



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

November 27, 2018

Randal Barnes, Administrator
Valley View Nursing & Rehabilitation
1140 North Allumbaugh Street
Boise, ID 83704-8700

Provider #: 135098

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

Dear Mr. Barnes:

On **November 14, 2018**, 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

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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 **December 10, 2018**. Failure to submit an acceptable PoC by **December 10, 2018**, may result in the imposition of civil monetary penalties by **January 1, 2019**.

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 **December 19, 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 **February 12, 2019**. A change in the seriousness of the deficiencies on **December 29, 2018**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **December 19, 2018**, includes the following:

Denial of payment for new admissions effective **February 14, 2019**.
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 **May 14, 2019**, 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 **November 14, 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:

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<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:

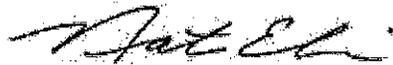
BFS Letters (06/30/11)

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

This request must be received by **December 10, 2018**. If your request for informal dispute resolution is received after **December 10, 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: 12/11/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135098	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 11/14/2018
NAME OF PROVIDER OR SUPPLIER VALLEY VIEW NURSING & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1140 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	<p>INITIAL COMMENTS</p> <p>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 with a census of 85 on the date of the survey.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on November 13 and 14, 2018. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.</p> <p>The survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	K 000	<p>This Plan of Correction is submitted as required under State and Federal regulations and statutes applicable to long-term providers. The Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is specifically denied. The submission of this plan of Correction does not constitute agreement by the facility that the surveyors findings and/or conclusions constitute a deficiency, or that the scope and severity of the deficiencies cited are correctly applied.</p> <p style="text-align: center;">RECEIVED DEC 18 2018 FACILITY STANDARDS</p>	
K 100 SS=F	<p>General Requirements - Other CFR(s): NFPA 101</p> <p>General Requirements - Other 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: Based on record review and interview, the facility</p>	K 100	<p>K100</p> <p>Residents: The water management plan did contain control measures. The control measures will be documented to attain compliance for our residents.</p>	12/19/18

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

TITLE

(X6) DATE

[Signature] Administrator 12-17-18

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 failed to ensure the control measures for the water management plan were monitored for their effective implementation to ensure the prevention of transmission of waterborne pathogens such as Legionella. Failure to monitor control measures has the potential to hinder early detection of problematic areas needing corrective action to prevent the passage of bacterium in complex water systems. This deficient practice affected 85 residents, staff and visitors on the date of the survey. Findings include: During review of provided inspection, maintenance and testing records conducted on 11/13/18 from 8:45 - 10:00 AM, no records were available that indicated the facility was monitoring and no records were available that showed the facility implemented control measures to help mitigate the passage of waterborne pathogens. When asked if the Maintenance Director stated the facility was not documenting this procedure. Reference: CFR standard: 42 CFR 483.80 Additional reference: Center for Medicaid/Medicare Services S&C 17-30	K 100	Other Residents: The water management plan was present and contained the control measures. The control measures will be documented to attain compliance for our residents. Measures: The control measures will be documented to follow procedures set out in water management plan. Corrective Actions: The control meares documentation will be reviewed each month in a facility monthly QAPI meeting to ensure its compliance.	
K 232 SS=D	Aisle, Corridor, or Ramp Width CFR(s): NFPA 101 Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or	K 232	K232 Residents: The chairs were removed from the hallway upon notification of issue.	12/19/18

