



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

March 15, 2019

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 **March 6, 2019**, 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

Darwin Royeca, Administrator  
March 15, 2019  
Page 2 of 4

you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office. If a State Form with deficiencies was issued, it should be signed, dated and returned along with the CMS-2567 Form.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **March 28, 2019**. Failure to submit an acceptable PoC by **March 28, 2019**, may result in the imposition of civil monetary penalties by **April 19, 2019**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.
- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567. If a State Form was issued as well, it should also be signed, dated and returned.

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

Remedies may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **April 10, 2019**, (Opportunity to Correct). Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **June 4, 2019**. A change in the seriousness of the deficiencies on **April 20, 2019**, may result in a change in the remedy.

Darwin Royeca, Administrator  
March 15, 2019  
Page 3 of 4

The remedy, which will be recommended if substantial compliance has not been achieved by **April 10, 2019**, includes the following:

Denial of payment for new admissions effective **June 6, 2019**.  
42 CFR §488.417(a)

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **September 6, 2019**, if substantial compliance is not achieved by that time.

**Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.**

If you believe these deficiencies have been corrected, you may contact Nate Elkins, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, option 3; Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **March 6, 2019**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

Darwin Royeca, Administrator  
March 15, 2019  
Page 4 of 4

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

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

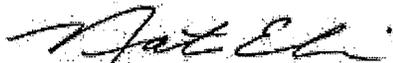
BFS Letters (06/30/11)

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

This request must be received by **March 28, 2019**. If your request for informal dispute resolution is received after **March 28, 2019**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, 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: 03/15/2019  
FORM APPROVED  
OMB NO. 0938-0391

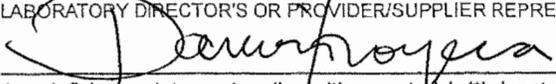
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135069	(X2) MULTIPLE CONSTRUCTION A. BUILDING 04 - ENTIRE STRUCTURE  B. WING _____	(X3) DATE SURVEY COMPLETED  03/06/2019
--	--	--	--

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 000	<p>INITIAL COMMENTS</p> <p>The facility is comprised of two (2) SNF/NF small house model buildings, identical in design. Construction of the two SNF/NF buildings was completed in January 2015. The buildings are defined as buildings Galena and Hemmingway which house residential sleeping rooms. Building Edelweiss houses the physical therapy occupancy which serves the SNF/NF residents, administrative offices and an assisted living facility separated by two-hour construction. All buildings are type II (000) construction equipped with automatic sprinkler protection, corridor smoke detection. Type 2 Emergency Electrical Systems with automatic transfer switching is provided for building Galena and Hemmingway. Building Edelweiss EES provides emergency power for the Assisted Living, Physical Therapy and Administrative offices. Both buildings A and C have commercial kitchens which are separated by one-hour construction. The facility is licensed for 32 SNF/NF beds, and had a census of 29 on the date of the survey.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on March 6, 2019. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.</p> <p>The Survey was conducted by:</p> <p>Linda Chaney Health Facility Surveyor Facility Fire Safety and Construction</p>	K 000		
K 211 SS=F	<p>Means of Egress - General CFR(s): NFPA 101</p>	K 211		4/1/19

**RECEIVED**  
**MAR 29 2019**  
**FACILITY STANDARDS**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 3/27/19
---	------------------------	----------------------

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.

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

PRINTED: 03/15/2019  
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  03/06/2019
--	--	--	--

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 211	<p>Continued From page 1</p> <p>Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure exits were maintained in accordance with NFPA 101, free of obstructions for full use at all times. Failure to maintain means of egress free of obstruction has the potential to hinder evacuation of residents during an emergency. This deficient practice affected 29 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour on March 6, 2019, from approximately 12:00 PM to 1:30 PM, observation of the back, side and kitchen exits and sidewalks at both buildings revealed an accumulation of snow and ice ranging in depth from 2 to 14 inches. Snow and ice were blocking the exit doors and path of egress to the public way from full, instant access. When asked, the Maintenance Director stated the facility had kept all exits and paths of egress clear of snow all winter. On the day of survey, the Maintenance Director stated he was unable to clear the snow due to being in Boise on an errand for the facility.</p> <p>Actual NFPA standard:</p>	K 211	<p><b>K 211 MEANS OF EGRESS - GENERAL</b></p> <p>This facility will ensure that exits are maintained in accordance with NFPA 101, free of obstructions for full use at all times.</p> <p>All residents have the potential to be affected by this practice</p> <p>On March 8, 2019 Facility maintenance director cleared all obstructions of ice and snow in the back, sides, kitchen exits and sidewalks in both buildings.</p> <p>Maintenance Director will ensure that all exits were maintained and free of obstructions at all times and ensure that accumulated snow and ice were removed from the back, sides, kitchen exits and sidewalks in both buildings every after snow storms.</p> <p>If facility experiences heavy and constant snow storms, facility will hire additional help for snow removal.</p> <p>Maintenance Director will document snow removal. Documentation audit and facility rounds will be done by the Administrator or designee to ensure compliance.</p>	
-------	---	-------	---	--

