



IDAHO DEPARTMENT OF
HEALTH & WELFARE

.BRAD LITTLE – Governor
DAVE JEPPESEN – 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

February 13, 2020

Darwin Royeca, Administrator
Bell Mountain Village & Care Center
620 N. 6th St.
Bellevue, ID 83313-5174

Provider #: 135069

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

Dear Mr. Royeca:

On **February 4, 2020**, a Facility Fire Safety and Construction survey was conducted at **Bell Mountain Village & Care Center** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. Please provide **ONLY ONE** completion date for each federal and state tag in column (X5)

Completion Date to signify when you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign 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 **February 26, 2020**. Failure to submit an acceptable PoC by **February 26, 2020**, may result in the imposition of civil monetary penalties by **March 19, 2020**.

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 **March 10, 2020**, (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 4, 2020**. A change in the seriousness of the deficiencies on **March 20, 2020**, may result in a change in the remedy.

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

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February 13, 2020
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achieved by **March 10, 2020**, includes the following:

Denial of payment for new admissions effective **May 4, 2020**.
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 **August 4, 2020**, 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 **February 4, 2020**, 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>

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Go to the middle of the page to Information Letters section and click on State and select the following:

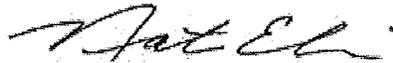
BFS Letters (06/30/11)

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

This request must be received by **February 26, 2020**. If your request for informal dispute resolution is received after **February 26, 2020**, 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: 02/21/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135069	(X2) MULTIPLE CONSTRUCTION A. BUILDING 04 - ENTIRE STRUCTURE B. WING _____	(X3) DATE SURVEY COMPLETED 02/04/2020
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NAME OF PROVIDER OR SUPPLIER BELL MOUNTAIN VILLAGE & CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 620 NORTH SIXTH STREET BELLEVUE, ID 83313
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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) COMPLETION DATE
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K 000	INITIAL COMMENTS The facility is comprised of two (2) 16-bed SNF/NF pods, originally constructed in 2015. The two primary pods house residential sleeping rooms, and ancillary services with physical therapy housed in the Administration building. The therapy section that supports the SNF/NF is further separated to the Assisted Living by two-hour construction. All buildings are type II (111) construction equipped with automatic sprinkler protection and an interconnected fire alarm/smoke detection system. Each building is provided a separate, on-site Emergency Power Supply System (EPSS) diesel-fired generator. The facility is licensed for 32 SNF/NF beds, and had a census of 30 on the date of the survey. The following deficiencies were cited during the annual fire/life safety survey conducted on February 4, 2020. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70. The Survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction	K 000		
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,	K 353	RECEIVED MAR - 5 2020 FACILITY STANDARDS K 353 SPRINKLER SYSTEM - MAINTENANCE AND TESTING. This facility will ensure fire suppression system were maintained in accordance with NFPA 25.	3/31/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Dawn Royce</i>	TITLE <i>Administrator</i>	(X6) DATE <i>03/04/2020</i>
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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 353	<p>Continued From page 1</p> <p>maintenance, inspection and testing are maintained in a secure location and readily available.</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. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure fire suppression systems were maintained in accordance with NFPA 25. Failure to ensure fire suppression systems are inspected as required, has the potential to hinder system performance during a fire event. This deficient practice affected 30 residents and staff on the date of the survey.</p> <p>Findings include:</p> <p>During review of provided maintenance and inspection records conducted on 2/4/20 from 8:45 - 11:00 AM, records revealed the following missing documentation:</p> <ul style="list-style-type: none"> - No record of a quarterly waterflow alarm testing and inspection completed during the second quarter of 2019 - No record for monthly control valve inspection(s) on secured control valves. - No record for monthly gauge inspection on the wet system. 	K 353	<p>All resident has the potential to be affected by this practice</p> <p>The maintenance /Safety Director had been educated by the Administrator regarding deficient practice and applicable NFPA standards on 02/25/2020.</p> <p>Quarterly waterflow alarm testing and inspection were scheduled with vendor and scheduled to be done on or before 3/31/2020.</p> <p>Monthly control valve inspection and Monthly gauge inspection on wet system will be done and recorded on or before 3/31/2020.</p> <p>Administrator or Designee will do a monthly X 6 record audits to ensure compliance.</p> <p>Please see exhibit A for Inspection Documentation.</p>		

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K 353	Continued From page 2 Interview of the Maintenance Director conducted on 10/16/19 at approximately 11:15 AM revealed he was not aware of the missing documentation prior to the date of the survey. Actual NFPA standard: NFPA 25 5.2.4 Gauges. 5.2.4.1* Gauges on wet pipe sprinkler systems shall be inspected monthly to ensure that they are in good condition and that normal water supply pressure is being maintained. 5.2.5 Waterflow Alarm and Supervisory Devices. Waterflow alarm and supervisory alarm devices shall be inspected quarterly to verify that they are free of physical damage. 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. 13.3 Control Valves in Water-Based Fire Protection Systems. 13.3.2 Inspection. 13.3.2.1 All valves shall be inspected weekly. 13.3.2.1.1 Valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly.	K 353			
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour	K 372	K 372 SUBDIVISION OF BUILDING SPACES – SMOKE BARRIER.	3/31/20	

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K 372	<p>Continued From page 3</p> <p>fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier.</p> <p>19.3.7.3, 8.6.7.1(1)</p> <p>Describe any mechanical smoke control system in REMARKS.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, the facility failed to ensure smoke barriers were maintained to resist the passage of smoke and ensure performance of all protective systems as designed. Failure to ensure smoke compartments are maintained to resist the passage of smoke, has the potential for fire, smoke and dangerous gases to pass into the interstitial spaces, delaying the response of fire alarms and fire suppression systems, hindering their response time. This deficient practice affected 14 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 2/4/20 from 11:00 AM - 3:00 PM, observation of the suspended ceiling in the west exit of the Hemmingway building, revealed one missing suspended ceiling tile approximately two feet by two feet in size. Interview of the Maintenance Engineer at approximately 1:30 PM, revealed he was aware of the missing ceiling tile prior to the date of the survey.</p> <p>Actual NFPA standard:</p>	K 372	<p>The facility will ensure that smoke barriers were maintained to resist the passage of smoke and ensure performance of all protective systems as designed.</p> <p>All resident has the potential to be affected by this practice.</p> <p>The maintenance /Safety director have been educated regarding the deficient practice and applicable NFPA standards on 02/25/2020.</p> <p>The missing suspended ceiling tile in the west exit of Hemingway building was replaced on 2/05/2020.</p> <p>Maintenance/Safety Director will do a facility inspection monthly and after vendor services to ensure that all suspended ceiling tiles are put back into place when moved by vendors for access. A random audit will be done monthly X 6 by the Administrator to ensure compliance.</p> <p>Please exhibit B.</p>		

