



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 9, 2019

Cindy Riedel, Administrator
Bridgeview Estates
1828 Bridgeview Boulevard
Twin Falls, ID 83301-3051

Provider #: 135113

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

Dear Ms. Riedel:

On **July 30, 2019**, a Facility Fire Safety and Construction survey was conducted at **Bridgeview Estates** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

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

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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 22, 2019**. Failure to submit an acceptable PoC by **August 22, 2019**, may result in the imposition of civil monetary penalties by **September 12, 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 **September 3, 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 **October 28, 2019**. A change in the seriousness of the deficiencies on **September 13, 2019**, 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 **September 3, 2019**, includes the following:

Denial of payment for new admissions effective **October 30, 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 **January 30, 2020**, if substantial compliance is not achieved by that time.

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

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

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **July 30, 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:

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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:

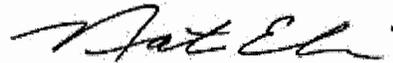
BFS Letters (06/30/11)

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

This request must be received by **August 22, 2019**. If your request for informal dispute resolution is received after **August 22, 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: 08/06/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135113	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE NF BLDG B. WING _____	(X3) DATE SURVEY COMPLETED 07/30/2019
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NAME OF PROVIDER OR SUPPLIER BRIDGEVIEW ESTATES	STREET ADDRESS, CITY, STATE, ZIP CODE 1828 BRIDGEVIEW BOULEVARD TWIN FALLS, ID 83301
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	INITIAL COMMENTS The facility is a single story, type V (III) building constructed in 1992 with an addition in 1996. A two-hour wall separates the Skilled Nursing Facility from an Assisted Living Facility and the subsequently attached multi-story independent living. The facility is fully sprinklered with an interconnected fire alarm/smoke detection system. There is piped in medical gas and an on-site, natural gas, spark ignited Emergency Power Supply System (EPSS) generator. Currently the facility is licensed for 116 SNF/NF beds, and had a census of 67 on the dates of the survey. The following deficiencies were cited during the annual life safety code survey conducted on July 29 - 30, 2019. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Chapter 19, Existing Healthcare Occupancies, in accordance with 42 CFR 483.70. The Survey was conducted by: RECEIVED Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction AUG 26 2019 FACILITY STANDARDS	K 000		
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 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:	K 211	K211 The facility will ensure that means of egress are maintained free of obstructions to their full, instant use. The front entrance doors across from the primary nurses's station were adjusted the egress alarm contacts to appropriate settings. Then tested alarms. Both doors activated the irreversible process of release with approximately 15 lbs of pressure applied. All residents of the facility have the potential to be affected by the deficient practice. All doors were inspected for proper operation as noted above. All doors met compliance. Maintenance department will check and record the functionality of the delayed egress operation of the magnetic locking system on a weekly basis through the Tels system. Maintenance Supervisor will report to month QAPI the findings of the weekly inspections	07/31/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Cynthia M. Redel</i>	TITLE <i>Executive Director</i>	(X6) DATE 8/22/19.
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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>Based on observation, operational testing and interview, the facility failed to ensure that means of egress were maintained free of obstructions to their full, instant use. Failure to ensure doors equipped with magnetic locking arrangements would release under operation of installed delayed egress components has the potential to hinder emergency evacuation of residents. This deficient practice affected 11 residents and staff on the date(s) of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 7/29/19 from 2:00 - 3:00 PM, observation of the front entrance doors across from the primary nurse's station, revealed both doors were equipped and signed for delayed egress operation of the magnetic locking system. Operational testing of both doors established the door on the left as facing from the inside, would not activate the irreversible process of release with approximately 15 lbf pressure applied.</p> <p>Interview of the Maintenance Supervisor at approximately 2:45 PM established he was not aware of the doors not operating as designed.</p> <p>Actual NFPA standard:</p> <p>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.</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</p>	K 211		

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K 211	<p>Continued From page 2</p> <p>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:</p> <p>(1) The door leaves shall unlock in the direction of egress upon actuation of one of the following:</p> <p>(a) Approved, supervised automatic sprinkler 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</p>	K 211		

