



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor  
RUSSEL S. BARON – Director

TAMARA PRISOCK—ADMINISTRATOR  
DIVISION OF LICENSING & CERTIFICATION  
DEBBY RANSOM, R.N., R.H.I.T. – Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: (208) 334-6626  
FAX: (208) 364-1888  
E-mail: [fsb@dhw.idaho.gov](mailto:fsb@dhw.idaho.gov)

July 28, 2017

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

Provider #: 135090

Dear Mr. Roedel:

On **July 27, 2017**, we conducted an on-site revisit to verify that your facility had achieved and maintained compliance. We presumed, based on your allegation of compliance, that your facility was in substantial compliance as of **July 18, 2017**. However, based on our on-site revisit we found that your facility is not in substantial compliance with the following participation requirements:

- **0291-Emergency Lighting-NFPA 101 Bld: 01**
- **0353-Sprinkler System - Maintenance And Testing-NFPA 101 Bld: 01**
- **0918-Electrical Systems - Essential Electric System-NFPA 101 Bld: 01**

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.

**NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3.) **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Benjamin Roedel, Administrator  
July 28, 2017  
Page 2 of 3

Your Plan of Correction (PoC) for the deficiencies must be submitted by **August 7, 2017**.

The components of a Plan of Correction, as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained.
- Include dates when corrective action will be completed in column (X5).

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

**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 the deficiencies have been corrected, you may contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 0009; phone number: (208) 334-6626, option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

Benjamin Roedel, Administrator  
July 28, 2017  
Page 3 of 3

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. 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](#)

This request must be received by **August 7, 2017**. If your request for informal dispute resolution is received after **August 7, 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, comments or concerns, please contact Nate Elkins, Supervisor, Long Term Care at (208) 334-6626, option 2.

Sincerely,



Nate Elkins, Supervisor  
Long Term Care

NE/lj  
Enclosures

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

PRINTED: 07/27/2017  
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  R 07/27/2017
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NAME OF PROVIDER OR SUPPLIER  SHAW MOUNTAIN OF CASCADIA	STREET ADDRESS, CITY, STATE, ZIP CODE 909 RESERVE STREET BOISE, ID 83712
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS  On July 27, 2017, an on-site follow up survey of your facility was conducted to verify correction of deficiencies noted during the survey of June 23, 2017. Shaw Mountain of Cascadia was found not to be in substantial compliance with federal life safety code as of July 27, 2017.  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 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, observation, testing 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.  Findings include:  During the follow-up visit, on July 27, 2017, no documentation could be produced to show the testing of the emergency lighting system throughout the facility for thirty (30) seconds. The Plan of Correction stated this testing was completed and documented on the TELS system. Upon further testing of random emergency lights in the facility revealed that the emergency light in	{K 291}	K291  Corrective Action:  All emergency lighting was tested and logged by the ESS to confirm all emergency lighting is properly working.  Identification:  All residents are identified as possibly being affected by this deficiency.  Systemic Changes:  1. Log created and will be utilized to monitor completion of monthly testing of emergency lighting. 2. Continue monthly audits of emergency lighting for compliance. 3. Directors / ESS staff in-serviced regarding reporting of emergency light issue to ESS.	7-31-17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>T. Benjamin H. Paschel</i>	TITLE  <i>Executive Director</i>	(X6) DATE  8-7-17
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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 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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AUG - 7 2017

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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{K 291}	<p>Continued From page 1</p> <p>the kitchen hallway was not operational. When asked, the ESS stated the facility was unaware the duration of the testing had to be included on the log, or identification of the units tested. He further stated that the facility was not aware the emergency light in the kitchen hallway was not operational because he had recently tested it and it had worked properly.</p> <p>Actual NFPA reference:</p> <p>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</p>	{K 291}	<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>	
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**RECEIVED**  
**AUG - 7 2017**  
**FACILITY STANDARDS**