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K 372	Continued From page 4 19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.5 and shall have a minimum 1.2-hour fire resistance rating, unless otherwise permitted by one of the following: (1) This requirement shall not apply where an atrium is used, and both of the following criteria also shall apply: (a) Smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with 8.6.7(1)(c). (b) Not less than two separate smoke compartments shall be provided on each floor. (2)*Smoke dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air-conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.8 has been provided for smoke compartments adjacent to the smoke barrier. 8.5.2.3 A smoke barrier required for an occupied space below an interstitial space shall not be required to extend through the interstitial space, provided that the construction assembly forming the bottom of the interstitial space provides resistance to the passage of smoke equal to that provided by the smoke barrier.	K 372			
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors	K 374	K 374 SUBDIVISION OF BUILDING SPACES – SMOKE BARRIER DOOR The facility will ensure that all smoke and fire barriers were maintained to limit the transfer of smoke, fire and dangerous gases between compartments.	3/31/20	

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K 374	<p>Continued From page 5</p> <p>are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure smoke and fire barriers were maintained to limit the transfer of smoke, fire and dangerous gases between compartments. Failure to maintain installed fire rated assemblies that limit transfer of combustion products, has the potential to hinder egress and the ability to shelter in place. This deficient practice affected 30 residents and staff on the date of the survey.</p> <p>Findings include:</p> <p>1) During review of facility maintenance and inspection records conducted on 2/4/20 from 8:45 - 11:00 AM, no records were provided indicating automatic roll-down fire doors equipped with fusible links were inspected and tested annually in accordance with NFPA 80 guidelines.</p> <p>2) During the facility tour conducted on 2/4/20 from 11:00 AM - 3:00 PM, both buildings were observed to have automatic roll-down fire doors equipped with fusible links installed in the pass-through opening from the kitchen to the main living area. Further observation revealed both doors were equipped with inspection tags requiring an annual drop test in accordance with NFPA 80, however neither tag had information</p>	K 374	<p>All resident has the potential to be affected by this practice.</p> <p>The maintenance /Safety director have been educated regarding the deficient practice and applicable NFPA standards on 02/25/2020.</p> <p>Both building's automatic roll-down fire doors equipped with fusible Links inspection and testing are scheduled to be done by the facility vendor on 03/03/2020.</p> <p>During the 03/03/2020 testing and inspection, vendors will still need to schedule back to the facility due to not having supplies/parts to fix 2 of the doors. Vendor scheduled to be back to service doors on or before 3/31/2020</p> <p>Roll-down fire doors equipped with fusible links inspection and testing are now routinely scheduled annually with facility vendor. Inspection and testing will be maintained by the maintenance/safety director in the Life Safety binder.</p>		

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K 374	Continued From page 6 indicating this drop test had been conducted within the past twelve months. When asked if these doors had been tested annually, the Maintenance Engineer stated he was not aware of the annual testing requirement. Actual NFPA standard: 19.3.7.8* Doors in smoke barriers shall comply with 8.5.4 and all of the following: (1) The doors shall be self-closing or automatic-closing in accordance with 19.2.2.2.7. (2) Latching hardware shall not be required (3) The doors shall not be required to swing in the direction of egress travel. 8.5.4.4* Doors in smoke barriers shall be self-closing or automatic-closing in accordance with 7.2.1.8 and shall comply with the provisions of 7.2.1. 7.2.1.15.2 Fire-rated door assemblies shall be inspected and tested in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Smoke door assemblies shall be inspected and tested in accordance with NFPA 105, Standard for Smoke Door Assemblies and Other Opening Protectives. NFPA 80 5.2* Inspections. 5.2.1* Fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ.	K 374	A record audit/inspection will be done annually by the Administrator to ensure compliance.		
K 511	Utilities - Gas and Electric	K 511			

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K 511 SS=F	Continued From page 7 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 installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure safe electrical installations in accordance with NFPA 70 and approved, listed assemblies such as UL 1363 XYBS. Failure to provide safe electrical installations has the potential to expose residents to the risks of arc fires and possible electrical shock. This deficient practice affected 30 residents and staff on the date of the survey. Findings include: During the facility tour conducted on 2/4/20 from 11:00 AM - 3:30 PM, observations of installed electrical installations revealed the following: - The main electrical shutoff panel and generator transfer switch was blocked from access of less than three feet by a washer stored in front of the panels. - Room 3A was observed to be using a relocatable power tap (RPT) to supply power to an oxygen concentrator, substituting the direct	K 511	K 511 UTILITIES – GAS AND ELECTRIC Facility will ensure to maintain safe electrical installation in accordance with NFPA 70. The maintenance /Safety director have been educated regarding the deficient practice and applicable NFPA standards on 02/14/2020 and 02/25/2020. Staff were educated regarding the deficient practice on 02/14/2020. The stored washer in front of the electrical panel was moved out of the control room and no longer blocking the main electrical shutoff panel and the generator transfer switch. Room 3A oxygen concentrator was unplugged from the relocatable power tap and is now plugged in directly to the facility wall outlet.	3/31/20	

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K 511	Continued From page 8 wiring of the facility. Actual NFPA standard: 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 may be marked on the equipment, included in the product instructions, or included in the appropriate listing and labeling 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	K 511	All resident has the potential to be affected by this practice. Facility wide room inspection was done by the maintenance/safety director on 2/10/2020 and 3/3/2020 to ensure no oxygen concentrator are plugged in a relocatable power tap. Maintenance/Safety Director will do a facility inspection monthly to ensure electrical shutoff panel and the generator transfer switch are not blocked and oxygen concentrator are not plugged into a relocatable power tap. A random inspection will be done Monthly X 6 by the Administrator to ensure compliance Please see exhibit C for inspection record.		

