



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor  
RICHARD M. ARMSTRONG – Director

TAMARA PRISOCK – ADMINISTRATOR  
DIVISION OF LICENSING & CERTIFICATION  
DEBRA RANSOM, R.N., R.H.I.T., Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0009  
PHONE 208-334-6626  
FAX 208-364-1888

July 3, 2017

Benjamin Roedel, Administrator  
Shaw Mountain of Cascadia  
909 Reserve Street  
Boise, ID 83712-6508

Provider #: 135090

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

Dear Mr. Roedel:

On **June 23, 2017**, a Facility Fire Safety and Construction survey was conducted at **Shaw Mountain of Cascadia** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

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

Benjamin Roedel, Administrator  
July 3, 2017  
Page 2 of 4

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 **July 17, 2017**. Failure to submit an acceptable PoC by **July 17, 2017**, may result in the imposition of civil monetary penalties by **August 5, 2017**.

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 will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **July 28, 2017**, (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 **July 28, 2017**. A change in the seriousness of the deficiencies on **July 28, 2017**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **July 28, 2017**, includes the following:

Benjamin Roedel, Administrator  
July 3, 2017  
Page 3 of 4

Denial of payment for new admissions effective **September 16, 2017**.  
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 **December 16, 2017**, 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 **June 23, 2017**, 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>

Benjamin Roedel, Administrator  
July 3, 2017  
Page 4 of 4

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 **July 17, 2017**. If your request for informal dispute resolution is received after **July 17, 2017**, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135090	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  06/23/2017
NAME OF PROVIDER OR SUPPLIER  SHAW MOUNTAIN OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 909 RESERVE STREET BOISE, ID 83712	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS  The facility is a Type V(111) single story building. The original building was built in 1963 with an addition in 1971. The east portion of the building was significantly re-modeled in 2007 and a special care unit set-up in the wing. The facility is fully sprinklered. There is a complete fire alarm/smoke detection system installed to include coverage in sleeping rooms. The facility is currently licensed for 98 SNF beds.  The following deficiencies were cited during the annual fire/life safety survey conducted on June 23, 2017. 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:  Linda Chaney Health Facility Surveyor Facility Fire Safety and Construction	K 000	This Plan of Correction is the center's credible allegation of compliance.  Preparation and/or execution of the plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of federal and state law.  Definitions:  ABHR = Alcohol Based Hand Rub Dispenser  Daily = Monday through Friday  ESS = Environmental Service Supervisor / Maintenance Supervisor  FLS = Fire and Life Safety  IDT = Interdisciplinary Team  LN = Licensed Nurse	
K 161 SS=F	NFPA 101 Building Construction Type and Height  Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5  Construction Type 1 I (442), I (332), II (222) Any number of stories  non-sprinklered and  sprinklered	K 161	<b>RECEIVED</b>  <b>JUL 17 2017</b>  <b>FACILITY STANDARDS</b>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE 7/17/17

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135090</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/23/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>SHAW MOUNTAIN OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>909 RESERVE STREET BOISE, ID 83712</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
K 161	Continued From page 1 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111)  7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the smoke and fire resistive properties of the structure were maintained. Failure to maintain the fire resistive properties of the structure by sealing penetrations in walls and ceilings, could result in fire and smoke passing between compartments during a fire event. This deficient practice affected 70 residents, staff and visitors on the date of the survey. The facility is licensed for 98 SNF/NF beds and had a census of 70 on the day of the survey.	K 161	<b>K161</b>  <b>Corrective Action:</b>  1. All penetrations noted have been filled as per regulation required. 2. ESS completed inspection of the building and no other penetrations were found.  <b>Identification:</b>  All residents are identified as possibly being affected by this deficiency.  <b>Systemic Changes:</b>  1. ESS to continue monthly audits of smoke barriers for compliance. 2. Staff in-serviced regarding reporting of smoke barrier issues to ESS.  <b>Monitor:</b>  Administrator / IDT Designee to review monthly audits for compliance. Audits to be completed at the following frequencies:  1. Monthly for 3 months. 2. Quarterly for 6 months.	<b>7/18/17</b>

