



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

C.L. "BUTCH" OTTER -- Governor  
RUSSELL S. BARRON -- Director

TAMARA PRISOCK -- ADMINISTRATOR  
DIVISION OF LICENSING & CERTIFICATION  
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

June 5, 2018

Cindy Riedel, Administrator  
Bridgeview Estates  
1828 Bridgeview Boulevard  
Twin Falls, ID 83301-3051

Provider #: 135113

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

Dear Ms. Riedel:

On **May 25, 2018**, a Facility Fire Safety and Construction survey was conducted at **Bridgeview Estates** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies. 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

Cindy Riedel, Administrator  
June 5, 2018  
Page 2 of 4

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 the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office. If a State Form with deficiencies was issued, it should be signed, dated and returned along with the CMS-2567 Form.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **June 18, 2018**. Failure to submit an acceptable PoC by **June 18, 2018**, may result in the imposition of civil monetary penalties by **July 10, 2018**.

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. If a State Form was issued as well, it should also be signed, dated and returned.

All references to federal regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Remedies may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **June 29, 2018**, (Opportunity to Correct). Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **June 29, 2018**. A change in the seriousness of the deficiencies on **June 29, 2018**, may result in a change in the remedy.

Cindy Riedel, Administrator  
June 5, 2018  
Page 3 of 4

The remedy, which will be recommended if substantial compliance has not been achieved by **June 29, 2018**, includes the following:

Denial of payment for new admissions effective **August 25, 2018**.  
42 CFR §488.417(a)

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **November 25, 2018**, 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 Nate Elkins, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, option 3; Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **May 25, 2018**, 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:

Cindy Riedel, Administrator  
June 5, 2018  
Page 4 of 4

<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:

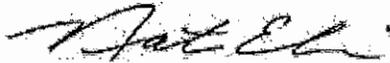
BFS Letters (06/30/11)

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

This request must be received by **June 18, 2018**. If your request for informal dispute resolution is received after **June 18, 2018**, 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, option 3.

Sincerely,



Nate Elkins, Supervisor  
Facility Fire Safety and Construction

NE/lj  
Enclosures

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

PRINTED: 06/01/2018  
FORM APPROVED  
OMB NO. 0938-0391

|   |   |   |   |   |
|---|---|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>135113</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  | (X3) DATE SURVEY COMPLETED<br><br><b>05/25/2018</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BRIDGEVIEW ESTATES</b> |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1828 BRIDGEVIEW BOULEVARD<br/>TWIN FALLS, ID 83301</b>              |   |
| (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                                |
| E 000   | <p>Initial Comments</p> <p>The facility is a single story, type V (III) building constructed in 1992 with an addition in 1996. The building is fully sprinklered and has multiple exits to grade. A two-hour wall separates the Skilled Nursing Facility from Assisted Living Facility and independent apartments. Currently the facility is licensed for 116 SNF/NF beds, and had a census of 67 on the dates of the survey.</p> <p>The facility was found to be in substantial compliance during the initial Emergency Preparedness Survey conducted on May 24 - 25, 2018. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.</p> <p>The survey was conducted by:</p> <p>Linda Chaney<br/>Health Facility Surveyor<br/>Facility Fire Safety &amp; Construction</p> | E 000   |   |   |

RECEIVED  
JUN 18 2018  
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
*Cynthia M. Rudel* TITLE  
*Executive Director* (X6) DATE  
*6/18/18*