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K 211	Continued From page 3 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 (5) The egress side of doors equipped with delayed-egress locks shall be provided with emergency lighting in accordance with Section 7.9.	K 211	K325 The facility will ensure Alcohol Based Hand Rub (ABHR) dispensers are installed in accordance with the NFPA101.	
K 325 SS=D	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 horizontal spacing * 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 * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 This REQUIREMENT is not met as evidenced by:	K 325	The alcohol based hand rub dispenser was relocated to adjacent wall away from electric outlets. Maintenance Supervisor inspected all (ABHR) dispensers in the SNF facility All dispensers were installed in accordance with the NFPA 101. All residents have to potential to be affected by this deficient practice. Maintenance Dept. will assure all ABHR installed in the future will be installed in accordance with NFPA 101. Maintenance Supervisor will report monthly to QAPI if any (ABHR) locations are changed	07-31-19

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K 325	<p>Continued From page 4</p> <p>Based on observation and interview, the facility failed to ensure Alcohol Based Hand Rub (ABHR) dispensers were installed in accordance with NFPA 101. Failure to ensure ABHR dispensers are installed away from ignition sources such as electrical outlets, has the potential to increase the risks associated with fires from flammable liquids. This deficient practice affected 1 resident in 1 of 8 smoke compartments on the date(s) of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 7/29/19 from 2:00 - 4:00 PM, observation of the north physical therapy room abutting room 403 revealed an ABHR dispenser installed directly above an electrical outlet. Interview of the Maintenance Supervisor at approximately 3:30 PM, established he was not aware of this installation prior to the survey date.</p> <p>Actual NFPA standard:</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</p>	K 325		

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K 325 Continued From page 5
aerosols as defined in NFPA30B, Code for the Manufacture and Storage of Aerosol Products.
(4) Dispensers shall be separated from each other by horizontal spacing of not less than 48 in. (1220 mm).
(5) Not more than an aggregate 10 gal (37.8 L) of alcohol 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).
(6) One dispenser complying with 19.3.2.6 (2) or (3) per room and located in that room shall not be included in the aggregated quantity addressed in 19.3.2.6(5).
(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.
(8) Dispensers shall not be installed in the following locations:
(a) Above an ignition source within a 1 in. (25 mm) horizontal distance from each side of the ignition source
(b) To the side of an ignition source within a 1 in. (25mm) horizontal distance from the ignition source
(c) Beneath an ignition source within a 1 in. (25 mm) vertical distance from the ignition source
(9) Dispensers installed directly over carpeted floors shall be permitted only in sprinklered smoke compartments.
(10) The alcohol-based hand-rub solution shall not exceed 95 percent alcohol content by volume.
(11) Operation of the dispenser shall comply with the following criteria:
(a) The dispenser shall not release its contents except when the dispenser is activated, either

K 325

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K 325	Continued From page 6 manually or automatically by touch-free activation. (b) Any activation of the dispenser shall occur only when an object is placed within 4 in. (100 mm) of the sensing device. (c) An object placed within the activation zone and left in place shall not cause more than one activation. (d) The dispenser shall not dispense more solution than the amount required for hand hygiene consistent with label instructions. (e) The dispenser shall be designed, 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=D	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	K 353	K353 The facility will ensure that the fire supression system are maintained in accordance with NFPA25 1. Please see (exhibit 1-k) Letter from Delta Fire. 2. The corroded fire Suppression pendants were replaced by Delta Fire. All residents have the potential to be affected by the deficient practice. All fire suppression pendants were inspected for corroded penants in the dry system. Delta will continue to inspect the pendants annually	7-31-19

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K 353	<p>Continued From page 7</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that fire suppression systems were maintained in accordance with NFPA 25. Failure to ensure sprinkler pendants were maintained free of leakage and obstructions such as paint, dirt and corrosion and systems testing was conducted as required, has the potential to hinder system response during a fire event. This deficient practice affected staff on the date of the survey.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1) During review of provided sprinkler inspection testing and maintenance conducted on 7/29/19 from 9:00 AM - 2:00 PM, no records were available indicating the last 10-year dry sprinkler pendant testing or replacement. 2) During the facility tour conducted on 7/29/19 from 2:30 - 4:00 PM, observation of installed fire suppression pendants in the main Kitchen revealed two (2) corroded sprinkler pendants over the main cookline. <p>Interview of the Maintenance Supervisor at approximately 3:00 PM established he was not aware of these pendant impediments prior to the date of the survey.</p> <p>Actual NFPA standard:</p> <p>NFPA 25 5.2* Inspection. 5.2.1 Sprinklers. 5.2.1.1* Sprinklers shall be inspected from the floor level annually.</p>	K 353	<p>Maintenance Supervisor will add a monthly dry system pendant inspection and document results</p> <p>Maintenance Supervisor will report findings to monthly QAPI.</p> <p>See (attachment K-2) bill from Delta.</p>	

