citation.

**Other residents:**

Residents residing in the facility have the potential to be affected by this issue.

**Measures:**

Staff Development Coordinator (SDC) started the annual training on 11/28. Training will be added to trainings to be completed.
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<tr>
<td>K 926</td>
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<td>Continued From page 9 maintained an ongoing continuing education program for staff which includes periodic review of safety guidelines and usage requirements for medical gases and their cylinders. When asked, the Training Coordinator stated the facility was not aware of the requirement for medical gas training.</td>
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**Actual NFPA Standard:**

**NFPA 101**

19.3.2.4 Medical Gas. Medical gas storage and administration areas shall be in accordance with Section 8.7 and the provisions of NFPA 99, Health Care Facilities Code, applicable to administration, maintenance, and testing.

**NFPA 99**

11.5.2 Gases in Cylinders and Liquefied Gases in Containers.

11.5.2.1 Qualification and Training of Personnel.

11.5.2.1.1* Personnel concerned with the application and maintenance of medical gases and others who handle medical gases and the cylinders that contain the medical gases shall be trained on the risks associated with their handling and use.

11.5.2.1.2 Health care facilities shall provide programs of continuing education for their personnel.

11.5.2.1.3 Continuing education programs shall include periodic review of safety guidelines and usage requirements for medical gases and their cylinders.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

 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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<td>E 000</td>
<td>Initial Comments</td>
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<td>RECEIVED</td>
<td>DEC 18 2017</td>
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<td>Unless otherwise indicated, the general use of the terms &quot;facility&quot; or &quot;facilities&quot; refers to all provider and suppliers affected by this regulation. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. Unless otherwise indicated, the general use of the terms &quot;facility&quot; or &quot;facilities&quot; refers to all provider and suppliers affected by this regulation. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. 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 and had a census of 91 on the date of the survey. The following deficiencies were cited during the Emergency Preparedness Survey conducted on November 21 - 22, 2017. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73. The survey was conducted by: Linda Chaney Health Facility Surveyor Facility Fire Safety &amp; Construction Establishment of the Emergency Program (EP)</td>
<td>E 001</td>
<td>FACILITY STANDARDS</td>
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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.
The [facility, except for Transplant Center] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements:

* [For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.

* [For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach.

This REQUIREMENT is not met as evidenced by:

Based on record review and interview, the facility failed to establish and maintain a current, comprehensive Emergency Preparedness Program which includes policies and procedures in accordance with 42 CFR 483.73. Failure to meet this standard has the potential to hinder facility response during an emergency which requires coordination and cooperation with local resources available. This deficient practice affected 91 residents, staff and visitors on the date of the survey. The facility is currently licensed for 120 SNF/NF beds and had a census
E 001 Continued From page 2 of 91 on the day of the survey.

Refer to E-004 as it relates to the facility failure to develop and maintain the EP program.

CFR Reference:
42 CFR 483.73

E 004 Develop EP Plan, Review and Update Annually

[The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section.]

* [For hospitals at §482.15 and CAHs at §485.625(a):] The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.

The emergency preparedness program must include, but not be limited to, the following elements:

(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least annually.

* [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that...
**Corrective Action:**

The program will be reviewed at the monthly safety meeting. The safety committee will report on the program to the monthly QAPI meeting.

The program will be reviewed yearly by the safety committee.

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### Corrective Action Details

**E 004**

- **Corrective Action:**
  - The program will be reviewed at the monthly safety meeting. The safety committee will report on the program to the monthly QAPI meeting.
  - The program will be reviewed yearly by the safety committee.

**Findings include:**

- **Review of the facility emergency plan on November 21, 2017, from approximately 8:30 AM to 2:30 PM, revealed the facility was missing required elements of the standard.**

- The provided policies and procedures varied in dates from 2011 to 2014 and no documentation of a current review and annual update was available. When asked, the Administrator stated the facility had recently received the emergency plan from their corporate offices, and he was not aware that it was not complete or out of date.

- a. Refer to E 0009 as it relates to cooperation and collaboration with local, tribal, regional, State and Federal Emergency Preparedness officials.