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K 232	<p>Continued From page 2</p> <p>unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure that the means of egress was unobstructed. Providing furniture in a means of egress which is not fixed to the wall or floor impedes corridors and hinders egress of residents during a fire or other emergency. This deficient practice affected 19 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During the tour of the facility conducted on 11/13/18 from 10:30 AM - 4:00 PM, non-fixed furniture consisting of two (2) chairs, was observed to be placed in the corridor outside room 211. Further observation revealed the corridors to be eight (8) feet width and the section of chairs measured approximately 24-1/2 inches from the wall.</p> <p>Actual NFPA standard:</p> <p>19.2.3.4* Any required aisle, corridor, or ramp shall be not less than 48 in. (1220 mm) in clear width where serving as means of egress from patient sleeping rooms, unless otherwise permitted by one of the following: (1) Aisles, corridors, and ramps in adjunct areas not intended for the housing, treatment, or use of</p>	K 232	<p>Other Residents:</p> <p>Other chairs in hallways and common areas were removed to ensure compliance.</p> <p>Measures:</p> <p>Area was cleared on 11-14-18. Maintenance and environmental staff trained on requirement.</p> <p>Corrective Measures:</p> <p>Hallways to be added to daily round checklist to ensure they are clear. Maintenance Supervisor will report results monthly at the facility QAPI meeting.</p>	

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K 232	Continued From page 3 inpatients shall be not less than 44 in. (1120 mm) in clear and unobstructed width. (2)*Where corridor width is at least 6 ft (1830 mm), noncontinuous projections not more than 6 in. (150 mm) from the corridor wall, above the handrail height, shall be permitted. (3) Exit access within a room or suite of rooms complying with the requirements of 19.2.5 shall be permitted. (4) Projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in.(1525 mm). (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c)*The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment (5)*Where the corridor width is at least 8 ft (2440 mm), projections into the required width shall be permitted for fixed furniture, provided that all of the following conditions are met: (a) The fixed furniture is securely attached to the floor or to the wall. (b) The fixed furniture does not reduce the clear unobstructed corridor width to less than 6 ft (1830 mm), except as permitted by 19.2.3.4(2). (c) The fixed furniture is located only on one side of the corridor. (d) The fixed furniture is grouped such that each grouping does not exceed an area of 50 ft ² (4.6 m ²). (e) The fixed furniture groupings addressed in	K 232			

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K 232	Continued From page 4 19.2.3.4(5)(d) are separated from each other by a distance of at least 10 ft (3050 mm). (f)*The fixed furniture is located so as to not obstruct access to building service and fire protection equipment. (g) Corridors throughout the smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the fixed furniture spaces are arranged and located to allow direct supervision by the facility staff from a nurses ' station or similar space. (h) The smoke compartment is protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.8.	K 232		
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9.18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure doors equipped with special locking arrangements, were provided with battery powered emergency lighting. Failure to provide emergency lighting for doors equipped with delayed egress potentially hinders identification of exits utilized for resident egress during an emergency. This deficient practice affected 85 residents, staff and visitors on the date of the survey. Findings include: During the facility tour conducted on 11/13/18	K 291	K291 Residents: Emergency lighting was added to delayed egress doors . Other Residents: Residents, visitors and staff have the potential be affected by this issue. Measures: The lighting to the delayed egress doors was installed to attain compliance with this citation. Corrective Measures: Maintenance department will check the lighting monthly for compliance. Maintenance will report to QAPI monthly regarding compliance.	12/19/18

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K 291	<p>Continued From page 5</p> <p>from approximately 10:30 AM - 4:00 PM, observation of the exit doors revealed all primary exits on both floors were equipped with magnetic locking arrangements, which included a delayed egress component. However, these doors were not provided with battery powered emergency lighting. Due to the number of locations the locking arrangement was observed, this was found to be systemic throughout the facility and no further documentation was deemed necessary.</p> <p>Asked about this arrangement, the Maintenance Director stated he was not aware these doors were required to be equipped with emergency lighting.</p> <p>Actual NFPA standard:</p> <p>19.2.9 Emergency Lighting. 19.2.9.1 Emergency lighting shall be provided in accordance with Section 7.9.</p> <p>7.9 Emergency Lighting. 7.9.1 General. 7.9.1.1* Emergency lighting facilities for means of egress shall be provided in accordance with Section 7.9 for the following:</p> <p>(1) Buildings or structures where required in Chapters 11 through 43 (2) Underground and limited access structures as addressed in Section 11.7 (3) High-rise buildings as required by other sections of this Code (4) Doors equipped with delayed-egress locks (5) Stair shafts and vestibules of smokeproof enclosures, for which the following also apply: (a) The stair shaft and vestibule shall be permitted to include a standby generator that is</p>	K 291			