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 000  | <p>INITIAL COMMENTS</p> <p>The facility is a single story, type V (III) building constructed in 1992 with an addition in 1996. The building is fully sprinklered and has multiple exits to grade. A two-hour wall separates the Skilled Nursing Facility from Assisted Living Facility and independent apartments. Currently the facility is licensed for 116 SNF/NF beds, and had a census of 67 on the dates of the survey.</p> <p>The following deficiencies were cited during the annual life safety code survey conducted on May 24 - 25, 2018. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Chapter 19, Existing Healthcare Occupancies, in accordance with 42 CFR 483.70, and 42 CFR 483.80.</p> <p>The Survey was conducted by:</p> <p>Linda Chaney<br/>Health Facility Surveyor<br/>Facility Fire Safety &amp; Construction<br/>General Requirements - Other<br/>CFR(s): NFPA 101</p> <p>General Requirements - Other<br/>List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by:<br/>Based on record review, and interview, the facility failed to develop and implement a water management plan. Failure to develop and</p> | K 000  | <p>K100</p> <p>The facility will development and implement a water management plan</p> <ul style="list-style-type: none"> <li>• A initial Baseline test was completed by HHE Environmental Services on 12-27-17</li> <li>• Bridgeview will test annually . Next test 12 2018</li> <li>• A water management team will meet monthly .</li> <li>• Describe the building water systems using test and flow diagrams of the systems</li> <li>• Identify areas where Legionella could grow and spread</li> <li>• Decide where control measures would be applied and how to monitor them</li> </ul> |  |
| K 100<br>SS=F  |  | K 100  |  | 7/24/18<br>8/1/18                            |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Lynna M. Linder* TITLE: *Executive Director* (X6) DATE: *6/18/18*

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 100   | Continued From page 1<br>implement a facility specific water management plan could increase risk of growth and spread of Legionella and other opportunistic pathogens in building water systems. This deficient practice could potentially affect all residents, visitors and staff on the date of the survey.<br><br>Findings include:<br><br>During the review of facility records on May 24, 2018, from approximately 8:30 AM to 2:00 PM, no documentation of a water management plan, to include a facility risk assessment, control measures, and testing protocols could be produced. The facility did have a basic template of instruction on water management from their corporate office, but not a facility specific plan. When asked, the Administrator stated the facility was in the process of developing a water management plan.<br><br>Actual Standard:<br><br>42 CFR § 483.80 Infection control.<br><br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>Additional Reference:<br><br>Centers for Medicare/Medicaid Services S&C Letter 17-30. | K 100   | <ul style="list-style-type: none"> <li>Establish ways to intervene when control limits are not met</li> <li>Make sure the program is running as designed and is effective</li> <li>Document and communicate the activities</li> </ul> <p>The practice could potentially effect all residents, visitors and staff.</p> <p>The Director of Maintenance will yearly check out the water system according to our water management plan.</p> <p>The Director of Maintenance will report back to QA of any concerns noted in the audits</p> |   |
| K 222<br>SS=D   | Egress Doors<br>CFR(s): NFPA 101  | K 222   |   |   |

*Cindy Redel 6/18/18*

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|--------------------|--|---------------|---|----------------------|

|       |   |       |  |                   |
|-------|---|-------|--|-------------------|
| K 222 | Continued From page 2<br><br>Egress Doors<br>Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements:<br>CLINICAL NEEDS OR SECURITY THREAT LOCKING<br>Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times.<br>18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6<br>SPECIAL NEEDS LOCKING ARRANGEMENTS<br>Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation.<br>18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4<br>DELAYED-EGRESS LOCKING ARRANGEMENTS<br>Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and | K 222 | K222 Egress Doors<br><br>The facility will ensure that special locking arrangements are in accordance with NFPA 101 .<br><br>The exit door used for freight deliveries near the kitchen will lock drop with the 15 seconds . The company out of Ketchum will ensure the door is compliant with the lock dropping after 15 seconds .<br><br>The maintenance director will audit all doors within the facility that have the delayed egress door. (9) doors.<br><br>All doors labeled as a delayed egress doors will be checked monthly by the Maintenance Director to assure the door's magnetic lock will release after 15 seconds . . Any issues will be taken care of immediately. | 7/24/18<br>8-1-18 |
|-------|---|-------|--|-------------------|

The maintenance director will report back to the monthly QA of issues with the audits

