



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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TAMARA PRISOCK—ADMINISTRATOR  
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P.O. Box 83720  
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February 7, 2019

Jeri Herrera, Administrator  
Valley Vista Care Center Of Sandpoint  
220 South Division  
Sandpoint, ID 83864-1759

Provider #: 135055

Dear Ms. Herrera:

On **January 31, 2019**, a survey was conducted at Valley Vista Care Center Of Sandpoint by the Idaho Department of Health and Welfare, Division of Licensing and Certification, 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/or Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern 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. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct." **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **February 18, 2019**. Failure to submit an acceptable PoC by **February 18, 2019**, may result in the imposition of penalties by **March 12, 2019**.

The components of a Plan of Correction as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained; and
- Include dates when corrective action will be completed in column (X5).

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **March 7, 2019 (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 **May 1, 2019**. A change in the seriousness of the deficiencies on **March 17, 2019**, may result in a change

in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **May 1, 2019** includes the following:

Denial of payment for new admissions effective **May 1, 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 non-compliance, 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 **July 31, 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, CMS will provide you with a separate formal notification of that determination.**

If you believe these deficiencies have been corrected, you may contact Debby Ransom, RN, RHIT, Bureau Chief, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 5; fax number: (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 1, 2019** 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:

Jeri Herrera, Administrator  
February 7, 2019  
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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)

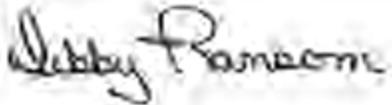
2001-10 Long Term Care Informal Dispute Resolution Process

2001-10 IDR Request Form

This request must be received by **February 18, 2019**. If your request for informal dispute resolution is received after **February 18, 2019**, 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, comments or concerns, please contact Debby Ransom, RN, RHIT, Bureau Chief at (208) 334-6626, option 5.

Sincerely,



Debby Ransom, RN, RHIT, Chief  
Bureau of Facility Standards

dr/

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001540</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/31/2019</b>
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NAME OF PROVIDER OR SUPPLIER  <b>VALLEY VISTA CARE CENTER OF SANDPOINT</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>220 SOUTH DIVISION SANDPOINT, ID 83864</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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C 000	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the facility's state licensure survey conducted at the facility from January 28, 2019 to January 31, 2019.</p> <p>The team members conducting the survey were:</p> <p>Edith Cecil, RN, Team Coordinator</p> <p>Survey Abbreviations:</p> <p>DON = Director of Nursing LPN = Licensed Practical Nurse RN = Registered Nurse</p>	C 000		
C 409	<p>02.120,05,i Required Room Closet Space</p> <p>i. Closet space in each sleeping room shall be twenty inches by twenty-two inches (20" x 22") per patient/resident. Common closets utilized by two (2) or more patients/residents shall be provided with substantial dividers for separation of each patient's/resident's clothing for prevention of cross contamination. All closets shall be equipped with doors. Freestanding closets shall be deducted from the square footage in the sleeping room.</p> <p>This Rule is not met as evidenced by: Based on observation, and resident interview, and the facility's plan review, it was determined the facility failed to ensure there was 3 square feet per resident of personal closet space for residents in the 100 and 300 Halls. The small</p>	C 409	Request waiver to continue.	3/7/19

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Electronically Signed	TITLE	(X6) DATE  02/18/19
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Bureau of Facility Standards

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C 409	<p>Continued From page 1</p> <p>closets created the potential for residents to have insufficient space for storing clothing and personal items. Findings include:</p> <p>Closets in the 100 Hall provided 2.43 square feet (36 inches x 19.5 inches) of personal closet space. In the 300 Hall there was 2.41 square feet (33 inches by 21 inches) of personal closet space.</p> <p>On 6/23/16 the facility was granted a waiver for closet space in rooms 102, 108, 109, and 304, located on the 100 and 300 halls.</p> <p>On 1/30/19 at 11:40 AM, the residents residing in rooms 108 (Resident # 53) and 304 (Resident #17,) without roommates, stated they had no complaint regarding their closet space.</p> <p>On 1/30/19 at 11:20 AM, rooms 102 and 109 were utilized as staff office space.</p>	C 409		
C 422	<p>02.120,05,p,vii Capacity Requirments for Toilets/Bath Areas</p> <p>vii. On each patient/resident floor or nursing unit there shall be at least one (1) tub or shower for every twelve (12) licensed beds; one (1) toilet for every eight (8) licensed beds; and one (1) lavatory with mirror for every eight (8) licensed beds. Tubs, showers, and lavatories shall be connected to hot and cold running water.</p> <p>This Rule is not met as evidenced by: Based on staff interview and waiver review, it was determined the facility failed to ensure there</p>	C 422	Request waiver to continue.	3/7/19

