



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 Eider Street  
P.O. Box 83720  
Boise, ID 83720-0009  
PHONE 208-334-6626  
FAX 208-364-1888

September 26, 2019

Randal Barnes, Administrator  
Valley Vista Care Center of St Maries  
820 Elm Street  
St Maries, ID 83861-2119

Provider #: 135075

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

Dear Mr. Barnes:

On **September 17, 2019**, a Facility Fire Safety and Construction survey was conducted at **Valley Vista Care Center of St Maries** 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 **October 9, 2019**. Failure to submit an acceptable PoC by **October 9, 2019**, may result in the imposition of civil monetary penalties by **October 31, 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 **October 22, 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 **December 16, 2019**. A change in the seriousness of the deficiencies on **November 1, 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 **October 22, 2019**, includes the following:

Denial of payment for new admissions effective **December 17, 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 **March 17, 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 **September 17, 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:

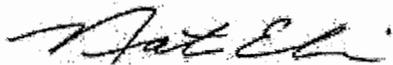
BFS Letters (06/30/11)

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

This request must be received by **October 9, 2019**. If your request for informal dispute resolution is received after **October 9, 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: 09/25/2019  
FORM APPROVED  
OMB NO. 0938-0391

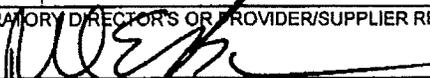
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135075</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE NF STRUCTURE - BUILDING AND APARTMENT B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/17/2019</b>
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NAME OF PROVIDER OR SUPPLIER <b>VALLEY VISTA CARE CENTER OF ST MARIES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>820 ELM STREET ST MARIES, ID 83861</b>
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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 multi-story, Type II(111) structure, originally constructed in 1979. There is a two-story atrium within the center of the building and openings to the atrium are equipped with drop down fire doors. The facility is fully sprinklered with an interconnected fire alarm/smoke detection system. There are two (2), on-site Emergency Power Supply System (EPSS) generators, a diesel-fire and a spark-ignited set. Currently the facility is licensed for 74 SNF/NF beds, and had a census of 63 on the date of the survey.  The following deficiencies were cited during the annual fire/life safety survey conducted on September 17, 2019. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.  The Survey was conducted by:  Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction	K 000		
K 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: Based on observation, operational testing and	K 211	<b>K 211</b>  <b>Residents: Door at main entry and north stairs from dining room were adjusted to ensure they released under applied pressure.</b>	<b>10/18/19</b>

RECEIVED  
OCT 07 2019  
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>Administrator</b>	(X8) DATE <b>10-7-19</b>
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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>interview, the facility failed to ensure that special locking arrangements were operational in accordance with NFPA 101. Failure to ensure doors equipped with magnetic locking arrangements and delayed egress components released as designed, has the potential to hinder the safe evacuation of residents during an emergency. This deficient practice affected 13 residents and staff on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 9/17/19 from 11:00 AM - 3:00 PM, observation and operational testing of the following doors equipped with delayed egress failed to demonstrate the door would release under applied pressure as designed:</p> <ul style="list-style-type: none"> <li>- The doors at the main entry were observed to be equipped with Wanderguard and signed with the applicable delayed egress requirement. Operational testing of the left door of the main entry as faced from the inside, revealed it would not release under applied pressure.</li> <li>- The door exiting to the north stairs from the main dining room was observed to be equipped with magnetic locking arrangements and required delayed egress component. Operational testing of this door established it would not release under applied pressure.</li> </ul> <p>Interview of the Maintenance Supervisor at approximately 12:30 PM established he was not aware these doors were not operating in accordance with the standard.</p> <p>Actual NFPA standard:</p> <p>7.2.1.6* Special Locking Arrangements.</p>	K 211	<p><b>Other Residents:</b> Remainder of delayed egress doors were tested to ensure proper release.</p> <p><b>Systemic Measures:</b> All delayed egress doors to be placed on preventative maintenance schedule.</p> <p><b>Monitoring:</b> Maintenance to perform monthly testing of delayed egress to ensure doors release under applied pressure. Results to be reviewed at monthly QAPI meeting.</p>	

