March 5, 2019

Mary Ruth Butler, Administrator
Mountain Valley of Cascadia
601 West Cameron Avenue
Kellogg, ID 83837-2004

Provider #: 135065

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Ms. Butler:

On February 28, 2019, a Facility Fire Safety and Construction survey was conducted at Mountain Valley Of Cascadia 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 **March 18, 2019.** Failure to submit an acceptable PoC by **March 18, 2019,** may result in the imposition of civil monetary penalties by **April 8, 2019.**

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 **April 4, 2019,** (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 **May 29, 2019.** A change in the seriousness of the deficiencies on **April 14, 2019,** may result in a change in the remedy.
The remedy, which will be recommended if substantial compliance has not been achieved by April 4, 2019, includes the following:

Denial of payment for new admissions effective May 28, 2019. 
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 August 28, 2019, 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 February 28, 2019, 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 **March 18, 2019**. If your request for informal dispute resolution is received after **March 18, 2019**, 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

Enclosures
The building is a type V (111), single story structure originally constructed in 1971. It is fully sprinklered in accordance with NFPA 13 and is equipped with a complete fire alarm/detection system. Emergency power is supplied by a natural gas diesel generator system with a propane alternate backup. Currently, the facility is licensed for 68 beds with a census of 62 on the date of survey.

The following deficiencies were cited during the annual Fire/Life Safety survey conducted on February 28, 2019. 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:

Nate Elkins, Supervisor
Facility Fire Safety & Construction Program

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>K 000</td>
<td>INITIAL COMMENTS</td>
<td></td>
</tr>
</tbody>
</table>

**K 000**

The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified

| 19.2.3.4, 19.2.3.5 |
| This REQUIREMENT is not met as evidenced by:

Based on observation and interview, the facility failed to ensure means of egress were

**K 232**

This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Mountain Valley of Cascadia does not admit that the deficiencies listed on the CMS Form 2567 exist, nor does the Facility admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.

**K 232**

Resident Specific
Hanging plants that projected more than 4 inches from the wall into the corridors were removed as well as awning above the beauty shop door.

**Other Residents**
Hanging plants that projected more than 4 inches from the wall into the corridors were removed as well as awning above the beauty shop door.
Maintained free of obstructions. Failure to eliminate items that project into the exit access corridors more than 4 inches has the potential to hinder egress during an emergency. This deficient practice affected 62 residents, staff, and visitors on the date of the survey.

Findings include:

1.) During the facility tour on February 28, 2019, from approximately 1:00PM to 3:30PM, observation of all the exit access corridors revealed hanging plants installed on brackets that projected more than 4 inches from the wall into the corridors.

2.) During the facility tour on February 28, 2019, from approximately 1:00PM to 3:30PM, observation of all the exit access corridor in the 200 hallway revealed an awning above the beauty shop door projecting more than 4 inches into the corridor.

When asked, the Maintenance Director stated the facility was uncertain of the requirements for non-continuous projections.

Actual NFPA Standard:
19.2.3.4 Any required aisle, corridor, or ramp shall be not less than 48 in. (1220 mm) in clear width where serving as means of egress from patient sleeping rooms, unless otherwise permitted by one of the following:
(1) Aisles, corridors, and ramps in adjunct areas not intended for the housing, treatment, or use of inpatients shall be not less than 44 in. (1120 mm) in clear and unobstructed width.
(2) Where corridor width is at least 6 ft (1830 mm), non-continuous projections not more than 6
Continued From page 2

In. (150 mm) from the corridor wall, above the handrail height, shall be permitted.

(3) Exit access within a room or suite of rooms complying with the requirements of 19.2.5 shall be permitted.

(4) Projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met:

(a) The wheeled equipment does not reduce the clear unobstructed

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 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.9, 8.2.3, TIA 12-2

Other Residents

The maintenance director has placed monitoring of semi-annual kitchen hood suppression system inspection, testing and maintenance on TELS program to be completed each March and September. It has also been added to the fire protection summary sheet.

Facility Systems

The maintenance director was educated on the requirements for NFPA 19.3.2.5.1. Re-education was provided by Chief Executive Officer to include but not limited to, inspecting, testing, and maintaining fire-extinguishing systems for commercial cooking.
This REQUIREMENT is not met as evidenced by:

Based on record review and interview, the facility failed to ensure that the fire-extinguishing systems for the commercial cooking operations were inspected, tested, and maintained properly. Failure to inspect, test, and maintain the fire extinguisher systems for the commercial cooking system every 6 months has the potential to hinder the performance of the extinguishing system increasing the risk of fires associated with grease-laden vapors during cooking procedures. This deficient practice affected staff and vendors of the main kitchen on the date of the survey.

Findings include:

During record review of the kitchen hood maintenance documents conducted on February 28, 2019 between 10:00AM-12:00PM, records provided indicated only one (1) of two (2) semi-annual kitchen hood suppression system inspection, testing and maintenance was completed. When asked about the missing documentation, the Maintenance Director acknowledged the missing inspection.

Actual NFPA standard:

NFPA 101, Chapter 19
19.3.2.5.1 Cooking facilities shall be protected in accordance with 9.2.3, unless otherwise permitted by 19.3.2.5.2, 19.3.2.5.3, or 19.3.2.5.4.

NFPA 101.9.2.3 Commercial Cooking Equipment. Commercial cooking equipment shall be in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of
### NFPA 96
#### Chapter 10 Fire-Extinguishing Equipment

10.2.6 Automatic fire-extinguishing systems shall be installed in accordance with the terms of their listing, the manufacturer's instructions, and the following standards where applicable:

1. NFPA 12
2. NFPA 13
3. NFPA 17
4. NFPA 17A

11.2 Inspection, Testing, and Maintenance of Fire-Extinguishing Systems.

11.2.1 Maintenance of the fire-extinguishing systems and listed exhaust hoods containing a constant or fire-activated water system that is listed to extinguish a fire in the grease removal devices, hood exhaust plenums, and exhaust ducts shall be made by properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction at least every 6 months.

NFPA 17A

4.3.1.5 All discharge nozzles shall be provided with caps or other suitable devices to prevent the entrance of grease vapors, moisture, or other foreign materials into the piping.
March 5, 2019

Mary Ruth Butler, Administrator
Mountain Valley of Cascadia
601 West Cameron Avenue
Kellogg, ID 83837-2004

Provider #: 135065

RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER

Dear Ms. Butler:

On February 28, 2019, an Emergency Preparedness survey was conducted at Mountain Valley of Cascadia by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. Your facility was found to be in substantial compliance with Federal regulations during this survey.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, which states that the facility complies with the requirements of CFR 42, 483.70(a) of the federal requirements. This form is for your records only and does not need to be returned.

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

Sincerely,

Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosure
The facility is a single story, type V (111) structure, originally constructed in 1971. A full NFPA 13 compliant fire sprinkler system is installed and there is smoke detection throughout. The facility is situated within a municipal fire district. Emergency power is supplied by a natural gas generator system, with an optional propane backup fuel supply. The facility is currently licensed for 68 SNF/NF beds, with a census of 62 on the day of the survey.

The facility was found to be in substantial compliance during the emergency preparedness survey conducted on February 28, 2019. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.

The Survey was conducted by:

Nate Elkins, Supervisor
Facility Fire Safety & Construction Program