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{K 291}	<p>Continued From page 2</p> <p>shall be kept by the owner for inspection by the authority having jurisdiction.</p> <p>7.9.3.1.2 Testing of required emergency lighting systems shall be permitted to be conducted as follows:</p> <p>(1) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall be provided.</p> <p>(2) Not less than once every 30 days, self-testing/self-diagnostic battery-operated emergency lighting equipment shall automatically perform a test with a duration of a minimum of 30 seconds and a diagnostic routine.</p> <p>(3) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall indicate failures by a status indicator.</p> <p>(4) A visual inspection shall be performed at intervals not exceeding 30 days.</p> <p>(5) Functional testing shall be conducted annually for a minimum of 1-1/2 hours.</p> <p>(6) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall be fully operational for the duration of the 1-1/2-hour test.</p> <p>(7) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction.</p> <p>7.9.3.1.3 Testing of required emergency lighting systems shall be permitted to be conducted as follows:</p> <p>(1) Computer-based, self-testing/self-diagnostic batteryoperated emergency lighting equipment shall be provided.</p> <p>(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.</p> <p>(3) The emergency lighting equipment shall automatically perform annually a test for a</p>	{K 291}		

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{K 291}	Continued From page 3 minimum of 1172 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 353} SS=F	<p>NFPA 101 Sprinkler System - Maintenance and Testing</p> <p>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.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</p> <p>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 record review and interview, the facility failed to ensure fire suppression systems were 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.</p>	{K 353}	<p>K353</p> <p>Corrective Action:</p> <ol style="list-style-type: none"> <li>ESS scheduled Simplex Grinnell to be at facility to begin completing all required testing, and or sprinkler head replacements on all heads 20 years and older. (Scheduled for week of August 3<sup>rd</sup>)</li> </ol> <p>Identification:</p> <p>All residents are identified as possibly being affected by this deficiency.</p> <p>Systemic Changes:</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>Monitor:</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>	8/4/17

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{K 353}	Continued From page 4  Findings include:  During the review of facility inspection records conducted on July 27, 2017, no record of the fourth quarter, 2016 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 Environmental Service Supervisor (ESS) stated the facility thought the quarterly sprinkler inspection dated September 30, 2016 was for the fourth quarter. The facility produced three (3) total inspection and testing documents.  During the interview, the facility contacted the sprinkler company and requested the fourth quarter 2016 sprinkler inspection documentation. The sprinkler company stated they could not locate a fourth quarter sprinkler inspection for the facility. Upon further review of the sprinkler records of testing/replacement of the fast response sprinkler heads, the Administrator stated that the sprinkler company had given them a bid of approximately twenty thousand dollars to replace the sprinkler heads so they were looking in to having them tested rather than replaced.  Actual NFPA standard:  NFPA 25  5.2.5 Waterflow Alarm and Supervisory Devices. Waterflow alarm and supervisory alarm devices	{K 353}			

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{K 353}	Continued From page 5 shall be inspected quarterly to verify that they are free of physical damage.	{K 353}		
{K 918} SS=F	<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> <p>NFPA 101 Electrical Systems - Essential Electric System</p> <p>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.</p> <p>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</p>	{K 918}	<p>K918</p> <p><b>Corrective Action:</b></p> <p>ESS conducted a monthly load test on July 27, 2017. Weekly load test to be conducted on regular schedule every Tuesday.</p> <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. 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.</li> <li>2. The generator log to completed and a hard copy to be placed in the ESS binder after the monthly/weekly load test is completed.</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>1. Weekly for 4 weeks.</li> <li>2. Monthly for 3 months.</li> <li>3. Quarterly for 6 months.</li> </ol>	7/27/17

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{K 918}	<p>Continued From page 6</p> <p>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)</p> <p>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 all residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During the follow-up revisit on July 27, 2017, revealed the facility Plan of Correction stated the monthly generator test was conducted on July 18, 2017, but no records were available to show compliance. When asked, the Environmental Service Supervisor (EES) stated he planned to run the monthly load test on July 31, 2017.</p> <p>Actual NFPA standard:</p> <p>NFPA 99</p> <p>3-4.4.1 Maintenance and Testing of Essential Electrical System. 3-4.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches. (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</p>	{K 918}		

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{K 918}	<p>Continued From page 7</p> <p>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>* 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 Power Systems, Chapter 6.</li> <li>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.</li> <li>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.</li> </ol> <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</p>	{K 918}		

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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>R</b> <b>07/27/2017</b>
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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>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 918}	<p>Continued From page 8</p> <p>appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly.</p> <p>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.</p> <p>6-4.2*</p> <p>Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>(a) Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating</p> <p>(b) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations.</p>	{K 918}		