



IDAHO DEPARTMENT OF
HEALTH & WELFARE

G.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 3050 0001 2128 2521

June 19, 2014

Sheila Kellogg, Administrator
Life Care Center of Valley View
1130 North Allumbaugh Street
Boise, ID 83704

Provider #: 135098

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Ms. Kellogg:

On **June 9, 2014**, a Facility Fire Safety and Construction survey was conducted at **Life Care Center of Valley View** 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

Sheila Kellogg, Administrator
June 19, 2014
Page 2 of 4

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 **July 2, 2014**. Failure to submit an acceptable PoC by **July 2, 2014**, may result in the imposition of civil monetary penalties by **July 22, 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 **July 14, 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 **July 14, 2014**. A change in the seriousness of the deficiencies on **July 14, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **July 14, 2014**, includes the following:

Sheila Kellogg, Administrator
June 19, 2014
Page 3 of 4

Denial of payment for new admissions effective **September 9, 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 **December 9, 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 **June 9, 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>

Sheila Kellogg, Administrator
June 19, 2014
Page 4 of 4

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 **July 2, 2014**. If your request for informal dispute resolution is received after **July 2, 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: 06/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135098	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 06/09/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF VALLEY VIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NORTH ALLUMBAUGH STREET BOISE, ID 83704
--	--

(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
--------------------	--	---------------	---	----------------------

K 000	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 during the annual fire/life safety survey conducted on June 9, 2014. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70. The survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	K 000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.	
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 1/4 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 Roller latches are prohibited by CMS regulations in all health care facilities.	K 018	RECEIVED JUN 30 2014 FACILITY STANDARDS K 018 Residents Affected: The doors for residents in rooms 103,114,119, and 125 have been adjusted and latch when closed.	7-11-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE Administrator Designer / RVP (X6) DATE 6-30-14

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.

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

Printed: 06/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135098	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 06/09/2014
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF VALLEY VIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NORTH ALLUMBAUGH STREET BOISE, ID 83704		
(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
K 018	Continued From page 1 This Standard is not met as evidenced by: Based on observation and operational testing, the facility failed to ensure resident room doors latched securely and resist the passage of smoke during a fire event. Failure to ensure that resident room doors fully close and latch would allow smoke and dangerous gases to pass freely into adjacent smoke compartments. This deficient practice affected 4 residents, staff and visitors in 1 of 5 smoke compartments on the first floor. The facility is licensed for 120 SNF beds and had a census of 87 on the date of the survey. Findings include: During the facility tour conducted on June 9, 2014 between the hours of 11:30 AM and 2:20 PM operational testing of resident doors 103, 114, 119, and 125 located on the first floor would not latch. This observation was acknowledged by the Maintenance Supervisor and accompanying Maintenance staff. Actual NFPA Standard: NFPA 101; 19.3.6.3 Corridor Doors. 19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that	K 018	Other residents that may be affected: All residents have the potential to be affected. All doors to resident rooms were checked to insure they latch upon closing and adjusted as necessary. All resident room doors in the facility were checked to insure they latch upon closing and adjusted as necessary. Measures or systemic changes made: The Maintenance Supervisor/designee will check resident room doors and smoke compartment doors weekly to insure that they will latch when closed. Monitoring of deficient practice: A QA monitor of resident room doors and smoke corridor doors will be set up by the Maintenance Supervisor/designee. These doors will be monitored weekly for 3 months. The results will be reported to the CQI committee.	

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

Printed: 06/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135098	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 06/09/2014
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF VALLEY VIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NORTH ALLUMBAUGH STREET BOISE, ID 83704		
(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
K 018	Continued From page 2 resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke.	K 018		
K 021 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2	K 021	K021 Residents Affected: No specific residents were identified. The latching system on the smoke compartment doors: on the 1 st floor (at the reception office) and on the 2 nd floor (door to the dining room) has been adjusted to latch and closed when the fire alarm is activated.	7-11-14