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

PRINTED: 07/03/2017  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135090</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/23/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>SHAW MOUNTAIN OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>909 RESERVE STREET BOISE, ID 83712</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
K 161	<p>Continued From page 2</p> <p>Findings include:</p> <p>During the facility tour on June 23, 2017, from approximately 12:30 PM to 3:30 PM, observation revealed the following penetrations:</p> <ol style="list-style-type: none"> <li>1.) Bathroom off of dish room, annular penetration at pipe under sink. There is also an annular penetration at the sprinkler pipe going through the wall.</li> <li>2.) Medication room, approximately 2" circular hole in the wall under the sink.</li> <li>3.) Beauty Salon, annular penetration at pipe under sink. There is also an annular penetration at the sprinkler pipe going through the wall.</li> <li>4.) Uniform Fitting Room, annular penetration at the sprinkler pipe going through the wall.</li> <li>5.) Mini-Break Room by activities office, annular penetration at pipe under sink.</li> <li>6.) Social Center, annular penetration at pipe under sink.</li> </ol> <p>After repeatedly identifying annular penetrations at pipes running through walls and ceilings throughout the facility, this finding was deemed "systemic". No further documentation was necessary. When asked, the Maintenance Assistant stated the facility was unaware of the penetrations.</p> <p>Actual NFPA standard:</p> <p>19.1.6 Minimum Construction Requirements. 19.1.6.1 Health care occupancies shall be limited to the building construction types specified in Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7. (See 8.2.1.)</p> <p>8.2 Construction and Compartmentation. 8.2.1 Construction. 8.2.1.1 Buildings or structures occupied or used</p>	K 161		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135090	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  06/23/2017
NAME OF PROVIDER OR SUPPLIER  SHAW MOUNTAIN OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 909 RESERVE STREET BOISE, ID 83712	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 161	Continued From page 3 in accordance with the individual occupancy chapters, Chapters 11 through 43, shall meet the minimum construction requirements of those chapters..	K 161		
K 211 SS=F	NFPA 101 Means of Egress - General  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 STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure that fire and smoke door assemblies were inspected in accordance with NFPA 80 and NFPA 105. Failure to inspect and test fire and smoke doors, could result in a lack of system performance as designed which could hinder the safe evacuation of residents during a fire or other emergency. This deficient practice affected all residents, staff and visitors on the date of the survey. The facility is licensed for 98 SNF/NF beds and had a census of 70 on the day of the survey.  Findings include:  During record review on June 23, 2017, from approximately 9:00 AM to 12:00 PM, no record was available demonstrating an initial inspection and testing of the fire and smoke door assemblies had been completed. When asked about the missing documentation, the Maintenance Assistant stated the facility was not aware of the new requirement.	K 211	<b>K211</b>  <b>Corrective Action:</b>  1. ESS to complete an inspection and testing of smoke door assemblies. 2. Record will be kept of all inspections / testing of fire and smoke within the ESS binder.  <b>Identification:</b>  All residents are identified as possibly being affected by this deficiency.  <b>Systemic Changes:</b>  1. ESS to inspect and test fire and smoke doors assemblies at the time of fire drills. 3. The inspection will be documented and a record kept within the ESS binder. 4. Staff in-serviced regarding reporting of smoke barrier issues to ESS.  <b>Monitor:</b>  Administrator / IDT Designee to review monthly audits for compliance. Audits to be completed at the following frequencies:  1. Monthly for 3 months. 2. Quarterly for 6 months.	7/18/17