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NAME OF PROVIDER OR SUPPLIER BRIDGEVIEW ESTATES	STREET ADDRESS, CITY, STATE, ZIP CODE 1828 BRIDGEVIEW BOULEVARD TWIN FALLS, ID 83301
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K 353	<p>Continued From page 8</p> <p>5.2.1.1.1* Sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., upright, pendent, or sidewall).</p> <p>5.2.1.1.2 Any sprinkler that shows signs of any of the following shall be replaced:</p> <ul style="list-style-type: none"> (1) Leakage (2) Corrosion (3) Physical damage (4) Loss of fluid in the glass bulb heat responsive element (5)*Loading (6) Painting unless painted by the sprinkler manufacturer <p>5.3.1.1.1.6* Dry sprinklers that have been in service for 10 years shall be replaced or representative samples shall be tested and then retested at 10-year intervals.</p>	K 353	Type text here	
K 363 SS=F	<p>Corridor - Doors</p> <p>CFR(s): NFPA 101</p> <p>Corridor - Doors</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material.</p> <p>Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors</p>	K 363	<p>K363</p> <p>Facility will ensure that doors entering resident rooms from the corridor will close and latch.</p> <p>Rooms 433 and 456 were repaired to meet compliance with NFPA 101</p> <p>All residents have the potential to be affected by the deficient practice.</p> <p>All rooms within the SNF area were inspected for closure and latching.</p> <p>Maintenance Supervisor has added the door closing and latching to the room inspections on TELS. This will ensure that each resident room will be inspected each quarter.</p> <p>Maintenance Supervisor with report deficiencies to the monthly QA</p>	7-30-19

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K 363	<p>Continued From page 9</p> <p>complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.</p> <p>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and operational testing, the facility failed to ensure that doors entering resident rooms from the corridor would close and latch. Failure to ensure corridor doors close and latch has the potential to allow smoke and dangerous gases to pass between compartments and affect the safe egress of residents during a fire. This deficient practice affected 27 residents and staff on the date(s) of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 7/29/19 from 2:00 - 4:00 PM, observation and operational testing of resident room doors revealed the door to resident room 433 and room 456 would not latch when closed.</p>	K 363		
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K 363	Continued From page 10 Actual NFPA standard: 19.3.6.3.5* Doors shall be provided with a means for keeping the door closed that is acceptable to the authority having jurisdiction, and the following requirements also shall apply: (1) The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. (2) Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.7.	K 363	K511 The facility will ensure electrical installations are safe and used in accordance with approved, listed assemblies. In accordance with NFPA70. Maintenance removed the relocatable power taps from daisy chain in 411 and plugged directly into outlet. Maintenance removed the extension cord and plugged RPT directly into outlet. Central supply removed the boxes by the in wall electric cadet heater. Closet in SE dining hall remounted electrical box cover. The food services director office removed coffee maker from PRT and plugged directly into wall outlet	
K 511 SS=F	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 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure safe electrical installations in accordance with NFPA 70 and approved, listed assemblies. Failure to ensure electrical installations are safe and used in accordance with approved, listed assemblies, has the potential to increase the risk of arc fires and exposing residents and staff to electrical shock. This deficient practice affected 39 residents and staff	K 511	All residents have the potential to be affected by the deficient practice All were in serviced to above deficient practice as of 8-19-19 Exhibit (K-3) The corrective action will be monitored by the assignment of department heads to inspect their rooms for these deficient practice and submit a monthly audit of their findings to the Maintenance department. See Exhibit k-3 educations <i>Maintenance will report to monthly QA of the findings</i>	8-20-19