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K 511	<p>Continued From page 9 accordance with any instructions included in the listing or labeling.</p> <p>110.26 Spaces About Electrical Equipment. Access and working space shall be provided and maintained about all electrical equipment to permit ready and safe operation and maintenance of such equipment. (A) Working Space. Working space for equipment operating at 600 volts, nominal, or less to ground and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A)(1), (A)(2), and (A)(3) or as required or permitted elsewhere in this Code. (1) Depth of Working Space. The depth of the working space in the direction of live parts shall not be less than that specified in Table 110.26(A)(1) unless the requirements of 110.26(A)(1)(a), (A)(1)(b), or (A)(1)(c) are met. Distances shall be measured from the exposed live parts or from the enclosure or opening if the live parts are enclosed.</p> <p>ARTICLE 400 Flexible Cords and Cables</p> <p>400.8 Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces Exception to (4): Flexible cord and cable shall be</p>	K 511		

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K 511	Continued From page 10 permitted to be attached to building surfaces in accordance with the provisions of 368.56(B) (5) Where concealed by walls, floors, or ceilings or located above suspended or dropped ceilings (6) Where installed in raceways, except as otherwise permitted in this Code (7) Where subject to physical damage	K 511		
K 522 SS=F	Additional reference: UL 1363 XYBS HVAC - Any Heating Device CFR(s): NFPA 101 HVAC - Any Heating Device Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: * is chimney or vent connected. * takes air for combustion from outside. * provides for a combustion system separate from occupied area atmosphere. 19.5.2.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that wall mounted heaters were maintained free of obstructions. Electric wall heaters are historically linked to fires when required clearance is not maintained. This deficient practice affected 30 residents and staff on the date of the survey. Findings include: The facility was observed to have electric wall heaters (cadet heaters) installed throughout both	K 522	K 522 HVAC – ANY HEATING DEVICE Facility will ensure that wall mounted heaters were maintained free of obstructions and follow the manufacturer's safe clearance recommendation of at least 3 feet clearance in front of the heater and twelve inches to the sides and above the heater. The maintenance /Safety director have been educated regarding the deficient practice on 2/25/2020.	3/31/20

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K 522	<p>Continued From page 11</p> <p>buildings. Each heater had a safety label attached indicating no storage within three feet of all sides. The findings of combustible storage in front of the wall heaters was determined to be systemic in nature with these listed observations:</p> <ul style="list-style-type: none"> a. The Galena building therapy office had a desk in front of the electric wall heater (cadet heater) b. The Galena building dietary manger office had a nurse's cart blocking the cadet heater. c. Room 16A of Galena had a chair blocking the cadet heater. d. Room 12A of Galena had a laundry basket with clothing in it blocking the cadet heater. e. Room 8A of Galena had a trash can placed in front of the cadet heater. f. Room 6A of Galena had a wooden stool placed in front of the cadet heater. g. Room 3A of Galena had a wood dresser abutting the cadet heater. h. The Hemmingway building therapy office had a desk in front of the cadet heater. i. The Hemmingway salon had a chair backed up against the cadet heater. j. Room 15C of Hemmingway had a wooden dresser in front of the cadet heater. k. Room 10C of Hemmingway had a wooden table abutting the cadet heater. l. The ante room for rooms 4C and 5C of Hemmingway had a wooden dresser abutting the cadet heater. m. Room 1C of Hemmingway had a wooden table abutting the cadet heater. <p>Due to the extent and number of the above findings, it was determined this condition was systemic in both buildings and no further documentation was deemed necessary.</p>	K 522	<p>Staff were educated regarding the deficient practice and the importance of not storing combustible materials in front of the cadet wall heaters and follow the manufacturer's safe clearance recommendation of at least 3 feet clearance in front of the heater and twelve inches to the sides and above the heater.</p> <p>Galena building therapy office desk in front of the wall heater was moved to observe at least 3 feet clearance in front of the cadet wall heater.</p> <p>The nurse's cart that is in the dietary manager office was moved and no longer blocking the cadet wall heater.</p> <p>Room 16A's chair that was blocking the wall heater was moved and no longer blocking the cadet wall heater.</p>	

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		K 522	<p>Room 12A's laundry basket was moved and no longer blocking the cadet wall heater.</p> <p>Room 8A's trash can was moved and no longer in front of the cadet wall heater.</p> <p>Room 6A's wooden stool was moved and longer in front of the cadet wall heater.</p> <p>Room 3A's wood dresser that is abutting the wall heater was moved to observe proper clearance from side of heater per manufacturer's recommendation.</p> <p>Hemingway building therapy office desk in front of the wall heater was moved to observe at least 3 feet clearance in front of the cadet wall heater.</p> <p>Room 15C's wooden dresser was moved and no longer ion front of the cadet wall heater.</p> <p>Room 10C's wooden table abutting the cadet wall heater was moved to observe proper clearance per manufacturer's recommendation.</p>	

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K 522	Continued From page 12 Actual NFPA standard: 19.5.2.2* Any heating device, other than a central heating plant, shall be designed and installed so that combustible material cannot be ignited by the device or its appurtenances, and the following requirements also shall apply: (1) If fuel-fired, such heating devices shall comply with the following: (a) They shall be chimney connected or vent connected. (b) They shall take air for combustion directly from the outside. (c) They shall be designed and installed to provide for complete separation of the combustion system from the atmosphere of the occupied area. (2) Any heating device shall have safety features to immediately stop the flow of fuel and shut down the equipment in case of either excessive temperature or ignition failure.	K 522	4C and 5C ante room's wooden dresser was moved or taken out to storage. Room 1A's wooden table abutting the cadet wall heater was moved to observe proper clearance per manufacturer's recommendation. All resident has the potential to be affected by this practice. Facility wide rooms and offices inspection was conducted by the maintenance/Safety Director to ensure the safe clearances are followed per manufacturer's recommendation.		
K 741 SS=F	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language	K 741	Maintenance/Safety Director will ensure that cadet heater clearance inspections were conducted weekly X 4 and then monthly. A random record audit and room inspections will be done monthly X 6 by the Administrator to ensure compliance. Please see exhibit D.	3/31/20	

