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

July 9, 2015

Debra "Debbie" Mills, Administrator
Valley View Nursing & Rehabilitation
1130 North Allumbaugh Street
Boise, ID 83704

Provider #: 135098

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

Dear Ms. Mills:

On **July 1, 2015**, a Facility Fire Safety and Construction survey was conducted at **Valley View Nursing & Rehabilitation** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. Please provide ONLY ONE completion date for each federal and state tag in column (X5) Completion Date to signify when you allege that each tag will be back in compliance. **NOTE**: The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to

Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign 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 22, 2015**. Failure to submit an acceptable PoC by **July 22, 2015**, may result in the imposition of civil monetary penalties by **August 11, 2015**.

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 **August 5, 2015**, (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 **August 5, 2015**. A change in the seriousness of the deficiencies on **August 5, 2015**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **August 5, 2015**, includes the following:

Denial of payment for new admissions effective **October 1, 2015.**
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 **January 1, 2016**, 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 **July 1, 2015**, 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

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 22, 2015.** If your request for informal dispute resolution is received after **July 22, 2015**, 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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135098	A. BUILDING 01 - ENTIRE BUILDING B. WING _____	07/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW NURSING & REHABILITATION	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 July 1, 2015. 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: Nathan Elkins Health Facility Surveyor Facility Fire Safety & Construction	K 000	The statements made in this Plan of Correction are not an admission to or an agreement with the stated deficiencies. To remain in compliance with all Federal and State Regulations, the facility has taken or will take actions set forth in the following Plan of Correction. Please accept this Plan of Correction as the facility's allegation of compliance such that all stated deficiencies have been or will be corrected by the specified date(s). RECEIVED 2 0 2015 FACILITY STANDARDS	
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4	K 025	Smoke barriers will provide at least one half hour resistance rating in accordance with 8.3 **Residents Affected:** 1) missing ceiling tile in janitors closet on 1st floor replaced. 2) Hole has been sealed in mechanical room. **Other residents that may be affected:** All residents have the potential to be affected. All smoke barriers have been inspected to meet code.	7/21/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Debbie Mills | TITLE: Executive Director | (X6) DATE: 7/20/15