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

Printed: 06/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135098	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 06/09/2014	
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF VALLEY VIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NORTH ALLUMBAUGH STREET BOISE, ID 83704		
(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
K 021	<p>Continued From page 3</p> <p>This Standard is not met as evidenced by: Based upon observation, operational testing and interview, the facility failed to ensure that corridor doors equipped with automatic closures would completely close when activated. Failure to ensure complete closure of smoke compartment doors would allow smoke and dangerous gases to move freely into and between exit access corridors compromising egress. This deficient practice affected 4 residents, staff and visitors in 2 of 5 smoke compartments on the first floor; visitors and assigned staff in 1 of 5 smoke compartments on the second floor. The facility is licensed for 120 SNF beds and had a census of 87 on the day of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on June 9, 2014 between 11:30 AM to 11:45 AM, operational testing of the smoke barrier doors at the main reception office located on the first floor revealed they would not completely close and latch. This failure exposed a gap of approximately 1/2 inch between the doors. When asked if he was aware of the doors not closing completely, the Assistant Maintenance staff stated he was not.</p> <p>2) During the facility tour conducted on June 9, 2014 between 2:00 PM and 3:00 PM, testing of 1 of 2 doors leading from the main second floor dining room into the corridor revealed it would not completely close leaving a gap of approximately 1/2 inch. When asked, the Maintenance Supervisor stated he was not aware this door was not completely closing.</p> <p>Actual NFPA standard:</p>	K 021	<p>Other residents that may be affected:</p> <p>All residents have the potential To be affected. The other smoke compartment doors in the building have been checked to insure they are latching properly during operational testing.</p> <p>Measures or systemic changes made:</p> <p>Regular monthly audits of smoke compartment doors in the building (1st floor, 2nd floor and the dining rooms) will occur. During fire drills the Maintenance designee will check smoke compartment doors in the building to insure they completely close and latch. He will provide a report to the Maintenance Director.</p>	

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

Printed: 06/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135098	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 06/09/2014
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF VALLEY VIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NORTH ALLUMBAUGH STREET BOISE, ID 83704		
(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
K 021	Continued From page 4 19.2.2.2.6* Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier, or hazardous area enclosure shall be permitted to be held open only by an automatic release device that complies with 7.2.1.8.2. The automatic sprinkler system, if provided, and the fire alarm system, and the systems required by 7.2.1.8.2 shall be arranged to initiate the closing action of all such doors throughout the smoke compartment or throughout the entire facility. 7.2.1.8.2 In any building of low or ordinary hazard contents, as defined in 6.2.2.2 and 6.2.2.3, or where approved by the authority having jurisdiction, doors shall be permitted to be automatic-closing, provided that the following criteria are met: (1) Upon release of the hold-open mechanism, the door becomes self-closing. (2) The release device is designed so that the door instantly releases manually and upon release becomes self-closing, or the door can be readily closed. (3) The automatic releasing mechanism or medium is activated by the operation of approved smoke detectors installed in accordance with the requirements for smoke detectors for door release service in NFPA 72, National Fire Alarm Code®. (4) Upon loss of power to the hold-open device, the hold-open mechanism is released and the door becomes self-closing. (5) The release by means of smoke detection of one door in a stair enclosure results in closing all doors serving that stair.	K 021	Monitoring of deficient practice: The results will be reported to the CQI committee. The Maintenance Director will bring the report to the QA monthly meeting for review and monitoring.	7-11-14
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1	K 029		

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

Printed: 06/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135098	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 06/09/2014	
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF VALLEY VIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NORTH ALLUMBAUGH STREET BOISE, ID 83704		
(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
K 029	<p>Continued From page 5</p> <p>and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This Standard is not met as evidenced by: Based on observation, the facility failed to ensure that self-closing doors to a hazardous area were not impeded from closing completely during a fire event. Failure to ensure that hazardous area doors will self close during an emergency will allow smoke and dangerous gases to escape and enter adjacent smoke compartments. This deficient practice affected all residents in the main dining hall, kitchen staff and visitors on the date of the survey. The facility is licensed for 120 SNF/NF beds and had a census of 87 on the day of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on June 9, 2014 between 2:00 PM and 3:00 PM observation of the door from the Kitchen into the service corridor abutting the Assisted living Dining room revealed that it was propped open by a door wedge. Acknowledging the observation, the Maintenance Supervisor removed the wedge and closed the door.</p> <p>2) During the facility tour conducted on June 9, 2014 between 2:00 PM and 3:00 PM, observation of the Kitchen door from the dishwashing area into the main access corridor for the Assisted</p>	K 029	<p>K 029</p> <p>Residents Affected:</p> <p>No specific residents were affected. The trash cans in the closure area of the smoke compartment door have been relocated. The wedge holding the other fire door open was removed.</p> <p>Other residents that may be affected:</p> <p>All residents have the potential to be affected.</p>	7-11-14

