



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 3050 0001 2128 3405**

August 29, 2014

Brian Sawyer, Administrator  
Valley Vista Care Center of St Maries  
820 Elm Street  
St Maries, ID 83861-2119

Provider #: 135075

**RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER  
LETTER**

Dear Mr. Sawyer:

On **August 18, 2014**, a Facility Fire Safety and Construction survey was conducted at **Valley Vista Care Center Of St Maries** 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

Brian Sawyer, Administrator  
August 29, 2014  
Page 2 of 4

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 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 **September 11, 2014**. Failure to submit an acceptable PoC by **September 11, 2014**, may result in the imposition of civil monetary penalties by **September 30, 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 **September 22, 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 **September 22, 2014**. A change in the seriousness of the deficiencies on **September 22, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by

Brian Sawyer, Administrator  
August 29, 2014  
Page 3 of 4

**September 22, 2014**, includes the following:

Denial of payment for new admissions effective **November 18, 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 **February 18, 2015**, 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 **August 18, 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/NursingFa>

Brian Sawyer, Administrator  
August 29, 2014  
Page 4 of 4

[ilities/tabid/434/Default.aspx](#)

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 **September 11, 2014**. If your request for informal dispute resolution is received after **September 11, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135075</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02</b> - ENTIRE NF STRUCTURE - BUILDING AND APARTMENT B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/18/2014</b>
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NAME OF PROVIDER OR SUPPLIER <b>VALLEY VISTA CARE CTR OF ST MARIES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>820 ELM STREET ST MARIES, ID 83861</b>
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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	INITIAL COMMENTS  The original construction of the facility was a single story, Type V(111) building with a two story addition and renovation completed in 1997. Included were updated sprinkler and fire alarm systems. In 2000 the Behavior Care Unit addition was completed. Currently the building is licensed for 74 SNF/NF beds.  The following deficiencies were cited during the annual fire/life safety survey conducted on August 18, 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 execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusion set forth in the Statement of Deficiencies rendered by the reviewing agency. The Plan of Correction is prepared and executed solely because the provisions of the Federal and State laws require it. This provider does not maintain that the alleged deficiencies do not individually, or collectively, jeopardize the health and safety of its residents, nor are they of such character as to limit this provider's capacity to render adequate resident care. Furthermore, the provider asserts that it is in substantial compliance with regulations governing the operation and licensure of long term care facilities, and this Plan of Correction, in its entirety, constitutes this providers allegation of compliance.	
K 027 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7  This Standard is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure that smoke	K 027	Completion dates are provided for the procedural procession purposes to comply with state and federal regulations, and correlate with the most recent contemplated or accomplished corrective action. These dates do not necessarily correspond chronologically to the date the provider is under the opinion it was in compliance with requirements of participation or that corrective action was necessary.  <b>RECEIVED</b> <b>SEP 05 2014</b> <b>FACILITY STANDARDS</b>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Brian V. Sawyer</i>	TITLE <i>NHA</i>	(X6) DATE <i>9/3/14</i>
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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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NAME OF PROVIDER OR SUPPLIER <b>VALLEY VISTA CARE CTR OF ST MARIES</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>820 ELM STREET ST MARIES, ID 83861</b>		
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K 027	Continued From page 1 barrier doors would close completely. Failure to ensure smoke barrier doors completely close would allow smoke and dangerous gases to pass freely between smoke compartments affecting egress capability during a fire. This deficient practice affected 2 residents, staff and visitors in 1 of 5 smoke compartments on the date of the survey. The facility is licensed for 74 SNF/NF beds and had a census of 66 on the day of the survey.  Findings include:  During the facility tour conducted on August 18, 2014 from 12:45 PM to 2:00 PM, observation and operational testing of the smoke barrier doors adjacent to rooms 227 and 228 found they would not close completely leaving an approximately 1/2" inch wide by four inch long gap along the bottom door leading edge when activated. Further observation found this due to warp and shifting in the door frame. Interview of the Maintenance Supervisor indicated he was not aware of these doors not completely sealing.  Actual NFPA standard:  19.3.7.6* Doors in smoke barriers shall comply with 8.3.4 and shall be self-closing or automatic-closing in accordance with 19.2.2.2.6. Such doors in smoke barriers shall not be required to swing with egress travel. Positive latching hardware shall not be required.	K 027	<ol style="list-style-type: none"> <li>1. Replaced trim on this door to assure a smoke barrier.</li> <li>2. All residents have the potential to be affected. Through Maintenance rounds all smoke doors were assessed for proper closing.</li> <li>3. Maintenance will do monthly rounds and audits.</li> <li>4. Maintenance will report to administration monthly in QA for three months.</li> </ol>	8/20/14
K 029 SS=E	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 and/or 19.3.5.4 protects hazardous areas. When	K 029		