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K 741	<p>Continued From page 13</p> <p>that prohibits smoking shall not be required.</p> <p>(3) Smoking by patients classified as not responsible shall be prohibited.</p> <p>(4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision.</p> <p>(5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.</p> <p>(6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.</p> <p>18.7.4, 19.7.4</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, observation and interview, the facility failed to ensure smoking requirements were in accordance with the facility policies and NFPA 101. Failure to ensure smoking regulations are followed, exposes the residents to the increased risks of fires that are historically linked to healthcare occupancies. This deficient practice affected 30 residents and staff on the date of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on 2/4/20 from 11:00 AM to 3:00 PM, observation of the smoking area at the Galena building revealed the area had approximately eighteen inches of snow covering all benches inside the space. Further observation did not reveal an ABC fire extinguisher, trash can with a self-closing lid, or a fire blanket was provided.</p> <p>Observation of the back door exiting to the designated smoking area revealed three (3)</p>	K 741	<p>K 741 SMOKING REGULATIONS</p> <p>Facility will ensure smoking requirements were in accordance with facility policies and NFPA 101.</p> <p>All resident has the potential to be affected by this practice.</p> <p>The maintenance /Safety director have been educated regarding the deficient practice and applicable NFPA standards on 02/25/2020.</p> <p>Staff were educated regarding the deficient practice and the importance of taking resident in the designated smoking area.</p> <p>Maintenance/Safety Director removed the makeshift ashtray outside the back exit and had cleared the snow that is covering benches for both Hemingway and Galen buildings.</p>	

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K 741	<p>Continued From page 14</p> <p>chairs placed at the back of the building with two (2) cigarette butts placed on the brick facade ledge of the back door. Additionally, fresh ashes and char marks were observed at the base of each of the chairs.</p> <p>Asked at the time of this observation if the residents and staff were using the designated smoking area provided, the Maintenance Engineer stated he was unsure if the smoking area was being used.</p> <p>2) During the facility tour conducted on 2/4/20 from 11:00 AM to 3:00 PM, observation of the smoking area at the Hemmingway building revealed the area had approximately eighteen inches of snow covering all benches inside the space. Further observation did not reveal an ABC fire extinguisher, trash can with a self-closing lid, or a fire blanket was provided.</p> <p>Observation of the back door to exiting to the designated smoking area revealed two (2) chairs at the back of the building. Further observation of the base of the door revealed a make-shift ashtray that was comprised of the overhang can light shielding that had fallen out and a plastic cup.</p> <p>Asked at the time of this observation if he was aware of the use of non-compliant materials as an ashtray, the Maintenance Engineer stated he was not aware residents and staff were using the can light shield as an ashtray.</p> <p>3) During review of provided smoking policies conducted on 2/4/20 from 2:45 - 3:00 PM, policy referenced a designated smoking area that was to be equipped with a ABC fire extinguisher, fire</p>	K 741	<p>An ABC fire extinguisher, trash can with self-closing lid and a fire blanket had been ordered for both Galena and Hemingway building and should all be in the facility on or before 3/31/2020.</p> <p>Maintenance/Safety Director will ensure that snow was cleared above benches as soon as possible and cleared the pathway toward the designated smoking area every after snowstorm.</p> <p>Maintenance/Safety Director will do monthly inspection to ensure ABC fire extinguisher, trash can with self-closing lid and a fire blanket are in place and in good working order. A random inspection will be done Monthly X 6 by the Administrator to ensure compliance.</p>	

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K 741	Continued From page 15 blanket and ashtrays meeting the Life Safety Code requirements (Item 4 and 10 a-c) Actual NFPA standard: 19.7.4* Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or individual enclosed space where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 19.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.	K 741			
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial	K 914		3/31/20	

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K 914	<p>Continued From page 16</p> <p>installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results.</p> <p>6.3.4 (NFPA 99)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure facility electrical receptacles were maintained in accordance with NFPA 99. Failure to inspect and test resident care area electrical receptacles annually has the potential to hinder system response during an emergency that encompasses a loss of power. This deficient practice affected 30 residents and staff on the date of the survey.</p> <p>Findings include:</p> <p>During review of provided maintenance documents conducted on 2/4/20 from 8:45 - 11:00 AM, no documentation was available demonstrating annual outlet testing had been conducted.</p> <p>When interviewed on 2/4/20 at approximately</p>	K 914	<p>K 914 ELECTRICAL SYSTEMS - MAINTENANCE AND TESTING</p> <p>Facility will ensure that receptacles were maintained in accordance with NFPA 99.</p> <p>All resident has the potential to be affected by this practice.</p> <p>The maintenance /Safety director have been educated regarding the deficient practice and applicable NFPA standards on 02/25/2020.</p> <p>Maintenance/Safety Director inspected and tested all resident care area electrical receptacles on 02/25/2020.</p> <p>Maintenance/Safety Director will ensure that all resident care area electrical receptacles are inspected and tested annually. A record audit and inspection will be done annually by the Administrator to ensure compliance.</p> <p>Please see exhibit E for annual testing record.</p>		

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K 914	<p>Continued From page 17</p> <p>10:30 AM, the Maintenance Engineer stated he had not yet completed the outlet testing for resident care areas.</p> <p>Actual NFPA standard:</p> <p>NFPA 99 Chapter 6 Electrical Systems</p> <p>6.3.3.2 Receptacle Testing in Patient Care Rooms.</p> <p>6.3.3.2.1 The physical integrity of each receptacle shall be confirmed by visual inspection.</p> <p>6.3.3.2.2 The continuity of the grounding circuit in each electrical receptacle shall be verified.</p> <p>6.3.3.2.3 Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed.</p> <p>6.3.3.2.4 The retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 g (4 oz).</p> <p>6.3.4.1 Maintenance and Testing of Electrical System.</p> <p>6.3.4.1.1 Where hospital-grade receptacles are required at patient bed locations and in locations where deep sedation or general anesthesia is administered, testing shall be performed after initial installation, replacement, or servicing of the device.</p> <p>6.3.4.1.2 Additional testing of receptacles in patient care rooms shall be performed at intervals defined by documented performance data.</p> <p>6.3.4.1.3 Receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general</p>	K 914			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135069	(X2) MULTIPLE CONSTRUCTION A. BUILDING 04 - ENTIRE STRUCTURE B. WING _____		(X3) DATE SURVEY COMPLETED 02/04/2020
NAME OF PROVIDER OR SUPPLIER BELL MOUNTAIN VILLAGE & CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 620 NORTH SIXTH STREET BELLEVUE, ID 83313		
(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 914	Continued From page 18 anesthesia is administered, shall be tested at intervals not exceeding 12 months.	K 914			
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to 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. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA	K 918	K 918 ELECTRICAL SYSTEMS - ESSENTIAL ELECTRIC SYSTEM Facility will ensure the Emergency Power Supply System (EPSS) generator was maintained in accordance with NFPA 110. All resident has the potential to be affected by this practice. The maintenance /Safety director have been educated regarding the deficient practice and applicable NFPA standards on 02/25/2020. Testing and inspection were scheduled with vendor to include performing a four-hour load testing on the EPSS generator set and scheduled to be done on or before 03/31/2020. Maintenance/Safety Director will ensure that a four-hour load test on the EPSS generator sets are done at least once every 36 months. A record audit will be done annually by the Administrator to ensure compliance.	<i>3/31/20</i>	