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

PRINTED: 03/15/2019  
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  03/06/2019	
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 211	Continued From page 2 NFPA 101 19.2 Means of Egress Requirements. 19.2.1 General. Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7, unless otherwise modified by 19.2.2 through 19.2.11.  7.1.10 Means of Egress Reliability. 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K 211	Please see exhibit A	
K 222 SS=F	Egress Doors CFR(s): NFPA 101  Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: <b>CLINICAL NEEDS OR SECURITY THREAT LOCKING</b> Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 <b>SPECIAL NEEDS LOCKING ARRANGEMENTS</b> Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release	K 222	<b>K 222 EGRESS DOORS</b>  The facility will ensure that the back-exit door in the Galena Building is working and operational.  All residents in the Galena Building have the potential to be affected by this practice.  The maintenance /Safety director has been educated regarding the deficient practice.  The key pad override was tested by the Administrator and Maintenance Director and is now working.  Staff were in-service on the right key pad code number to release the magnetic lock.	4/1/19



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  03/06/2019
--	--	--	--

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 222	<p>Continued From page 4</p> <p>NFPA 101. Failure to provide operational delayed egress locking arrangements for magnetically controlled means of egress could hinder the safe evacuation of residents during a fire or other emergency. This deficient practice affected 14 residents, staff and visitors in the Galena building on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour on March 6, 2019, from approximately 12:00 PM to 1:30 PM, operational testing of the back-exit door in the Galena building, revealed the magnetic locking arrangement would not initiate the irreversible process to release the locking mechanism. Upon evaluating the key pad override it was determined the component was not operational. The Maintenance Director stated the facility was not aware the magnetic lock was not operating as designed.</p> <p>Actual NFPA standard:</p> <p>7.2.1.6* Special Locking Arrangements. 7.2.1.6.1 Delayed-Egress Locking Systems. 7.2.1.6.1.1 Approved, listed, delayed-egress locking systems shall be permitted to be installed on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6 or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 11 through 43, provided that all of the following criteria are met: (1) The door leaves shall unlock in the direction of egress upon actuation of one of the following: (a) Approved, supervised automatic sprinkler</p>	K 222		
-------	---	-------	--	--

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

PRINTED: 03/15/2019  
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  03/06/2019
--	--	--	--

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 222	<p>Continued From page 5</p> <p>system in accordance with Section 9.7</p> <p>(b) Not more than one heat detector of an approved, supervised automatic fire detection system in accordance with Section 9.6</p> <p>(c) Not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6</p> <p>(2) The door leaves shall unlock in the direction of egress upon loss of power controlling the lock or locking mechanism.</p> <p>(3)*An irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions:</p> <p>(a) The force shall not be required to exceed 15 lbf (67 N).</p> <p>(b) The force shall not be required to be continuously applied for more than 3 seconds.</p> <p>(c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening.</p> <p>(d) Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only.</p> <p>(4)*A readily visible, durable sign in letters not less than 1 in. (25 mm) high and not less than 1/8 in. (3.2 mm) in stroke width on a contrasting background that reads as follows shall be located on the door leaf adjacent to the release device in the direction of egress: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS</p> <p>(5) The egress side of doors equipped with delayed-egress locks shall be provided with emergency lighting in accordance with Section 7.9.</p>	K 222		
-------	---	-------	--	--

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

PRINTED: 03/15/2019  
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  03/06/2019
--	--	--	--