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K 321	<p>Continued From page 7 Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure doors to hazardous areas were maintained to the proper rating. Failure to ensure doors to boiler rooms are not equipped with transfer grilles and are maintained as a one-hour containment, has the potential to affect the means of egress and transfer of fires beyond the compartment of origin. This deficient practice affected the exit off the northeast side of the service corridor.</p> <p>Findings include:</p> <p>During the facility tour conducted on 11/13/18 from 10:30 AM - 4:00 PM, observation of the door to the riser room and boiler room revealed a transfer grille, approximately fourteen inches by twenty inches in size had been installed into the door leading into the space. Further observation of the rating of the assembly revealed the frame was tagged as a 3-hour rated assembly. When asked about the modification to the door, the Maintenance Director stated he had installed the vent to help alleviate the heat build-up in the space.</p> <p>Actual NFPA standard:</p> <p>19.3.2 Protection from Hazards. 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 8.7.1.</p>	K 321		

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K 321	Continued From page 8 19.3.2.1.5 Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Rooms with soiled linen in volume exceeding 64 gal (242 L) (6) Rooms with collected trash in volume exceeding 64 gal (242 L) (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard	K 321		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing 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. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____	K 353	K353 Residents: Quarterly waterflow testing will be completed. Other residents: Residents residing in the facility had the potential to be affected by this issue. Measures: Waterflow testing to be added to quarterly preventative maintenance checklist.	12/19/18

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K 353	Continued From page 9 Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to ensure fire suppression systems were maintained properly. Failure to inspect system components has the potential to hinder system performance during a fire event and/or render the facility not fully sprinklered after an activation or repair. This deficient practice affected 85 residents, staff and visitors on the date of the survey. Findings include: During review of provided facility inspection and testing records conducted on 11/13/18 from 8:45 - 10:30 AM, records were not available for the third quarter of 2018 waterflow alarm flow test. Actual NFPA standard: NFPA 25 5.3.3 Waterflow Alarm Devices. 5.3.3.1 Mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly.	K 353	Corrective Actions: Maintenance will report compliance at the monthly QAPI meetings.	
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers.	K 355	K355 Residents: The K style extinguisher was moved and properly signed prior to 730am on 11/14/18. The extinguisher at reception desk was mounted prior to 730am on 11/14/18.	12/19/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135098	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 11/14/2018	
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K 355	<p>Continued From page 10 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure fire extinguishers were installed properly. Failure to mount extinguishers at the correct height and install signs for special fire extinguishers in kitchens, has the potential to hinder staff response during a fire. This deficient practice affected staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 11/13/18 from approximately 10:30 AM to 4:00 PM, observation of installed portable fire extinguishers revealed the K-style fire extinguisher was not signed according to its use after activation of the UL 300 hood suppression system.</p> <p>Further observation of installation of fire extinguishers revealed the following location were not installed in accordance with NFPA 10:</p> <p>The reception desk at the lobby had an extinguisher sitting on the counter. The elevator equipment room extinguisher was mounted at 71 inches to the top of the extinguisher when measured from the floor. The extinguisher installed by the barbecue on the patio was installed at 67 inches to the top of the extinguisher when measured from the floor. The K-style fire extinguisher in the remodeled Kitchen on the second floor was blocked to access and did not have the appropriate sign for use.</p> <p>Actual NFPA standard:</p>	K 355	<p>The other two extinguishers were remounted at appropriate heights prior to 730am on 11/14/18.</p> <p>Other residents: Residents residing in the facility had the potential to be affected by this issue. The K style extinguisher was moved and properly signed prior to 730am on 11/14/18. The extinguisher at reception desk was mounted prior to 730am on 11/14/18. The other two extinguishers were remounted at appropriate heights prior to 730am on 11/14/18.</p> <p>Measures: Maintenance to monitor fire extinguisher heights and mounting through daily rounds.</p> <p>Corrective Actions: Maintenance will report compliance at the monthly QAPI meetings.</p>	