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K 511	<p>Continued From page 11 in 3 of 8 smoke compartments on the date(s) of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 7/29/19 from 2:00 - 4:30 PM, observation of installed electrical systems revealed the following:</p> <ul style="list-style-type: none"> - Room 411 had use of two (2) relocatable power taps (RPTs) that were observed connected in series (daisy-chained), substituting the fixed wiring of the facility to supply power to resident t.v. and lighting fixtures. - Central supply had a stack of boxes blocking the in-wall electric cadet heater. - The closet in the southeast dining hall had an open four inch by four inch electrical box with exposed wiring. <p>Interview of the Maintenance Supervisor on 7/29/19 revealed the power supply box had been serviced by the furnace vendor and he was unaware the live parts had not been recovered.</p> <ul style="list-style-type: none"> - Room 447 had a 3-1 non-grounded extension cord daisy-chained to a RPT, substituting the fixed wiring of the facility to supply power to the resident t.v. - The food service director office had a coffee maker plugged into a RPT. <p>Actual NFPA standard:</p> <p>NFPA 70</p> <p>110.27 Guarding of Live Parts. (A) Live Parts Guarded Against Accidental Contact. Except as elsewhere required or permitted by this Code, live parts of electrical</p>	K 511		

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K 511	<p>Continued From page 12</p> <p>equipment operating at 50 volts or more shall be guarded against accidental contact by approved enclosures or by any of the following means:</p> <p>(1) By location in a room, vault, or similar enclosure that is accessible only to qualified persons.</p> <p>(2) By suitable permanent, substantial partitions or screens arranged so that only qualified persons have access to the space within reach of the live parts. Any openings in such partitions or screens shall be sized and located so that persons are not likely to come into accidental contact with the live parts or to bring conducting objects into contact with them.</p> <p>(3) By location on a suitable balcony, gallery, or platform elevated and arranged so as to exclude unqualified persons.</p> <p>(4) By elevation of 2.5 m (8 ft) or more above the floor or other working surface.</p> <p>110.3 Examination, Identification, Installation, and Use of Equipment.</p> <p>(A) Examination. In judging equipment, considerations such as the following shall be evaluated:</p> <p>(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.</p> <p>(2) Mechanical strength and durability, including, for parts designed to enclose and protect other</p>	K 511		

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K 511	<p>Continued From page 13</p> <p>equipment, the adequacy of the protection thus provided</p> <p>(3) Wire-bending and connection space</p> <p>(4) Electrical insulation</p> <p>(5) Heating effects under normal conditions of use and also under abnormal conditions likely to arise in service</p> <p>(6) Arcing effects</p> <p>(7) Classification by type, size, voltage, current capacity, and specific use</p> <p>(8) Other factors that contribute to the practical safeguarding of persons using or likely to come in contact with the equipment.</p> <p>(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>400.8 Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following:</p> <p>(1) As a substitute for the fixed wiring of a structure</p> <p>(2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors</p> <p>(3) Where run through doorways, windows, or similar openings</p> <p>(4) Where attached to building surfaces</p> <p>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)</p> <p>(5) Where concealed by walls, floors, or ceilings or located above suspended or dropped ceilings</p> <p>(6) Where installed in raceways, except as otherwise permitted in this Code</p> <p>(7) Where subject to physical damage</p> <p>Additional reference: UL 1363 XBYS</p>	K 511		
K 914	Electrical Systems - Maintenance and Testing	K 914		

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K 914 SS=F	<p>Continued From page 14 CFR(s): NFPA 101</p> <p>Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure resident room electrical receptacles were maintained properly. Failure to test resident room electrical receptacles annually has the potential to hinder system response during an emergency that encompasses a loss of power. This deficient practice affected 65 residents and staff on the date(s) of the survey.</p> <p>Findings include:</p> <p>During review of provided maintenance documents conducted on 7/29/19 from 9:00 - 10:30 AM, no documentation was available</p>	K 914	<p>K914</p> <p>The faciity will ensure the resident's room Electricial receptacles are maintained properly. <i>were ✓</i></p> <p>All receptacles will be tested by 8-20-19 . The annual test will be April 8, 2020 .</p> <p>All residents have the potential to be affected by this deficient practice.</p> <p>Maintenance Supervisor will inspect documentation to ensure all rooms are completed within the 12 month intervals.</p> <p>Maintenace Supervisor will report any deficient practice to the monthly QAPI team (see Exhibit K-.5)</p>	8-20-19