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 324 K 324 SS=D	Continued From page 6 Cooking Facilities CFR(s): NFPA 101  Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2  This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to maintain the fire suppression system for the kitchen hood in accordance with NFPA 96. Failure to maintain Kitchen hood suppression systems could result in a lack of system performance, allowing fires to grow outside the protected area. This deficient practice affected staff and visitors in the kitchen on the date of the	K 324 K 324	<b>K 324 COOKING FACILITIES</b>  Facility will ensure to maintain the fire suppression system for the kitchen hood in accordance with NFPA 96.  All residents have the potential to be affected by this practice.  The maintenance /Safety director has been educated regarding the deficient practice.  Kitchen hood suppression systems were inspected on January 2019 and is now on a Semi-annual inspection schedule by the facility service provider.  Maintenance/Safety Director will ensure that all kitchen hoods are serviced semi-annually. A random record audit will be done by the Administrator to ensure compliance.	4/1/19
------------------------	---	----------------	--	--------

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

PRINTED: 03/15/2019  
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  03/06/2019
--	--	--	--

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 324 Continued From page 7 survey.  
Findings include:  
During document review on March 6, 2019, from approximately 8:30 AM to 12:00 PM, inspection records revealed the kitchen hood suppression systems in both buildings were not inspected during the last six months of 2018. Kitchen hood suppression systems were due for inspection in July of 2018 but were not inspected until January of 2019. Interview of the Maintenance Director revealed the facility was unaware the inspection had been overlooked in 2018.  
Actual NFPA standard:  
NFPA 96  
11.2.1\* Maintenance of the fire-extinguishing systems and listed exhaust hoods containing a constant or fire-activated water system that is listed to extinguish a fire in the grease removal devices, hood exhaust plenums, and exhaust ducts shall be made by properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction at least every 6 months.

K 325 SS=F Alcohol Based Hand Rub Dispenser (ABHR) CFR(s): NFPA 101  
Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met:  
\* Corridor is at least 6 feet wide  
\* Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols  
\* Dispensers shall have a minimum of 4-foot

K 324

K 325  
**K 325 ALCOHOL BASED HAND RUB DISPENSER**  
Facility will ensure that ABHR dispensers are tested in accordance with manufacturer's care and use instructions when refilled.

4/1/19

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

PRINTED: 03/15/2019  
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  03/06/2019
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 325	<p>Continued From page 8</p> <p>horizontal spacing</p> <ul style="list-style-type: none"> <li>* Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room</li> <li>* Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30</li> <li>* Dispensers are not installed within 1 inch of an ignition source</li> <li>* Dispensers over carpeted floors are in sprinklered smoke compartments</li> <li>* ABHR does not exceed 95 percent alcohol</li> <li>* Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11)</li> <li>* ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485</li> </ul> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure Alcohol Based Hand Rub Dispensers (ABHR) were maintained in accordance with NFPA 101. Failure to test and document the operation of ABHR dispensers in accordance with the manufacturer's care and use instructions each time a new refill is installed could result in inadvertently spilling flammable liquids, increasing the risk of fires. This deficient practice affected 29 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During the review of facility inspection records on March 6, 2019, from approximately 8:30 AM to 12:00 PM, records could not be produced indicating ABHR dispensers are tested in accordance with manufacturer's care and use instructions when a new refill is installed. ABHR</p>	K 325	<p>The maintenance /Safety director has been educated regarding the deficient practice.</p> <p>Maintenance/Safety Director have tested all ABHR dispensers on to ensure all dispensers are in proper working order, not releasing content unless manually activated and not dispensing more solution than the amount required for hand hygiene.</p> <p>Maintenance/Safety Director will ensure that all ABHR dispenser are tested and documented when refilled. Documentation of all tests are taped in the container and is located in the ABHR dispenser. A random audit will be done by the Administrator to ensure ABHR dispensers testing were completed to ensure compliance.</p> <p><b>Please see exhibit C.</b></p>		