- b. Refer to E 0013 as it relates to the development of policies and procedures, which are reviewed and updated annually, based on the
Emergency Plan; facility and community based risk assessment; and the communication plan.

c. Refer to E 0018 as it relates to the policies and procedures for tracking residents and staff in the event of a disaster.

d. Refer to E 0024 as it relates to the facility use of volunteers.

e. Refer to E 0026 as it relates to the facility role under 1135 waiver as declared by the Secretary and the provision of care at an alternate site identified by emergency management officials.

f. Refer to E 0029 as it relates to the development and annual update of the Communications Plan.

g. Refer to E 0030 as it refers to contact information required in the Communication Plan.

h. Refer to E 0036 as it relates to the development and implementation of an annual training and testing of the emergency preparedness plan.

i. Refer to E 0037 as it relates to the emergency training program and the staff knowledge of emergency procedures.

j. Refer to E 0039 as it relates to required testing exercises of the emergency plan.

The cumulative effect of these systemic deficient practices, impeded the facility's ability to meet the emergency preparedness standard(s) and the potential needs of the residents during an emergency or disaster.

Reference:
E 004 Continued From page 5

E 009 Local, State, Tribal Collaboration Process
SS=F CFR(s): 483.73(a)(4)

[(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:]

(4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts.

* [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. The facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the facility's needs in the event of an emergency.

This REQUIREMENT is not met as evidenced by:

Residents:
A comprehensive emergency preparedness program has been developed for the residents residing in the facility on the date of the survey.

Other Residents:
Other residents being admitted before completion of the revision and total implementation of the program have the potential to be affected.

Measures:
The facility has developed and is training staff on the new and improved emergency program. The program will include all elements in the requirement. This includes the collaboration with local, tribal, regional, State and federal emergency preparedness officials.
### Summary Statement of Deficiencies

**E 009 Continued From page 6**

Policy by contacting other entities and emergency responders within their community to promote an integrated response to emergency events. This deficient practice affected 91 residents, staff and visitors on the date of the survey. The facility is licensed for 120 SNF/NF beds and had a census of 91 on the day of the survey.

Findings include:

Review of the facility emergency plan on November 21, 2017, from approximately 8:30 AM to 2:30 PM, revealed the facility failed to collaborate with local, tribal, regional, State and Federal officials in an effort to maintain an integrated response. When asked, the Administrator stated the facility had not yet reached out to any of these organizations or participated in any of the planning or training they provide.

Reference:

42 CFR 483.73 (a) (4)

**E 013 Development of EP Policies and Procedures**

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<tr>
<td>E 009</td>
<td>Corrective Action: Maintenance supervisor or designee will report on monthly meeting with local, tribal, regional, State and federal emergency preparedness officials at the monthly QAPI meeting.</td>
<td>E 009</td>
<td></td>
<td>12/26/17</td>
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<tr>
<td>E 013</td>
<td>Residents: A comprehensive emergency preparedness program has been developed for the residents residing in the facility on the date of the survey.</td>
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Reference:

42 CFR 483.73 (a) (4)

(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.

*Additional Requirements for PACE and ESRD Facilities:
**Summary Statement of Deficiencies**

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

*For PACE at §460.84(b):* Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least annually.

*For ESRD Facilities at §494.62(b):* Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. These emergencies include, but are not limited to: Fire; equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This REQUIREMENT is not met as evidenced by:

Based on record review and interview, it was determined the facility failed to develop current, updated policies and procedures based on the Emergency Plan. Failure to develop current policies and procedures based on the emergency plan, a facility and community based risk.

**Other Residents:**
Other residents being admitted before completion of the revision and total implementation of the program have the potential to be affected.

**Measures:**
The current emergency plan has been reviewed and updated based on the facilities risk assessment.

**Corrective Actions:**
The program will be reviewed yearly at the monthly safety meeting.
If changes occur during the year, The program will be reviewed by the safety committee.
Staff will be trained on changes by the facility SDC.
A summary will be presented at the Monthly QAPI meeting.
E 013 Continued From page 8
assessment and the facility communications plan, limits the facility response capabilities in the protection of residents during a disaster. This deficient practice affected 91 residents, staff and visitors on the date of the survey. The facility is licensed for 120 SNF/NF beds and had a census of 91 on the day of the survey.

Findings include:

Review of the facility emergency plan on November 21, 2017, from approximately 8:30 AM to 2:30 PM, revealed the policies and procedures varied in dates from 2011 to 2014 and no documentation of a current review and annual update was available. No records were available to confirm the policies and procedures were based on a current Emergency Plan, facility-based risk assessment, or a communications plan for its development.