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

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K 918	<p>Continued From page 19 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Emergency Power Supply System (EPSS) generator was maintained in accordance with NFPA 110. Failure to perform required maintenance and testing of emergency generators has the potential to hinder system performance during emergencies such as a loss of power. This deficient practice affected 30 residents and staff on the date of the survey.</p> <p>Findings include:</p> <p>During the review of provided EPSS generator maintenance and inspection records conducted on 2/4/20 from 8:45 - 11:00 AM, no records were available indicating the facility had performed a four-hour load test on the EPSS generator set. When asked at approximately 10:30 AM about the missing load test documentation, the Maintenance Engineer stated he was not aware of the missing documentation and had thought the test was completed by the vendor prior to the survey date.</p> <p>Actual NFPA standard:</p> <p>NFPA 110</p> <p>Chapter 8 Routine Maintenance and Operational Testing</p> <p>8.4.9* Level 1 EPSS shall be tested at least once within every 36 months. 8.4.9.1 Level 1 EPSS shall be tested continuously for the duration of its assigned class (see Section 4.2).</p>	K 918			

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K 918	Continued From page 20 8.4.9.2 Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 continuous hours.	K 918	K 923 GAS EQUIPMENT – CYLINDER AND CONTAINER STORAGE		
K 923 SS=D	Gas Equipment - Cylinder and Container Storage CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure	K 923	Facility will ensure that medical gas cylinders such as oxygen were secured by a chain or a rack. All resident has the potential to be affected by this practice. The maintenance /Safety director have been educated regarding the deficient practice and applicable NFPA standards on 02/25/2020. The maintenance /Safety director had secured the 2 liquid oxygen cylinders by a chain. The "E" cylinder from the dietary manager's office was removed and stored and secured in the maintenance. Maintenance/Safety Director will do monthly oxygen room inspection ensure that all medical gas cylinders such as oxygen were secured by a chain or a rack. A random inspection will be done monthly X 6 by the Administrator to ensure compliance.	2/31/20	

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K 923	<p>Continued From page 21</p> <p>considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, the facility failed to ensure medical gas storage was in accordance with NFPA 99. Failure to secure medical gas cylinders such as oxygen has the potential to increase the exposure to fires and explosions associated with the unsafe handling of medical gases. This deficient practice affected staff on the date of the survey.</p> <p>During the facility tour conducted on 2/4/20 from 11:00 AM - 3:00 PM, observation of the oxygen storage and transfill area located on the south side of the Hemmingway building, revealed two (2) liquid oxygen cylinders were not secured by a chain or a rack. Further observation of the Galena building Dietary Manager's office, revealed an "E" cylinder, unsecured by rack, cart or chain.</p> <p>Interview at approximately 1:45 PM of the Maintenance Engineer about the unsecured cylinders, established he was unaware of the cylinders being unsecured prior to the date of the survey.</p> <p>NFPA 99</p> <p>5.1.3.3.2* Design and Construction. Locations for central supply systems and the storage of positive-pressure gases shall meet the following requirements: (1) They shall be constructed with access to move cylinders, equipment, and so forth, in and</p>	K 923		

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K 923	Continued From page 22 out of the location on hand trucks complying with 11.4.3.1.1. (2) They shall be secured with lockable doors or gates or otherwise secured. (3) If outdoors, they shall be provided with an enclosure (wall or fencing) constructed of noncombustible materials with a minimum of two entry/exits. (4) If indoors, they shall be constructed and use interior finishes of noncombustible or limited-combustible materials such that all walls, floors, ceilings, and doors are of a minimum 1-hour fire resistance rating. (5)*They shall be compliant with NFPA 70, National Electrical Code, for ordinary locations. (6) They shall be heated by indirect means (e.g., steam, hot water) if heat is required. (7) They shall be provided with racks, chains, or other fastenings to secure all cylinders from falling, whether connected, unconnected, full, or empty. (8)*They shall be supplied with electrical power compliant with the requirements for essential electrical systems as described in Chapter 6. (9) They shall have racks, shelves, and supports, where provided, constructed of noncombustible materials or limited-combustible materials. (10) They shall protect electrical devices from physical damage.	K 923			
K 927 SS=E	Gas Equipment - Transfilling Cylinders CFR(s): NFPA 101 Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care	K 927	K 927 GAS EQUIPMENT – TRANSFILLING CYLINDER Facility will ensure that medical gas storage and operations, such as transfilling, were provided with sufficient mechanical ventilation for transfilling operations along with self-closing door.	8/31/20	

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K 927	<p>Continued From page 23</p> <p>rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure medical gas storage and operations, such as transfilling, were in accordance with NFPA 99. Failure to provide sufficient mechanical ventilation for transfilling operations along with the required self-closing door, has the potential to increase the exposure to fires and explosions associated with the unsafe handling of medical gases. This deficient practice affected staff on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 2/4/20 from 11:00 AM - 3:00 PM, observation and operational testing of the door entering the oxygen transfill and storage area, abutting the south side wall of the Kitchen in the Hemmingway building, revealed the double doors were not equipped to self-close. Further observation revealed this space was not equipped with mechanical ventilation.</p> <p>Interview of the Maintenance Engineer at approximately 2:00 PM, established he was not aware mechanical ventilation was not provided and that the doors entering this space were required to self-close.</p> <p>Actual NFPA standard:</p>	K 927	<p>All resident has the potential to be affected by this practice.</p> <p>The maintenance /Safety director have been educated regarding the deficient practice and applicable NFPA standards on 02/25/2020.</p> <p>The maintenance /Safety director had turned the switch on for the mechanical ventilation in the oxygen storage and transfilling room on 02/25/2020.</p> <p>The maintenance /Safety director had installed a self-closing device on the door on 03/04/2020</p> <p>Maintenance/Safety Director will do monthly oxygen room inspection ensure that the mechanical ventilation in the oxygen storage and transfilling room is always on and the self-closing door device is in good working order. A random inspection will be done Monthly X 6 by the Administrator to ensure compliance.</p>	