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K 211	<p>Continued From page 2</p> <p>7.2.1.6.1 Delayed-Egress Locking Systems. 7.2.1.6.1.1 Approved, listed, delayed-egress locking systems shall be permitted to be installed on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6 or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 11 through 43, provided that all of the following criteria are met:</p> <p>(1) The door leaves shall unlock in the direction of egress upon actuation of one of the following: (a) Approved, supervised automatic sprinkler system in accordance with Section 9.7 (b) Not more than one heat detector of an approved, supervised automatic fire detection system in accordance with Section 9.6 (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: (a) The force shall not be required to exceed 15 lbf (67 N). (b) The force shall not be required to be continuously applied for more than 3 seconds. (c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening. (d) Once the lock has been released by the application of force to the releasing device,</p>	K 211		

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K 211	Continued From page 3 relocking shall be by manual means only. (4)*A readily visible, durable sign in letters not less than 1 in. (25 mm) high and not less than 1.8 in. (3.2 mm) in stroke width on a contrasting background that reads as follows shall be located on the door leaf adjacent to the release device in the direction of egress: <b>PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS</b> (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		
K 293 SS=F	Exit Signage CFR(s): NFPA 101  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, the facility failed to ensure means of egress signs were in accordance with NFPA 101. Installation of egress signs that are not indicative of the clear path of travel, has the potential to misdirect the designated path of travel and hinder safe egress of residents during an emergency. This deficient practice affected 31 residents and staff on the date of the survey.  Findings include:  During the facility tour conducted on 9/17/19 from 11:00 AM - 3:00 PM, observation of installed exit	K 293	<b>K 293</b>  <b>Residents:</b> Exit sign at the smoke barrier doors at room 217 and the exit sign at the north exit of the main dining room were repaired to ensure they illuminated the proper direction of exit access.  <b>Other Residents:</b> Remainder of exit signs were examined to ensure proper direction to exit access.  <b>Systemic Measures:</b> All exit signs to be placed on monthly checks for proper directional illumination.	<b>10/18/19</b>

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K 293	Continued From page 4 signs in the following locations indicated the path of egress was to a wall due to the illuminated arrow installed in the sign:  - The chevron at the exit sign installed at the smoke barrier doors at room 217 directed travel to the right hand wall when exiting toward the front of the facility - The chevron at the exit sign installed at the north exit of the main dining room, directed travel to the right hand wall.  Actual NFPA standard:  7.10 Marking of Means of Egress.  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 access.	K 293	<b>Monitoring: Maintenance to perform monthly checks of exit signs to ensure signs are illuminating correct exit access. Results to be reviewed at monthly QAPI meeting.</b>	
K 311 SS=F	Vertical Openings - Enclosure CFR(s): NFPA 101  Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility	K 311	<b>K 311</b>  <b>Residents: Drop down fire doors were tested on October 3, 2019.</b>  <b>Other Residents: Drop down fire doors were tested on October 3, 2019.</b>  <b>Systemic Measures: Annual inspection of the drop down doors has been scheduled</b>	<b>10/18/19</b>