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

PRINTED: 07/03/2017  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135090</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - ENTIRE BUILDING</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/23/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>SHAW MOUNTAIN OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>909 RESERVE STREET BOISE, ID 83712</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	
K 211	Continued From page 4  Actual NFPA standard:  NFPA 101  19.2.1 General. Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7, unless otherwise modified by 19.2.2 through 19.2.11.  7.2.1 Door Openings. 7.2.1.15 Inspection of Door Openings. 7.2.1.15.1* Where required by Chapters 11 through 43, the following door assemblies shall be inspected and tested not less than annually in accordance with 7.2.1.15.2 through 7.2.1.15.8: (1) Door leaves equipped with panic hardware or fire exit hardware in accordance with 7.2.1.7 (2) Door assemblies in exit enclosures (3) Electrically controlled egress doors (4) Door assemblies with special locking arrangements subject to 7.2.1.6  7.2.1.15.2 Fire-rated door assemblies shall be inspected and tested in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Smoke door assemblies shall be inspected and tested in accordance with NFPA 105, Standard for Smoke Door Assemblies and Other Opening Protectives.  NFPA 80 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 211			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135090</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - ENTIRE BUILDING</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/23/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>SHAW MOUNTAIN OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>909 RESERVE STREET BOISE, ID 83712</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
K 211	Continued From page 5 NFPA 105 5.2 Specific Requirements. 5.2.1* Inspections. 5.2.1.1 Smoke door assemblies shall be inspected annually. 5.2.1.2 Doors shall be operated to confirm full closure. 5.2.1.3 Hardware and gaskets shall be inspected annually, and any parts found to be damaged or inoperative shall be replaced.	K 211		
K 291 SS=F	NFPA 101 Emergency Lighting  Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9.18.2.9.1, 19.2.9.1 This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to provide monthly emergency lighting test documentation. Failure to test the emergency lighting could inhibit egress of residents during an emergency. This deficient practice affected all residents, staff and visitors on the day of survey. The facility is licensed for 98 SNF/NF beds with a census of 70 on the date of survey.  Findings include:  During record review on June 23, 2017, from approximately 9:00 AM to 12:00 PM, review of the emergency lighting test logs revealed the last monthly thirty (30) second test of the emergency lighting was conducted in October 2016. When asked, the Maintenance Assistant stated the facility was unaware the tests were not completed or documentation maintained.  Actual NFPA reference:	K 291	<b>K291</b>  <b>Corrective Action:</b>  All emergency lighting was tested and logged by the ESS to confirm all emergency lighting is properly working.  <b>Identification:</b>  All residents are identified as possibly being affected by this deficiency.  <b>Systemic Changes:</b>  1. The log will be printed from TELS and placed in the ESS binder after emergency lighting is tested. 2. Continue monthly audits of emergency lighting for compliance. 3. Staff in-serviced regarding reporting of emergency light issue to ESS.  <b>Monitor:</b>  Administrator / IDT Designee to review monthly audits for compliance. Audits to be completed at the following frequencies:  1. Monthly for 3 months. 2. Quarterly for 6 months.	7/18/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135090</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - ENTIRE BUILDING</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/23/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>SHAW MOUNTAIN OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>909 RESERVE STREET BOISE, ID 83712</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	
K 291	Continued From page 6  NFPA 101 19.2.9 Emergency Lighting. 19.2.9.1 Emergency lighting shall be provided in accordance with Section 7.9. 7.9.3 Periodic Testing of Emergency Lighting Equipment. 7.9.3.1 Required emergency lighting systems shall be tested in accordance with one of the three options offered by 7.9.3.1.1, 7.9.3.1.2, or 7.9.3.1.3. 7.9.3.1.1 Testing of required emergency lighting systems shall be permitted to be conducted as follows: (1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, except as otherwise permitted by 7.9.3.1.1(2). (2)*The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction. (3) Functional testing shall be conducted annually for a minimum of 1-1/2 hours if the emergency lighting system is battery powered. (4) The emergency lighting equipment shall be fully operational for the duration of the tests required by 7.9.3.1.1(1) and (3). (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. 7.9.3.1.2 Testing of required emergency lighting systems shall be permitted to be conducted as follows: (1) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall be provided. (2) Not less than once every 30 days, self-testing/self-diagnostic battery-operated emergency lighting equipment	K 291			

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

PRINTED: 07/03/2017  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135090</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - ENTIRE BUILDING</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/23/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>SHAW MOUNTAIN OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>909 RESERVE STREET BOISE, ID 83712</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	
K 291	Continued From page 7 shall automatically perform a test with a duration of a minimum of 30 seconds and a diagnostic routine. (3) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall indicate failures by a status indicator. (4) A visual inspection shall be performed at intervals not exceeding 30 days. (5) Functional testing shall be conducted annually for a minimum of 11?2 hours. (6) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall be fully operational for the duration of the 11?2-hour test. (7) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. 7.9.3.1.3 Testing of required emergency lighting systems shall be permitted to be conducted as follows: (1) Computer-based, self-testing/self-diagnostic batteryoperated emergency lighting equipment shall be provided. (2) Not less than once every 30 days, emergency lighting equipment shall automatically perform a test with a duration of a minimum of 30 seconds and a diagnostic routine. (3) The emergency lighting equipment shall automatically perform annually a test for a minimum of 11?2 hours. (4) The emergency lighting equipment shall be fully operational for the duration of the tests required by 7.9.3.1.3(2) and (3). (5) The computer-based system shall be capable of providing a report of the history of tests and failures at all times.	K 291			
K 325 SS=F	NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR)	K 325			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135090	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  06/23/2017
NAME OF PROVIDER OR SUPPLIER  SHAW MOUNTAIN OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 909 RESERVE STREET BOISE, ID 83712	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 325	Continued From page 8  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 STANDARD is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure Alcohol Based Hand Rub Dispensers (ABHR) were maintained in accordance with NFPA 101. Failure to provide a program to test and document the operation of ABHR dispensers in accordance with the manufacturer's care and use instructions each time a new refill is installed could cause accidental spilling of flammable liquids or , increasing the risk of fires. This deficient practice affected 70 residents, staff and visitors on the date of the survey. The facility is licensed for 98	K 325	K325  <b>Corrective Action:</b>  1. ESS audited all ABHR with auditing log.  <b>Identification:</b>  All residents are identified as possibly being affected by this deficiency.  <b>Systemic Changes:</b>  1. ESS or assistant to inspect and test all ABHR when refilling dispensers in accordance with manufacture's care and use instructions. 2. Auditing system was created and to be utilized to confirm all dispensers are following and in compliance with NFPA 101.  <b>Monitor:</b>  Administrator / IDT Designee to review monthly audits for compliance. Audits to be completed at the following frequencies:  1. Monthly for 3 months. 2. Quarterly for 6 months.	7/18/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135090</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - ENTIRE BUILDING</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/23/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>SHAW MOUNTAIN OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>909 RESERVE STREET BOISE, ID 83712</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
K 325	<p>Continued From page 9 SNF/NF residents and had a census of 70 on the day of the survey.</p> <p>Findings include:</p> <p>During the review of facility inspection records conducted on June 23, 2017 from approximately 9:00 AM to 12:00 PM, no records were available indicating ABHR dispensers are tested in accordance with manufacturer's care and use instructions when a new refill is installed. ABHR dispensers were observed throughout the facility and when asked, the Maintenance Assistant stated the facility was not aware of the requirement to test ABHR dispensers each time a new refill is installed.</p> <p>Actual NFPA standard:</p> <p>NFPA 101</p> <p>19.3.2.6* Alcohol-Based Hand-Rub Dispensers. Alcohol-based hand-rub dispensers shall be protected in accordance with 8.7.3.1, unless all of the following conditions are met:</p> <p>(1) Where dispensers are installed in a corridor, the corridor shall have a minimum width of 6 ft (1830 mm).</p> <p>(2) The maximum individual dispenser fluid capacity shall be as follows:</p> <p>(a) 0.32 gal (1.2 L) for dispensers in rooms, corridors, and areas open to corridors</p> <p>(b) 0.53 gal (2.0 L) for dispensers in suites of rooms</p> <p>(3) Where aerosol containers are used, the maximum capacity of the aerosol dispenser shall be 18 oz. (0.51 kg) and shall be limited to Level 1 aerosols as defined in NFPA30B, Code for the Manufacture and Storage of Aerosol Products.</p>	K 325		