Interview of the Administrator revealed that the policies and procedures had come from the corporate offices, and the facility did not participate in their development.

Reference:

42 CFR 483.73 (b)

<table>
<thead>
<tr>
<th>E 018</th>
<th>Procedures for Tracking of Staff and Patients</th>
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<tr>
<td>SS=F</td>
<td>CFR(s): 483.73(b)(2)</td>
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E 018

[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be

Residents:
A comprehensive emergency preparedness program has been developed for the residents residing in the facility on the date of the survey.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
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<tr>
<th>(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:</th>
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<tr>
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<th>(X3) DATE SURVEY COMPLETED</th>
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<td>11/22/2017</td>
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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

<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>
<th>(X5) COMPLETION DATE</th>
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<tr>
<td></td>
<td>E 018 Continued From page 9 reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:</td>
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<td>(2) A system to track the location of on-duty staff and sheltered patients in the facility's care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the facility must document the specific name and location of the receiving facility or other location.</td>
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<td><em>[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b);]</em> Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location.</td>
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<td></td>
<td><em>[For Inpatient Hospice at §418.113(b)(6);]</em> Policies and procedures. (i) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location.</td>
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**Other Residents:**

Other residents being admitted before completion of the revision and total implementation of the program have the potential to be affected.

**Measures:**

The program has been updated to include a policy for tracking on duty staff, a policy for tracking relocated staff members at receiving facility.

**Corrective Actions:**

The emergency program will be reviewed annually at safety meeting. Safety committee will report to monthly QAPI meeting.
### SUMMARY STATEMENT OF DEFICIENCIES

**E 018** Continued From page 10

*For CMHCs at §485.920(b):* Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.

*For OPOs at § 486.360(b):* Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records.

*For ESRD at § 494.62(b):* Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients.

This REQUIREMENT is not met as evidenced by:

Based on record review and interview, it was determined the facility failed to provide a current policy for tracking on-duty staff during an emergency, or if relocated, a policy for documentation of the receiving facility or other location for those relocated staff members. Lack of a tracking policy for on-duty staff has the potential to hinder the facility's ability to provide care and continuation of services during an emergency. This deficient practice affected 91 residents, staff and visitors on the date of the survey. The facility is licensed for 120 SNF/NF beds and had a census of 91 on the day of the survey.

Findings Include:

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| (X4) ID | (X5) COMPLETION DATE |
| Prefix | Tag | ID | Prefix | Tag | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) |
| STREET ADDRESS, CITY, STATE, ZIP CODE | | STREET ADDRESS, CITY, STATE, ZIP CODE | | | |
| E 018 | 11/22/2017 | 1140 NORTH ALLUMBAUGH STREET | BOISE, ID 83704 | | |
## Statement of Deficiencies and Plan of Correction

### (X1) Provider/Supplier/Clinical Laboratory Identification Number:

135098

### (X2) Multiple Construction

A. Building

B. Wing

### (X3) Date Survey Completed:

11/22/2017

### Name of Provider or Supplier

Valley View Nursing & Rehabilitation

### Street Address, City, State, Zip Code

1140 North Allumbaugh Street

Boise, ID 83704

### Summary Statement of Deficiencies

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<th>Tag</th>
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<td>E 024</td>
<td>Policies/Procedures-Volunteers and Staffing</td>
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### Provider's Plan of Correction

- **Residents:** A comprehensive emergency preparedness program has been developed for the residents residing in the facility on the date of the survey.

- **Other Residents:** Other residents being admitted before completion of the revision and total implementation of the program have the potential to be affected.

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*Note: The above text is a snippet from a larger document. The full document can be accessed via the 'Printed' link.*
Continued From page 12

strategies to address surge needs during an emergency.

This REQUIREMENT is not met as evidenced by:

Based on record review and interview, it was determined the facility failed to develop, document and maintain current emergency policies, procedures and operational plans for the use of volunteers to address surge needs during an emergency. Lack of current plans and policies for the use of volunteers has the potential to hinder the facility's ability to care for residents and provide continuation of care during a disaster. This deficient practice affected 91 residents, staff and visitors on the date of the survey. The facility is licensed for 120 SNF/NF beds and had a census of 91 on the day of the survey.

Findings Include:

Review of the facility emergency plan on November 21, 2017, from approximately 8:30 AM to 2:30 PM, revealed the plan did not address the use of volunteers, or integration of State and Federally designated health care professionals to address surge needs during an emergency. When asked, the Administrator revealed that the policies and procedures had come from the corporate offices, and the facility was unaware the Emergency Plan did not address the use of volunteers.