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

PRINTED: 03/15/2019  
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  03/06/2019	
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 325	<p>Continued From page 9</p> <p>dispensers were observed throughout the facility and when asked, the Maintenance Director stated the facility was aware of the requirement but had failed to maintain documentation.</p> <p>Actual NFPA standard:</p> <p>NFPA 101</p> <p>19.3.2.6* Alcohol-Based Hand-Rub Dispensers. Alcohol-based hand-rub dispensers shall be protected in accordance with 8.7.3.1, unless all of the following conditions are met:</p> <p>(1) Where dispensers are installed in a corridor, the corridor shall have a minimum width of 6 ft (1830 mm).</p> <p>(2) The maximum individual dispenser fluid capacity shall be as follows:</p> <p>(a) 0.32 gal (1.2 L) for dispensers in rooms, corridors, and areas open to corridors</p> <p>(b) 0.53 gal (2.0 L) for dispensers in suites of rooms</p> <p>(3) Where aerosol containers are used, the maximum capacity of the aerosol dispenser shall be 18 oz. (0.51 kg) and shall be limited to Level 1 aerosols as defined in NFPA30B, Code for the Manufacture and Storage of Aerosol Products.</p> <p>(4) Dispensers shall be separated from each other by horizontal spacing of not less than 48 in. (1220 mm).</p> <p>(5) Not more than an aggregate 10 gal (37.8 L) of alcohol-based hand-rub solution or 1135 oz (32.2 kg) of Level 1 aerosols, or a combination of liquids and Level 1 aerosols not to exceed, in total, the equivalent of 10 gal (37.8 L) or 1135 oz (32.2 kg), shall be in use outside of a storage cabinet in a single smoke compartment, except as otherwise provided in 19.3.2.6(6).</p> <p>(6) One dispenser complying with 19.3.2.6 (2) or</p>	K 325		

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

PRINTED: 03/15/2019  
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  03/06/2019
--	--	--	--

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 325	<p>Continued From page 10</p> <p>(3) per room and located in that room shall not be included in the aggregated quantity addressed in 19.3.2.6(5).</p> <p>(7) Storage of quantities greater than 5 gal (18.9 L) in a single smoke compartment shall meet the requirements of NFPA 30, Flammable and Combustible Liquids Code.</p> <p>(8) Dispensers shall not be installed in the following locations:</p> <p>(a) Above an ignition source within a 1 in. (25 mm) horizontal distance from each side of the ignition source</p> <p>(b) To the side of an ignition source within a 1 in. (25 mm) horizontal distance from the ignition source</p> <p>(c) Beneath an ignition source within a 1 in. (25 mm) vertical distance from the ignition source</p> <p>(9) Dispensers installed directly over carpeted floors shall be permitted only in sprinklered smoke compartments.</p> <p>(10) The alcohol-based hand-rub solution shall not exceed 95 percent alcohol content by volume.</p> <p>(11) Operation of the dispenser shall comply with the following criteria:</p> <p>(a) The dispenser shall not release its contents except when the dispenser is activated, either manually or automatically by touch-free activation.</p> <p>(b) Any activation of the dispenser shall occur only when an object is placed within 4 in. (100 mm) of the sensing device.</p> <p>(c) An object placed within the activation zone and left in place shall not cause more than one activation.</p> <p>(d) The dispenser shall not dispense more solution than the amount required for hand hygiene consistent with label instructions.</p> <p>(e) The dispenser shall be designed,</p>	K 325		
-------	--	-------	--	--

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

PRINTED: 03/15/2019  
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  03/06/2019
--	--	--	--

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 325	Continued From page 11 constructed, and operated in a manner that ensures that accidental or malicious activation of the dispensing device is minimized. (f) The dispenser shall be tested in accordance with the manufacturer's care and use instructions each time a new refill is installed.	K 325		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101  Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____  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 inspect system components as required, has the potential to hinder system performance during a fire event and/or render the facility not fully sprinklered after an activation or repair. This deficient practice affected 29 residents, staff and	K 353	<b>K 353 SPRINKLER SYSTEM</b>  Facility will ensure that the fire suppression system are maintained in accordance with NFPA 25.  All residents have the potential to be affected by this practice.  The maintenance /Safety director had been educated regarding the deficient practice.  The Fire suppression system has been inspected for 4 <sup>th</sup> Quarter 2018 and 1 <sup>st</sup> quarter 2019 and is now on regular quarterly schedule with the facility service provider.  Maintenance/Safety Director will ensure that all fire suppression systems are inspected quarterly. A random record audit will be done by the Administrator to ensure compliance.	4/1/19

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

PRINTED: 03/15/2019  
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  03/06/2019
--	--	--	--

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 353	Continued From page 12 visitors on the date of the survey.  Findings include:  During review of provided facility inspection and testing records conducted on March 6, 2019, from approximately 8:30 AM - 12:00 PM, documentation for a third quarter, 2018 waterflow alarm flow test could not be produced. When asked, the Administrator stated the facility was aware the third quarter, 2018 sprinkler inspection had been missed and had already implemented a Plan of Correction (POC) to include training and scheduling to prevent this from happening again.  Actual NFPA standard:  NFPA 25  5.3.3 Waterflow Alarm Devices. 5.3.3.1 Mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly.	K 353		
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101  Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2	K 511	<b>K 511 UTILITIES – GAS ELECTRIC</b>  Facility will ensure safe electrical installations in accordance with their listed assemblies and requirements under NFPA 70.  Resident room 3A's concentrator is now plugged in directly to a wall outlet.  Resident room 4C's multi-Plug adaptor has been removed and is no longer in room for use.	4/1/19