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

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K 355	Continued From page 11 NFPA 10 1-6.3 Fire extinguishers shall be conspicuously located where they will be readily accessible and immediately available in the event of fire. Preferably they shall be located along normal paths of travel, including exits from areas. 1-6.10 Fire extinguishers having a gross weight not exceeding 40 lb (18.14 kg) shall be installed so that the top of the fire extinguisher is not more than 5 ft (1.53 m) above the floor. Fire extinguishers having a gross weight greater than 40 lb (18.14 kg) (except wheeled types) shall be so installed that the top of the fire extinguisher is not more than 3 1/2 ft (1.07 m) above the floor. In no case shall the clearance between the bottom of the fire extinguisher and the floor be less than 4 in. (10.2 cm). 5.5.5* Class K Cooking Media Fires. Fire extinguishers provided for the protection of cooking appliances that use combustible cooking media (vegetable or animal oils and fats) shall be listed and labeled for Class K fires. 5.5.5.3* A placard shall be conspicuously placed near the extinguisher that states that the fire protection system shall be actuated prior to using the fire extinguisher.	K 355		
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing	K 511	K511 Residents: The daisy chained RPT was removed upon discovery. The power supply to the microwave was corrected to ensure compliance with requirement.	12/19/18

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K 511	<p>Continued From page 12 installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to maintain safe electrical installations. Failure to provide safe electrical installations has been historically linked to the increased potential of arc fires. This deficient practice affected staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 11/13/18 from approximately 8:45 AM to 4:00 PM, observation of electrical installations in the facility revealed the following:</p> <p>1) Observation of the Activities area revealed the installation at the rear of the room had a relocatable power tap (RPT) daisy-chained into another RPT.</p> <p>2) Observation of the MDS nurse's office revealed a RPT used to supply power to a microwave.</p> <p>Actual NFPA standard NFPA 70 110.2 Approval. The conductors and equipment required or permitted by this Code shall be acceptable only if approved.</p>	K 511	<p>Other Residents: Residents residing in the facility had the potential to be affected by this issue. The daisy chained RPT was removed upon discovery. The power supply to the microwave was corrected to ensure compliance with requirement.</p> <p>Measures: Maintenance to monitor for RPT's through daily rounds.</p> <p>Corrective Actions: Maintenance will report compliance at the monthly QAPI meetings.</p>	

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K 511	<p>Continued From page 13</p> <p>Informational Note: See 90.7, Examination of Equipment for Safety, and 110.3, Examination, Identification, Installation, and Use of Equipment. See definitions of Approved, Identified, Labeled, and Listed.</p> <p>110.3 Examination, Identification, Installation, and Use of Equipment. (A) Examination. In judging equipment, considerations such as the following shall be evaluated: (1) Suitability for installation and use in conformity with the provisions of this Code Informational Note: 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. Special conditions of use or other limitations and other pertinent information. Suitability of equipment may be evidenced by listing or labeling. (2) Mechanical strength and durability, including, for parts designed to enclose and protect other equipment, the adequacy of the protection thus provided (3) Wire-bending and connection space (4) Electrical insulation (5) Heating effects under normal conditions of use and also under abnormal conditions likely to arise in service (6) Arcing effects (7) Classification by type, size, voltage, current capacity, and specific use (8) Other factors that contribute to the practical safeguarding of persons using or likely to come in contact with the equipment (B) Installation and Use. Listed or labeled equipment shall be installed and used in</p>	K 511		