Reference:

42 CFR 483.73 (b) (6)

Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8)
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

IDENTIFICATION NUMBER: 135098

NAME OF PROVIDER OR SUPPLIER: VALLEY VIEW NURSING & REHABILITATION

ADDRESS: 1140 NORTH ALLUMBAUGH STREET

BOISE, ID 83704

SUMMARY STATEMENT OF DEFICIENCIES

E 026 Continued From page 13

[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:]

[(8) [6], (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.

*[For RNHCls at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials.

This REQUIREMENT is not met as evidenced by:

Based on record review and interview, it was determined the facility failed to document a current plan for the facility role under an 1135 waiver as declared by the Secretary and the provisions of care at an alternate care site identified by emergency management officials.

Residents:
A comprehensive emergency preparedness program has been developed for the residents residing in the facility on the date of the survey.

Other Residents:
Other residents being admitted before completion of the revision and total implementation of the program have the potential to be affected.

Measures:
The facility has updated its Emergency plan to include the facility's role under the 1135 waiver.

Corrective Actions:
The emergency program will be reviewed and updated annually at safety meeting. Safety committee will report to monthly QAPI meeting.
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<th>(X4) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>(X5) COMPLETION DATE</th>
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<td>(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
<td>PREFIX</td>
<td>(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
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<tr>
<td>E 026</td>
<td>Continued From page 14 beds and had a census of 91 on the day of the survey.</td>
<td>E 026</td>
<td>Residents: A comprehensive emergency preparedness program has been developed for the residents residing in the facility on the date of the survey.</td>
<td>12/26/17</td>
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<td>Findings Include:</td>
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<td>Other Residents: Other residents being admitted before completion of the revision and total implementation of the program have the potential to be affected.</td>
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<td></td>
<td>Review of the facility emergency plan on November 21, 2017, from approximately 8:30 AM to 2:30 PM, revealed the plan did not contain policies or procedures to address the facility role during a disaster event under an 1135 waiver. When asked, the Administrator stated that the policies and procedures had come from the corporate offices, and the facility was unaware the Emergency Plan did not address the facility role under an 1135 waiver.</td>
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<tr>
<td>E 029</td>
<td>Reference: 42 CFR 483.73 (b) (8) Development of Communication Plan CFR(s): 483.73(c) (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to document a current plan for facility communications. Communication plans are an essential component during an emergency. Failure to have a current communication plan has the potential to hinder both internal and external emergency response by personnel. This deficient practice affected 91 residents, staff and visitors on the</td>
<td>E 029</td>
<td>12/26/17</td>
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</table>
Findings Include:

Review of the facility emergency plan on November 21, 2017, from approximately 8:30 AM to 2:30 PM, revealed the facility did not have a current communication plan. The provided policies and procedures varied in dates from 2011 to 2014 and no documentation of a current review and annual update was available. When asked, the Administrator stated the facility had recently received the emergency plan from their corporate offices, and he was not aware that it was not complete or out of date.

Reference:

42 CFR 483.73 (c)

Names and Contact Information
CFR(s): 483.73(c)(1)

((c) The [facility, except RNHCl's, hospices, transplant centers, and HHAs] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:]

(1) Names and contact information for the following:
 (i) Staff.
 (ii) Entities providing services under arrangement.
 (iii) Patients' physicians
 (iv) Other [facilities].

Measures:
The facility communication plan has been updated. There has also been a current review.

Corrective Actions:
The annual review has been added to the safety committee calendar to be reviewed annually. Safety committee will report to QAPI meeting.

Residents:
A comprehensive emergency preparedness program has been developed for the residents residing in the facility on the date of the survey.

Other Residents:
Other residents being admitted before completion of the revision and total implementation of the
### SUMMARY STATEMENT OF DEFICIENCIES

**E 030** Continued From page 16

(v) Volunteers.

*For RNHCls at §403.748(c):* The communication plan must include all of the following:

1. Names and contact information for the following:
   1. Staff.
   2. Entities providing services under arrangement.
   3. Next of kin, guardian, or custodian.
   4. Other RNHCls.
   5. Volunteers.

*For ASCs at §416.45(c):* The communication plan must include all of the following:

1. Names and contact information for the following:
   1. Staff.
   2. Entities providing services under arrangement.
   3. Patients' physicians.
   4. Volunteers.