*Andy Kuebel 6/18/18*

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| K 222  | <p>Continued From page 3</p> <p>ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system.<br/>18.2.2.2.4, 19.2.2.2.4</p> <p>ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS<br/>Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted.<br/>18.2.2.2.4, 19.2.2.2.4</p> <p>ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS<br/>Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system.<br/>18.2.2.2.4, 19.2.2.2.4</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on observation, operational testing and interview, the facility failed to ensure that special locking arrangements were in accordance with NFPA 101. Failure to provide delayed egress locking arrangements for magnetically controlled means of egress could hinder the safe evacuation of residents during a fire or other emergency. This deficient practice affected staff and visitors on the dates of the survey.</p> <p>Findings include:</p> <p>During the facility tour on May 24, 2018, from approximately 2:00 PM to 4:00 PM, observation of the exit door used for freight deliveries near the kitchen, revealed it was labeled as a delayed egress door with signage stating the magnetic</p> | K 222  |   |                      |

*Cindy Bredel 6/18/18*

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| K 222  | <p>Continued From page 4</p> <p>lock would drop after 15 seconds. However, operational testing of the door revealed the magnetic lock would not release, even after 15 seconds or more. The Maintenance Director stated the facility was not aware the delayed egress component on the door was not functioning properly.</p> <p>Actual NFPA standard:</p> <p>7.2.1.6* Special Locking Arrangements.<br/>7.2.1.6.1 Delayed-Egress Locking Systems.<br/>7.2.1.6.1.1 Approved, listed, delayed-egress locking systems shall be permitted to be installed on door assemblies 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 11 through 43, provided that all of the following criteria are met:<br/>(1) The door leaves shall unlock in the direction of egress upon actuation of one of the following:<br/>    (a) Approved, supervised automatic sprinkler system in accordance with Section 9.7<br/>    (b) Not more than one heat detector of an approved, supervised automatic fire detection system in accordance with Section 9.6<br/>    (c) Not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6<br/>(2) The door leaves shall unlock in the direction of egress upon loss of power controlling the lock or locking mechanism.<br/>(3)*An irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved</p> | K 222  |   |                      |

*Cynthia M. Redel 6/18/18*

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| K 222   | Continued From page 5<br>by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions:<br>(a) The force shall not be required to exceed 15 lbf (67 N).<br>(b) The force shall not be required to be continuously applied for more than 3 seconds.<br>(c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening.<br>(d) Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only.<br>(4)*A readily visible, durable sign in letters not less than 1 in. (25 mm) high and not less than 1/8 in. (3.2 mm) in stroke width on a contrasting background that reads as follows shall be located on the door leaf adjacent to the release device in the direction of egress:<br>PUSH UNTIL ALARM SOUNDS<br>DOOR CAN BE OPENED IN 15 SECONDS<br>(5) The egress side of doors equipped with delayed-egress locks shall be provided with emergency lighting in accordance with Section 7.9. | K 222  |   |   |
| K 353<br>SS=E   | Sprinkler System - Maintenance and Testing<br>CFR(s): NFPA 101<br><br>Sprinkler System - Maintenance and Testing<br>Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.   | K 353  |   |   |

*Cynthia M. Reedee 6/18/15*

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>135113   | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 02 - ENTIRE NF BLDG<br><br>B. WING _____         | (X3) DATE SURVEY COMPLETED<br><br>05/25/2018  |                      |
|---|--|--|---|----------------------|
| NAME OF PROVIDER OR SUPPLIER<br><br>BRIDGEVIEW ESTATES  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1828 BRIDGEVIEW BOULEVARD<br>TWIN FALLS, ID 83301 |   |                      |
| (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 353   | <p>Continued From page 6</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.<br/>9.7.5, 9.7.7, 9.7.8, and NFPA 25<br/>This REQUIREMENT is not met as evidenced by:<br/>Based on observation and interview, the facility failed to ensure fire suppression system pendants were maintained free of obstructions such as paint or corrosion. Failure to maintain fire sprinkler pendants free of obstructions could hinder system performance during a fire event. This deficient practice could potentially affect staff and visitors in the kitchen and residents, staff and visitors utilizing the activities area on the dates of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on May 24, 2018, from approximately 2:00 PM to 4:00 PM, observation of the sprinkler head in the kitchen chemical storage room revealed it was corroded. Observation of the activities storage area revealed a painted sprinkler head. When asked, the Maintenance Director stated the facility was not aware of the corroded and painted sprinkler heads.</p> <p>Actual NFPA standard:<br/><br/>NFPA 25</p> | K 353  | <p><b>K353 Sprinkler System - Maintenance and Testing</b></p> <p>The facility will ensure the fires suppression system pendants are maintained free of obstructions such as paint or corrosion.</p> <p>The Sprinkler in the activity storage room was cleaned by Maintenance on 6-26-18 .</p> <p>The sprinkler in the kitchen storage room will be replaced on 6-19-18 by Delta.</p> <p>All residents and staff and visitors could be potentially effected by the sprinkler in the activity room .</p> <p>The sprinkler in the kitchen could effect the visitors and staff in that area .</p> <p>Delta fire inspects the sprinkler heads yearly .</p> | 6/19/18              |
| <p>FORM CMS-2567(02-99) Previous Versions Obsolete</p> <p>Event ID: 921221</p> <p><i>Cynthia M. Redel 6/18/18</i></p> |  | Facility   | <p>Maintenance will audit these inspections and bring an y issues to the monthly QA committee meeting .</p>   | <p>Page 7 of 9</p>   |