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135098	A. BUILDING 01 - ENTIRE BUILDING B. WING _____	07/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW NURSING & REHABILITATION	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 025	Continued From page 1 This Standard is not met as evidenced by: Based on observation and interview it was determined that the facility did not ensure that smoke barriers were maintained and would resist the passage of smoke. This deficiency can allow smoke and fire gasses to spread rapidly in a fire event. This deficient practice affected 49 residents, staff, and visitors on the date of the survey. The facility is licensed for 120 SNF/NF beds with a census of 84 on the day of survey. Findings include: 1.) During the tour of the facility on July 1, 2015 at approximately 10:00 AM, observation of the suspended ceiling in the Janitor's closet on the 1st floor revealed a missing ceiling tile. When asked, the Maintenance Supervisor stated the ceiling tile was missing due to a recent water leak. 2.) During the tour of the facility on July 1, 2015 at approximately 1:30 PM, observation of the mechanical room located in the dining room area on the 2nd floor revealed a rectangular hole approximately 15" x 8" cut into the upper portion of the wall near a HVAC unit with two conduit pipes and an electrical wire passing through the hole. When asked, the Maintenance Supervisor stated the facility was unaware the hole was required to be sealed. Actual NFPA Standard: 19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour. Exception No. 1: Where an atrium is used,	K 025	**Measures or systemic changes made:** Maintenance or designee will check barriers weekly to ensure barriers are continuous from outside was to outside wall, from floor to floor or from smoke barrier to smoke barrier or a combination thereof. **Monitoring of deficit practice:** Maintenance will develop an audit tool to monitor integrity of barrier walls. The monitor will be weekly for 3 months with results reported to the QAPI committee monthly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135098	A. BUILDING 01 - ENTIRE BUILDING B. WING _____	07/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW NURSING & REHABILITATION	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 025	Continued From page 2 smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with Exception No. 2 to 8.2.5.6(1). Not less than two separate smoke compartments shall be provided on each floor. Exception No. 2*: Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.3 has been provided for smoke compartments adjacent to the smoke barrier. 8.3.2* Continuity. Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces. Exception: A smoke barrier required for an occupied space below an interstitial space shall not be required to extend through the interstitial space, provided that the construction assembly forming the bottom of the interstitial space provides resistance to the passage of smoke equal to that provided by the smoke barrier	K 025		
K 027 SS=E	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	K 027	Smoke barrier doors will be maintained to ensure that smoke and dangerous gases do not pass freely between compartments. **Residents Affected:** Doors at cross corridor on 1st floor entering hallway #1 have been adjusted to fully close and seal.	7/21/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135098	A. BUILDING 01 - ENTIRE BUILDING B. WING _____	07/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW NURSING & REHABILITATION	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 027	Continued From page 3 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 maintain doors that protect corridor openings. Failure to maintain corridor doors could allow smoke and dangerous gases to pass freely between smoke compartments. This deficient practice affected 21 residents, staff, and visitors on the date of survey. The facility is licensed for 120 SNF/NF beds with a census of 84 on the day of survey. Findings include: During the facility tour on July 1, 2015 at approximately 9:30 AM, observation and operational testing of the cross corridor doors on the 1st floor entering hallway #1 revealed the doors when released from the magnetic hold open device failed to seal when closed. An opening of approximately one inch was observed. When asked, the Maintenance Supervisor stated they were unaware the doors did not resist the passage of smoke. Actual NFPA standard: 19.3.7.5 Openings in smoke barriers shall be protected by fire-rated glazing; by wired glass panels and steel frames; by substantial doors, such as 13/4-in. (4.4-cm) thick, solid-bonded wood core doors; or by construction that resists fire for not less than 20 minutes. Nonrated factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door shall be permitted.	K 027	**Other residents that may be affected:** All residents have the potential to be effected. All doors protecting corridor openings were checked and fully close and seal. **Measures or systemic changes made:** Maintenance Supervisor/designee will check corridor doors weekly to ensure complete closure and seal. **Monitoring of deficit practice:** A QA monitor of corridor doors closure and seal will be made by maintenance supervisor/designee. These doors will be monitored weekly for 3 months. Results will be presented to the monthly QAPI committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135098	A. BUILDING 01 - ENTIRE BUILDING B. WING _____	07/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW NURSING & REHABILITATION	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 027	Continued From page 4 Exception: Doors shall be permitted to have fixed fire window assemblies in accordance with 8.2.3.2.2. 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. 8.3.4 Doors. 8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles	K 027		
K 047 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD 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 This Standard is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure that exit signs clearly identified exits and were continuously illuminated during a power failure. Failure to maintain proper exit signage could confuse occupants and hinder safe evacuation in a dark smoke filled environment. This deficient practice affected 54 residents, staff and visitors on the date of the survey. The facility is licensed for 120 SNF beds and had a census of 84 on the day of the survey. Findings include:	K 047	All exit and directional signs will be displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting. **Residents Affected**: 1) exit sign located in assisted dining room has been replaced to ensure correct exit access. 2) Batteries have been replaced in exit signs in hallway #3 1st floor near rooms 122/123, hallway #3 1st floor near rooms 132/133 and hallway #1 2nd floor ear rooms 214/215l. **Other residents that may be affected:** All residents have the potential to be effected. All exit signs were checked to ensure the back-up battery is operational.	