*For Hospices at §418.113(c):* The communication plan must include all of the following:

1. Names and contact information for the following:
   1. Hospice employees.
   2. Entities providing services under arrangement.
   3. Patients' physicians.
   4. Other hospices.

*For OPOs at §486.360(c):* The communication plan must include all of the following:

1. Names and contact information for the following:
   1. Staff.
   2. Entities providing services under arrangement.

**Measures:**
The facility has updated its communication plan to include required contact information. The emergency plan has been reviewed and updated with this information.

**Corrective Action:**
The annual review and updating has been added to the safety committee calendar to be reviewed annually. Safety committee will report to QAPI meeting.
E 030 Continued From page 17

(iii) Volunteers.
(iv) Other OPOs.
(v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA).

This REQUIREMENT is not met as evidenced by:

Based on record review and interview, it was determined the facility failed to document a facility communication plan. Failure to have a communication plan complete with names and contact information, has the potential to hinder both internal and external emergency response by personnel. This deficient practice affected 91 residents, staff and visitors on the date of the survey. The facility is licensed for 120 SNF/NF beds and had a census of 91 on the day of the survey.

Findings Include:

Review of the facility emergency plan on November 21, 2017, from approximately 8:30 AM to 2:30 PM, revealed the facility did not have a current communication plan that included the names and contact information for staff, entities providing services under arrangement, resident's physicians, or volunteers. The provided policies and procedures varied in dates from 2011 to 2014 and no documentation of a current review and annual update was available. When asked, the Administrator stated the facility had recently received the emergency plan from their corporate offices, and he was not aware that it was not complete or out of date.

Reference:

42 CFR 483.73 (c) (1)
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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<td>12/26/17</td>
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<tr>
<td>E 036</td>
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<td>EP Training and Testing CFR(s): 483.73(d)</td>
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<td>SS=F</td>
<td></td>
<td>(d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.</td>
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<td><em>[For ICF/IIDs at §483.475(d):]</em> Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h).</td>
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<td><em>[For ESRD Facilities at §494.62(d):]</em> Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing</td>
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**Resident**

A comprehensive emergency preparedness program has been developed for the residents residing in the facility on the date of the survey.

**Other Residents**

Other residents being admitted before completion of the revision and total implementation of the program have the potential to be affected.

**Measures**

The facility has reviewed and updated the emergency preparedness plan. The facility trained and tested staff on the plan.

**Corrective Actions**

Training and testing for the Emergency Preparedness plan has been added to the training calendar.

SDC and Maintenance Supervisor will conduct the annual training.

Maintenance Supervisor will report to the QAPI committee.
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<th>E 036 Continued From page 19</th>
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<td>and orientation program must be reviewed and updated at least annually.</td>
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<tr>
<td>This REQUIREMENT is not met as evidenced by:</td>
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<tr>
<td>Based on record review and interview, it was determined the facility failed to provide a current emergency preparedness training and testing program. Lack of a current emergency training and testing program covering the emergency preparedness plan and policies for the facility has the potential to hinder staff response during a disaster. This deficient practice affected 91 residents, staff and visitors on the date of the survey. The facility is licensed for 120 SNF/NF beds and had a census of 91 on the day of the survey.</td>
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<td>Findings Include:</td>
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<tr>
<td>Review of the facility emergency plan on November 21, 2017, from approximately 8:30 AM to 2:30 PM, revealed the facility did not have a current emergency preparedness training and testing program. The provided policies and procedures varied in dates from 2011 to 2014 and no documentation of a current review and annual update was available. There was also no documentation that specific training and testing on the emergency preparedness plan or policies had been conducted. When asked, the Administrator stated the facility had recently received the emergency plan from their corporate offices, and he was not aware that it was not complete or out of date.</td>
<td></td>
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<tr>
<td>Reference:</td>
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<td>42 CFR 483.73 (d)</td>
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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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<tr>
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<td>EP Training Program</td>
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<td>SS=F</td>
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<td>(1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following:</td>
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<td>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.</td>
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<td>(ii) Provide emergency preparedness training at least annually.</td>
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<td>(iii) Maintain documentation of the training.</td>
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<td>(iv) Demonstrate staff knowledge of emergency procedures.</td>
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<td><em>[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:]</em> (1) Training program. The [Hospital or RHC/FQHC] must do all of the following:</td>
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<td>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles.</td>
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<td>(ii) Provide emergency preparedness training at least annually.</td>
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<td>(iii) Maintain documentation of the training.</td>
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<td>(iv) Demonstrate staff knowledge of emergency procedures.</td>
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<td><em>[For Hospices at §418.113(d):]</em> (1) Training. The hospice must do all of the following:</td>
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<td>(i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their</td>
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**Residents:**
A comprehensive emergency preparedness program has been developed for the residents residing in the facility on the date of the survey.