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K 311	<p>Continued From page 5</p> <p>failed to ensure drop-down down fire doors separating atrium areas to resident sleeping room corridors were tested annually in accordance with NFPA 80. Failure to conduct annual testing of drop-down fire doors has the potential to hinder the operation of those protective features and allow fire, smoke and dangerous gases to pass between compartments during a fire event. This deficient practice affected 63 residents and staff on the date of the survey.</p> <p>Findings include:</p> <p>During review of provided maintenance and inspection records conducted on 9/17/19 from 8:30 - 11:00 AM, no records were available demonstrating the installed drop-down fire doors separating the atrium from the resident sleeping room corridors were tested annually. Interview of the Maintenance Supervisor conducted at approximately 10:00 AM, established he thought the drop doors had been tested during an inspection of the fire dampers.</p> <p>Actual NFPA standard:</p> <p>8.6.7* Atriums. Unless prohibited by Chapters 11 through 43, an atrium shall be permitted, provided that the following conditions are met:</p> <p>(1) The atrium is separated from the adjacent spaces by fire barriers with not less than a 1-hour fire resistance rating, with opening protectives for corridor walls, unless one of the following is met:</p> <p>(a) The requirement of 8.6.7(1) shall not apply to existing, previously approved atriums.</p> <p>(b) Any number of levels of the building shall be permitted to open directly to the atrium without enclosure, based on the results of the engineering analysis required in 8.6.7(5).</p>	K 311	<p><b>Monitoring: Annual testing of the drop down doors has been scheduled. Results of annual testing to be reviewed at October QAPI meeting.</b></p>	

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K 311	Continued From page 6 (c)*Glass walls and inoperable windows shall be permitted in lieu of the fire barriers where all the following are met: i. Automatic sprinklers are spaced along both sides of the glass wall and the inoperable windows at intervals not to exceed 6 ft (1830 mm). ii. The automatic sprinklers specified in 8.6.7(1)(c)(i) are located at a distance from the glass wall not to exceed 12 in. (305 mm) and arranged so that the entire surface of the glass is wet upon operation of the sprinklers. iii. The glass wall is of tempered, wired, or laminated glass held in place by a gasket system that allows the glass framing system to deflect without breaking (loading) the glass before the sprinklers operate. iv. The automatic sprinklers required by 8.6.7(1)(c)(i) are not required on the atrium side of the glass wall and the inoperable window where there is no walkway or other floor area on the atrium side above the main floor level. v. Doors in the glass walls are of glass or other material that resists the passage of smoke. vi. Doors in the glass walls are self-closing or automatic-closing upon detection of smoke. vii. The glass is continuous vertically, without horizontal mullions, window treatments, or other obstructions that would interfere with the wetting of the entire glass surface.  NFPA 80 Chapter 5 Care and Maintenance  5.2* Inspections. 5.2.1* Fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ.	K 311		
K 321	Hazardous Areas - Enclosure	K 321		

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K 321 SS=F	<p>Continued From page 7 CFR(s): NFPA 101</p> <p><b>Hazardous Areas - Enclosure</b> Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9</p> <p>Area                      Automatic Sprinkler Separation N/A</p> <p>a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and operational testing, the facility failed to ensure that doors to hazardous areas would self-close and latch in accordance with NFPA 101. Failure to ensure self-closing doors from the corridor to hazardous areas would latch, has the potential to allow fire, smoke and dangerous gases to enter the corridor and affect</p>	K 321	<p><b>K 321</b></p> <p><b>Residents:</b> The soiled linen door located inside the Behavioral Unit was adjusted to ensure it would fully close and latch when activated.</p> <p><b>Other Residents:</b> Other self-closing doors were tested and no other issues were encountered.</p> <p><b>Systemic Measures:</b> Self closing doors were placed on a monthly preventative maintenance check list.</p> <p><b>Monitoring:</b> Monthly testing of the self-closing doors has been added to the PM. Results of annual testing to be reviewed at monthly QAPI meeting.</p>	<b>10/18/19</b>