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

PRINTED: 03/15/2019  
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  03/06/2019
--	--	--	--

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 511	<p>Continued From page 13</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure safe electrical installations in accordance with their listed assemblies and those requirements under NFPA 70. Use of relocatable power taps (RPTs) outside of those defined in the referenced standard, UL 1363, has the potential to expose residents to risks of electrocution and arc fires. This deficient practice affected 4 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour on March 6, 2019, from approximately 12:00 PM to 1:30 PM, observation of installed electrical systems revealed the following:</p> <p>Galena Building: Resident room 3A had an oxygen concentrator plugged into a Relocatable Power Tap (RPT). Hemmingway Building: Resident room 4C had a Multi-Plug Adapter (MPA) in use and resident room 14C had a medical bed plugged into a Relocatable Power Tap (RPT).</p> <p>Actual NFPA standard:</p> <p>NFPA 70</p> <p>110.2 Approval. The conductors and equipment required or permitted by this Code shall be acceptable only if approved.</p> <p>Informational Note: See 90.7, Examination of Equipment for Safety, and 110.3, Examination, Identification, Installation, and Use of Equipment.</p>	K 511	<p>Resident room 14C's bed is now plugged in directly to a wall outlet.</p> <p>All residents have the potential to be affected by this practice.</p> <p>The maintenance /Safety director has been educated regarding the deficient practice.</p> <p>Facility room rounds were done by the facility maintenance / safety director to ensure electrical installations are only used in accordance with their listed assemblies and requirements under NFPA 70.</p> <p>Maintenance/Safety Director will ensure room inspection are done at least quarterly and that all electrical installations are only used in accordance with their listed assemblies and requirements under NFPA 70. A random record and room audit will be done by the Administrator to ensure compliance.</p> <p><b>Please see exhibit D.</b></p>	
-------	--	-------	---	--

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

PRINTED: 03/15/2019  
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  03/06/2019
--	--	--	--

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 511	<p>Continued From page 14 See definitions of Approved, Identified, Labeled, and Listed.</p> <p>110.3 Examination, Identification, Installation, and Use of Equipment. (A) Examination. In judging equipment, considerations such as the following shall be evaluated: (1) Suitability for installation and use in conformity with the provisions of this Code Informational Note: Suitability of equipment use may be identified by a description marked on or provided with a product to identify the suitability of the product for a specific purpose, environment, or application. Special conditions of use or other limitations and other pertinent information. Suitability of equipment may be evidenced by listing or labeling. (2) Mechanical strength and durability, including, for parts designed to enclose and protect other equipment, the adequacy of the protection thus provided (3) Wire-bending and connection space (4) Electrical insulation (5) Heating effects under normal conditions of use and also under abnormal conditions likely to arise in service (6) Arcing effects (7) Classification by type, size, voltage, current capacity, and specific use (8) Other factors that contribute to the practical safeguarding of persons using or likely to come in contact with the equipment (B) Installation and Use. Listed or labeled equipment shall be installed and used in accordance with any instructions included in the listing or labeling.</p> <p>Additional reference: UL 1363 XBYS.GuidelInfo</p>	K 511		
-------	--	-------	--	--

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

PRINTED: 03/15/2019  
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  03/06/2019
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 511	Continued From page 15 Relocatable Power Taps	K 511			
K 918 SS=F	Electrical Systems - Essential Electric System 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 111, 700.10 (NFPA 70)	K 918	<b>K 918 ELECTRICAL SYSTEMS - ESSENTIAL ELECTRIC SYSTEM</b>  Facility will ensure Emergency Power Supply System (EPSS) are maintained in accordance with NFPA 110 and that generator sets are inspected weekly and exercise under load at least monthly.  All residents have the potential to be affected by this practice.  The maintenance /Safety director has been educated regarding the deficient practice.  Weekly inspections and monthly under load generator exercises have been conducted.  Maintenance/Safety Director will ensure that all generator sets are inspected weekly and exercise under load monthly. And records of all test are filed in the binder that is located in the Administrator's office. A random audit will be done by the Administrator to ensure record keeping is accurate and filed and weekly inspection, monthly under load are conducted timely.	4/1/19	

