



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

July 30, 2020

Shelly Cunningham, Administrator
Valley Vista Care Center of Sandpoint
220 South Division
Sandpoint, ID 83864-1759

Provider #: 135055

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

Dear Ms. Cunningham:

On **July 21, 2020**, a Facility Fire Safety and Construction survey was conducted at **Valley Vista Care Center of Sandpoint** 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 one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed.

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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 **August 27, 2020**. Failure to submit an acceptable PoC by **August 27, 2020**, may result in the imposition of civil monetary penalties by **September 18, 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 **August 25, 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 **October 19, 2020**. A change in the seriousness of the deficiencies on **September 4, 2020**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **August 25, 2020**, includes the following:

Denial of payment for new admissions effective **October 21, 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 **January 21, 2021**, 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 **July 21, 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:

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

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

BFS Letters (06/30/11)

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

This request must be received by **August 27, 2020**. If your request for informal dispute resolution is received after **August 27, 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: 07/29/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135055	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 07/21/2020
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NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF SANDPOINT	STREET ADDRESS, CITY, STATE, ZIP CODE 220 SOUTH DIVISION SANDPOINT, ID 83864
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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	<p>INITIAL COMMENTS</p> <p>The facility is a single story, type V (111) fire resistive structure with multiple exits to grade, originally constructed in 1959 with subsequent renovations. The building is equipped with an on-site, diesel powered, Emergency Power Supply System (EPSS) generator set, is fully sprinklered and equipped with an interconnected fire alarm system. Currently, the facility is licensed for 73 SNF/NF beds, with a census of 58 on the date of the survey.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted July 21, 2020. The facility was surveyed under the Life Safety Code 2012 Edition, Existing Health Care Occupancies in accordance with 42 CFR 483.70.</p> <p>The Survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction</p>	K 000	<p>Preparation and execution of this POC does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusions set forth in the statement of deficiencies rendered by the reviewing agency. The plan of correction is prepared and executed solely because the provisions of federal and state law require it.</p> <p style="text-align: center;">RECEIVED AUG 12 2020 FACILITY STANDARD</p>	
K 211 SS=D	<p>Means of Egress - General CFR(s): NFPA 101</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 means of egress were maintained in accordance with NFPA 101. Placement of wheeled equipment in the corridors</p>	K 211	<p>K 211</p> <p>Corrective action accomplished for those residents found to have been affected by the deficient practice:</p> <p>There were no negative outcomes to the facility residents, staff or visitors as a result of this finding. The new nurse was informed of the proper storage of carts and requirements for maintaining means of egress free from all obstructions.</p>	08/12/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Stacy Cunningham</i>	TITLE <i>ADMINISTRATOR</i>	(X5) DATE <i>08/12/20</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 211	<p>Continued From page 1</p> <p>that limits the corridor access, has the potential to hinder safe egress of residents during a fire or other emergency. This deficient practice affected 13 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 7/21/20 from approximately 2:00 - 3:00 PM, observation of the 500 hall of the facility revealed two (2) nurse's carts parked unattended outside of room 203 for approximately 8 minutes. When asked at approximately 2:35 PM about these carts, the nurse on duty at the nurse's station stated when not in use, the carts were "stored" at that location.</p> <p>Actual NFPA standard:</p> <p>19.2.3.4* Any required aisle, corridor, or ramp shall be not less than 48 in. (1220 mm) in clear width where serving as means of egress from patient sleeping rooms, unless otherwise permitted by one of the following:</p> <p>(1) Aisles, corridors, and ramps in adjunct areas not intended for the housing, treatment, or use of inpatients shall be not less than 44 in. (1120 mm) in clear and unobstructed width.</p> <p>(2)*Where corridor width is at least 6 ft (1830 mm), noncontinuous projections not more than 6 in. (150 mm) from the corridor wall, above the handrail height, shall be permitted.</p> <p>(3) Exit access within a room or suite of rooms complying with the requirements of 19.2.5 shall be permitted.</p> <p>(4) Projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met:</p> <p>(a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60</p>	K 211	<p>(K 211 continued)</p> <p>Identification of residents having the potential to be affected by the same deficient practice and corrective action(s) taken:</p> <p>All residents, staff and visitors have the potential to be affected by the practice. No negative outcomes have resulted.</p> <p>All licensed nurses received in-services on the proper storage of medication carts while not in use and the maintenance of unobstructed corridors as a means of egress.</p> <p>Systemic changes to prevent recurrence:</p> <p>Utilization of laptops have been recently implemented on the nurse carts. The periodic recharging of the laptops required the cart to be temporarily stationary near an electrical outlet in the corridor. Laptops are now being removed from the cart and charged at the nurse's station allowing proper storage of the nurse carts out of the corridor.</p>	