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K 029	<p>Continued From page 2</p> <p>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, operational testing and interview, the facility failed to ensure that doors to hazardous areas would self-close. Failure to ensure hazardous area doors will self close would allow smoke and dangerous gases to pass freely into corridors and hinder safe egress during a fire. This deficient practice affected 19 residents, staff and visitors in 2 of 5 smoke compartments on the date of the survey. The facility is licensed for 74 SNF/NF beds and had a census of 66 on the day of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on August 18, 2014 from 12:45 PM to 2:00 PM, observation of the corridor door into the full cylinder Oxygen Room located at the main reception found it would not self-close. When questioned about this door, the Maintenance Supervisor stated this door had been closing properly during his preventative maintenance testing.</p> <p>2) During the facility tour conducted on August 18, 2014 from 12:45 PM to 2:00 PM, observation and operational testing of the corridor door into the soiled section of the Laundry demonstrated it would not self-close. Interview of the</p>	K 029	<ol style="list-style-type: none"> <li>1. All affected doors were adjusted for proper closure.</li> <li>2. All residents have the potential to be affected. Through Maintenance rounds all doors were assessed for proper closing.</li> <li>3. Maintenance will do monthly rounds and audits.</li> <li>4. Maintenance will report to administration monthly in QA for three months.</li> </ol>	8/20/14

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K 029	<p>Continued From page 3</p> <p>Maintenance Supervisor found he was not aware this door was not self-closing.</p> <p>3) During the facility tour conducted on August 18, 2014 from 1:30 PM to 2:30 PM, observation and operational testing of the Medical Records and Chart Room office doors in the support services corridor found they were not equipped with self-closing devices. Further investigation found both these rooms measured approximately eight feet by ten feet; eighty square feet. Interview of the Maintenance Supervisor found he was not aware these doors were required to be self-closing.</p> <p>4) During the facility tour conducted on August 18, 2014 from 2:00 PM to 3:00 PM, observation and operational testing of the corridor door to the empty Oxygen Cylinder Storage closet at the main reception found that it would not self-close. Interview of the Maintenance Supervisor indicated he was not aware of this condition.</p> <p>Actual NFPA standard:</p> <p>3.3.13.2 Area, Hazardous. An area of a structure or building that poses a degree of hazard greater than that normal to the general occupancy of the building or structure, such as areas used for the storage or use of combustibles or flammables; toxic, noxious, or corrosive materials; or heat-producing appliances.</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</p>	K 029		

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K 029	Continued From page 4 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: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft <sup>2</sup> (9.3 m <sup>2</sup> ) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft <sup>2</sup> (4.6 m <sup>2</sup> ), 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 door.	K 029		
K 075 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5	K 075		

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K 075	Continued From page 5  This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that highly combustible material was stored in a safe manner. Failure to provide proper protection of hazardous storage would result in smoke and dangerous gases passing freely into corridors during a fire and hindering egress capabilities. This deficient practice affected residents using the dining hall, staff and visitors in 1 of 5 smoke compartments on the date of the survey. The facility is licensed for 74 SNF/NF beds and had a census of 66 on the day of the survey.  Findings include:  During the facility tour conducted on August 18, 2014 from 1:15 PM to 2:00 PM, observation by the surveyor, Administrator and the Maintenance Supervisor of the dining room found (2) 32 gal soiled linen and trash storage receptacles placed into a recessed area beside the handwash sink. These receptacles were observed parked in this location during the initial facility tour at 9:15 AM and again parked there during the facility tour at 1:15 PM; 1:30 PM; and 2:00 PM. Interview of the Maintenance Supervisor and Administrator indicated they were not aware that these receptacles must be separated, or contained in a designated hazardous area storage.  Actual NFPA standard: 19.7.5.5 Soiled linen or trash collection receptacles shall not exceed 32 gal (121 L) in capacity. The	K 075	<ol style="list-style-type: none"> <li>The dirty linen barrel was relocated to a proper distance from garbage barrel.</li> <li>All residents have the potential to be affected. Through Maintenance rounds potential hazards will be identified and corrected.</li> <li>Maintenance will do monthly rounds and audits.</li> <li>Maintenance will report to administration monthly in QA for three months.</li> </ol>	8/28/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135075</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02</b> - ENTIRE NF STRUCTURE - BUILDING AND APARTMENT B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/18/2014</b>
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K 075	Continued From page 6 average density of container capacity in a room or space shall not exceed 0.5 gal/ft <sup>2</sup> (20.4 L/m <sup>2</sup> ). A capacity of 32 gal (121 L) shall not be exceeded within any 64-ft <sup>2</sup> (5.9-m <sup>2</sup> ) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) shall be located in a room protected as a hazardous area when not attended. Exception: Container size and density shall not be limited in hazardous areas.	K 075		
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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135075</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02 - ENTIRE NF STRUCTURE - BUILDING AND APARTMENT</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/18/2014</b>
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C 000	<p><b>16.03.02 INITIAL COMMENTS</b></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 original construction of the facility was a single story, Type V(111) building with a two story addition and renovation completed in 1997. Included were updated sprinkler and fire alarm systems. In 2000 the Behavior Care Unit addition was completed. Currently the building is licensed for 74 SNF/NF beds.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on August 18, 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.</p> <p>The Survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	C 000		
C 226	<p><b>02.106 FIRE AND LIFE SAFETY</b></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.</p> <p>This Rule is not met as evidenced by:</p>	C 226		

**RECEIVED**  
**SEP 05 2014**  
**FACILITY STANDARDS**

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

*Brian V. Sawyer*

TITLE  
*NHA*

(X6) DATE  
*9/3/14*

Bureau of Facility Standards

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C 226	Continued From Page 1  Please refer to federal CMS form 2567 "K" tags:  K 027 Smoke compartment doors K 029 Hazardous areas K 075 Combustible storage over 32 gal.	C 226	Please review POC for tags mentioned	8/20/14