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K 927	Continued From page 24 NFPA 99 11.5.2.3 Transfilling Liquid Oxygen. Transfilling of liquid oxygen shall comply with 11.5.2.3.1 or 11.5.2.3.2, as applicable. 11.5.2.3.1 Transfilling to liquid oxygen base reservoir containers or to liquid oxygen portable containers over 344.74 kPa (50 psi) shall include the following: (1) A designated area separated from any portion of a facility wherein patients are housed, examined, or treated by a fire barrier of 1 hour fire-resistive construction. (2) The area is mechanically ventilated, is sprinklered, and has ceramic or concrete flooring. (3) The area is posted with signs indicating that transfilling is occurring and that smoking in the immediate area is not permitted. (4) The individual transfilling the container(s) has been properly trained in the transfilling procedures. 9.3.7.5.3.2 Mechanical exhaust shall be at a rate of 1 L/sec of airflow for each 300 L (1 cfm per 5 ft3 of fluid) designed to be stored in the space and not less than 24 L/sec (50 cfm) nor more than 235 L/sec (500 cfm).	K 927			

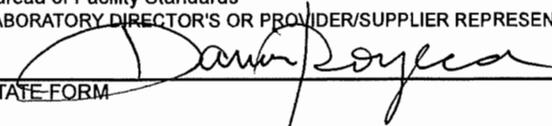
Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001050	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 03 - ENTIRE STRUCTURE B. WING _____	(X3) DATE SURVEY COMPLETED 02/04/2020
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NAME OF PROVIDER OR SUPPLIER BELL MOUNTAIN VILLAGE & CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 620 NORTH SIXTH STREET BELLEVUE, ID 83313
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C 260	<p>02.106.07,h Weekly Cleaning of Range Hoods/Filters</p> <p>h. All range hoods and filters shall be cleaned at least weekly. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure grease filters for range hoods were cleaned at least weekly. Failure to provide weekly cleaning of range hood grease filters has the potential for an excessive build-up in grease, resulting in grease fires in the hood system. This deficient practice affected staff on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 2/4/20 from 11:00 AM - 3:00 PM, observation of both building's kitchens failed to reveal any posted cleaning schedule of the grease filters in the hood system. Interview of the Dietary Manager and the cook on duty established the filters were cleaned bi-weekly and not weekly as required.</p> <p>Actual IDAPA standard:</p> <p>16.03.02.106.07(h) h. All range hoods and filters shall be cleaned at least weekly.</p> <p style="text-align: center;">RECEIVED MAR -5 2020 FACILITY STANDARDS</p>	C 260	<p>This facility will ensure all range hoods and filters were cleaned at least weekly.</p> <p>All resident has the potential to be affected by this practice</p> <p>Staff were educated regarding the deficient practice and regarding the importance of cleaning grease filters for range hoods on 2/14/2020.</p> <p>The maintenance /Safety Director had been educated by the Administrator regarding deficient practice and applicable NFPA standards on 02/25/2020.</p> <p>Grease filters for range hoods for both Galena and Hemingway building were cleaned and recorded on 03/04/2020.</p> <p>Dietary Manager or Designee will ensure Grease filters for range hoods for both Galena and Hemingway building were cleaned and recorded weekly.</p> <p>Dietary Manager or Designee will do a monthly X 6 record audits to ensure compliance.</p>	
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Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <i>Administrator</i>	(X6) DATE <i>03/04/2020</i>
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IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – 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

February 13, 2020

Darwin Royeca, Administrator
Bell Mountain Village & Care Center
620 N. 6th St.
Bellevue, ID 83313-5174

Provider #: 135069

RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER

Dear Mr. Royeca:

On **February 4, 2020**, an Emergency Preparedness survey was conducted at **Bell Mountain Village & Care Center** 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.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **February 26, 2020**. Failure to submit an acceptable PoC by **February 26, 2020**, may result in the imposition of civil monetary penalties by **March 19, 2020**.

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 **March 10, 2020**, (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 **March 29, 2020**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **March 10, 2020**, includes the following:

Denial of payment for new admissions effective **May 4, 2020**.
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 **August 4, 2020**, 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 **February 4, 2020**, 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)

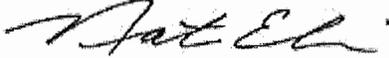
2001-10 Long Term Care Informal Dispute Resolution Process
2001-10 IDR Request Form

Darwin Royeca, Administrator
February 13, 2020
Page 4 of 4

This request must be received by **February 26, 2020**. If your request for informal dispute resolution is received after **February 26, 2020**, 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

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NAME OF PROVIDER OR SUPPLIER BELL MOUNTAIN VILLAGE & CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 620 NORTH SIXTH STREET BELLEVUE, ID 83313
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E 000	Initial Comments The facility is comprised of two (2) 16-bed SNF/NF pods, originally constructed in 2015. The two primary pods house residential sleeping rooms, and ancillary services with physical therapy housed in the Administration building. The property is located within a county fire district, with both state and federal EMS services available. The therapy section that supports the SNF/NF is further separated to the Assisted Living by two-hour construction. All buildings are type II (111) construction equipped with automatic sprinkler protection and an interconnected fire alarm/smoke detection system. Each building is provided a separate, on-site Emergency Power Supply System (EPSS) diesel-fired generator. The facility is licensed for 32 SNF/NF beds, and had a census of 30 on the date of the survey. The following deficiencies were cited during the annual emergency preparedness survey conducted on February 4, 2020. 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 & Construction	E 000		
E 004 SS=E	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive	E 004		

RECEIVED
MAR -5 2020
FACILITY STANDARDS

3/31/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Dawn Royce* TITLE: Administrator (X6) DATE: 03/04/2020

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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NAME OF PROVIDER OR SUPPLIER BELL MOUNTAIN VILLAGE & CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 620 NORTH SIXTH STREET BELLEVUE, ID 83313		
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E 004	<p>Continued From page 1</p> <p>emergency preparedness program that meets the requirements of this section.</p> <p>The emergency preparedness program must include, but not be limited to, the following elements:</p> <p>(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following:</p> <p>* [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.</p> <p>* [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed and updated at least annually.</p> <p>* [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, the facility failed to demonstrate the Emergency Plan (EP) had been reviewed and updated annually. Failure to review the EP annually to ensure it is relevant to</p>	E 004	<p>SPECIFIC ISSUE:</p> <p>The Cove of Cascadia's Emergency Management Plan was reviewed and updated on or before March 10, 2020 by facility QAPI committee and community emergency personnel to include current and comprehensive policy and procedures and updated geographic, site-specific all-hazards risk assessment. See also: E 0006, E 0007, E 0013, E 0024, E 0031, E 0035, E 0041,</p> <p>OTHER RESIDENTS:</p> <p>All residents are potentially affected by deficient practice.</p> <p>SYSTEMIC CHANGES:</p> <p>Staff educated on or before 03/10/2020 by Administrator or designee regarding updated facility emergency management plan.</p>		