7/21/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135098	A. BUILDING 01 - ENTIRE BUILDING B. WING _____	07/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW NURSING & REHABILITATION	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 5 1.) During the facility tour on July 1, 2015 at approximately 11:30 AM observation of the exit sign located inside of the Assist Dining Room on the 2nd floor did not clearly identify the correct exit access direction. The directional arrows of the sign pointed to two walls prior to exiting from the room. When asked, the Maintenance Supervisor stated the facility was unaware of the incorrect exit signage. 2.) During the facility tour on July 1, 2015 between 8:30 AM and 2:00 PM, observation and operational testing revealed the exit signage was not operational when the battery backup test button was pushed in the following locations: Hallway #3 1st floor near rooms 122/123 Hallway #3 1st floor near rooms 132/133 Hallway #1 2nd floor near rooms 214/215 Actual NFPA standard: 19.2.10 Marking of Means of Egress. 19.2.10.1 Means of egress shall have signs in accordance 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. 7.10.2* Directional Signs. A sign complying with 7.10.3 with a directional indicator showing the direction of travel shall be placed in every location where the direction of travel to reach the nearest exit is not apparent. 7.10.5.2* Continuous Illumination. Every sign required to be illuminated by 7.10.6.3	K 047	**Measures or systemic changes made:** Maintenance Supervisor/designee will monitor all exit lights to ensure the back-up batteries are operational. **Monitoring of deficit practice:** A QA monitor will be developed to check the lights weekly for 3 months, reporting results to QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135098	A. BUILDING 01 - ENTIRE BUILDING B. WING _____	07/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW NURSING & REHABILITATION	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 6 and 7.10.7 shall be continuously illuminated as required under the provisions of Section 7.8. Exception*: Illumination for signs shall be permitted to flash on and off upon activation of the fire alarm system.	K 047		
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This Standard is not met as evidenced by: Based on record review, observation and interview, the facility failed to complete 4-year interval testing on the fire dampers as required under NFPA 90A. Failure to ensure dampers will operate to manufacturer's specifications can allow fire and toxic gases to spread through the facility. This deficient practice affected all residents, staff and visitors on the date of the survey. The facility is licensed for 120 SNF/NF beds with a census of 84 on the day of the survey. Findings include: During record review and observation of the facility HVAC system plans on July 1, 2015 at approximately 8:30 AM, the facility failed to provide a 4-year interval testing report of the fire dampers. When asked, the Maintenance Supervisor stated that the facility was unaware of the required damper testing. Actual NFPA standard:	K 067	The heating, ventilating, and air conditioning will comply with the provisions of section 9.2. **Residents Affected:** Maintenance Supervisor scheduled a testing of the fire dampers. **Other residents that may be affected:** All residents have the potential to be affected. Maintenance will schedule every 4 years testing of the dampers to include fusible links (where applicable) shall be removed, all dampers will be operated to verify that they fully close, the latch, if provided, will be checked and moving parts will be lubricated as needed.	7/21/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135098	A. BUILDING 01 - ENTIRE BUILDING B. WING _____	07/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW NURSING & REHABILITATION	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 067	Continued From page 7 NFPA 90A 3-4.7 Maintenance. At least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify that they fully close; the latch, if provided, shall be checked; and moving parts shall be lubricated as necessary Also see UL listing: UL Standard 555: Standard for Safety for Fire Dampers	K 067	**Measures or systemic changes made:** Maintenance supervisor will schedule testing of damper every 4 years. Records will of testing will be kept with preventive maintenance program. **Monitoring of deficit practice:** The testing of the dampers will be included in the preventive maintenance program and will be monitored through that program by the Maintenance Director of designee.	
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This Standard is not met as evidenced by: Based on observation, operational testing, and interview the facility failed to maintain the intended function of an exit door. Failure to maintain the intended function of an exit door could allow unauthorized exit of residents from the property and could hinder proper accountability during an emergency. This deficient practice affected three residents utilizing the Physical Therapy Gym, staff, and visitors on the date of survey. The facility is licensed for 120 SNF/NF beds with a census of 84 on the day of survey. Findings include: During the facility tour on July 1, 2015 at approximately 9:30 AM, observation and operational testing of the outside delayed egress gate connecting the skilled nursing facility and the independent living apartments revealed the gate	K 130	**Residents Affected:** The hardware and signage on gate will be removed. Gate does not operate as an exit door to prevent unauthorized exit of residents during an emergency. **Other residents that may be affected:** Gate is intended only to separate courtyards between level of care. **Measures or systemic changes made:** Staff will be educated that gate does not operate as an egress gate.	7/21/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135098	A. BUILDING 01 - ENTIRE BUILDING B. WING _____	07/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW NURSING & REHABILITATION	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 130	Continued From page 8 would not release the lock within 15 seconds, instead the locks released immediately upon application of force. When questioned, the maintenance supervisor stated he was unaware the delayed egress system was not operational. Actual NFPA reference: 7.2.1.6 Special Locking Arrangements. 7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed-egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met. (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6. (b) The doors shall unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.	K 130	**Monitoring of deficit practice:** Maintenance shall develop a QA tool to monitor gate function. The gate will be monitored weekly for 3 months and reported to QAPI committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135098	A. BUILDING 01 - ENTIRE BUILDING B. WING _____	07/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW NURSING & REHABILITATION	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 130	Continued From page 9 (d) * On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS	K 130		