



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

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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

August 3, 2020

Emilee Kulin, Administrator
Mountain Valley of Cascadia
601 West Cameron Avenue
Kellogg, ID 83837-2004

Provider #: 135065

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

Dear Ms. Kulin:

On **July 22, 2020**, a Facility Fire Safety and Construction survey was conducted at **Mountain Valley Of Cascadia** 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.

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August 3, 2020
Page 2 of 4

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 17, 2020**. Failure to submit an acceptable PoC by **August 17, 2020**, may result in the imposition of civil monetary penalties by **September 7, 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 26, 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 20, 2020**. A change in the seriousness of the deficiencies on **September 5, 2020**, may result in a change in the remedy.

Emilee Kulin, Administrator
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The remedy, which will be recommended if substantial compliance has not been achieved by **August 26, 2020**, includes the following:

Denial of payment for new admissions effective **October 22, 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 22, 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 22, 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 17, 2020**. If your request for informal dispute resolution is received after **August 17, 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

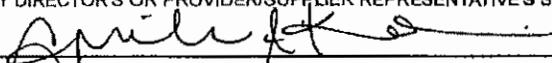
NE/lj
Enclosures

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

Printed: 07/30/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135065	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE NF STRUCTURE B. WING _____	(X3) DATE SURVEY COMPLETED 07/22/2020
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VALLEY OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 601 WEST CAMERON AVENUE KELLOGG, ID 83837	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	<p>INITIAL COMMENTS</p> <p>The facility is a single story, type V (111) structure, originally constructed in 1971, located within a rural fire district. The building is fully sprinklered with and interconnected fire alarm/smoke detection system. Emergency power is supplied by a natural gas, Emergency Power Supply System (EPSS) generator set, with an optional propane backup fuel supply. The facility is currently licensed for 68 SNF/NF beds, with a census of 64 on the day of the survey.</p> <p>The following deficiencies were cited during the annual Fire/Life Safety survey conducted on July 22, 2020. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.</p> <p>The survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction</p>	K 000	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Mountain Valley of Cascadia does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.</p>	
K 293 SS=F	<p>Exit Signage CFR(s): NFPA 101</p> <p>Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and operational testing, the facility failed to ensure means of egress were</p>	K 293	<p>K293</p> <p>Resident Specific:</p> <p>Additional signage was installed that is visible when smoke barrier doors are closed.</p>	

RECEIVED
AUG 06 2020
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE
 CEO 8/7/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 293	<p>Continued From page 1</p> <p>maintained in accordance with NFPA 101. Failure to ensure exits are clearly marked and identifiable, has the potential to hinder egress of residents during a fire or other emergency. This deficient practice affected 35 residents, staff and visitors of the 300 hallway on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 7/22/20 from 10:00 AM - 2:00 PM, observation and operational testing of the smoke compartment doors located at rooms 300 and 301 revealed the doors were not equipped with a sign indicating the exit and common path of travel, when the smoke barrier doors were closed.</p> <p>Actual NFPA standard:</p> <p>NFPA 101</p> <p>19.2.4 Number of Means of Egress. 19.2.4.1 The number of means of egress shall be in accordance with 7.4.1.1 and 7.4.1.3 through 7.4.1.6. 19.2.4.2 Not less than two exits shall be provided on every story. 19.2.4.3 Not less than two separate exits shall be accessible from every part of every story. 19.2.4.4* Not less than two exits shall be accessible from each smoke compartment, and egress shall be permitted through an adjacent compartment(s), provided that the two required egress paths are arranged so that both do not pass through the same adjacent smoke compartment.</p> <p>19.2.10 Marking of Means of Egress. 19.2.10.1 Means of egress shall have signs in</p>	K 293	<p>Other Residents:</p> <p>Additional signage was installed that is visible when smoke barrier doors are closed.</p> <p>Facility systems:</p> <p>The maintenance director was educated on the requirements for NFPA 19.2.4 (7.5 & 7.10.1.2.1). Re-education was provided by Maintenance Resource Supervisor to include but not limited to, all exit signs must be visible when smoke barrier doors are closed. The system has been amended to include oversight from the Chief Executive Officer during facility rounding and monthly environmental audits tracked on TELS.</p> <p>Monitor:</p> <p>The Chief Executive Office and/or designee will audit that corridor exit signage is visible when smoke barrier doors are closed once per week for 2 weeks, then once per month for 1 month to validate all signage is visible starting the week of August 17, 2020. The review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed</p>	

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K 293	Continued From page 2 accordance with Section 7.10, unless otherwise permitted by 19.2.10.2, 19.2.10.3, or 19.2.10.4. 7.5 Arrangement of Means of Egress. 7.5.1.3.1 Where more than one exit, exit access, or exit discharge is required from a building or portion thereof, such exits, exit accesses, or exit discharges shall be remotely located from each other and be arranged to minimize the possibility that more than one has the potential to be blocked by any one fire or other emergency condition. 7.10.1.2 Exits. 7.10.1.2.1* Exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign that is readily visible from any direction of exit	K 293	with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 6 weeks, as it deems appropriate. Chief Executive Officer will review all tools during daily stand up meeting. Date of Compliance: August 26, 2020	8/26/2020
K 324 SS=D	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	K 324	<u>K324</u> Resident Specific: On 7/22/2020, the maintenance director adjusted the grease filter located on the back of the hood once it had been identified it had settled down from installation.	