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

Printed: 06/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135098	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 06/09/2014
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF VALLEY VIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NORTH ALLUMBAUGH STREET BOISE, ID 83704		
(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
K 029	<p>Continued From page 6</p> <p>Living dining hall revealed that it was propped open with a trash can. Upon observation of this, the Assistant Maintenance staff removed the obstruction to the door and informed the kitchen staff that the door must be allowed to close freely.</p> <p>Actual NFPA standard:</p> <p>19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:</p> <ol style="list-style-type: none"> (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft² (9.3 m²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft² (4.6 m²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the 	K 029	<p>Measures or systemic changes made:</p> <p>The dietary staff has been inserviced regarding keeping fire exits/smoke compartment door areas clear and not wedged open. A magnetic door holder has been installed to eliminate issues with a door wedge use. (Please see the picture)</p> <p>Monitoring of deficient practice:</p> <p>A QA monitor of the dietary compartment doors will be set up by the Maintenance Supervisor/ designee. This will be monitored 2 X's per week for 2 weeks, then weekly for 4 weeks, then monthly.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135098	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 06/09/2014
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF VALLEY VIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NORTH ALLUMBAUGH STREET BOISE, ID 83704		
(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
K 029	Continued From page 7 door.	K 029		
K 047 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that exit signs clearly identified exits. This failure would confuse occupants as to the location of an actual safe means of egress during a fire event. This deficient practice approximately 6 staff and visitors in 1 of 5 smoke compartments on the date of the survey. The facility is licensed for 120 SNF beds and had a census of 87 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on June 9, 2014 at 3:00 PM it was observed by the surveyor and the Maintenance Supervisor that the exit sign on the second floor between the main office and the exit staircase did not clearly identify the stairs as the exit. The directional arrows of the sign also indicated the business office as an exit. When asked if he had ever noticed the sign was pointing into a dead-end office, the Maintenance Supervisor stated he had not.</p> <p>Actual NFPA standard:</p> <p>19.2.10 Marking of Means of Egress. 19.2.10.1 Means of egress shall have signs in accordance</p>	K 047	<p>K 047</p> <p>Residents Affected:</p> <p>No specific residents were identified. The exit sign with double arrows by the business office has been replaced with a sign that has one arrow pointing in the correct exit direction. (please see the picture)</p> <p>Other residents that may be affected:</p> <p>Residents on the 2nd floor have the potential to be affected. All exit signs with arrows have been audited to insure that they accurately indicate the exit way.</p> <p>Measures or systemic changes made:</p> <p>The exit signs will have arrows pointing in the right exit direction.</p>	7-11-14