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K 914	<p>Continued From page 15 demonstrating an annual test conducted on resident room outlets.</p> <p>Interview of the Director of Maintenance on 7/30/19 at approximately 10:30 AM established he had not yet completed an annual test on resident room outlets.</p> <p>Actual NFPA standard:</p> <p>NFPA 99 Chapter 6 Electrical Systems</p> <p>6.3.3.2 Receptacle Testing in Patient Care Rooms. 6.3.3.2.1 The physical integrity of each receptacle shall be confirmed by visual inspection. 6.3.3.2.2 The continuity of the grounding circuit in each electrical receptacle shall be verified. 6.3.3.2.3 Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed. 6.3.3.2.4 The retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 g (4 oz).</p> <p>6.3.4.1 Maintenance and Testing of Electrical System. 6.3.4.1.1 Where hospital-grade receptacles are required at patient bed locations and in locations where deep sedation or general anesthesia is administered, testing shall be performed after initial installation, replacement, or servicing of the device. 6.3.4.1.2 Additional testing of receptacles in patient care rooms shall be performed at intervals defined by documented performance data.</p>	K 914		

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K 914	Continued From page 16 6.3.4.1.3 Receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months.	K 914		
K 930 SS=D	<p>Gas Equipment - Liquid Oxygen Equipment CFR(s): NFPA 101</p> <p>Gas Equipment - Liquid Oxygen Equipment The storage and use of liquid oxygen in base reservoir containers and portable containers comply with sections 11.7.2 through 11.7.4 (NFPA 99). 11.7 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure liquid, or cryogenic, oxygen cylinders were secured in accordance with NFPA 99. Failure to ensure cryogenic oxygen cylinders are secured by either a cart or chain, has the potential to expose residents and staff to the risks associated when cryogenic oxygen that comes in contact with skin or a hydrocarbon. This deficient practice affected 8 residents and staff in 1 of 8 smoke compartments on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 7/29/19 from 2:00 - 4:00 PM, observation of the oxygen transfill and storage room abutting room(s) 430 and 432, revealed 1 of 9 cryogenic oxygen cylinders was not secured by a chain or placed in a rack or cart.</p> <p>Actual NFPA standard:</p> <p>11.7.3 Container Storage, Use, and Operation. 11.7.3.1* Containers shall be stored, used, and operated in accordance with the manufacturer ' s</p>	K 930	<p>K 930 The facility will ensure that the liquid, or cryogenic, oxygen cylinders are secured in accordance with NFPA 99.</p> <p>The cylinder was removed by Norco. All other cylinders were secured in the SNF facility</p> <p>All residents have the potential to be affected by the deficient practice.</p> <p>Maintenance Director will audit central supply room monthly x 1 quarter. Then quarterly x 3.</p> <p>Any deficient practice will be brought to the monthly QAPI e Maintenance</p> <p>See attached 02 Training Exhibit K-3</p>	8-22-19

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K 930	<p>Continued From page 17 instructions and labeling.</p> <p>11.7.3.2 Containers shall not be placed in the following areas:</p> <ul style="list-style-type: none"> (1) Where they can be tipped over by the movement of a door (2) Where they interfere with foot traffic (3) Where they are subject to damage from falling objects (4) Where exposed to open flames and high-temperature devices <p>11.7.3.3* Liquid oxygen base reservoir containers shall be secured by one of the following methods while in storage or use to prevent tipping over caused by contact, vibration, or seismic activity:</p> <ul style="list-style-type: none"> (1) Securing to a fixed object with one or more restraints (2) Securing within a framework, stand, or assembly designed to resist container movement (3) Restraining by placing the container against two points of contact 	K 930		



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
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Boise, ID 83720-0009
PHONE 208-334-6626
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August 9, 2019

Cindy Riedel, Administrator
Bridgeview Estates
1828 Bridgeview Boulevard
Twin Falls, ID 83301-3051

Provider #: 135113

RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER

Dear Ms. Riedel:

On **July 30, 2019**, an Emergency Preparedness survey was conducted at **Bridgeview Estates** 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 **August 22, 2019**. Failure to submit an acceptable PoC by **August 22, 2019**, may result in the imposition of civil monetary penalties by **September 12, 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 **September 3, 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 **September 22, 2019**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **September 3, 2019**, includes the following:

Denial of payment for new admissions effective **October 30, 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 **January 30, 2020**, if substantial compliance is not achieved by that time.