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

PRINTED: 03/15/2019  
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  03/06/2019
--	--	--	--

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 918	<p>Continued From page 16</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure Emergency Power Supply Systems (EPSS) were maintained in accordance with NFPA 110. Failure to inspect and test generators, could hinder the performance of the equipment during an emergency. This deficient practice affected 29 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>Review of the facility generator inspection and testing records on March 6, 2019, from approximately 8:30 AM to 12:00 PM, revealed the facility had not performed monthly load tests in June 2018 and failed to provide the following weekly generator inspection logs:</p> <p>Galena Building: December 23, 2018 - December 29, 2018, January 13, 2019 - January 19, 2019, January 20, 2019 - January 26, 2019, January 27, 2019 - February 2, 2019 and all of February 2019.</p> <p>Hemmingway Building: March 18, 2018 - March 24, 2018, April 29, 2018 - May 5, 2018, all of May and June 2018, July 1, 2018 - July 7, 2018, December 30, 2018 - January 5, 2019, January 13, 2019 - January 19, 2019, January 20, 2019 - January 26, 2019, January 27, 2019 - February 2, 2019, and all of February 2019.</p> <p>When asked, the Maintenance Director stated the facility was aware of the requirement for monthly load tests and weekly inspections but had been very busy with snow removal and may have missed a couple of inspections.</p>	K 918	Please see exhibit E.	
-------	--	-------	-----------------------	--

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

PRINTED: 03/15/2019  
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  03/06/2019
--	--	--	--

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 918	Continued From page 17 Actual NFPA standard:  NFPA 110 8.4 Operational Inspection and Testing. 8.4.1* EPSSs, including all appurtenant components, shall be inspected weekly and exercised under load at least monthly. 8.4.2* Diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS nameplate kW rating	K 918		
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	K 923	K 923 GAS EQUIPMENT – CYLINDER AND CONTAINER STORAGE.  Facility will ensure that oxygen cylinders are secured and stored in a safe manner.  All residents have the potential to be affected by this practice.  The maintenance /Safety director has been educated regarding the deficient practice  The “E” style oxygen tank in the oxygen transfilling room has been removed from the oxygen transfilling room.	4/1/19

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

PRINTED: 03/15/2019  
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  03/06/2019
--	--	--	--

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 923	<p>Continued From page 18</p> <p>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."</p> <p>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 considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather.</p> <p>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 upon observation and interview the facility failed to ensure oxygen cylinders were secured and stored in a safe manner. Failure to secure and maintain cylinders can result in accidental physical damage, explosions, and could create an oxygen enriched atmosphere. This deficient practice affected staff and visitors on the day of survey.</p> <p>Findings include:</p> <p>During the facility tour on March 6, 2019, from approximately 12:00 PM to 1:30 PM, observation of the exterior access, oxygen transfilling room in the Galena building, revealed an "E" style oxygen tank not properly secured in a cylinder stand or cart. When asked, the Maintenance Director stated the residents housed at the skilled nursing facility do not use "E" style tanks, only the "buddy jugs" that are transfilled by staff. The facility was</p>	K 923	<p>Maintenance/Safety Director will ensure that "E" style oxygen tanks are secured and stored in a safe manner.</p> <p>Environmental rounds will be done by the Maintenance/Safety Director to ensure that "E" style oxygen tank are secured and stored safely when in the property. A random room audit will be done by the Administrator to ensure compliance.</p>	
-------	--	-------	--	--

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

PRINTED: 03/15/2019  
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  03/06/2019
--	--	--	--

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 923	<p>Continued From page 19 unaware of an "E" style tank being on the premises.</p> <p>Actual NFPA standard: NFPA 99</p> <p>11.3 Cylinder and Container Storage Requirements. 11.3.2.6 Cylinder or container restraints shall comply with 11.6.2.3. 11.6.2.3 Cylinders shall be protected from damage by means of the following specific procedures: (1) Oxygen cylinders shall be protected from abnormal mechanical shock, which is liable to damage the cylinder, valve, or safety device. (2) Oxygen cylinders shall not be stored near elevators or gangways or in locations where heavy moving objects will strike them or fall on them. (3) Cylinders shall be protected from tampering by unauthorized individuals. (4) Cylinders or cylinder valves shall not be repaired, painted, or altered. (5) Safety relief devices in valves or cylinders shall not be tampered with. (6) Valve outlets clogged with ice shall be thawed with warm - not boiling - water. (7) A torch flame shall not be permitted, under any circumstances, to come in contact with a cylinder, cylinder valve, or safety device. (8) Sparks and flame shall be kept away from cylinders. (9) Even if they are considered to be empty, cylinders shall not be used as rollers, supports, or for any purpose other than that for which the supplier intended them. (10) Large cylinders (exceeding size E) and</p>	K 923		
-------	--	-------	--	--

