



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7012 1010 0002 0836 3974

May 28, 2014

Jed Gines, Administrator
Bridgeview Estates
1828 Bridgeview Boulevard
Twin Falls, ID 83301-3051

Provider #: 135113

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Mr. Gines:

On **May 20, 2014**, a Facility Fire Safety and Construction survey was conducted at **Bridgeview Estates** 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 and a similar State Form 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

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page 2). After each deficiency has been answered and dated, the administrator should sign both Statement of Deficiencies and Plan of Correction, Form CMS-2567 and State Form, in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **June 10, 2014**. Failure to submit an acceptable PoC by **June 10, 2014**, may result in the imposition of civil monetary penalties by **June 29, 2014**.

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 and the state licensure survey report, State Form.

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 **June 24, 2014**, (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 **June 24, 2014**. A change in the seriousness of the deficiencies on **June 24, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **June 24, 2014**, includes the following:

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Denial of payment for new admissions effective **August 20, 2014**.
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 **November 20, 2014**, 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 Mark P. Grimes, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, 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 **May 20, 2014**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

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Go to the middle of the page to Information Letters section and click on State and select the following:

BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process
2001-10 IDR Request Form

This request must be received by **June 10, 2014**. If your request for informal dispute resolution is received after **June 10, 2014**, 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.

Sincerely,



Mark P. Grimes, Supervisor
Facility Fire Safety and Construction

MPG/lj

Enclosures

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

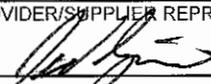
Printed: 05/23/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135113	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	(X3) DATE SURVEY COMPLETED 05/20/2014
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NAME OF PROVIDER OR SUPPLIER BRIDGEVIEW ESTATES	STREET ADDRESS, CITY, STATE, ZIP CODE 1828 BRIDGEVIEW BOULEVARD TWIN FALLS, ID 83301
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	<p>INITIAL COMMENTS</p> <p>The facility is a single story, type V (III) building constructed in 1992 with an addition in 1996. The building is fully sprinklered and has exits to grade. A two hour wall separates the facility from Assisted Living and independent apartments. Currently the facility is licensed for 116 SNF/NF beds.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on April 19 and 20, 2014. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.</p> <p>The Survey was conducted by:</p> <p>Dan Holbrook Health Facility Surveyor</p>	K 000	<p style="text-align: right;"><i>RECEIVED</i> <i>JUN - 5 2014</i> <i>FACILITY STANDARDS</i></p> <p><i>Preparation and/or execution of the plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies</i></p>	
K 018 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p>	K 018	<p>K018</p> <p>The identified door of resident room #411 was immediately fixed replacing the defective hinge. The door now latches appropriately.</p> <p>Facility Maintenance Staff checked all other doors on 4/19/14 to ensure there were no more problem doors.</p>	6/18/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Executive Director	(X6) DATE 6/4/14
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 018	<p>Continued From page 1</p> <p>This Standard is not met as evidenced by: Based on observation and operational testing the facility failed to ensure resident room corridor doors were provided with a means suitable for keeping the doors closed. Corridor doors that can not remain closed will allow products of combustion to pass through the smoke partition. This deficiency affected 15 residents, staff and visitors in one of seven smoke compartments. The facility is licensed for 116 beds and had a census of 83 residents on the day of survey.</p> <p>Findings include:</p> <p>During the tour of the facility on April 19 at 3:05 pm observation and operational testing of the corridor door of resident sleeping room #411 revealed that the door would not latch when in the closed position. This was observed and noted by Maintenance Engineer and Surveyor.</p> <p>The finding was acknowledged by the General Manager and the Maintenance Engineer at the exit interview on April 20, 2014.</p> <p>Actual NFPA Standard</p> <p>19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by</p>	K 018	<p>Facility Maintenance Staff will conduct & log monthly inspections of resident fire doors.</p> <p>Maintenance Director will inspect 10 doors monthly for 3 months, then quarterly thereafter to ensure proper latching; any issues identified will be brought to our quality assurance and performance improvement meeting.</p>	