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K 211	Continued From page 2 in.(1525 mm). (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c)*The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment (5)*Where the corridor width is at least 8 ft (2440 mm), projections into the required width shall be permitted for fixed furniture, provided that all of the following conditions are met: (a) The fixed furniture is securely attached to the floor or to the wall. (b) The fixed furniture does not reduce the clear unobstructed corridor width to less than 6 ft (1830 mm), except as permitted by 19.2.3.4(2). (c) The fixed furniture is located only on one side of the corridor. (d) The fixed furniture is grouped such that each grouping does not exceed an area of 50 ft ² (4.6 m ²). (e) The fixed furniture groupings addressed in 19.2.3.4(5)(d) are separated from each other by a distance of at least 10 ft (3050 mm). (f)*The fixed furniture is located so as to not obstruct access to building service and fire protection equipment. (g) Corridors throughout the smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the fixed furniture spaces are arranged and located to allow direct supervision by the facility staff from a nurses ' station or similar space. (h) The smoke compartment is protected throughout by an approved, supervised automatic	K 211	(K 211 continued) Monitoring to ensure compliance: This will be monitored by the Director of Nursing and/or designee 5 x week for 3 months and reported to the QAPI committee monthly.	

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K 211	Continued From page 3 sprinkler system in accordance with 19.3.5.8.	K 211		
K 511 SS=D	<p>Utilities - Gas and Electric CFR(s): NFPA 101</p> <p>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</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure safe electrical installations were installed in accordance with NFPA 70. Blocking electric wall heaters and failing to ensure large appliances such as air conditioners are plugged directly into the wall without an extension cord, increases the potential for fires by arcing to the facility residents. This deficient practice affected staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 7/21/20 from 10:45 AM - 3:00 PM, observation of installed electrical systems revealed the following:</p> <ul style="list-style-type: none"> - Observation of the initial COVID - 19 staff and visitor screening room that was housed in what was formerly the staff breakroom, revealed the installed air conditioning unit was using an extension cord for supplying power from the wall outlet behind the screening desk. 	K 511	<p>K 511</p> <p>Corrective action for residents found to have been affected by the deficient practice:</p> <p>There were no negative outcomes to the facility residents as a result of this practice.</p> <p>Air conditioning unit was removed.</p> <p>Bread cart next to the cadet heater was moved to allow 3 feet of required clearance. Cadet heater is not used and was removed from the wall in the kitchen pantry area.</p> <p>Identification of residents having the potential to be affected by the same deficient practice and corrective action(s) taken:</p> <p>There were no negative outcomes to the facility residents or staff as a result of this practice.</p> <p>Wall heater was removed. Electrician installed an additional outlet which allowed the air conditioning unit to be properly positioned for exterior exhaust without the use of an extension cord. Maintenance Director</p>	08/12/20

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K 511	<p>Continued From page 4</p> <p>When asked at approximately 1:45 PM about the use of the extension cord, the Maintenance director stated the wall where the unit was placed for exterior exhaust did not have a power supply outlet.</p> <p>- During the survey tour of the main Kitchen, observation of the pantry revealed a bread cart was parked directly in front of a cadet wall heater that was operated by a thermostat located on the wall next to the door to the exterior of the building.</p> <p>Actual NFPA standard: NFPA 70</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 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</p>	K 511	<p>(K 511 continued)</p> <p>completed a facility walk through/audit for unapproved use of extension cords and other unused equipment needing removal.</p> <p>Systemic changes to prevent recurrence:</p> <p>Maintenance Director will include inspections for use of extension cords on monthly facility walk through checklist.</p> <p>Monitoring to ensure compliance:</p> <p>Monthly inspections will be reported to QAPI committee monthly for continued compliance.</p>		

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K 511	Continued From page 5 (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. ARTICLE 400 Flexible Cords and Cables 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 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 923 SS=E	Gas Equipment - Cylinder and Container Storage CFR(s): NFPA 101	K 923	K 923 – See next page		

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K 923	Continued From page 6 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 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: Based on observation and interview, the facility failed to ensure storage of medical gas cylinders	K 923	K 923 Corrective action for residents found to have been affected by the deficient practice: There were no negative outcomes to the facility residents as a result of this finding. The two cylinders without tags were properly placed in the "EMPTY" rack with the appropriate tags. Drywall was installed in the structure to meet the "non-combustible" construction requirements. Identification of residents having the potential to be affected by the same deficient practice and corrective action(s) taken: There were no negative outcomes to the facility residents as a result of this finding. The two cylinders without tags were promptly moved to the "EMPTY" rack and properly tagged. Measures taken to prevent recurrence: All staff were in-serviced on proper use of FULL/IN-USE/EMPTY tagging as well	08/12/20	