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K 511	Continued From page 14 accordance with any instructions included in the listing or labeling.	K 511		
K 521 SS=F	Additional reference: UL 1363 XBYS.GuidelInfo Relocatable Power Taps HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure installed fire dampers were maintained. Failure to ensure fire dampers installed in fuel-fired Heating Ventilation and Air Conditioning (HVAC) equipment are maintained, has the potential to allow smoke, fire and dangerous gases to pass between compartments during a fire. This deficient practice affected 85 residents, staff and visitors on the date of the survey. Findings include: During review of facility maintenance records conducted on 11/13/18 from 8:45 - 10:30 AM, records provided for fire damper inspection indicated fire dampers were installed throughout all smoke compartments on both floors. Further	K 521	K521 Residents: The facility is working with a company to reconfigure ceiling tiles to allow access to dampers. Upon access the dampers will be maintained. Other Residents: Residents residing in the facility had the potential to be affected by this issue. The facility is working with a company to reconfigure ceiling tiles to allow access to dampers. Upon access the dampers will be maintained. Measures: Damper testing to be added to yearly preventative maintenance checklist initially then to every 4 years to ensure compliance.	12/19/18

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K 521	<p>Continued From page 15</p> <p>review established that thirteen dampers were identified as "no access" and one was found to have failed. When asked about if these deficiencies had been remedied the Maintenance Director stated he was not aware of any corrections having been completed at this time.</p> <p>Actual NFPA standard:</p> <p>NFPA 101 19.5.2 Heating, Ventilating, and Air-Conditioning. 19.5.2.1 Heating, ventilating, and air-conditioning shall comply with the provisions of Section 9.2 and shall be installed in accordance with the manufacturer ' s specifications, unless otherwise modified by 19.5.2.2.</p> <p>9.2 Heating, Ventilating, and Air-Conditioning. 9.2.1 Air-Conditioning, Heating, Ventilating Ductwork, and Related Equipment. Air-conditioning, heating, ventilating ductwork, and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems, or NFPA 90B, Standard for the Installation of Warm Air Heating</p> <p>NFPA 90A 5.4.8 Maintenance. 5.4.8.1 Fire dampers and ceiling dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives.</p> <p>NFPA 80 19.4* Periodic Inspection and Testing. 19.4.1 Each damper shall be tested and inspected 1 year after installation.</p>	K 521	<p>Corrective Actions: Maintenance will report compliance at the monthly QAPI meetings.</p>	

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K 918	<p>Continued From page 17</p> <p>manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.</p> <p>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure the EES (Essential Electrical System) generator was maintained properly. Failure to test for load monthly has the potential of hindering system performance during a power loss or other emergency. This deficient practice affected 85 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During review of annual inspection and maintenance records conducted on 11/13/18 from approximately 8:45 - 10:30 AM, records provided for the monthly generator testing revealed monthly testing conducted for the prior year to date had only documented the load placed on the system during one test, as only one report indicated the amp draw placed on the EES generator.</p> <p>When asked, the Maintenance Engineer stated he was not aware the documentation for monthly load testing was missing the recording of the amp load.</p> <p>Actual NFPA standard:</p>	K 918	<p>Corrective Actions:</p> <p>Maintenance will report compliance at the monthly QAPI meetings.</p>	