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

PRINTED: 03/15/2019  
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  03/06/2019
--	--	--	--

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 923	Continued From page 20 containers larger than 45 kg (100 lb) weight shall be transported on a proper hand truck or cart complying with 11.4.3.1. (11) Freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. (12) Cylinders shall not be supported by radiators, steam pipes, or heat ducts.	K 923		
K 926 SS=D	Gas Equipment - Qualifications and Training CFR(s): NFPA 101  Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on record review, and interview, the facility failed to ensure staff were properly trained on the risks associated with the handling and use of medical gases. Failure to provide an education program which includes periodic review of safety guidelines and usage requirements for medical gases and their cylinders, could result in a life threatening or catastrophic accident. This deficient practice could potentially affect 6 residents using oxygen on the date of the survey.  Findings include:  During the review of facility training records conducted on March 6, 2019, from approximately	K 926	K 926 GAS EQUIPMENT - QUALIFICATION AND TRAINING.  Facility will ensure that staff were properly trained on the risk associated with the handling and use of medical gasses.  All staff and residents have the potential to be affected by this practice.  Staff has been educated on the risk associated with handling and use of medical gasses during the monthly staff in-service.  Training and education will be included with the facility's new hire orientation program. Review of safety guidelines and usage requirements for medical gasses and cylinder will be scheduled with the facility's staff in service and will be done at least annually.	4/1/19

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

PRINTED: 03/15/2019  
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  03/06/2019
--	--	--	--

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 926	<p>Continued From page 21</p> <p>8:30 AM to 12:00 PM, no records were available indicating the facility maintained an ongoing continuing education program for staff which includes periodic review of safety guidelines and usage requirements for medical gases and their cylinders. When asked, the Maintenance Director stated the facility was not aware of the requirement for medical gas training.</p> <p>Actual NFPA Standard:</p> <p>NFPA 101 19.3.2.4 Medical Gas. Medical gas storage and administration areas shall be in accordance with Section 8.7 and the provisions of NFPA 99, Health Care Facilities Code, applicable to administration, maintenance, and testing.</p> <p>NFPA 99 11.5.2 Gases in Cylinders and Liquefied Gases in Containers. 11.5.2.1 Qualification and Training of Personnel. 11.5.2.1.1* Personnel concerned with the application and maintenance of medical gases and others who handle medical gases and the cylinders that contain the medical gases shall be trained on the risks associated with their handling and use. 11.5.2.1.2 Health care facilities shall provide programs of continuing education for their personnel. 11.5.2.1.3 Continuing education programs shall include periodic review of safety guidelines and usage requirements for medical gases and their cylinders.</p>	K 926	<p>Business Office Manager will ensure that training is completed for each new hire and review of safety guidelines and usage requirements for medical gasses and cylinders are done at least annually. Records for this training will be filed in the individual employee file and in the facility in-service binder that is located in the business office.</p>	
-------	---	-------	---	--



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

March 15, 2019

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 **March 6, 2019**, 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 **March 28, 2019**. Failure to submit an acceptable PoC by **March 28, 2019**, may result in the imposition of civil monetary penalties by **April 19, 2019**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.
- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567. If a State Form was issued as well, it should also be signed, dated and returned.

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

Remedies may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **April 10, 2019**, (Opportunity to Correct). Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on . A change in the seriousness of the deficiencies on **April 29, 2019**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **April 10, 2019**, includes the following:

Denial of payment for new admissions effective **June 6, 2019**.  
42 CFR §488.417(a)

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

Darwin Royeca, Administrator

March 15, 2019

Page 3 of 4

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **September 6, 2019**, if substantial compliance is not achieved by that time.

**Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.**

If you believe these deficiencies have been corrected, you may contact Nate Elkins, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, option 3; Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **March 6, 2019**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

<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

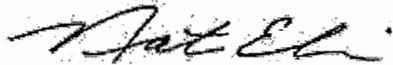
2001-10 IDR Request Form

Darwin Royeca, Administrator  
March 15, 2019  
Page 4 of 4

This request must be received by **March 28, 2019**. If your request for informal dispute resolution is received after **March 28, 2019**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626, option 3.