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K 923	<p>Continued From page 7</p> <p>such as oxygen, were maintained in accordance with NFPA 99. Failure to ensure outdoor storage was of a non-combustible material and all cylinders are segregated for full and empty, has the potential to increase the risk of fires associated with storage and inadvertently use the incorrect cylinder during an emergency requiring supplemental oxygen. This deficient practice affected those residents requiring supplemental oxygen treatment and staff on the date of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on 7/21/20 from 1:00 - 3:00 PM, observation of the storage area located on the northwest side of the building, revealed an approximately eight foot by four foot structure that housed the oxygen cylinder storage. Further observation revealed this structure built to house medical gas cylinders. Further observation of the interior of the structure revealed the building was comprised of wood framing with an asphalt-impregnated building wrap and asphalt shingles; wood siding and composite doors.</p> <p>Interview of the Maintenance Director at approximately 1:45 PM established this structure was built to facilitate a secure area to house medical gas cylinder storage.</p> <p>2) During the facility tour conducted on 7/21/20 from 1:00 - 3:00 PM, observation of the storage unit revealed 96 "E" cylinders and 10 "A" cylinders, or approximately 2371 cubic ft of oxygen stored. Additionally, the method used for segregation of these cylinders was labeling tags placed over the neck and valve area of the cylinder, each with a perforated section marked</p>	K 923	<p>(K 923 continued)</p> <p>as segregation of empty and full cylinders for emergency use purposes.</p> <p>Monitoring to ensure compliance:</p> <p>The Administrator and/or Designee will audit the O2 storage weekly for 4 weeks and monthly thereafter. QAPI committee will review the current Plan of Correction on an annual basis and make changes as necessary.</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135055	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 07/21/2020	
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF SANDPOIN'		STREET ADDRESS, CITY, STATE, ZIP CODE 220 SOUTH DIVISION SANDPOINT, ID 83864		
(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 8</p> <p>"Full", "In Use" and "Empty", indicating the status of the cylinder when the respective section was removed from the tag.</p> <p>Further observation of the stored cylinders revealed two (2) cylinders without tags stored in a section of rack housing cylinders equipped with tags marked "Full", failing to identify the status of these cylinders.</p> <p>Actual NFPA standard:</p> <p>NFPA 99</p> <p>11.3.2* Storage for nonflammable gases greater than 8.5 m³ (300 ft³), but less than 85 m³ (3000 ft³), at STP shall comply with the requirements in 11.3.2.1 through 11.3.2.3.</p> <p>11.3.2.1 Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry.</p> <p>11.3.2.2 Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor.</p> <p>11.3.2.3 Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following:</p> <p>(1) Minimum distance of 6.1 m (20 ft)</p> <p>(2) Minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems</p> <p>(3) Enclosed cabinet of noncombustible construction having a minimum fire protection rating of 1/2 hour</p> <p>11.6.2.3 Cylinders shall be protected from</p>	K 923		

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K 923	<p>Continued From page 9</p> <p>damage by means of the following specific procedures:</p> <p>(1) Oxygen cylinders shall be protected from abnormal mechanical shock, which is liable to damage the cylinder, valve, or safety device.</p> <p>(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.</p> <p>(3) Cylinders shall be protected from tampering by unauthorized individuals.</p> <p>(4) Cylinders or cylinder valves shall not be repaired, painted, or altered.</p> <p>(5) Safety relief devices in valves or cylinders shall not be tampered with.</p> <p>(6) Valve outlets clogged with ice shall be thawed with warm - not boiling - water.</p> <p>(7) A torch flame shall not be permitted, under any circumstances, to come in contact with a cylinder, cylinder valve, or safety device.</p> <p>(8) Sparks and flame shall be kept away from cylinders.</p> <p>(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.</p> <p>(10) Large cylinders (exceeding size E) and containers larger than 45 kg (100 lb) weight shall be transported on a proper hand truck or cart complying with 11.4.3.1.</p> <p>(11) Freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart.</p> <p>(12) Cylinders shall not be supported by radiators, steam pipes, or heat ducts.</p> <p>11.6.5 Special Precautions - Storage of Cylinders and Containers. 11.6.5.1 Storage shall be planned so that cylinders can be used in the order in which they</p>	K 923			

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K 923	Continued From page 10 are received from the supplier. 11.6.5.2 If empty and full cylinders are stored within the same enclosure, empty cylinders shall be segregated from full cylinders. 11.6.5.3 Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed in a rapid manner.	K 923			



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

July 30, 2020

Shelly Cunningham, Administrator
Valley Vista Care Center of Sandpoint
220 South Division
Sandpoint, ID 83864-1759

Provider #: 135055

RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER

Dear Ms. Cunningham:

On **July 21, 2020**, an Emergency Preparedness survey was conducted at Valley Vista Care Center of Sandpoint by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. Your facility was found to be in substantial compliance with Federal regulations during this survey.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, which states that the facility complies with the requirements of CFR 42, 483.70(a) of the federal requirements. This form is for your records only and does not need to be returned.

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

Sincerely,

A handwritten signature in black ink that reads "Nate Elkins". The signature is written in a cursive, flowing style.

Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj

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E 000	<p>Initial Comments</p> <p>The facility is a single story, type V (111) fire resistive structure with multiple exits to grade, originally constructed in 1959 with subsequent renovations. The facility is located within a rural fire district with both county and state EMS services available. The building is equipped with an on-site, diesel powered, Emergency Power Supply System (EPSS) generator set, is fully sprinklered and equipped with an interconnected fire alarm system. Currently, the facility is licensed for 73 SNF/NF beds, with a census of 58 on the date of the survey.</p> <p>The facility was found to be in substantial compliance during the Emergency Preparedness survey conducted on July 21, 2020. The facility was surveyed under the Emergency Preparedness Rule, in accordance with 42 CFR 483.73.</p> <p>The Survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	E 000			

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

TITLE

(X6) DATE

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.