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K 918	Continued From page 18	K 918			
K 930 SS=D	<p>NFPA 110</p> <p>8.4 Operational Inspection and Testing. 8.4.1* EPSSs, including all appurtenant components, shall be inspected weekly and exercised under load at least monthly.</p> <p>Gas Equipment - Liquid Oxygen Equipment CFR(s): NFPA 101</p> <p>Gas Equipment - Liquid Oxygen Equipment The storage and use of liquid oxygen in base reservoir containers and portable containers comply with sections 11.7.2 through 11.7.4 (NFPA 99). 11.7 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation the facility failed to ensure medical gases were stored properly. Failure to secure oxygen cylinders has the potential increasing the risks of injury and explosions due to falling cylinders. This deficient practice affected staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 11/13/18 from 1:00 - 3:15 PM, observation of the oxygen storage area at the rear service area of the facility, revealed nine (9) LOX (Liquid oxygen) cylinders that were not secured in a rack or with a restraint.</p> <p>Actual NFPA standard: NFPA 99</p>	K 930	<p>K930</p> <p>Residents: The 9 LOX cylinders have now been secured to attain compliance.</p> <p>Other Residents: Residents residing in the facility had the potential to be affected by this issue. The 9 LOX cylinders have now been secured to attain compliance.</p> <p>Measures: Maintenance to monitor for continued compliance through daily rounds.</p> <p>Corrective Actions: Maintenance will report compliance at the monthly QAPI meetings.</p>	12/19/18	

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K 930	Continued From page 19 11.7 Liquid Oxygen Equipment. 11.7.3.3* Liquid oxygen base reservoir containers shall be secured by one of the following methods while in storage or use to prevent tipping over caused by contact, vibration, or seismic activity: (1) Securing to a fixed object with one or more restraints (2) Securing within a framework, stand, or assembly designed to resist container movement (3) Restraining by placing the container against two points of contact	K 930			



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

November 27, 2018

Randal Barnes, Administrator
Valley View Nursing & Rehabilitation
1140 North Allumbaugh Street
Boise, ID 83704-8700

Provider #: 135098

RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER

Dear Mr. Barnes:

On **November 14, 2018**, an Emergency Preparedness 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 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. 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 the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office.

FILE COPY

Your Plan of Correction (PoC) for the deficiencies must be submitted by **December 10, 2018**. Failure to submit an acceptable PoC by **December 10, 2018**, may result in the imposition of civil monetary penalties by **January 1, 2019**.

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 **December 19, 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 . A change in the seriousness of the deficiencies on **January 11, 2019**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **December 19, 2018**, includes the following:

Denial of payment for new admissions effective **February 14, 2019**.
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 **May 14, 2019**, 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 **November 14, 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:

<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

Randal Barnes, Administrator

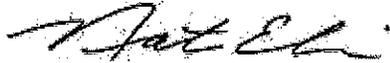
November 27, 2018

Page 4 of 4

This request must be received by **December 10, 2018**. If your request for informal dispute resolution is received after **December 10, 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,

A handwritten signature in black ink, appearing to read "Nate Elkins".

Nate Elkins, Supervisor
Facility Fire Safety and Construction

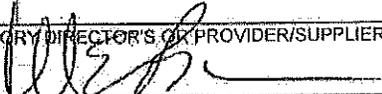
NE/lj

Enclosures

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

Printed: 11/20/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/14/2018
NAME OF PROVIDER OR SUPPLIER VALLEY VIEW NURSING & REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1140 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
E 000	Initial Comments The facility is a two story Type II (111) completed in 1985. It underwent a complete renovation in 2009. The facility is equipped with an emergency backup diesel-fired generator and is located in a municipal fire district, with additional county and state EMS services available. 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 with a census of 85 on the date of the survey. The following deficiencies were cited during the initial Emergency Preparedness Survey conducted on November 13 and 14, 2018. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73. The Survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	E 000	RECEIVED DEC 19 2018 FACILITY STANDARDS This Plan of Correction is submitted as required under State and Federal regulations and statutes applicable to long-term providers. The Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is specifically denied. The submission of this plan of Correction does not constitute agreement by the facility that the surveyors findings and/or conclusions constitute a deficiency or that the scope and severity of the deficiencies cited are correctly applied.	
E 006 SS=F	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.*	E 006	E006 Residents: The emergency preparedness program has been updated to contain and integrate the community based risk assessment.	12/19/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE **Administrator** (X6) DATE **12-10-18**