**Other Residents:**
Other residents being admitted before completion of the revision and total implementation of the program have the potential to be affected.

**Measures:**
The facility has reviewed and updated the emergency preparedness plan. The facility trained their staff on the plan.

**Corrective Actions:**
Training for the emergency Preparedness plan has been added to the training calendar.
SDC and Maintenance Supervisor will conduct the annual training.
Maintenance Supervisor will report to the QAPI committee.
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<th>E 037</th>
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<td>(ii) Demonstrate staff knowledge of emergency procedures.</td>
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<td>(iii) Provide emergency preparedness training at least annually.</td>
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<td>(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.</td>
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*For PRTFs at §441.184(d):* (1) Training program. The PRTF must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) After initial training, provide emergency preparedness training at least annually.
(iii) Demonstrate staff knowledge of emergency procedures.
(iv) Maintain documentation of all emergency preparedness training.

*For PACE at §460.84(d):* (1) The PACE organization must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least annually.
(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in...
Continued From page 22

case of an emergency.
(iv) Maintain documentation of all training.

*For CORFs at §485.68(d):* (1) Training. The CORF must do all of the following:
(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.

*For CAHs at §485.625(d):* (1) Training program. The CAH must do all of the following:
(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures.
E 037 Continued From page 23 procedures.

*For CMHCs at §485.920(d):* (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually.

This REQUIREMENT is not met as evidenced by:

Based on record review and interview, it was determined the facility failed to provide a current emergency preparedness training program. Lack of a current emergency training program covering the emergency preparedness plan and policies for the facility has the potential to hinder staff response during a disaster. This deficient practice affected 91 residents, staff and visitors on the date of the survey. The facility is licensed for 120 SNF/NF beds and had a census of 91 on the day of the survey.

Findings Include:

Review of the facility emergency plan on November 21, 2017, from approximately 8:30 AM to 2:30 PM, revealed the facility did not have a current emergency preparedness training program. The provided policies and procedures varied in dates from 2011 to 2014 and no documentation of a current review and annual update was available. There was also no documentation that specific training on the emergency preparedness plan or policies had
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER
VALLEY VIEW NURSING & REHABILITATION

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

E 037 Continued From page 24
been conducted. When asked, the Administrator stated the facility had recently received the emergency plan from their corporate offices, and he was not aware that it was not complete or out of date.

Reference:
42 CFR 483.73 (d) (1)

E 039 EP Testing Requirements
SS=F CFR(s): 483.73(d)(2)
(2) Testing. The [facility, except for LTC facilities, RNHClS and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCls and OPOs] must do all of the following:

*[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:]

(i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event.
(ii) Conduct an additional exercise that may include, but is not limited to the following:
(A) A second full-scale exercise that is

Residents:
A comprehensive emergency preparedness program has been developed for the residents residing in the facility on the date of the survey.

Other Residents:
Other residents being admitted before completion of the revision and total implementation of the program have the potential to be affected.

Measures:
The facility emergency plan has been reviewed and updated. Testing has been added to the yearly calendar. Testing to include an annual exercise with local agencies.
## Corrective Actions:
The facility will conduct annual testing with local agencies. The emergency plan will be reviewed annually and updated as needed by the Safety Committee. Safety minutes will be presented at the facility QAPI meeting.
Findings Include:

Review of the facility emergency plan on November 21, 2017, from approximately 8:30 AM to 2:30 PM, revealed the facility did not have a current emergency preparedness testing program. The provided policies and procedures varied in dates from 2011 to 2014 and no documentation of a current review and annual update was available. There was also no documentation that specific testing, to include an annual exercise on the emergency preparedness plan or policies had been conducted. When asked, the Administrator stated the facility had recently received the emergency plan from their corporate offices, and he was not aware that it was not complete or out of date.

Reference:

42 CFR 483.73 (d) (2)