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E 004	Continued From page 2 identified facility risks, has the potential to provide information not relevant to the facility procedures and hinder staff emergency response and training during a disaster. This deficient practice affected 30 residents, staff and visitors on the date of the survey. Findings include: During review of the provided EP conducted on 2/4/20 from 8:45 - 11:00 AM, documentation failed to demonstrate the plan was reviewed to ensure continuity of the information provided was relevant to the facility risks and geographic location, but established it provided multiple references to another facility not located within the same county or geographically relevant risk area. Reference: 42 CFR 483.73 (a)	E 004	MONITOR: Upon completion of initial education with staff, Administrator or designee will monitor the effectiveness of the emergency management plan through staff interview and provide outcomes to QAPI committee on a monthly basis. Additional education will be provided as necessary. Plan to be updated as indicated.		
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 every 2 years. 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.* (2) Include strategies for addressing emergency events identified by the risk assessment. *[For LTC facilities at §483.73(a)(1):] Emergency Plan. The LTC facility must develop and maintain	E 006		3/31/20	

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E 006	<p>Continued From page 3</p> <p>an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:</p> <p>(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>(2) Include strategies for addressing emergency events identified by the risk assessment.</p> <p>*[For ICF/IIDs at §483.475(a)(1):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:</p> <p>(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):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:</p> <p>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.</p> <p>(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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility</p>	E 006	<p>SPECIFIC ISSUE:</p> <p>The Cove of Cascadia's all hazard risk assessment was reviewed and updated on or before March 10, 2020 by facility QAPI committee and community emergency personnel to include but not limited to community based risk assessment with local empirical data for the community based component, current and comprehensive policy and procedures and updated site-specific all-hazards risk assessment.</p> <p>OTHER RESIDENTS:</p> <p>All residents are potentially affected by deficient practice.</p> <p>SYSTEMIC CHANGES:</p> <p>Staff educated on or before 3/10/2020 by Administrator or designee regarding updated all-hazard risk assessment.</p>		

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E 006	Continued From page 4 failed to develop a Hazard Vulnerability Analysis (HVA) for the EP plan that considered a community based risk assessment such as a county all-hazard mitigation plan and known geographically relevant risks such as wildfire or avalanches. Failure to consider available county hazard mitigation data when developing the facility EP HVA and relevant policies and procedures, has the potential to hinder training and response of staff, by not fully addressing known hazards of the area as identified by county EMS. This deficient practice affected 30 residents, staff and visitors on the date of the survey. Findings include: During review of provided EP documentation conducted on 2/4/20 from 8:45 - 11:00 AM, documentation provided revealed the plan did not include documented information as defined under the county all-hazard mitigation plan, or a copy of the county plan. At approximately 11:15 AM, the Administrator was asked if the facility had a copy of the county plan, or if it was used when developing the HVA. The Administrator stated he was unaware if it was consulted and that the assessment was completed internally through facility management and staff. Further review of the facility HVA established two (2) high-hazard risks, both wildfire and avalanche, documented by the county to the facility location, had not been identified or addressed in the HVA. Reference: 42 CFR 483.73 (a) (1) - (2)	E 006	MONITOR: Upon completion of initial education with staff, Administrator or designee will monitor the effectiveness of the emergency management plan through staff interview and provide outcomes to QAPI committee on a monthly basis. Additional education will be provided as necessary. Plan to be updated as indicated.		
E 007	EP Program Patient Population	E 007			

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E 007 SS=D	<p>Continued From page 5 CFR(s): 483.73(a)(3)</p> <p>[(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:]</p> <p>(3) Address [patient/client] population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.**</p> <p>*[For LTC facilities at §483.73(a)(3):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually.</p> <p>(3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.</p> <p>*NOTE: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the facility failed to provide an emergency plan, policies and procedures which addressed the types of services the facility has the ability to provide during an emergency. Failure to address the types of services the facility has the ability to provide, has the potential to hinder continuity of care and emergency management response during an emergency. This deficient practice</p>	E 007	<p>SPECIFIC ISSUE: The Cove of Cascadia's Emergency Management Plan was reviewed and updated on or before March 10, 2020 by facility QAPI committee and community emergency personnel to address resident population including persons at risk, staff succession planning, and facilities ability to provide in an emergency.</p> <p>OTHER RESIDENTS: All residents are potentially affected by deficient practice.</p> <p>SYSTEMIC CHANGES: Staff educated on or before 3/10/2020 by Administrator or designee regarding facilities resident population including persons at risk, staff succession planning, and facilities ability to provide in an emergency.</p>	3/31/20
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E 007	Continued From page 6 affected 30 residents, staff and visitors on the date of the survey. Findings include: On 2/4/20 from 8:45 - 11:00 AM, review of provided emergency plan, policies and procedures, revealed the plan failed to define what types of services the facility had the ability to provide during an emergency. Reference: 42 CFR 483.73 (a) (3)	E 007	MONITOR: Upon completion of initial education with staff, Administrator or designee will monitor the effectiveness of the emergency management plan through staff interview and provide outcomes to QAPI committee on a monthly basis. Additional education will be provided as necessary. Plan to be updated as indicated.		
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 every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC 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. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies	E 013	SPECIFIC ISSUE: The Cove of Cascadia's Emergency Management Plan was reviewed and updated on or before March 10, 2020 by facility QAPI committee and community emergency personnel to include updated and site-specific policy and procedures for all identified areas of the facility risk assessment and communication.	3/21/20	

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E 013	<p>Continued From page 7</p> <p>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 every 2 years. 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:</p> <p>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 30 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>On 2/4/20 from 8:45 - 11:00 AM, review of the provided emergency plan, policies and procedures, revealed the facility HVA did not utilize and consider the county all-hazard mitigation plan and known, identified risks such as wildfire or avalanches, when developing the policies and procedures, only using information generated from internal staff management discussions.</p> <p>Reference: 42 CFR 483.73 (b)</p>	E 013	<p>OTHER RESIDENTS: All residents are potentially affected by deficient practice.</p> <p>SYSTEMIC CHANGES: Staff educated on or before 3/10/2020 by Administrator or designee regarding facilities updated policies per the facility assessment and communications plan.</p> <p>MONITOR: Upon completion of initial education with staff, Executive Director or designee will monitor the effectiveness of the emergency management plan through staff interview and provide outcomes to QAPI committee on a monthly basis. Additional education will be provided as necessary. Plan to be updated as indicated.</p>	