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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E 006	<p>Continued From page 1</p> <p>*[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents.</p> <p>*[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients.</p> <p>(2) Include strategies for addressing emergency events identified by the risk assessment.</p> <p>* [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to develop an EP plan that included a geographically relevant facility based and community based risk assessment. Failure to provide a relevant facility and community based risk assessment, has the potential to focus staff training and resources on hazards that are not consistent with the facility location. This deficient practice affected 85 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>On 11/13/18 from 8:45 AM - 4:00 PM, review of the provided emergency plan, policies and procedures, revealed the facility HVA (Hazard</p>	E 006	<p>Other Residents: Other residents being admitted before the revision of the program have the potential to be affected. The emergency preparedness program has been updated to contain and integrate the community based risk assessment.</p> <p>Measures: The facility program will include all elements in the requirement. This includes the relevant Geographic and community identified risks.</p> <p>Corrective Action: Maintenance supervisor or designee will continue to attend community Emergency Preparedness meetings and report at the monthly QAPI meeting.</p>	

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E 006	Continued From page 2 Vulnerability Analysis) did not include relevant geographic and community identified risks as established in the county all-hazard mitigation plan. Asked if the county plan was used when developing this HVA, the Maintenance Director stated it was not and that the assessment was completed internally. Reference: 42 CFR 483.73 (a) (1) - (2)	E 006		
E 013 SS=F	Development of EP Policies and Procedures CFR(s): 483.73(b) (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or	E 013	E013 Residents: The emergency preparedness program now includes relevant information from the county all hazard mitigation plan. Other Residents: Other residents being admitted before the revision of the program have the potential to be affected. The emergency preparedness program now includes relevant information from the county all hazard mitigation plan. Measures: The current emergency plan has updated to include the required community information.	12/19/18

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E 013	<p>Continued From page 3 safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least annually.</p> <p>*[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to ensure policies and procedures were aligned with a community-based and facility-based HVA. Failure to develop policies based on relevant facility and community based risks, has the potential to confuse staff and result in irrelevant training on hazards that are not consistent with the facility location. This deficient practice affected 85 residents, staff and visitors on the date of the survey.</p> <p>Findings include: On 11/13/18 from 8:45 AM - 4:00 PM, review of the provided emergency plan, policies and procedures, revealed the facility HVA (Hazard Vulnerability Analysis) did not have relevant information from the county all-hazard mitigation plan developed in 2017, such as earthquakes or tornadoes, however policies and procedures did</p>	E 013	<p>Corrective Actions: The program will be reviewed yearly at the monthly safety meeting. Maintenance supervisor or designee will continue to attend community Emergency Preparedness meetings. If changes occur during the year, the program will be reviewed by the safety committee. Staff will be trained on changes by the facility SDC. A summary will be presented at the Monthly QAPI meeting.</p>		

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E 013	Continued From page 4 address these threats, as did the county plan. Reference: 42 CFR 483.73 (b) Additional Reference: E - 0006	E 013		
E 024 SS=D	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge	E 024	E024 Residents: The emergency preparedness plan has been updated to include the facility's policy regarding the use volunteers during an emergency. Other Residents: Other residents being admitted before the revision of the program have the potential to be affected. The emergency preparedness plan has been updated to include the facility's policy regarding the use volunteers during an emergency. Measures: A new policy has been developed regarding the use of volunteers during an emergency. Staff will be educated on this policy.	12/19/18

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E 024	Continued From page 5 needs during an emergency. This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the facility failed to develop EOP which addressed the use of volunteers during an emergency. Lack of a plan, policy and procedure specific to the use of volunteers, potentially hinders the facility's ability to provide continuity of care during a disaster. This deficient practice had the potential to affect the 85 residents, staff and visitors in the facility on the date of the survey. Findings include: Review of provided emergency plan, policies and procedures conducted on 11/13/18 from 8:45 AM - 4:00 PM, failed to demonstrate a plan, policy or procedure for the use of volunteers during an emergency. Reference: 42 CFR 483.73 (b) (6)	E 024	Corrective Actions: The emergency program will be reviewed annually at safety meeting. Maintenance Supervisor or Designee will report at monthly QAPI meeting.		
E 031 SS=F	Emergency Officials Contact Information CFR(s): 483.73(c)(2) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following:	E 031	E031 Residents: The phone numbers for the State Licensing and Certification and State Long Term Ombudsman have been added to the facility emergency plan. Other Residents: Other residents being admitted before the revision of the program have the potential to be affected.	12/19/18	