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

PRINTED: 07/03/2017  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135090	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  06/23/2017
--	--	---	--

NAME OF PROVIDER OR SUPPLIER  SHAW MOUNTAIN OF CASCADIA	STREET ADDRESS, CITY, STATE, ZIP CODE 909 RESERVE STREET BOISE, ID 83712
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K 325	<p>Continued From page 10</p> <p>(4) Dispensers shall be separated from each other by horizontal spacing of not less than 48 in. (1220 mm).</p> <p>(5) Not more than an aggregate 10 gal (37.8 L) of alcohol-based hand-rub solution or 1135 oz (32.2 kg) of Level 1 aerosols, or a combination of liquids and Level 1 aerosols not to exceed, in total, the equivalent of 10 gal (37.8 L) or 1135 oz (32.2 kg), shall be in use outside of a storage cabinet in a single smoke compartment, except as otherwise provided in 19.3.2.6(6).</p> <p>(6) One dispenser complying with 19.3.2.6 (2) or (3) per room and located in that room shall not be included in the aggregated quantity addressed in 19.3.2.6(5).</p> <p>(7) Storage of quantities greater than 5 gal (18.9 L) in a single smoke compartment shall meet the requirements of NFPA 30, Flammable and Combustible Liquids Code.</p> <p>(8) Dispensers shall not be installed in the following locations:</p> <p>(a) Above an ignition source within a 1 in. (25 mm) horizontal distance from each side of the ignition source</p> <p>(b) To the side of an ignition source within a 1 in. (25 mm) horizontal distance from the ignition source</p> <p>(c) Beneath an ignition source within a 1 in. (25 mm) vertical distance from the ignition source</p> <p>(9) Dispensers installed directly over carpeted floors shall be permitted only in sprinklered smoke compartments.</p> <p>(10) The alcohol-based hand-rub solution shall not exceed 95 percent alcohol content by volume.</p> <p>(11) Operation of the dispenser shall comply with the following criteria:</p> <p>(a) The dispenser shall not release its contents except when the dispenser is activated,</p>	K 325		
-------	---	-------	--	--