Sincerely,

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

Nate Elkins, Supervisor  
Facility Fire Safety and Construction

NE/lj  
Enclosures

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

PRINTED: 03/15/2019  
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 _____  B. WING _____	(X3) DATE SURVEY COMPLETED  03/06/2019
--	--	--	--

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
--------------------	--	---------------	---	----------------------

E 000	Initial Comments  The facility is comprised of two (2) SNF/NF small house model buildings, identical in design. Construction of the two SNF/NF buildings was completed in January 2015. The buildings are defined as buildings Galena and Hemmingway which house residential sleeping rooms. Building Edelweiss houses the physical therapy occupancy which serves the SNF/NF residents, administrative offices and an assisted living facility separated by two-hour construction. All buildings are type II (000) construction equipped with automatic sprinkler protection, corridor smoke detection. Type 2 Emergency Electrical Systems with automatic transfer switching is provided for building Galena and Hemmingway. Building Edelweiss EES provides emergency power for the Assisted Living, Physical Therapy and Administrative offices. Both buildings A and C have commercial kitchens which are separated by one-hour construction. The facility is licensed for 32 SNF/NF beds, and had a census of 29 on the date of the survey.  The following deficiency was cited during the annual emergency preparedness survey conducted on March 6, 2019. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.  The Survey was conducted by:  Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction	E 000		
E 041 SS=F	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e)	E 041		

**RECEIVED**  
**MAR 29 2019**  
**FACILITY STANDARDS**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Dawn Troyer* TITLE Administrator (X6) DATE 3/27/19

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.

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

PRINTED: 03/15/2019  
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 _____  B. WING _____	(X3) DATE SURVEY COMPLETED  03/06/2019
--	--	--	--

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
--------------------	--	---------------	---	----------------------

E 041	<p>Continued From page 1</p> <p>(e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section.</p> <p>§483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section.</p> <p>§482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated.</p> <p>482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code.</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</p>	E 041	<p><b>E 041 HOSPITAL CAH AND LTC EMERGENCY POWER</b></p> <p>This facility will ensure that weekly generator inspection and monthly load testing are done in accordance with NFPA 110.</p> <p>All residents have the potential to be affected by this practice.</p> <p>The maintenance /Safety director has been educated regarding the deficient practice</p> <p>Weekly inspections and monthly under load generator exercises have been conducted.</p> <p>Maintenance/Safety Director will ensure that weekly generator inspection and monthly load testing will be done in accordance to NFPA 110. And records of all test are filed in the binder that is located in the Administrator's office. A random audit will be done by the Administrator to ensure record keeping is accurate and filed and weekly inspection, monthly under load are conducted timely.</p>	4/1/19
-------	---	-------	---	--------

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

PRINTED: 03/15/2019  
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 _____  B. WING _____	(X3) DATE SURVEY COMPLETED  03/06/2019
--	--	--	--

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
--------------------	--	---------------	---	----------------------

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

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

PRINTED: 03/15/2019  
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 _____  B. WING _____	(X3) DATE SURVEY COMPLETED  03/06/2019
--	--	--	--

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
--------------------	--	---------------	---	----------------------

E 041	<p>Continued From page 3 issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure the generator for the EES (Essential Electrical System) was maintained in accordance with NFPA 110. Failure to inspect and test EES generators could result in a lack of system reliability during a power loss. This deficient practice affected 29 residents, staff and visitors on the date of the survey.</p> <p>Findings Include:</p> <p>During review of the facility maintenance inspection records and emergency preparedness plan, conducted on March 6, 2019 from approximately 8:30 AM - 12:00 PM, records provided for the emergency generator revealed missing documentation for weekly inspections and monthly load testing in accordance with NFPA 110. When asked, the Maintenance Director stated the facility was aware of the requirement for monthly load tests and weekly inspections but had been very busy with snow removal and may have missed a couple of inspections.</p>	E 041		
-------	---	-------	--	--

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

PRINTED: 03/15/2019  
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 _____  B. WING _____	(X3) DATE SURVEY COMPLETED  03/06/2019
--	--	--	--

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
--------------------	--	---------------	---	----------------------

E 041	Continued From page 4 Reference:  42 CFR 483.73 (e) (2)	E 041		
-------	--	-------	--	--