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

Printed: 06/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135098	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 06/09/2014
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF VALLEY VIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NORTH ALLUMBAUGH STREET BOISE, ID 83704		
(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
K 047	Continued From page 8 with Section 7.10. 7.10.1.2* Exits. Exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign readily visible from any direction of exit access.	K 047	<p>Monitoring of deficient practice:</p> <p>A QA monitor of the exit signs with arrows has been set up by the Maintenance Supervisor/designee. It will be monitored monthly for 3 months. The results will be reported to the CQI committee.</p>	
K 072 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10</p> <p>This Standard is not met as evidenced by: Based on observation the facility failed to ensure that means of egress were continuously maintained free of all obstructions. Failure to ensure clear and unobstructed means of egress would affect the rapid removal of residents staff and visitors in the event of an emergency evacuation. This deficient practice affected 20 residents, all staff and visitors in 1 of 5 smoke compartments on the first floor and 51 residents, all staff and visitors in 5 of 5 smoke compartments on the second floor on the date of the survey. The facility is licensed for 120 SNF beds and had a census of 87 on the day of the survey.</p> <p>Findings include:</p> <p>1) During the initial facility tour conducted at 9:30 AM on June 9, 2014, a nurse med pass cart was observed in the corridor directly outside room 124. This cart was again observed parked at this</p>	K 072		
			<p>K 072</p> <p>Residents Affected:</p> <p>No specific residents were identified. Nurses med pass carts, on either floor, are not being stored in the hallways and/or in the path of egress. All doors were checked to insure that delayed egress lock is activated and functioning as designed.</p>	7-11-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135098	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 06/09/2014
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF VALLEY VIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NORTH ALLUMBAUGH STREET BOISE, ID 83704		
(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
K 072	<p>Continued From page 9</p> <p>location during the facility tour conducted on June 9, 2014 at 12:00 PM and again prior to the exit conference conducted at 4:00 PM on that day.</p> <p>2) During the initial facility tour conducted at 9:15 AM on June 9, 2014, a nurse med pass cart was observed parked at the main nurses station on the first floor in the path of egress for east to west travel in the exit corridor. This cart was observed parked in the same location during the main facility tour conducted on June 9, 2014 at 11:30 AM and again prior to the exit conference at 4:00 PM.</p> <p>3) During the initial facility tour conducted at 9:45 AM on June 9, 2014 three nurses med pass carts were observed parked at the second floor main nurses station impeding direct egress travel through the corridors. These carts were again observed parked in the same location during the facility tour conducted on June 9, 2014 from 3:00 PM to 4:00 PM.</p> <p>4) During the facility tour conducted on June 9, 2014 at 11:45 AM, operational testing of the exit door between resident rooms 118 and 119 revealed the delayed egress lock was deactivated and not functional as designed. When the lock was activated and engaged for testing, it would not release from either the panic mechanism during a time delay, or by use of the keypad as required. When asked, the Assistant Maintenance staff stated that this lock was not functional and that a service vendor had been notified to repair it. He further stated the locking mechanism was deactivated until repairs were completed to allow unhindered exit.</p> <p>Actual NFPA standard: 7.1.10 Means of Egress Reliability. 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or</p>	K 072	<p>Other residents that may be affected:</p> <p>All residents have the potential to be affected.</p> <p>Measures or systemic changes made:</p> <p>All licensed nursing staff have been in serviced about appropriate locations to store nursing carts when not in use.</p> <p>Monitoring of deficient practice:</p> <p>A QA monitor checking for use/storing of nurses med pass carts will be set up by the SDC/designee. This will be monitored 2X per week for a month, then monthly for 2 months. The results will be reported to the CQI committee.</p>	

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

Printed: 06/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135098	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 06/09/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF VALLEY VIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NORTH ALLUMBAUGH STREET BOISE, ID 83704
--	--

(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
--------------------	--	---------------	---	----------------------

K 072	Continued From page 10 impediments to full instant use in the case of fire or other emergency.	K 072		
K 147 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure adequate electrical safety in accordance with NFPA 70. Failure to ensure that electrical systems are accessible and properly used can impede emergency operations and cause electrical fire or shock. This deficient practice affected all residents using common areas, approximately 7 staff and all visitors in 2 of 5 smoke compartments on the first floor on the date of the survey. The facility is licensed for 120 beds and had a census of 87 on the day of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on June 9, 2014 from 12:00 PM to 4:00 PM a microwave oven was found plugged into a relocatable power tap in the Social Services office and the second floor Activity Room. When asked, the Maintenance Supervisor said he was not aware that these were in use in this manner.</p> <p>2) During the facility tour conducted on June 9, 2014 from 1:45 PM to 2:30 PM it was observed that the electrical panel in the storage area located in the main entrance corridor next to the main dining room had a floor scrubber and floor cleaning supplies stored in front of the panel blocking access. When questioned, the Maintenance Supervisor said he was not aware</p>	K 147	<p>K 147</p> <p>Residents Affected:</p> <p>No specific residents were identified.</p> <p>The microwave oven in the social service office and the activity room have been plugged into a regular outlet.</p> <p>The floor scrubber will not be stored in front of the electrical panel.</p> <p>For the breaker to the range in the therapy gym will install appropriate switch at the stove so staff can turn off power on the stove after each use to protect therapy patients in that area.</p>	7-11-14