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

PRINTED: 07/03/2017  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135090	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  06/23/2017
NAME OF PROVIDER OR SUPPLIER  SHAW MOUNTAIN OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 909 RESERVE STREET BOISE, ID 83712	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 325	Continued From page 11 either 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 345 SS=F	NFPA 101 Fire Alarm System - Testing and Maintenance  Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25  This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure fire alarm systems were maintained in accordance with NFPA 72. Failure	K 345	K345  <b>Corrective Action:</b>  ESS contacted the company that conducts the annual fire inspection, State Fire, and scheduled them to arrive on July 18 <sup>th</sup> , 2017 to confirm all indicated deficiencies have been corrected. If deficiencies have not been corrected they will be correcting them that day or as soon as parts are available.  <b>Identification:</b>  All residents are identified as possibly being affected by this deficiency.	7/18/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135090	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  06/23/2017
NAME OF PROVIDER OR SUPPLIER  SHAW MOUNTAIN OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 909 RESERVE STREET BOISE, ID 83712	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 345	<p>Continued From page 12</p> <p>to maintain fire alarm systems could result in a lack of system performance during a fire event. This deficient practice affected 70 residents, staff and visitors on the date of the survey. The facility is licensed for 98 SNF/NF beds and had a census of 70 on the day of the survey.</p> <p>Findings include:</p> <p>During review of the facility fire alarm inspection records conducted on June 23, 2017, from approximately 9:00 AM to 12:00 PM, the annual fire alarm inspection report dated September 30, 2016, indicated the following deficiencies as well as no documentation for corrective actions.</p> <p>1.) Smoke detector in room "Resident Care Manger 2" LED is bad. 2.) Batteries fail load test. 3.) In Mechanical Room 571 Duct Detector M298 did not shut down AHU unit. 4.) Old heat detectors that are not connected to fire panel need to be removed.</p> <p>When asked, the Maintenance Assistance stated the facility was not aware the deficiencies were not corrected.</p> <p>Actual NFPA standard:</p> <p>19.3.4 Detection, Alarm, and Communications Systems. 19.3.4.1 General. Health care occupancies shall be provided with a fire alarm system in accordance with Section 9.6.</p> <p>9.6.1.3 A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm and Signaling</p>	K 345	<p><b>Systemic Changes:</b></p> <ol style="list-style-type: none"> <li>ESS and facility vendor that conducts fire alarm inspection to review all material immediately after they conduct the inspection.</li> <li>All findings of old equipment or deficiencies will then be discussed and a date will be set to correct the findings.</li> <li>ESS and Administrator to review all fire alarm inspections following each inspection.</li> </ol> <p><b>Monitor:</b></p> <p>Administrator / IDT Designee to review monthly audits for compliance. Audits to be completed at the following frequencies:</p> <ol style="list-style-type: none"> <li>Monthly for 3 months.</li> <li>Quarterly for 6 months.</li> </ol>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135090	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____		(X3) DATE SURVEY COMPLETED  06/23/2017
NAME OF PROVIDER OR SUPPLIER  SHAW MOUNTAIN OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 909 RESERVE STREET BOISE, ID 83712		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 345	Continued From page 13 Code, unless it is an approved existing installation, which shall be permitted to be continued in use.  NFPA 72 14.2.1.2.2 System defects and malfunctions shall be corrected. 14.2.1.2.3 If a defect or malfunction is not corrected at the conclusion of system inspection, testing, or maintenance, the system owner or the owner's designated representative shall be informed of the impairment in writing within 24 hours.	K 345			
K 353 SS=F	NFPA 101 Sprinkler System - Maintenance and Testing  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 STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure fire suppression systems were	K 353	<b>K353</b> <b>Corrective Action:</b>  1. ESS did locate the proper documentation for the 4 <sup>th</sup> quarter sprinkler inspection and it was placed in the ESS binder. 2. ESS scheduled State Fire to arrive on July 18 <sup>th</sup> to replace sprinkler heads that are older than 20 years.  <b>Identification:</b>  All residents are identified as possibly being affected by this deficiency.  <b>Systemic Changes:</b>  1. ESS and facility vendor that conducts fire alarm inspection to review all material immediately after they conduct the inspection. 2. All findings of old equipment or deficiencies will then be discussed and a date will be set to correct the findings. 3. ESS and Administrator to review all fire alarm inspections following each inspection.	7/18/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135090	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  06/23/2017
NAME OF PROVIDER OR SUPPLIER  SHAW MOUNTAIN OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 909 RESERVE STREET BOISE, ID 83712	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 353	<p>Continued From page 14</p> <p>maintained in accordance with NFPA 25. Failure to provide required maintenance, inspection and testing could hinder system performance during a fire event. This deficient practice affected all residents, staff and visitors on the date of the survey. The facility is licensed for 98 SNF/NF beds and had a census of 70 on the day of the survey.</p> <p>Findings include:</p> <p>During the review of facility inspection records conducted on June 23, 2017 from approximately 9:00 AM to 12:00 PM, no record of the fourth quarter sprinkler inspection could be located. Also, on the annual sprinkler inspection dated June 29, 2016, the fast response sprinkler heads were identified as being more than twenty years old (dated 1996) requiring testing or replacement. No documentation could be produced to show this deficiency had been corrected. When asked, the Maintenance Assistant stated the facility was not aware of these deficiencies or missing quarterly inspection.</p> <p>Actual NFPA standard:</p> <p>NFPA 25</p> <p>5.2.5 Waterflow Alarm and Supervisory Devices. Waterflow alarm and supervisory alarm devices shall be inspected quarterly to verify that they are free of physical damage.</p> <p>5.3.1.1.1.3* Sprinklers manufactured using fast-response elements that have been in service for 20 years shall be replaced, or representative samples shall be tested and then retested at 10-year intervals.</p>	K 353	<p><b>Monitor:</b></p> <p>Administrator / IDT Designee to review monthly audits for compliance. Audits to be completed at the following frequencies:</p> <ol style="list-style-type: none"> <li>1. Monthly for 3 months.</li> <li>2. Quarterly for 6 months.</li> </ol>	

