



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 Eder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
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CERTIFIED MAIL: 7012 3050 0001 2128 2583

August 29, 2014

Daniel Kennick, Administrator
Valley Vista Care Center of Sandpoint
220 South Division
Sandpoint, ID 83864-1759

Provider #: 135055

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

Dear Mr. Kennick:

On **August 20, 2014**, a Facility Fire Safety and Construction survey was conducted at **Valley Vista Care Center of Sandpoint** 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

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September 24, 2014, includes the following:

Denial of payment for new admissions effective **November 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 **February 20, 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 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/NursingFa>

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

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

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[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,

A handwritten signature in black ink, appearing to read 'M. Grimes', with a long horizontal flourish extending to the right.

Mark P. Grimes, Supervisor
Facility Fire Safety and Construction

MPG/lj
Enclosures

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

Printed: 08/28/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135055	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 08/20/2014
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF SANDPOIN'		STREET ADDRESS, CITY, STATE, ZIP CODE 220 SOUTH DIVISION SANDPOINT, ID 83864		
(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 single story, Type V(111) structure. The building is protected throughout by automatic fire extinguishing and fire alarm systems. The building was originally constructed in 1959 with an addition in 1985. There have been several minor additions and remodels with a major remodeling completed in 2001. The facility currently is licensed for 73 SNF/NF beds. The following deficiencies were cited during the annual fire/life safety survey conducted on August 20, 2014. The facility was surveyed under the Life Safety Code 2000 Edition, Existing Health Care Occupancy and 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 conclusions 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 federal and state law require it. <p style="text-align: center;">RECEIVED SEP 11 2014 FACILITY STANDARDS</p>	
K 022 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4 This Standard is not met as evidenced by: Based on observation and interview, the facility	K 022	Corrective Action A new illuminating exit sign has been purchased to be placed above the door separating the 300 hall from the front lobby and front exit. Additionally, illuminating exit signs have been purchased to replace the non-illuminating signs above the 400 and 500 hall doors. An electrician has been contacted to install the signs and the installation is due to be completed no later than 9/24/14. Other Residents On 9/4/14, the maintenance supervisor conducted a comprehensive assessment of the facility to ensure that no other non-illuminating exit signs were present and that all other exit signs were visible in paths of egress. No other non-illuminating exit signs were identified.	9/24/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Dan Kennel* TITLE *NAN* (X6) DATE *9/9/14*

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.

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K 022	<p>Continued From page 1</p> <p>failed to ensure that exit signs clearly identified exits. Failure to ensure that exits are identified clearly would hinder the safe evacuation of occupants during an emergency. This deficient practice affected 44 residents, staff and visitors in 3 of 6 smoke compartments on the date of the survey. The facility is licensed for 73 SNF/NF beds and had a census of 67 on the day of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on August 20, 2014 from 10:30 AM to 11:30 AM, observation by the surveyor and the Environmental Director of the exit sign outside the Activity Room found that it indicated the path of egress was east toward the front of the building. Further inspection of this path found that when the smoke compartment doors between resident rooms 309 and 310 were closed, visibility of the exit sign at the front door was obstructed and the path of egress was no longer clearly identifiable. When interviewed, the Environmental Director stated he had not been aware that this condition existed and acknowledged that the doors obstructed the exit sign.</p> <p>2) During the facility tour conducted on August 20, 2014 from 10:30 AM to 11:30 AM, observation of the exit signs located at the bulkhead above the smoke compartment doors leading into the 400 wing and the doors leading both in and out of the 500 wing were non-illuminated plastic signs. When interviewed, the Environmental Director stated he thought these signs were appropriate for the application.</p> <p>Actual NFPA standard:</p>	K 022	<p>Facility Systems Effective 9/4/14, the replacement of any exit signs and any remodeling project within the facility will be reviewed by the maintenance supervisor and/or the administrator to ensure that replacement signs are illuminating and the paths of egress remain clearly marked with illuminating exit signs.</p> <p>Monitoring The maintenance supervisor or designee will conduct a monthly audit beginning in September 2014 to ensure that exit signs are illuminating and paths of egress are clearly marked. The results of these audits will be shared at the monthly QA meeting beginning with the next meeting tentatively scheduled for 9/17/14. After 3 months, the Quality Assurance Committee will determine the need for ongoing auditing.</p>	