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135075</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE NF STRUCTURE - BUILDING AND APARTMENT B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/17/2019</b>
NAME OF PROVIDER OR SUPPLIER <b>VALLEY VISTA CARE CENTER OF ST MARIES</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>820 ELM STREET ST MARIES, ID 83861</b>		
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K 321	<p>Continued From page 8</p> <p>the safe egress of residents during a fire. This deficient practice affected 31 residents and staff on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 9/17/19 from 11:00 AM - 3:00 PM, observation and operational testing of the soiled linen door located inside the Behavioral unit, revealed the door would not fully close and latch when activated.</p> <p>Actual NFPA standard:</p> <p>19.3.2 Protection from Hazards.</p> <p>19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.7.1.</p> <p>19.3.2.1.1 An automatic extinguishing system, where used in hazardous areas, shall be permitted to be in accordance with 19.3.5.9.</p> <p>19.3.2.1.2* Where the sprinkler option of 19.3.2.1 is used, the areas shall be separated from other spaces by smoke partitions in accordance with Section 8.4.</p> <p>19.3.2.1.3 The doors shall be self-closing or automatic-closing.</p> <p>19.3.2.1.5 Hazardous areas shall include, but shall not be restricted to, the following:</p> <p>(1) Boiler and fuel-fired heater rooms</p> <p>(2) Central/bulk laundries larger than 100 ft2 (9.3 m2)</p> <p>(3) Paint shops</p> <p>(4) Repair shops</p> <p>(5) Rooms with soiled linen in volume exceeding 64 gal (242 L)</p>	K 321		

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K 321	Continued From page 9 (6) Rooms with collected trash in volume exceeding 64 gal (242 L) (7) Rooms or spaces larger than 50 ft <sup>2</sup> (4.6 m <sup>2</sup> ), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard	K 321		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101  Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked  b) Who provided system test  c) Water system supply source  Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure fire suppression system sprinkler pendants were maintained in accordance with NFPA 25. Failure to replace pendants that are obstructed due to corrosion or non-factory applied paint, has the potential to hinder suppression system response	K 353	<b>K 353</b>  <b>Residents:</b> The <del>paint on the</del> sprinkler in the housekeeping storage area was removed on <del>9/17/19</del> . The two sprinklers in the kitchen were replaced on 9/23/19.  <b>Other Residents:</b> The remaining sprinklers in the facility were visually inspected and issues corrected if/as needed.  <b>Systemic Measures:</b> Visual inspection of sprinklers heads will be conducted quarterly to ensure compliance.	<b>10/18/19</b> <i>SB</i> <i>SB WAS REPLACED</i>

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K 353	<p>Continued From page 10 during a fire. This deficient practice affected 13 residents and staff on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 9/17/19 from 11:00 AM - 3:00 PM, observation of the installed fire suppression system sprinkler pendants, revealed the following obstructions:</p> <ul style="list-style-type: none"> <li>- The Housekeeping storage abutting resident room 214 had one (1) painted sprinkler.</li> <li>- The Main Kitchen had two (2) corroded sprinklers. One (1) was located at the dishwashing station and one (1) above the Kitchen cold storage.</li> </ul> <p>Actual NFPA standard:</p> <p>NFPA 25</p> <p>5.2* Inspection. 5.2.1 Sprinklers. 5.2.1.1* Sprinklers shall be inspected from the floor level annually. 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). 5.2.1.1.2 Any sprinkler that shows signs of any of the following shall be replaced: (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>	K 353	<p><b>Monitoring:</b> Quarterly inspections of the sprinklers heads has been added to the PM. Results of quarterly testing to be reviewed quarterly at QAPI meeting.</p>	

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K 511 K 511 SS=F	Continued From page 11 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, the facility failed to ensure safe electrical installations in accordance with NFPA 70. Failure to ensure electrical installations were in accordance with approved, listed assemblies and those provisions of the NFPA 70, has the potential to expose residents to electrical shock and the risk of arc fires. This deficient practice affected 31 residents and staff on the date of the survey.  Findings include:  During the facility tour conducted on 9/17/19 from 11:00 AM - 3:00 PM, observation of electrical installations in the facility revealed the following:  - The t.v. area of the Behavioral Unit was using a 3-1 non-grounded extension cord to supply power to the television. - The patio sitting area outside of the south end of the Behavioral Unit had a Ground Fault Interrupter (GFI) outlet that did not have a protective cover.	K 511 K 511	<b>K 511</b>  <b>Residents:</b> The extension cord was removed on 9/17/19. A protective cover was placed on the outlet in the patio sitting area outside of the Behavioral Unit on 9/18/19.  <b>Other Residents:</b> A visual inspection of the remainder of the facility was conducted to ensure compliance. Issues/concerns were corrected if/as needed.  <b>Systemic Measures:</b> Staff education on regulations regarding extension cords on 9/23/19.  Maintenance to monitor during walking rounds.  <b>Monitoring:</b> Results of walking rounds to be reviewed at monthly QAPI meeting.	<b>10/18/19</b>