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K 050	<p>Continued From page 3</p> <p>19, 2014 between the hours of 10:50 am and 12:15 revealed that the facility was conducting combined fire drills with the Assisted Living staff and using those to train SNF staff. Interview with the General Manager revealed that the facility was unaware each licensed and certified occupancy is required to conduct fire drills.</p> <p>This finding was acknowledged by the General Manager, Director of Nursing, and Maintenance Engineer during the exit interview on April 20, 2014 at 9:45 am.</p> <p>NFPA 101.19.7.1.1 The administration of every health care occupancy shall have, in effect and available to all supervisory personnel, written copies of a plan for the protection of all persons in the event of fire, for their evacuation to areas of refuge, and for their evacuation from the building when necessary. All employees shall be periodically instructed and kept informed with respect to their duties under the plan. A copy of the plan shall be readily available at all times in the telephone operator ' s position or at the security center. The provisions of 19.7.1.2 through 19.7.2.3 shall apply.</p> <p>NFPA 101.19.7.1.2* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible</p>	K 050	assurance and performance improvement meeting.	

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K 050	Continued From page 4 alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building.	K 050		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This Standard is not met as evidenced by: Based on observation, the facility failed to properly maintain the fire sprinkler system. Failure to properly maintain the fire sprinkler system may prevent the system from reacting appropriately in case of fire. This deficient practice affected all 7 smoke compartments and 83 residents in the skilled nursing facility, staff, and visitors. The facility is licensed for 116 beds with a census of 83 the day of survey. Findings include: During the facility survey on April 19, 2014 between the hours of 1:30 pm and 3:55 pm observation and interview revealed sprinkler head escutcheons (trim rings) were missing: resident room 420, hallway 400 east end, and the medical storage room. More were observed but not documented due to system wide observation. Interview with Maintenance Engineer during the survey revealed the facility was not aware of the missing sprinkler head escutcheons. This condition was observed by the Maintenance Engineer and the Surveyor.	K 062	K062 Sprinkler head escutcheons in resident room 420, hallway 400 east end, and the medical storage room were immediately replaced. Facility wide inspection was done on 5/19/14 and one sprinkler head escutcheon was replaced. All others were found in good working condition. Facility Maintenance Staff will check sprinkler head escutcheons monthly to ensure proper placement. Maintenance Director will inspect sprinkler head escutcheons monthly for 3 months, then quarterly thereafter to ensure	6/18/14

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K 062	Continued From page 5 This finding was acknowledged by the General manager and Maintenance Engineer at the exit interview on April 20, 2014 at 9:45 am. Actual NFPA Standards: NFPA 101, 4.6.12.1 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 protection, or other feature shall thereafter be continuously maintained in accordance with applicable NFPA requirements or as directed by the authority having jurisdiction. NFPA 13, 3-2.7.2* Escutcheon plates used with a recessed or flush-type sprinkler shall be part of a listed sprinkler assembly.	K 062	proper placement; any issues identified will be brought to our quality assurance and performance improvement meeting.	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This Standard is not met as evidenced by: Based on observation and interview the facility failed to prohibit the use of extension cords for devices requiring connection to permanent hard wired outlets. Extension cords have been the cause of many healthcare fires. This deficient practice affected one of seven smoke compartments in the SNF facility, 1 resident, staff, and visitors. The facility is licensed for 116 beds and had a census of 83 the day of the survey.	K 147	K147 The cord in room 452 was immediately removed. Facility wide inspection was done on 5/19/14 and no other ungrounded, lightweight, 3 outlet extension cords were found.	6/18/14