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E 031	<p>Continued From page 6</p> <p>(i) Federal, State, tribal, regional, or local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance.</p> <p>*[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to ensure current contact information for emergency management officials and other resources of assistance was provided in the emergency communication plan. Failure to provide information for resources available to the facility has the potential to hinder facility response and continuity of care for the 85 residents, staff and visitors in the facility on the date of the survey.</p> <p>Findings include:</p> <p>On 11/13/18 from 8:45 AM - 4:00 PM, review of the provided EOP, revealed the failed to include contact information for emergency officials as follows: No phone number for the State Licensing and Certification agency. No phone number for the State Long Term Care Ombudsman.</p> <p>Reference:</p> <p>42 CFR 483.73 (c) (2)</p>	E 031	<p>The phone numbers for the State Licensing and Certification and State Long Term Omsbudsman have been added to the facility emergency plan.</p> <p>Measures: The emergency plan has been updated to include the phone numbers of the State Licensing and Certification and State Long Term Omsbudsman.</p> <p>Corrective Actions: The emergency plan will be reviewed at the safety meeting. Maintenance Supervisor will report changes or updates at monthly QAPI meeting.</p>	

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E 041 E 041 SS=F	Continued From page 7 Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source	E 041 E 041	E041 Residents: Monthly testing and documentation of load places on the system. This will include the AMP draw. Other Residents: Residents residing in the facility had the potential to be affected by this issue. Monthly testing and documentation of load places on the system. This will include the AMP draw. Measures: Documentation of generator testing including AMP draw to be added to the monthly preventative maintenance checklist. Corrective Actions: Maintenance will report compliance at the monthly QAPI meetings.	12/19/18

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E 041	<p>Continued From page 8</p> <p>to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates.</p> <p>*[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes.</p> <p>(1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000.</p> <p>(i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011.</p> <p>(ii) Technical Interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011.</p> <p>(iii) TIA 12-3 to NFPA 99, issued August 9, 2012.</p> <p>(iv) TIA 12-4 to NFPA 99, issued March 7, 2013.</p> <p>(v) TIA 12-5 to NFPA 99, issued August 1, 2013.</p> <p>(vi) TIA 12-6 to NFPA 99, issued March 3, 2014.</p> <p>(vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011.</p> <p>(viii) TIA 12-1 to NFPA 101, issued August 11,</p>	E 041		

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E 041	<p>Continued From page 9</p> <p>2011.</p> <p>(ix) TIA 12-2 to NFPA 101, issued October 30, 2012.</p> <p>(x) TIA 12-3 to NFPA 101, issued October 22, 2013.</p> <p>(xi) TIA 12-4 to NFPA 101, issued October 22, 2013.</p> <p>(xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure the emergency electrical system (EES) generator was maintained in accordance with NFPA 110. Failure to maintain EES generators has the potential to render the facility without essential backup electrical power during a power outage or other emergency. This deficient practice affected 85 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During review of provided facility EES generator maintenance and inspection records conducted on 11/13/18 from 8:45 - 10:30 AM, records indicated only one of the monthly load tests conducted in the previous year, had documented the amp load during the test. Interview of the Maintenance Director determined he was not aware the load had not been documented.</p> <p>Reference:</p> <p>42 CFR 483.73 (e) (1)</p> <p>Additional reference CMS 2567 K-tag 918</p>	E 041			