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K 511	<p>Continued From page 12</p> <ul style="list-style-type: none"> <li>- The cadet heater at the north wall of the dining room was observed to have a unit safety label indicating the required clearance was three (3) feet on all sides. Further observation revealed this heater had a chair and two (2) rolling stools placed directly in front of it, leaving approximately six (6) inches clearance in front of it.</li> <li>- The chart room office window had a window air conditioner that was using a relocatable power tap (RPT) for supplying power from the outlet.</li> </ul> <p>Actual NFPA standard:</p> <p>NFPA 70 110.3 Examination, Identification, Installation, and Use of Equipment. (A) Examination. In judging equipment, considerations such as the following shall be evaluated:</p> <ol style="list-style-type: none"> <li>(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.</li> <li>(2) Mechanical strength and durability, including, for parts designed to enclose and protect other equipment, the adequacy of the protection thus provided</li> <li>(3) Wire-bending and connection space</li> <li>(4) Electrical insulation</li> <li>(5) Heating effects under normal conditions of use and also under abnormal conditions likely to</li> </ol>	K 511		

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K 511	<p>Continued From page 13</p> <p>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>110.27 Guarding of Live Parts.</p> <p>(A) Live Parts Guarded Against Accidental Contact. Except as elsewhere required or permitted by this Code, live parts of electrical 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>(B) Prevent Physical Damage. In locations where electrical equipment is likely to be exposed to physical damage, enclosures or guards shall be so arranged and of such strength as to prevent such damage.</p>	K 511		

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K 511	Continued From page 14 (C) Warning Signs. Entrances to rooms and other guarded locations that contain exposed live parts shall be marked with conspicuous warning signs forbidding unqualified persons to enter. Informational Note: For motors, see 430.232 and 430.233. For over 600 volts, see 110.34.  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  Additional reference: UL 1363 XBYS	K 511		
K 791 SS=E	Construction, Repair, and Improvement Operations CFR(s): NFPA 101  Construction, Repair, and Improvement Operations Construction, repair, and improvement operations shall comply with 4.6.10. Any means of egress in any area undergoing construction, repair, or improvements shall be inspected daily to ensure its ability to be used instantly in case of emergency and compliance with NFPA 241. 18.7.9, 19.7.9, 4.6.10, 7.1.10.1	K 791	<b>K 791</b>  <b>Residents:</b> The temporary wall between the kitchen and the main dining room has been removed. The old wall will be sheet rocked to create an approved barrier.	<b>10/18/19</b>