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

Printed: 06/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135098	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 06/09/2014
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF VALLEY VIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NORTH ALLUMBAUGH STREET BOISE, ID 83704		
(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
K 147	<p>Continued From page 11 this was a problem. 3) During the facility tour conducted on June 9, 2014 between 12:45 PM and 2:00 PM observation and operational testing of the controls to the stove located in the physical therapy gym revealed the electrical power was not disconnected between use as required. When asked, staff stated that the power was controlled by the circuit breaker in the electrical closet, but had not been turned off. Staff further stated it had been used for baking several hours earlier. Staff could not identify the breaker and required Maintenance to turn it off.</p> <p>Actual NFPA standard: NFPA 70 - 110.3 Examination, Identification, Installation, and Use of Equipment. (A) Examination. In judging equipment, considerations such as the following shall be evaluated: (1) Suitability for installation and use in conformity with the provisions of this Code FPN: Suitability of equipment use may be identified by a description marked on or provided with a product to identify the suitability of the product for a specific purpose, environment, or application. Suitability of equipment may be evidenced by listing or labeling. (2) Mechanical strength and durability, including, for parts designed to enclose and protect other equipment, the adequacy of the protection thus provided (3) Wire-bending and connection space (4) Electrical insulation (5) Heating effects under normal conditions of use and also under abnormal conditions likely to arise in service (6) Arcing effects (7) Classification by type, size, voltage, current</p>	K 147	<p>Other residents that may be affected:</p> <p>All residents have the potential to be affected. A review of all the relocatable power taps in the building has been completed and any equipment that was inappropriately plugged in has been removed. This has the potential to affect all residents in the building. Other electrical panels were Audited to insure nothing was stored In front of them. Any resident that may participate in therapy has the potential to be affected.</p>	

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

Printed: 06/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135098	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 06/09/2014
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF VALLEY VIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NORTH ALLUMBAUGH STREET BOISE, ID 83704		
(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
K 147	Continued From page 12 capacity, and specific use (8) Other factors that contribute to the practical safeguarding of persons using or likely to come in contact with the equipment (B) Installation and Use. Listed or labeled equipment shall be installed and used in accordance with any instructions included in the listing or labeling. 110.26 Spaces About Electrical Equipment. Sufficient access and working space shall be provided and maintained about all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons.	K 147	Measures or systemic changes made: All staff will be inserviced regarding appropriate equipment use with power strips. Housekeeping staff have been inserviced about keeping electrical panels clear. All therapy staff will be inserviced regarding use of the range and turning off the power between uses. Monitoring of deficient practice: A QA monitor checking for clearance in front of electrical panels will be completed by the Maintenance/designee. This will be monitored weekly for 3 months. The results will be reported to the CQI committee. The Rehabilitation Manager/designee will monitor to insure that the stove being off between uses. This will be monitored daily for 2 weeks then 3X per week for 3 months. The results will be reported to the CQI committee.	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001810	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 06/09/2014
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF VALLEY VIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NORTH ALLUMBAUGH STREET BOISE, ID 83704		
(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) COMPLETE DATE
C 000	16.03.02 INITIAL COMMENTS 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. 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 during the annual fire/life safety survey conducted on June 9, 2014. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70 and IDAPA 16.03.02 Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities. The survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	C 000	RECEIVED JUN 30 2014 FACILITY STANDARDS Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law. Please see the Plan of Correction for Federal tags:	
C 226	02.106 FIRE AND LIFE SAFETY 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.	C 226	K018- Door Latches K021-Door closures K029-Hazardous area K047-Exit signage K072-Clear and unobstructed egress K147-Electrical wiring and equipment	7-11-14

Bureau of Facility Standards

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

TITLE

(X6) DATE

[Signature] Administrator Designated/RVP 6-30-14

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001810	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 06/09/2014
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF VALLEY VIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NORTH ALLUMBAUGH STREET BOISE, ID 83704		
(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) COMPLETE DATE
C 226	Continued From page 1 This Rule is not met as evidenced by: Refer to federal tags: K018 - Door Latches K021 - Door closures K029 - Hazardous area K047 - Exit signage K072 - Clear and unobstructed egress K147 - Electrical wiring and equipment	C 226		