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K 022	Continued From page 2 7.10.1.4* Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. Sign placement shall be such that no point in an exit access corridor is in excess of 100 ft (30 m) from the nearest externally illuminated sign and is not in excess of the marked rating for internally illuminated signs. Exception: Signs in exit access corridors in existing buildings shall not be required to meet the placement distance requirements.	K 022		
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 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 This Standard is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure that hazardous area doors were self-closing. Failure to ensure that hazardous areas are protected with self-closing doors would allow smoke and dangerous gases to pass freely into corridors effecting safe egress during a fire. This deficient practice affected 18 residents, staff and visitors in 1 of 6 smoke compartments on the date of the	K 029	Corrective Action Self-closing devices were purchased and installed on the medical records office door and the human resources storage room (tub room) doors by the maintenance department on 9/5/14. The housekeeping chemicals identified as being improperly stored in the closet across from room #401 were removed and relocated to a proper storage location external to the building on 8/20/14 by the housekeeping supervisor. Other Residents An audit conducted by the maintenance supervisor on 9/4/14 revealed that all other doors separating hazardous areas from other areas are equipped with self-closing devices as required. Facility Systems Effective 9/4/14, any doors requiring replacement will be assessed by the maintenance supervisor for the need of a self-closing device. Should one be deemed necessary, the device will be ordered and on-hand to be installed at the same time that the door is installed or replaced. On 8/20/14, the housekeeping supervisor was instructed by the administrator that no chemicals will be transferred to alternate storage locations on the premises without first determining if that storage location meets the NFPA Life Safety Code Standard for storing potential hazardous materials.	9/24/14

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K 029	<p>Continued From page 3 survey. The facility is licensed for 73 SNF/NF beds and had a census of 67 on the day of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on August 20, 2014 from 10:30 AM to 12:00 PM, observation by the surveyor and the Environmental Director of the supply cabinet/closet directly across from resident room 401 found it contained over ten gallons of combustible liquids including alcohol-based hand rub; assorted paper goods and cleaning chemicals. Further investigation revealed this cabinet/closet was not sprinklered or rated construction and did not have self-closing doors. Interview of the Environmental Director indicated these materials were moved from exterior storage into the corridor cabinet to isolate products from freezing temperatures.</p> <p>2) During the facility tour conducted on August 20, 2014 from 10:30 AM to 12:00 PM, observation and operational testing of the door to the Medical Records office found it was not equipped with a self-closing device. Further inspection found this room measured approximately eight feet by twelve feet (96 square feet). When interviewed, the Environmental Director stated he was not aware this door was required to self-close.</p> <p>3) During the facility tour conducted on August 20, 2014 from 10:30 AM to 12:00 PM, observation and operational testing by the surveyor and the Environmental Director found that the tub room across from resident room 409 was not equipped with a self-closing device. Further inspection of this room found it had been converted into a storage area with wood racking and measured approximately six feet by ten feet.</p>	K 029	<p>Monitoring The maintenance supervisor will conduct a 100% building audit monthly for the next 3 months to ensure the presence of self-closing devices on doors as required, and to ensure that they function appropriately. In conjunction with this audit, the maintenance supervisor or designee will audit to ensure that no chemicals or potentially hazardous materials are improperly stored. The results of this audit will be shared at the monthly quality assurance meeting beginning with the next scheduled QA meeting on 9/17/14. After 3 months of auditing, the Quality Assurance Committee will determine the ongoing need for auditing.</p>	

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K 029	<p>Continued From page 4</p> <p>Interview of the Environmental Director indicated this room had been converted from a tub room to a storage closet to accommodate a lack of storage in the facility.</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 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 	K 029	