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K 791	<p>Continued From page 15</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that construction projects were protected from the habitable spaces of the facility by an approved barrier. Providing plastic sheeting as barriers for corridor walls separating construction projects and using standard plywood for access doors, fails to ensure non-combustible separation exists between continuing construction projects and those areas used by facility residents. This practice potentially exposes those residents to all risks associated with construction hazardous area activities. This deficient practice affected those residents using the main dining hall and staff on the date of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on 9/17/19 from 8:30 - 11:00 AM, observation of the construction project between the Main Kitchen and the facility dining room, a wall that was observed as being installed in the dining area with a gypsum board face. Further observation of this wall revealed the seams were covered with a white plastic tape that was falling down in some areas and a plywood sheet used as an access door.</p> <p>2) Continued observation of the inside of the construction area and the opposing side of the wall separating the dining room, revealed the plywood access door was not a rated assembly and the interior, or construction side of the assembly, was not covered with a barrier and the wall cavities were filled with a standard fiberglass insulation. In addition, observation of the west wall revealed a framed opening to the corridor. Further observation established the opening had</p>	K 791	<p><b>Other Residents:</b> The temporary wall between the kitchen and the main dining room has been removed. The old wall will be sheet rocked to create an approved barrier.</p> <p><b>Systemic Measures:</b> New areas of construction will be monitored to ensure approved barriers are present.</p> <p><b>Monitoring:</b> As construction continues, areas will be monitored to ensure habitable spaces of the facility are protected by an approved barrier. Results of monitoring will be reviewed at monthly QAPI meeting.</p>	

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K 791	Continued From page 16 only a plastic sheeting separating the corridor to the construction project at this location.  3) When asked at approximately 11:30 AM why the construction project was not separated by one-hour construction to the facility, the Maintenance Supervisor stated he was not aware the vendor's provided barriers did not meet the requirement.  Actual NFPA standard:  NFPA 101  19.7.9 Construction, Repair, and Improvement Operations. 19.7.9.1 Construction, repair, and improvement operations shall comply with 4.6.10. 19.7.9.2 The means of egress in any area undergoing construction, repair, or improvements shall be inspected daily for compliance with 7.1.10.1 and shall also comply with NFPA 241, Standard for Safeguarding Construction, Alteration, and Demolition Operations.  4.6.10 Construction, Repair, and Improvement Operations. 4.6.10.1* Buildings, or portions of buildings, shall be permitted to be occupied during construction, repair, alterations, or additions only where required means of egress and required fire protection features are in place and continuously maintained for the portion occupied or where alternative life safety measures acceptable to the authority having jurisdiction are in place.  NFPA 241  4.3 Temporary Enclosures. 4.3.1 Only noncombustible panels,	K 791		

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K 791	Continued From page 17 flame-resistant tarpaulins, or approved materials of equivalent fire-retardant characteristics shall be used. 4.3.2 Any other fabrics or plastic films used shall be certified as conforming to the requirements of Test Method #2 contained in NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. 4.3.3 Where used to enclose structures, forming equipment, and similar items, the enclosing material shall be fastened securely or guarded by construction so it cannot be blown by the wind against heaters or other sources of ignition.	K 791		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101  Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to	K 918	<b>K 918</b>  <b>Residents:</b> The generator was load tested on 9/27/19. A fuel sample test was also performed on 9/27/19.  <b>Other Residents:</b> Four hour load test has been added to the schedule to be to be performed 36 months from previous 4 hour load test.  <b>Systemic Measures:</b> Maintenance staff educated on requirement of four hour load testing every 36 months.	<b>10/18/19</b>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135075</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE NF STRUCTURE - BUILDING AND APARTMENT B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/17/2019</b>	
NAME OF PROVIDER OR SUPPLIER <b>VALLEY VISTA CARE CENTER OF ST MARIES</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>820 ELM STREET ST MARIES, ID 83861</b>		
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K 918	<p>Continued From page 18</p> <p>manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.</p> <p>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure the EPSS generator set was maintained in accordance with NFPA 110. Failure to maintain the EPSS generator as defined under NFPA standards has the potential to render the facility without emergency power during extended power outages or other disasters. This deficient practice affected 63 residents and staff on the date of the survey.</p> <p>Findings include:</p> <p>During review of the facility maintenance and inspection records for the EPSS generator set conducted on 9/17/19 from 8:30 - 11:00 AM, no record was available demonstrating a 4-hour load test had been conducted within the past three years. Further review of the annual service inspection records failed to demonstrate a fuel sample test was conducted since 2017.</p> <p>Interview conducted at approximately 10:45 AM established the Maintenance Supervisor was not aware of the last time a four-hour load test had been conducted.</p> <p>Actual NFPA standard:</p>	K 918	<p><b>Monitoring: Results of load test to be reviewed at QAPI meeting following load test.</b></p>	