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K 324	Continued From page 3 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 observation, the facility failed to ensure kitchen hood systems were maintained in accordance with NFPA 96. Failure to ensure grease laden vapors do not bypass hood filters could allow grease build-up inside the exhaust system, increasing the risk of grease fires. This deficient practice affected staff of the main Kitchen on the date of the survey. Findings include: During the facility tour conducted on 7/22/20 from 10:00 AM - 2:00 PM, observation of the main Kitchen hood system revealed an approximately 2-1/2 inch gap between the hood grease filters located on the back, or east side of the hood. Actual NFPA standard: NFPA 96 6.2.3 Grease Filters. 6.2.3.3 Grease filters shall be arranged so that all exhaust air passes through the grease filters.	K 324	Other Residents: On 7/22/2020, the maintenance director adjusted the grease filter located on the back of the hood once it had been identified it had settled down from installation. Facility systems: The maintenance director was educated on the requirements for NFPA 96 (6.2.3 & 6.2.3.3). Re-education was provided by Maintenance Resource Supervisor to include but not limited to, ensuring grease filters are arranged so that all exhaust air passes through filter. The system has been amended to include oversight from the Chief Executive Officer during facility rounding tracked on TELS. Monitor: The Chief Executive Office and/or designee will audit that the grease filter is arranged to ensure all exhaust air passes through filter twice per week for 2 weeks, then once per week for 4 weeks to validate grease filter in place starting the week of August 17,	
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	K 923		

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K 923	Continued From page 4 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 medical gases were stored in accordance with NFPA 99. Failure to ensure medical gas cylinders were properly segregated and secured in either a rack, cart or chained, has the potential for these cylinder to become	K 923	2020. The review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 6 weeks, as it deems appropriate. Chief Executive Officer will review all tools during daily stand up meeting. Date of Compliance: August 26, 2020 923 Resident Specific: On 7/22/2020, the maintenance director removed the Nitrogen cylinder from the therapy department and removed the "empty" oxygen cylinder from the "full" oxygen rack and placed on "empty" cylinder rack. Other Residents: On 7/22/2020, the maintenance director removed the Nitrogen cylinder from the therapy department and removed the "empty" oxygen cylinder from the "full" oxygen rack and placed on "empty" cylinder rack.	8/26/2020

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K 923	<p>Continued From page 5</p> <p>damaged or fall, increasing the potential for explosions and create confusion during an emergency requiring supplemental oxygen. This deficient practice affected 28 residents, staff and visitors, as well as those residents requiring supplemental oxygen on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 7/22/20 from 10:00 AM to 2:00 PM, observation of stored medical gases revealed the following:</p> <ul style="list-style-type: none"> - Observation of the Physical Therapy department abutting the Activity Kitchen revealed one (1) unsecured Nitrogen cylinder stored under a desk. - Observation of the oxygen storage room abutting central supply, revealed cylinders stored in the space both with and without protective caps on the valve and signs on the wall above the storage racks indicating a rack for "Full" and a rack for "Empty" cylinders. Further observation revealed one (1) cylinder without a protective cap stored with seven (7) cylinders with caps on the storage side marked "Full". At approximately 1:15 PM, when asked about the method for determining the full cylinders and empty cylinders, a nurse stationed at the nurse's station stated the cylinders with protective caps were determined "full" and those without were considered "empty". <p>Actual NFPA standard:</p> <p>11.6 Operation and Management of Cylinders. 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</p>	K 923	<p>Facility systems:</p> <p>The maintenance director was educated on the requirements for NFPA 99 (11.6 & 11.6.2.3). Re-education was provided by Maintenance Resource Supervisor to include but not limited to, ensuring all Nitrogen and Oxygen cylinders are stored properly including segregation of "full" and "empty" cylinders. The system has been amended to include oversight from the Chief Executive Officer during facility rounding.</p> <p>Monitor:</p> <p>The Chief Executive Office and/or designee will audit that the Nitrogen and Oxygen cylinders are stored properly including segregation of "full" and "empty" cylinders three times per week for 2 weeks, then once per week for 4 weeks to validate proper storage of all cylinders starting the week of August 17, 2020. The review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency</p>		

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K 923	<p>Continued From page 6</p> <p>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.</p> <p>11.6.5.1 Storage shall be planned so that cylinders can be used in the order in which they are received from the supplier.</p> <p>11.6.5.2 If empty and full cylinders are stored within the same enclosure, empty cylinders shall be segregated from full cylinders.</p>	K 923	<p>of the monitoring after 6 weeks, as it deems appropriate. Chief Executive Officer will review all tools during daily stand up meeting.</p> <p>Date of Compliance: August 26, 2020</p>	8/26/2020

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135065	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE NF STRUCTURE B. WING _____	(X3) DATE SURVEY COMPLETED 07/22/2020	
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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
K 923	Continued From page 7 11.6.5.2.1 When the facility employs cylinders with integral pressure gauge, it shall establish the threshold pressure at which a cylinder is considered empty. 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

August 3, 2020

Emilee Kulin, Administrator
Mountain Valley of Cascadia
601 West Cameron Avenue
Kellogg, ID 83837-2004

Provider #: 135065

RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER

Dear Ms. Kulin:

On **July 22, 2020**, an Emergency Preparedness survey was conducted at Mountain Valley of Cascadia 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,

Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj

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

Printed: 07/30/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135065	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/22/2020
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VALLEY OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 601 WEST CAMERON AVENUE KELLOGG, ID 83837		
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E 000	<p>Initial Comments</p> <p>The facility is a single story, type V (111) structure, originally constructed in 1971, located within a rural fire district. The building is fully sprinklered with and interconnected fire alarm/smoke detection system. Emergency power is supplied by a natural gas, Emergency Power Supply System (EPSS) generator set, with an optional propane backup fuel supply. The facility is currently licensed for 68 SNF/NF beds, with a census of 64 on the day of the survey.</p> <p>The facility was found to be in substantial compliance during the emergency preparedness survey conducted on July 22, 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.