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

PRINTED: 07/03/2017  
FORM APPROVED  
OMB NO: 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135090</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - ENTIRE BUILDING</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/23/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>SHAW MOUNTAIN OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>909 RESERVE STREET BOISE, ID 83712</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
K 363 SS=D	<p>NFPA 101 Corridor - Doors</p> <p>Corridor - Doors 2012 EXISTING</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. 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.</p> <p>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</p> <p>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.</p> <p>This STANDARD is not met as evidenced by: Based on observation and operational testing, the facility failed to ensure that corridor doors would latch when closed. Corridor doors that fail</p>	K 363	<p><b>K363</b></p> <p><b>Corrective Action:</b></p> <p>The door latch on resident room #113 was replaced on July 11, 2017 and is properly latching.</p> <p><b>Identification:</b></p> <p>One resident was identified as possibly being affected by this deficiency.</p> <p><b>Systemic Changes:</b></p> <ol style="list-style-type: none"> <li>ESS to continue performing monthly audits of corridor doors for compliance.</li> <li>Staff in-serviced regarding reporting of corridor doors when not properly working / latching.</li> </ol> <p><b>Monitor:</b></p> <p>Administrator / IDT Designee to review monthly audits for compliance. Audits to be completed at the following frequencies:</p> <ol style="list-style-type: none"> <li>Monthly for 3 months.</li> <li>Quarterly for 6 months.</li> </ol>	7/18/17