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

Printed: 09/25/2019  
FORM APPROVED  
OMB NO. 0938-0391

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K 918	Continued From page 19 8.3.8 A fuel quality test shall be performed at least annually using tests approved by ASTM standards.  8.4.9* Level 1 EPSS shall be tested at least once within every 36 months. 8.4.9.1 Level 1 EPSS shall be tested continuously for the duration of its assigned class (see Section 4.2). 8.4.9.2 Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 continuous hours.	K 918		



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

September 26, 2019

Randal Barnes, Administrator  
Valley Vista Care Center of St Maries  
820 Elm Street  
St Maries, ID 83861-2119

Provider #: 135075

**RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER**

Dear Mr. Barnes:

On **September 17, 2019**, an Emergency Preparedness survey was conducted at **Valley Vista Care Center Of St Maries** 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 **October 9, 2019**. Failure to submit an acceptable PoC by **October 9, 2019**, may result in the imposition of civil monetary penalties by **October 31, 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 **October 22, 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 **November 10, 2019**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **October 22, 2019**, includes the following:

Denial of payment for new admissions effective **December 17, 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.

Randal Barnes, Administrator

September 26, 2019

Page 3 of 4

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **March 17, 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 **September 17, 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

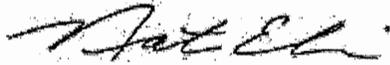
2001-10 IDR Request Form

Randal Barnes, Administrator  
September 26, 2019  
Page 4 of 4

This request must be received by **October 9, 2019**. If your request for informal dispute resolution is received after **October 9, 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: 09/25/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135075</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/17/2019</b>
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NAME OF PROVIDER OR SUPPLIER <b>VALLEY VISTA CARE CENTER OF ST MARIES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>820 ELM STREET ST MARIES, ID 83861</b>
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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 multi-story, Type II(111) structure, originally constructed in 1979. There is a two-story atrium within the center of the building and openings to the atrium are equipped with drop down fire doors. The facility is fully sprinklered with an interconnected fire alarm/smoke detection system. There are two (2), on-site Emergency Power Supply System (EPSS) generators, a diesel-fire and a spark-ignited set. The facility is located within a county fire district with both state and federal EMS support services available. Currently the facility is licensed for 74 SNF/NF beds, and had a census of 63 on the date of the survey.</p> <p>The following deficiencies were cited during the Emergency Preparedness Survey conducted on September 17, 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 &amp; Construction</p>	E 000	<p><b>RECEIVED</b></p> <p><b>OCT - 9 2019</b></p> <p><b>FACILITY STANDARDS</b></p>	
E 015 SS=D	<p>Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1)</p> <p>[(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and</p>	E 015	<p><b>E 015</b></p> <p><b>Residents: A policy and procedure was developed for utilities loss that is relevant to the loss of sewage and waste disposal during a disaster.</b></p>	<b>10/18/19</b>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <i>Administrator</i>	(X6) DATE <i>10-7-19</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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E 015	<p>Continued From page 1</p> <p>procedures must address the following:</p> <p>(1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following:</p> <p>(i) Food, water, medical and pharmaceutical supplies</p> <p>(ii) Alternate sources of energy to maintain the following:</p> <p>(A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.</p> <p>(B) Emergency lighting.</p> <p>(C) Fire detection, extinguishing, and alarm systems.</p> <p>(D) Sewage and waste disposal.</p> <p>*[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures.</p> <p>(6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following:</p> <p>(iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following:</p> <p>(A) Food, water, medical, and pharmaceutical supplies.</p> <p>(B) Alternate sources of energy to maintain the following:</p> <p>(1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.</p> <p>(2) Emergency lighting.</p> <p>(3) Fire detection, extinguishing, and alarm systems.</p> <p>(C) Sewage and waste disposal.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	E 015	<p><b>Other Residents:</b> The policy and procedure will address utilities loss of sewage and disposal during a disaster.</p> <p><b>Systemic Measures:</b> Emergency policies will be reviewed yearly to ensure compliance with requirements of emergency plan.</p> <p><b>Monitoring:</b> After yearly review by safety committee, if there are changes they will be reviewed at monthly QAPI meeting.</p>		