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

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

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **July 30, 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)

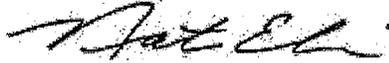
2001-10 Long Term Care Informal Dispute Resolution Process
2001-10 IDR Request Form

Cindy Riedel, Administrator
August 9, 2019
Page 4 of 4

This request must be received by **August 22, 2019**. If your request for informal dispute resolution is received after **August 22, 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: 08/06/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135113	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/30/2019
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NAME OF PROVIDER OR SUPPLIER BRIDGEVIEW ESTATES	STREET ADDRESS, CITY, STATE, ZIP CODE 1828 BRIDGEVIEW BOULEVARD TWIN FALLS, ID 83301
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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
E 000	<p>Initial Comments</p> <p>The facility is a single story, type V (III) building constructed in 1992 with an addition in 1996. A two-hour wall separates the Skilled Nursing Facility from an Assisted Living Facility and the subsequently attached multi-story independent living. The facility is fully sprinklered with an interconnected fire alarm/smoke detection system. It is located within a municipal fire district with both county and state EMS services available. There is piped in medical gas and an on-site, natural gas, spark ignited Emergency Power Supply System (EPSS) generator. Currently the facility is licensed for 116 SNF/NF beds, and had a census of 65 on the dates of the survey.</p> <p>The following deficiency was cited during the Emergency Preparedness Survey conducted on July 29 - 30, 2019. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.</p> <p>The survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction</p>	E 000	<p>RECEIVED</p> <p>AUG 26 2019</p> <p>FACILITY STANDARDS</p>	
E 036 SS=D	<p>EP Training and Testing CFR(s): 483.73(d)</p> <p>(d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this</p>	E 036		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
<i>Cynthia M. Redel</i>	<i>Executive Director</i>	<i>8/22/19</i>

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: 08/06/2019
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135113	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/30/2019
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NAME OF PROVIDER OR SUPPLIER BRIDGEVIEW ESTATES	STREET ADDRESS, CITY, STATE, ZIP CODE 1828 BRIDGEVIEW BOULEVARD TWIN FALLS, ID 83301
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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
E 036	<p>Continued From page 1 section. The training and testing program must be reviewed and updated at least annually.</p> <p>*[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h).</p> <p>*[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the facility failed to provide an emergency prep training and testing program for the Emergency Plan (EP) contents. Lack of a facility staff testing program covering the contents of the EP, has the potential to hinder staff response during a disaster. This deficient practice affected 65 residents, staff and visitors on the date of the survey.</p>	E 036	<p>E036</p> <p>The facility will ensure that the facility staff will be tested on the Emergency Preparedness Plan.</p> <p>On 8-19-19 all staff were given a test (crossword) puzzle on the current Emergency Plan The test will be maintained in the EP training and testing folder in Maintenance Office.</p> <p>All residents have the potential to be affected by the deficient practice.</p> <p>The 1st measurement will be the test followed by spot checks of their knowledge base through out the quarter.</p> <p>Maintenance director will present to QAPI the results of the cross work puzzle and the cross checks .</p> <p><i>see exhibit (IE)</i></p>	8-19-19

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

PRINTED: 08/27/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135113	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2019
NAME OF PROVIDER OR SUPPLIER BRIDGEVIEW ESTATES			STREET ADDRESS, CITY, STATE, ZIP CODE 1828 BRIDGEVIEW BOULEVARD TWIN FALLS, ID 83301		
(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 036	Continued From page 2 disaster. This deficient practice affected 65 residents, staff and visitors on the date of the survey. Findings include: On 7/29/19 from 9:00 - 10:00 AM, review of provided EP, along with associated inservices, revealed the facility had a training program, however no documentation was available demonstrating the facility had a testing program on those training(s), to test staff knowledge of the contents of the EP. Reference: 42 CFR 483.73 (d)	E 036			