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C 422	Continued From page 2  was 1 tub or shower for every 12 licensed beds. This failure had the potential for a negative effect for all residents living in the facility should they not have access to bathing facilities. Findings include:  The facility, licensed for 73 beds, was required to have 7 tubs or showers available for resident use. The facility had 5 bathing facilities.  On 7/21/16, the facility was granted a tub/shower waiver.  On 1/29/19 at 10:00 AM, a Group Interview was conducted with 6 residents (#11, #13, #23, #27, #37, and #51,) who resided in the facility. Each resident that participated in the Group Interview denied concerns or issues about insufficient bathing facilities.	C 422		
C 762	02.200,02,c,ii When Average Census 60-89 Residents  ii. In SNFs with an average occupancy rate of sixty (60) to eighty-nine (89) patients/residents a registered professional nurse shall be on duty for each a.m. shift (approximately 7:00 a.m. - 3:00 p.m.) and p.m. shift (approximately 3:00 p.m. to 11:00 p.m.) and no less than a licensed practical nurse on the night shift.  This Rule is not met as evidenced by: Based on review of the nursing schedule and staff interview, it was determined the facility did not meet the State requirement for RN coverage when the resident occupancy rate was between	C 762	Citation 0762 – When Average Census 60-89 Residents  Affected Residents	3/7/19

Bureau of Facility Standards

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C 762	<p>Continued From page 3</p> <p>60 and 89 residents. Inadequate RN coverage had the potential to negatively affect all residents living in the facility. Findings include:</p> <p>The three-week nursing schedule for 1/6/19 through 1/26/19, for actual RN coverage on the Day Shift (approximately 6:00 AM to 2:30 PM) and the Evening Shift (approximately 2:00 PM to 10:00 PM) documented the following:</p> <p>* On 1/13/19, an RN worked from 1:49 PM to 10:12 PM. There was no RN coverage for the Day Shift hours. The resident census was 65.</p> <p>* On 1/14/19, an RN worked from 8:05 AM to 4:04 PM. There was no RN coverage from 6:00 AM to 8:04 AM, or from 4:05 PM to 11:00 PM. The resident census was 66.</p> <p>* On 1/20/19, an RN worked from 1:50 PM to 11:38 PM. There was no RN coverage for the Day Shift hours. The resident census was 65.</p> <p>On 1/31/19 at 9:50 AM, the DON said there was no assigned RN coverage on the above-mentioned shifts.</p>	C 762	<p>On 01/13/2019, 01/14/2019, 01/20/2019 and 01/31/2019 this deficient practice had the potential to negatively affect all residents.</p> <p><b>Corrective Action</b> The schedule will be reviewed on or before 02/04/2019 to ensure there is adequate RN coverage for the current census. On 02/04/2019 the DNS was educated on the State RN coverage requirement.</p> <p><b>Systematic Changes</b> Daily census will be sent to DNS from Medical Records daily beginning on 03/07/2019. If Resident census is between 60-89 a RN will be scheduled from 6:00 a.m. to 2:00 p.m. and from 2:00 p.m. to 10 p.m.</p> <p><b>Monitoring</b> Beginning on 03/07/2019 a daily audit x 30 will be initiated. The nursing schedule will be compared to the census daily to ensure there is the required RN coverage. Audits will be completed weekly x 4 weeks beginning on 04/07/2019 then monthly x 2. Audit results will be reviewed at the monthly QAPI meeting. The DNS/Scheduler will be responsible for the audits and on-going compliance.</p>	
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