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E 015	Continued From page 2 Based on record review, it was determined the facility failed to develop policies and procedures in the Emergency Plan (EP), which identified the steps or methods for providing sewage and waste disposal should those utilities become compromised in a disaster requiring the need to shelter in place. Lack of policies and procedures for sewage and waste disposal during a disaster, has the potential to limit the ability to provide continuing care for residents housed in the facility. This deficient practice affected 63 residents, staff and visitors on the date of the survey.  Findings include:  On 9/17/19 from 8:30 - 11:00 AM, review of provided policies and procedures did not reveal a policy or procedure for utilities loss that was relevant to the loss of sewage and waste disposal during a disaster.  Reference: 42 CFR 483.73 (b) (1)	E 015		
E 041 SS=F	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e)  (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section.  §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section.	E 041	<b>E 041</b>  <b>Residents:</b> The generator was load tested on 9/27/19. A fuel sample test was also performed on 9/27/19.  <b>Other Residents:</b> Four hour load test has been added to the schedule to be to be performed 36 months from previous 4 hour load test.	<b>10/18/19</b>

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E 041	<p>Continued From page 3</p> <p>§482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated.</p> <p>482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code.</p> <p>482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates.</p> <p>*[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records</p>	E 041	<p><b>Systemic Measures:</b> Maintenance staff educated on requirement of four hour load testing every 36 months.</p> <p><b>Monitoring:</b> Results of load test to be reviewed at QAPI meeting following load test.</p>	

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E 041	<p>Continued From page 4</p> <p>Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: <a href="http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html">http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html</a>.</p> <p>If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes.</p> <p>(1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000.</p> <p>(i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011.</p> <p>(ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011.</p> <p>(iii) TIA 12-3 to NFPA 99, issued August 9, 2012.</p> <p>(iv) TIA 12-4 to NFPA 99, issued March 7, 2013.</p> <p>(v) TIA 12-5 to NFPA 99, issued August 1, 2013.</p> <p>(vi) TIA 12-6 to NFPA 99, issued March 3, 2014.</p> <p>(vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011.</p> <p>(viii) TIA 12-1 to NFPA 101, issued August 11, 2011.</p> <p>(ix) TIA 12-2 to NFPA 101, issued October 30, 2012.</p> <p>(x) TIA 12-3 to NFPA 101, issued October 22, 2013.</p> <p>(xi) TIA 12-4 to NFPA 101, issued October 22, 2013.</p> <p>(xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure the emergency and standby power systems were maintained and available to provide subsistence as required under the rule.</p>	E 041	

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NAME OF PROVIDER OR SUPPLIER <b>VALLEY VISTA CARE CENTER OF ST MARIES</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>820 ELM STREET ST MARIES, ID 83861</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 041	<p>Continued From page 5</p> <p>Failure to ensure emergency generators are maintained and tested in accordance with NFPA 99 and NFPA 110, potentially hinders the facility's ability to provide continuity of care during an emergency to the 63 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During review of the EES generator maintenance and testing logs conducted on 8/15/19 from 9:30 - 11:00 AM, documentation failed to show the following service was performed for the EPSS generator:</p> <ul style="list-style-type: none"> <li>- No record an annual fuel test had been performed on the diesel-fired generator set since 2017.</li> <li>- No record of a 4-hour load test conducted within the past three years on either EPSS generator.</li> </ul> <p>Reference: 42 CFR 483.73 (e) (1)</p>	E 041		