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

PRINTED: 07/03/2017  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135090</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - ENTIRE BUILDING</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/23/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>SHAW MOUNTAIN OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>909 RESERVE STREET BOISE, ID 83712</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
K 363	Continued From page 16 to latch will allow smoke and dangerous gases to enter the room, affecting egress and shelter in place during a fire event. This deficient practice affected one resident, staff and visitors on the date of the survey. The facility is licensed for 98 SNF/NF beds and had a census of 70 on the day of the survey.  Findings include:  During the facility tour conducted on June 23, 2017 from approximately 12:30 PM to 3:30 PM, observation and operational testing of the door to resident room #113 revealed the door would not latch properly when tested.  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		
K 511 SS=D	NFPA 101 Utilities - Gas and Electric  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.	K 511		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135090	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____		(X3) DATE SURVEY COMPLETED  06/23/2017
NAME OF PROVIDER OR SUPPLIER  SHAW MOUNTAIN OF CASCADIA		STREET ADDRESS, CITY, STATE, ZIP CODE 909 RESERVE STREET BOISE, ID 83712		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 511	<p>Continued From page 17 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide practical safeguarding of persons and property from hazards arising from the use of electricity. Failure to ensure proper electrical installations and use could result in electrocution or fire. This deficient practice affected 70 residents, staff and visitors on the date of the survey. The facility is licensed for 98 SNF/NF beds and had a census of 70 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour on June 23, 2017 from approximately 12:30 PM to 3:30 PM, observation of the facility revealed the following:</p> <ol style="list-style-type: none"> <li>1.) Kitchen storage room, blocked electrical panels.</li> <li>2.) Mechanical room by the business office, missing outlet cover and a junction box with exposed wires without a cover.</li> <li>3.) Business Manager's Office, daisy chain Relocatable Power Tap (RPT) to RPT.</li> <li>4.) Resident room #307 has a dangling RPT near the sink.</li> <li>5.) Central Supply, next to Uniform Fitting Room has a junction box with exposed wires without a cover. The storage room directly across from this Central Supply room also has a junction box with exposed wires without a cover.</li> <li>6.) Three (3) prong to two (2) adapter at the fish tank near the Activity Director's office.</li> </ol> <p>When asked, the Maintenance Assistant stated</p>	K 511	<p>K511</p> <p><b>Corrective Action:</b></p> <ol style="list-style-type: none"> <li>1. Kitchen storage was remarked with new red paint that clearly indicates when they can and cannot place storage items.</li> <li>2. Mechanical Room - Cover plate / outlet cover was placed on junction box.</li> <li>3. Daisy chain was removed from the business office.</li> <li>4. Resident room #307 Relocatable Power Tap was relocated.</li> <li>5. Central supply - cover was installed over the junction box.</li> <li>6. Three prongs to two adapter was removed and Fish Tank vendor was educated we cannot use that method at the facility.</li> </ol> <p><b>Identification:</b></p> <p>All residents are identified as possibly being affected by this deficiency.</p> <p><b>Systemic Changes:</b></p> <ol style="list-style-type: none"> <li>1. ESS to continue to conduct monthly inspections of facility rooms to ensure compliance regarding electrical compliance.</li> </ol> <p><b>Monitor:</b></p> <p>Administrator to review monthly inspections by ESS monthly for three months and quarterly thereafter.</p>	7/18/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135090</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/23/2017</b>	
NAME OF PROVIDER OR SUPPLIER  <b>SHAW MOUNTAIN OF CASCADIA</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>909 RESERVE STREET BOISE, ID 83712</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
K 511	<p>Continued From page 18 the facility was unaware of these deficiencies.</p> <p>Actual NFPA standard:</p> <p>NFPA 70 400.8 Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following:</p> <ul style="list-style-type: none"> <li>(1) As a substitute for the fixed wiring of a structure</li> <li>(2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors</li> <li>(3) Where run through doorways, windows, or similar openings</li> <li>(4) Where attached to building surfaces Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of 368.8.</li> <li>(5) Where concealed by walls, floors, or ceilings or located above suspended or dropped ceilings</li> <li>(6) Where installed in raceways, except as otherwise permitted in this Code</li> </ul> <p>110.12 Mechanical Execution of Work. Electrical equipment shall be installed in a neat and workmanlike manner. Informational Note: Accepted industry practices are described in ANSI/NECA 1-2006, Standard Practices for Good Workmanship in Electrical Contracting, and other ANSI-approved installation standards. (A) Unused Openings. Unused openings, other than those intended for the operation of equipment, those intended for mounting purposes, or those permitted as part of the design for listed equipment, shall be closed to afford</p>	K 511		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135090	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  06/23/2017
NAME OF PROVIDER OR SUPPLIER  SHAW MOUNTAIN OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 909 RESERVE STREET BOISE, ID 83712	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 511	Continued From page 19 protection substantially equivalent to the wall of the equipment. Where metallic plugs or plates are used with nonmetallic enclosures, they shall be recessed at least 6 mm (1.4 in.) from the outer surface of the enclosure. (B) Integrity of Electrical Equipment and Connections. Internal parts of electrical equipment, including busbars, wiring terminals, insulators, and other surfaces, shall not be damaged or contaminated by foreign materials such as paint, plaster, cleaners, abrasives, or corrosive residues. There shall be no damaged parts that may adversely affect safe operation or mechanical strength of the equipment such as parts that are broken; bent; cut; or deteriorated by corrosion, chemical action, or overheating.	K 511		
K 911 SS=F	NFPA 101 Electrical Systems - Other  Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567, Chapter 6 (NFPA 99) This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the Essential Electrical System (EES) generator was equipped with a remote manual stop switch. Failure to provide a remote stop switch prohibits the protection from the impact of adverse generator conditions. This deficient practice affected 70 residents, staff and visitors on the date of the survey. The facility is licensed for 98 SNF/NF beds and had a census of 70 on the day of the survey.	K 911	<b>K911</b> <b>Corrective Action:</b> ESS scheduled an electrician to install remote stop station button for the facility generator. Button will be installed the week of July 17, 2017. The button will be clearly labeled. <b>Identification:</b> All residents are identified as possibly being affected by this deficiency. <b>Systemic Changes:</b> Staff in-serviced on where the emergency remote stop button is located and how and when to use it. <b>Monitor:</b> Administrator / IDT Designee to review monthly audits for compliance. Audits to be completed at the following frequencies:  1. Monthly for 3 months. 2. Quarterly for 6 months.	7/18/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135090</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/23/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>SHAW MOUNTAIN OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>909 RESERVE STREET BOISE, ID 83712</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	
K 911	Continued From page 20 Findings include:  During the facility tour conducted on June 23, 2017 from approximately 12:30 PM to 3:30 PM, observation revealed the facility did not provide a remote manual stop switch for the EES generator located outside the room housing the prime mover. When asked, both the Maintenance Assistant and the Administrator stated the facility was not equipped with a remote stop switch.  Actual NFPA standard:  NFPA 110  5.6.5.6* All installations shall have a remote manual stop station of a type to prevent inadvertent or unintentional operation located outside the room housing the prime mover, where so installed, or elsewhere on the premises where the prime mover is located outside the building. 5.6.5.6.1 The remote manual stop station shall be labeled.	K 911			
K 918 SS=F	NFPA 101 Electrical Systems - Essential Electric System  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.	K 918	<b>K918</b>  <b>Corrective Action:</b>  ESS conducted a weekly load test on July 17, 2017. Monthly load test to be conducted July 18 <sup>th</sup> , 2017.  <b>Identification:</b>  All residents are identified as possibly being affected by this deficiency.	<b>7/18/17</b>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135090	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  06/23/2017
NAME OF PROVIDER OR SUPPLIER  SHAW MOUNTAIN OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 909 RESERVE STREET BOISE, ID 83712	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 21 Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the generator of the Emergency Power Supply System (EPSS) was inspected weekly and tested monthly. Failure to inspect and test EPSS generators could result in a lack of system reliability during a power loss. This deficient practice affected 70 residents, staff and visitors on the date of the survey. The facility is licensed for 98 SNF/NF residents and had a census of 70 on the day of the survey.  Findings include:  During review of the the facility generator inspection and testing records conducted on June 23, 2017, from approximately 9:00 AM to 12:00	K 918	<b>Systemic Changes:</b>  1. A 1:1 in-service to be conducted between the Administrator and ESS on the importance of ensuring the load test are completed in a timely manner, and documented. 2. The generator log will be in TELS, and a hard copy to be placed in the ESS binder after the monthly load test is completed.  <b>Monitor:</b>  Administrator / IDT Designee to review monthly audits for compliance. Audits to be completed at the following frequencies:  1. Monthly for 3 months. 2. Quarterly for 6 months.	