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K 029	Continued From page 5 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 070 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8 This Standard is not met as evidenced by: Based on observation and interview the facility failed to ensure portable space heaters were used in compliance with NFPA standards. Failure to ensure proper usage of portable space heating equipment could result in accidental electrocution or fire. This deficient practice affected no residents, staff and visitors in 1 of 6 smoke compartments. The facility is licensed for 73 SNF/NF beds and had a census of 67 on the day of the survey. Findings include: During the facility tour conducted on August 20, 2014 from 1:30 PM to 2:30 PM, observation and physical inspection of the Director of Nursing and Residential Services Coordinator offices found portable space heaters in use in both offices. When interviewed, the nursing staff in the DON	K 070	Corrective Action The portable heaters in the Director of Nursing and Residential Services Coordinator offices were removed by the administrator on 9/4/14. Other Residents A 100% building audit was conducted by the administrator on 9/4/14 to identify and remove any other portable heaters within the facility. Facility Systems All office staff and department managers were notified by an e-mail from the Nursing Home Administrator on 9/5/14 that portable heaters are no longer allowed to be used within the facility. The maintenance supervisor will proceed with the necessary steps to create separate smoke compartments between the administrative/lobby space and the resident rooms. This work will be completed no later than 11/1/14. Should it become necessary to heat the offices with portable heaters after the administrative offices and resident quarters have been divided into separate smoke compartments per NFPA standards, the maintenance supervisor will purchase the heaters and ensure that they meet the specifications in which the heating elements do not exceed 212 degrees F. The maintenance supervisor or designee will also perform monthly checks of all heaters and maintain a log to ensure the heaters remain in compliance.	9/24/14

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K 070	Continued From page 6 office stated she was always cold. Interview of the Environmental Director indicated he was aware portable space heaters were prohibited in healthcare facilities. Actual NFPA standard: 19.7.8 Portable Space-Heating Devices. Portable space-heating devices shall be prohibited in all health care occupancies. Exception: Portable space-heating devices shall be permitted to be used in nonsleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C).	K 070	Monitoring The maintenance supervisor will conduct a 100% building audit monthly for the next 3 months to ensure that no portable heaters are in use within the facility, unless such portable heaters have been issued by the maintenance supervisor following the separation of the resident rooms and administrative offices. The results of this audit will be shared at the monthly quality assurance meeting beginning with the next scheduled QA meeting on 9/17/14. After 3 months of auditing, the Quality Assurance Committee will determine the ongoing need for auditing.	
K 147 SS=F	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 ensure electrical installations were installed and maintained per NFPA 70. Failure to ensure proper electrical installations and maintenance could result in electrocution and/or fire. This deficient practice affected 34 residents, staff and visitors in 3 of 6 smoke compartments on the date of the survey. The facility is licensed for 73 SNF/NF beds and had a census of 67 on the day of the survey. Findings include: 1) During the facility tour conducted on August 20, 2014 from 11:45 AM to 2:45 PM, observation by the surveyor and the Environmental Director of the nurse's station in the 400 wing found a relocatable power tap hanging from the outlet	K 147	Corrective Action The power tap at the 400 hall nurses' station was secured to the wall by the maintenance supervisor on 8/20/14. The 6-2 multiple outlet converter was removed from the beauty salon by the maintenance supervisor on 8/20/14. The two floor scrubbers were removed from the boiler room on 8/20/14 so as to provide clear access to the electrical panel. Additionally, the file/audio cart was removed from the storage closet/ electrical panel room by the Director of Nursing office. Other Residents A 100% facility audit was conducted by the maintenance supervisor on 8/20/14 to ensure that no other power taps were unsecured or improperly used, no other multiple outlet converters were in use, and no other electrical panels had access blocked. The contract beautician was advised on 8/21/14 that multiple outlet converters were not authorized for use within the facility. Facility Systems An email was sent to all department managers by the administrator on 9/5/14 advising that multiple outlet converters are not authorized for use within the facility. The email also specified that no items were to be stored in such a manner as to block access to any electrical panels within the facility. Department Managers were directed to disseminate this information to their staff members as soon as possible but no later than 9/24/14.	9/24/14