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E 024 E 024 SS=D	Continued From page 8 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 every 2 years (annually for LTC).] 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 needs during an emergency. This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the facility failed to develop relevant policies and procedures which address the use of volunteers on site during an emergency. Failure to address	E 024 E 024	SPECIFIC ISSUE: The Cove of Cascadia's Emergency Management Plan was reviewed and updated on or before March 10, 2020 by facility QAPI committee and community emergency personnel to include updated and site-specific policy and procedures to include facility Volunteers and Staffing. OTHER RESIDENTS: All residents are potentially affected by deficient practice. SYSTEMIC CHANGES: Staff educated on or before 3/10/2020 by Administrator or designee regarding facilities updated policies regarding facility Volunteers and Staffing.	3/31/20	

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E 024	Continued From page 9 the use of volunteers in facility policies and procedures, potentially hinders the ability to provide continuity of care during a disaster. This deficient practice affected 30 residents, staff and visitors on the date of the survey. Findings include: Review of provided EP policies and procedures conducted on 2/4/20 from 8:45 - 11:00 AM, revealed the policy included was for another facility that was not located in the same county or within the same geographic risk area. Reference: 42 CFR 483.73 (b) (6)	E 024	MONITOR: Upon completion of initial education with staff, Administrator or designee will monitor the effectiveness of the emergency management plan through staff interview and provide outcomes to QAPI committee on a monthly basis. Additional education will be provided as necessary. Plan to be updated as indicated.		
E 031 SS=D	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 every 2 years (annually for LTC).] 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: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care	E 031	SPECIFIC ISSUE: The Cove of Cascadia's Emergency Management Plan was reviewed and updated on or before March 10, 2020 by facility QAPI committee and community emergency personnel to include updated and site-specific policy and procedures to include updated Emergency Officials Contact Information. OTHER RESIDENTS: All residents are potentially affected by deficient practice.	3/31/20	

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E 031	Continued From page 10 Ombudsman. (iv) Other sources of assistance. *[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 the EP had a communication plan that provided contact information for emergency management officials and other resources of assistance. Failure to provide contact information for state ombudsman and other sources of assistance, has the potential to hinder facility response and continuity of care for the 30 residents, staff and visitors in the facility on the date of the survey. Findings include: On 2/4/20 from 8:45 - 11:00 AM, review of the provided EP, failed to establish a communication plan was included that provided contact information for the state ombudsman. Reference: 42 CFR 483.73 (c) (2) LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8)	E 031	SYSTEMIC CHANGES: Staff educated on or before 3/10/2020 by Administrator or designee regarding updated Emergency Officials Contact Information MONITOR: Upon completion of initial education with staff, Administrator or designee will monitor the effectiveness of the emergency management plan through staff interview and provide outcomes to QAPI committee on a monthly basis. Additional education will be provided as necessary. Plan to be updated as indicated.		
E 035 SS=E		E 035			
	*[For ICF/IIDs at §483.475(c):] [(c) The ICF/IID				

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: 135069	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/04/2020
NAME OF PROVIDER OR SUPPLIER BELL MOUNTAIN VILLAGE & CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 620 NORTH SIXTH STREET BELLEVUE, ID 83313		
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E 035	<p>Continued From page 11</p> <p>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 every 2 years.] The communication plan must include all of the following:</p> <p>*[For LTC Facilities at §483.73(c):] [(c) The LTC 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:</p> <p>(8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, it was determined the facility failed to demonstrate the method or procedure of sharing information on the contents of the emergency plan with residents, families, or representatives. Failure to share the emergency plan contents with residents, families, or representatives, has the potential to create confusion and lack of understanding of the facility's response procedures during a disaster. This deficient practice potentially affected 30 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During review of the provided EP, policies and procedures conducted on 2/4/20 from 8:45 - 11:00 AM, no documentation was available</p>	E 035	<p>SPECIFIC ISSUE:</p> <p>The Cove of Cascadia's emergency management plan will be posted and available for all visitors and residents to review on or before March 10, 2020. Additionally, emergency plan will be discussed upon admission with all new residents and their advocates. Emergency management plan will be discussed ongoing with residents during resident council and education provided as needed.</p> <p>OTHER RESIDENTS:</p> <p>All residents are potentially affected by deficient practice.</p> <p>SYSTEMIC CHANGES:</p> <p>Staff educated on or before 3/10/2020 by Administrator or designee regarding communication of the emergency management plan to visitors and residents.</p>	3/21/20

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E 041	<p>Continued From page 13</p> <p>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.</p> <p>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 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. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org,</p>	E 041	<p>E 041 – HOSPITAL CAH and LTC EMERGENCY POWER</p> <p>Facility will ensure the Emergency and standby Power System was maintained and available to provide subsistence as required under the rule.</p> <p>All resident has the potential to be affected by this practice.</p> <p>The maintenance /Safety director have been educated regarding the deficient practice and applicable NFPA standards on 02/25/2020.</p> <p>Testing and inspection were scheduled with vendor to include performing a four-hour load testing on the EPSS generator set and scheduled to be done on or before 03/31/2020.</p> <p>Maintenance/Safety Director will ensure that a four-hour load test on the EPSS generator sets are done at least once every 36 months. A record audit will be done annually by the Administrator to ensure compliance.</p>	3/31/20	

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E 041	<p>Continued From page 14 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, 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 and standby power systems were maintained and available to provide subsistence as required under the rule. Failure to ensure emergency generators are maintained and tested in accordance with NFPA 99 and NFPA 110, potentially hinders the facility's ability to provide continuity of care during an emergency to the 30 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During review of the EES generator maintenance and testing logs conducted on 2/4/20 from 8:45 -</p>	E 041			

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E 041	Continued From page 15 11:00 AM, documentation failed to show a 4-hour load test was performed in the past three years. Interview of the Maintenance Engineer at approximately 10:45 AM established he was not aware of the load test having been conducted. Reference: 42 CFR 483.73 (e) (1)	E 041			