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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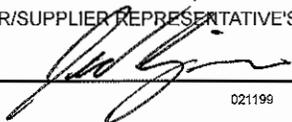
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K 147	<p>Continued From page 6</p> <p>Findings include</p> <p>Observation on April 19, 2014, at 1:50 pm in resident room #452 revealed a TV and lamp plugged into an ungrounded, lightweight, 3 outlet extension cord. This was observed by the Maintenance Engineer and Surveyor. The Maintenance Engineer stated he was unaware of the presence of the cord.</p> <p>This finding was acknowledged by the General Manager and the Maintenance Engineer at the exit interview on April 20, at 9:45 am.</p> <p>Actual NFPA Reference</p> <p>NFPA 70.4.1.400.8 Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following:</p> <ol style="list-style-type: none"> (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces <p>Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of 368.8.</p> <ol style="list-style-type: none"> (5) Where concealed by walls, floors, or ceilings or located above suspended or dropped ceilings (6) Where installed in raceways, except as otherwise permitted in this Code 	K 147	<p>Facility will educate residents and family member upon admission.</p> <p>Facility will educate staff on regulations regarding the use of extension cords.</p> <p>Maintenance Director will inspect 10 rooms monthly for 3 months, then quarterly thereafter to ensure that extension cords are not in use; any issues identified will be brought to our quality assurance and performance improvement meeting.</p>	

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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2.</p> <p>The facility is a single story, type V (III) building constructed in 1992 with an addition in 1996. The building is fully sprinklered and has exits to grade. A two hour wall separates the facility from Assisted Living and independent apartments. Currently the facility is licensed for 116 SNF/NF beds.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on April 19 and 20, 2014. The facility was surveyed under NFPA 101 Life Safety Code and IDAPA 16.03.02, Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities.</p> <p>The surveyor conducting the survey was:</p> <p>Dan Holbrook Health Facility Surveyor</p>	C 000	<p><i>Preparation and/or execution of the plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies</i></p> <p style="text-align: right;">RECEIVED JUN - 5 2014 FACILITY STANDARDS</p>	
C 226	<p>02.106 FIRE AND LIFE SAFETY</p> <p>106. FIRE AND LIFE SAFETY. Buildings on the premises used as facilities shall meet all the requirements of local, state and national codes concerning fire and life safety standards that are applicable to health care facilities. This RULE: is not met as evidenced by: Refer to the following deficiencies on form 2567</p> <p>K 18 Door latch K50 Fire Drills K 62 Fire Sprinklers K 147 Extension Cord</p>	C 226	<p>C226</p> <p>Refer to Facility POC in regards to tags: K018, K050, K062, K147</p>	6/18/14

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE

Executive Director

(X6) DATE

6/4/14

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C 252	<p>02.106,07 MAINTENANCE OF EQUIPMENT</p> <p>07. Maintenance of Equipment. The facility shall establish routine test, check and maintenance procedures for all equipment.</p> <p>This RULE: is not met as evidenced by: Based on observation and interview, the facility failed to maintain smoke barrier door latches. This deficient practice will allow products of combustion to pass between smoke compartments. The deficient practice affected two of seven smoke compartments, 19 residents, all staff, and all visitors. The facility is licensed for 116 beds and had a census of 83 the day of the survey.</p> <p>Findings include:</p> <p>Observation on April 19, 2014 at 3:20 pm revealed smoke barrier doors in hallway 4A/4C would not latch when allowed to swing closed. This was observed and noted by Maintenance Engineer and Surveyor.</p> <p>These findings were acknowledged by the General manager and Maintenance Engineer during the exit interview on April 20, 2014 at 9:45 am.</p> <p>Actual Rule reference: IDAPA 16.03.02 Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities.</p> <p>106. FIRE AND LIFE SAFETY.</p> <p>07. Maintenance of Equipment. The facility shall establish routine test, check and maintenance procedures for all equipment. (1-1-88)</p> <p>a. The use of any defective equipment on the premises of any facility is prohibited. (1-1-88)</p> <p>b. The administrator shall have all equipment</p>	C 252	<p>C252</p> <p>The identified door in hallway 4A/4C was immediately fixed tightening the defective hinge. The door now latches appropriately.</p> <p>Facility Maintenance Staff checked all other doors on 4/19/14 to ensure there were no more problem doors.</p> <p>Facility Maintenance Staff will conduct & log monthly inspections of smoke barrier doors.</p> <p>Maintenance Director will inspect 10 smoke barrier doors monthly for 3 months, then quarterly thereafter to ensure proper latching; any issues identified will be brought to our quality assurance and performance improvement meeting.</p>	6/18/14

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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C 252	Continued From Page 2 inspected for safe condition and function prior to use by any patient/resident, employee or visitor. (1-1-88)	C 252			

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.