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

PRINTED: 07/03/2017  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135090</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/23/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>SHAW MOUNTAIN OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>909 RESERVE STREET BOISE, ID 83712</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	
K 918	<p>Continued From page 22</p> <p>PM, records indicated missing weekly inspections for the following weeks:</p> <ol style="list-style-type: none"> <li>1.) All of June, July and August 2016</li> <li>2.) November 2016, week of 13th - 19th</li> <li>3.) December 2016, week of 25th - 31st</li> <li>4.) All of January 2017</li> <li>5.) February 2017, week of 5th - 11th</li> </ol> <p>Upon further observation, the facility was also missing monthly load tests in 2016 for June, July, August and January 2017.</p> <p>When asked, the Maintenance Assistant stated the facility was not aware of the missing inspections and test of the generator.</p> <p>Actual NFPA standard:</p> <p>NFPA 99</p> <p>3-4.4.1 Maintenance and Testing of Essential Electrical System.</p> <p>3-4.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches.</p> <p>(a) Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-4.3.1. Maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6.</p> <p>(b) Inspection and Testing.</p> <ol style="list-style-type: none"> <li>1. * Test Criteria. Generator sets shall be tested twelve (12) times a year with testing intervals between not less than 20 days or exceeding 40 days. Generator sets serving emergency and equipment systems shall be in accordance with NFPA 110, Standard for Emergency and Standby</li> </ol>	K 918			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135090	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  06/23/2017
NAME OF PROVIDER OR SUPPLIER  SHAW MOUNTAIN OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 909 RESERVE STREET BOISE, ID 83712	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	<p>Continued From page 23</p> <p>Power Systems, Chapter 6.</p> <p>2. Test Conditions. The scheduled test under load conditions shall include a complete simulated cold start and appropriate automatic and manual transfer of all essential electrical system loads.</p> <p>3. Test Personnel. The scheduled tests shall be conducted by competent personnel. The tests are needed to keep the machines ready to function and, in addition, serve to detect causes of malfunction and to train personnel in operating procedures.</p> <p>3-3.4.3 Recordkeeping. 3-3.4.3.1* General. A record shall be maintained of the tests required by this chapter and associated repairs or modification. At a minimum, this record shall contain the date, the rooms or areas tested, and an indication of which items have met or have failed to meet the performance requirements of this chapter.</p> <p>NFPA 110 Chapter 6 6-4 Operational Inspection and Testing. 6-4.1* Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly. Exception: If the generator set is used for standby power or for peak load shaving, such use shall be recorded and shall be permitted to be substituted for scheduled operations and testing of the generator set, provided the appropriate data are recorded. 6-4.2* Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a</p>	K 918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135090</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - ENTIRE BUILDING</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/23/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>SHAW MOUNTAIN OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>909 RESERVE STREET BOISE, ID 83712</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	
K 918	Continued From page 24 minimum of 30 minutes, using one of the following methods: (a) Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating (b) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer The date and time of day for required testing shall be decided by the owner, based on facility operations.	K 918			