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

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>135113 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 02 - ENTIRE NF BLDG<br><br>B. WING _____   | (X3) DATE SURVEY COMPLETED<br><br>05/25/2018 |
| NAME OF PROVIDER OR SUPPLIER<br><br>BRIDGEVIEW ESTATES |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1828 BRIDGEVIEW BOULEVARD<br>TWIN FALLS, ID 83301   |  |
| (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 353  | Continued From page 7<br>5.2.1 Sprinklers.<br><br>5.2.1.1* Sprinklers shall be inspected from the floor level annually.<br><br>5.2.1.1.1* Sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., upright, pendent, or sidewall).<br><br>5.2.1.1.2 Any sprinkler that shows signs of any of the following shall be replaced:<br>(1) Leakage<br>(2) Corrosion<br>(3) Physical damage<br>(4) Loss of fluid in the glass bulb heat responsive element<br>(5)*Loading<br>(6) Painting unless painted by the sprinkler manufacturer | K 353  | K911<br><br>The facility will ensure the Essential Electrical System (EES) generator is equipped with a remote manual stop.<br><br>The remote manual stop was ordered by A & K Electric and will add the generator stop switch as it arrives .<br><br>The deficient practice could affect 67 resident staff and residents.<br><br>Once the remote manual stop is replaced it should not have to be replaced again . On the monthly generator tests we could activate the switch to assure it is working<br><br>Maintenance Director will report to the monthly QA meeting about any deficiency to this working properly. | 7/24/18<br>3/1/18                            |
| K 911<br>SS=F  | Electrical Systems - Other<br>CFR(s): NFPA 101<br><br>Electrical Systems - Other<br>List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99)<br>This REQUIREMENT is not met as evidenced by:   | K 911  |  |  |

*Cynthia M. Redel RD 6/18/18*

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| K 911   | <p>Continued From page 8</p> <p>Based on observation and interview, the facility failed to ensure the Essential Electrical System (EES) generator was equipped with a remote manual stop station. Failure to provide a remote stop, potentially hinders the ability of staff to shut down the generator if required. This deficient practice affected 67 residents, staff and visitors on the dates of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on May 24, 2018 from approximately 2:00 PM to 4:00 PM, a remote manual stop station for the EES generator could not be located. When asked, the Maintenance Director stated the facility was not equipped with a remote stop station.</p> <p>Actual NFPA standard:</p> <p>NFPA 99</p> <p>6.4.1.1.16.2 Safety indications and shutdowns shall be in accordance with Table 6.4.1.1.16.2. (SEE TABLE)</p> <p>NFPA 110</p> <p>5.6.5.6* All installations shall have a remote manual stop station of a type to prevent inadvertent or unintentional operation located outside the room housing the prime mover, where so installed, or elsewhere on the premises where the prime mover is located outside the building.</p> <p>5.6.5.6.1 The remote manual stop station shall be labeled.</p> | K 911   |   |                      |   |

*Cynthia M. Reedee 6/18/18*