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K 147	<p>Continued From page 7</p> <p>above the cabinet on the southwest wall, supplying power to the computer station and printing equipment.</p> <p>2) During the facility tour conducted on August 20, 2014 from 11:45 AM to 2:45 PM, observation of the Beauty Salon by the surveyor and the Environmental Director revealed a 6 - 2 multiple outlet converter installed. Upon inquiry, Environmental Director indicated the beautician knew these multiple outlet converters were prohibited.</p> <p>3) During the facility tour conducted on August 20, 2014 from 11:45 AM to 2:45 PM, observation by the surveyor and the Environmental Director of the storage closet next to the Director of Nursing office found the electrical panel inside was blocked by a file/audio cart.</p> <p>4) During the facility tour conducted on August 20, 2014 from 11:45 AM to 2:45 PM, observation of the boiler room by the surveyor and the Environmental Director found the main electrical panels on the south wall were blocked by (2) floor scrubbers.</p> <p>Actual NFPA standard:</p> <p>1) 400.8 Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (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</p>	K 147	<p>Monitoring The maintenance supervisor or designee will conduct a 100% building audit monthly for the next 3 months to ensure that all power taps in use are properly secured and that no multiple outlet converters are in use. Additionally, the maintenance supervisor or designee will audit to ensure that all electrical panels have clear access to them. The results of this audit will be shared at the monthly quality assurance meeting beginning with the next scheduled QA meeting on 9/17/14. After 3 months of auditing, the Quality Assurance Committee will determine the ongoing need for auditing.</p>	

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

Printed: 08/28/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135055	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 08/20/2014
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NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF SANDPOINT	STREET ADDRESS, CITY, STATE, ZIP CODE 220 SOUTH DIVISION SANDPOINT, ID 83864
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K 147	<p>Continued From page 8</p> <p>similar openings</p> <p>(4) Where attached to building surfaces Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of 368.8.</p> <p>(5) Where concealed by walls, floors, or ceilings or located above suspended or dropped ceilings</p> <p>(6) Where installed in raceways, except as otherwise permitted in this Code</p> <p>2) 110.3 Examination, Identification, Installation, and Use of Equipment. (A) Examination. In judging equipment, considerations such as the following shall be evaluated:</p> <p>(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.</p> <p>(2) Mechanical strength and durability, including, for parts designed to enclose and protect other equipment, the adequacy of the protection thus provided</p> <p>(3) Wire-bending and connection space</p> <p>(4) Electrical insulation</p> <p>(5) Heating effects under normal conditions of use and also under abnormal conditions likely to arise in service</p> <p>(6) Arcing effects</p> <p>(7) Classification by type, size, voltage, current capacity, and specific use</p> <p>(8) Other factors that contribute to the practical safeguarding of persons using or likely to come in contact with the equipment</p> <p>(B) Installation and Use. Listed or labeled</p>	K 147		

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K 147	<p>Continued From page 9</p> <p>equipment shall be installed and used in accordance with any instructions included in the listing or labeling.</p> <p>3 and 4)</p> <p>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.</p> <p>(A) Working Space. Working space for equipment operating at 600 volts, nominal, or less to ground and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A)(1), (2), and (3) or as required or permitted elsewhere in this Code.</p> <p>(1) Depth of Working Space. The depth of the working space in the direction of live parts shall not be less than that specified in Table 110.26(A)(1) unless the requirements of 110.26(A)(1)(a), (b), or (c) are met. Distances shall be measured from the exposed live parts or from the enclosure or opening if the live parts are enclosed.</p>	K 147		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135055	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 08/20/2014
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF SANDPOINT		STREET ADDRESS, CITY, STATE, ZIP CODE 220 SOUTH DIVISION SANDPOINT, ID 83864		
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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 single story, Type V(111) structure. The building is protected throughout by automatic fire extinguishing and fire alarm systems. The building was originally constructed in 1959 with an addition in 1985. There have been several minor additions and remodels with a major remodeling completed in 2001. The facility currently is licensed for 73 SNF/NF beds. The following deficiencies were cited during the annual fire/life safety survey conducted on August 20, 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	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 conclusions 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 federal and state law require it.	
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		

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SEP 11 2014
FACILITY STANDARDS

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

Dan Kemil

TITLE

N/A

(X6) DATE

9/5/14

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135055	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 08/20/2014
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C 226	Continued From Page 1 This Rule is not met as evidenced by: Please refer to federal "K" tags on CMS 2567: K 022 Exit identification K 029 Hazardous areas K 070 Portable space heaters K 147 Electrical installations and appliances	C 226	Please refer to the "K" tags on the CMS-2567	9/24/14