



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSSELL S. BARRON – 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

December 12, 2017

Gary "Paul" Arnell, Administrator
The Orchards of Cascadia
404 North Horton Street
Nampa, ID 83651-6541

Provider #: 135019

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

Dear Mr. Arnell:

On **December 1, 2017**, a Facility Fire Safety and Construction survey was conducted at **The Orchards 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

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you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office. If a State Form with deficiencies was issued, it should be signed, dated and returned along with the CMS-2567 Form.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **December 26, 2017**. Failure to submit an acceptable PoC by **December 26, 2017**, may result in the imposition of civil monetary penalties by **January 14, 2018**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.
- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567. If a State Form was issued as well, it should also be signed, dated and returned.

All references to federal regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Remedies may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **January 5, 2018**, (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 **January 5, 2018**. A change in the seriousness of the deficiencies on **January 5, 2018**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **January 5, 2018**, includes the following:

Denial of payment for new admissions effective **March 1, 2018**.
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 **June 1, 2018**, 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 **December 1, 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:

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<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

Go to the middle of the page to Information Letters section and click on State and select the following:

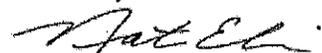
BFS Letters (06/30/11)

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

This request must be received by **December 26, 2017**. If your request for informal dispute resolution is received after **December 26, 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

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

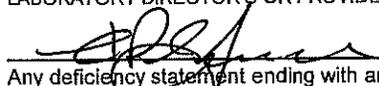
PRINTED: 12/11/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/01/2017
NAME OF PROVIDER OR SUPPLIER ORCHARDS OF CASCADIA, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH HORTON STREET NAMPA, ID 83651	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments The facility is a single story Type V (111) building built in 1959; an automatic fire sprinkler system was installed in 1973 as a retrofit and a new fire alarm/smoke detection system was installed in 2002. There had been an addition to the building in 1962. A remodel and extensions of A & B wing occurred in 1995 with a rehabilitation wing added in October 1995. The current rehab wing was remodeled extensively in 2006. The facility is currently licensed for 100 beds and had a census of 75 on the day of the survey. The following deficiencies were cited during the Emergency Preparedness survey conducted on November 30 and December 1, 2017. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73. The facility is currently licensed for 100 SNF/NF beds and had a census of 75 on the day of the survey. The Survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	E 000	<i>This plan of correction is submitted as required under Federal and State regulations and statutes applicable to long-term care providers. The plan of Correction does not constitute agreement by the facility that the surveyors findings constitute a deficiency and/or that the scope and severity of the deficiencies cited are correct applied.</i>	
E 001 SS=F	Establishment of the Emergency Program (EP) CFR(s): 483.73 The [facility, except for Transplant Center] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following	E 001	1. SPECIFIC ISSUE: The Orchards of Cascadia's Emergency Management Plan was reviewed and updated on or before Jan 5, 2018 by facility QAPI committee and community emergency personnel to include current and comprehensive policy and procedures and updated site-specific all-hazards risk assessment. 2. OTHER RESIDENTS: All residents are potentially affected by deficient practice. 3. SYSTEMIC CHANGES: Staff educated on or before 1/5/2018 by Executive Director or designee regarding facility emergency management plan.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE



Executive Director

12/22/17

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.

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E 001	Continued From page 1 elements: *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to establish and maintain a current, comprehensive Emergency Preparedness program which includes policies and procedures in accordance with 42 CFR 483.73. Failure to meet this standard has the potential to hinder facility response during an emergency which requires coordination and cooperation with local resources available. This deficient practice affected 75 residents, staff and visitors on the date of the survey. Refer to E-004 as it relates to the facility failure to develop and maintain the EP program CFR reference: 42 CFR 483.73	E 001	4. MONITOR Upon completion of initial education with staff, Executive Director or designee will monitor the effectiveness of the emergency management plan through staff interview and provide outcomes to QAPI committee on a monthly basis. Additional education will be provided as necessary. Plan to be updated as indicated.	
E 004 SS=F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a)	E 004	5. Date of Compliance:	1/5/2018

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E 004	<p>Continued From page 2</p> <p>[The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.]</p> <p>* [For hospitals at §482.15 and CAHs at §485.625(a):] The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.</p> <p>The emergency preparedness program must include, but not be limited to, the following elements:]</p> <p>(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least annually.</p> <p>* [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least annually.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, it was determined the facility failed to develop and maintain a current and comprehensive Emergency Preparedness program in accordance with 42 CFR 483.73. Lack of a current comprehensive emergency program has the potential to hinder resident access to continuing care during a disaster. This deficient</p>	E 004	<p>E 004</p> <p>1. SPECIFIC ISSUE: The Orchards of Cascadia's Emergency Management Plan was reviewed and updated on or before Jan 5, 2018 by facility QAPI committee and community emergency personnel to include current and comprehensive policy and procedures and updated geographic, site-specific all-hazards risk assessment. See also: E 0006, E 0007, E 0009, E 0013, E 0015, E 0018, E 0024, E 0026, E 0029, E 0030, E 0033, E 0034, E 0035, E 0036, E 0037, E 0039.</p> <p>2. OTHER RESIDENTS: All residents are potentially affected by deficient practice.</p> <p>3. SYSTEMIC CHANGES: Staff educated on or before 1/5/2018 by Executive Director or designee regarding updated facility emergency management plan.</p>	

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E 004	<p>Continued From page 3 practice affected 75 residents, staff and visitors on the date of the survey. Findings include:</p> <p>On 11/30/17 from 8:30 AM to 2:00 PM, review of the provided emergency plan, policies and procedures, revealed the facility had not developed a current policy or emergency plan in accordance with the standard. The provided policies and emergency plan ranged in dates from 2007 to 2016.</p> <p>Review of these policies and the included plan established the plan did not contain information that was specific to the geographical location of the facility. When asked, about the annual review of the outdated plan and why the review was conducted for policies and procedures which were not reflective of an all hazards approach to the facility's site specific risks, the Administrator stated the facility adopted the plan from the previous management and that this plan was carried forward in an effort to meet the current standard.</p> <p>a. Refer to E 0006 as it relates to conducting a facility-based and community-based risk assessment which includes strategies identified under an all-hazards approach.</p> <p>b. Refer to E 0007 as it relates to the facility resident population; continuation of operations; succession planning.</p> <p>c. Refer to E 0009 as it relates to the facility collaboration with local, tribal, regional State and Federal EP officials</p> <p>d. Refer to E 0013 as it relates to the</p>	E 004	<p>4. MONITOR: Upon completion of initial education with staff, Executive Director or designee will monitor the effectiveness of the emergency management plan through staff interview and provide outcomes to QAPI committee on a monthly basis. Additional education will be provided as necessary. Plan to be updated as indicated.</p> <p>5. Date of Compliance:</p>	1/5/2018

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E 004	<p>Continued From page 4</p> <p>development of policies and procedures, which are updated annually, based on the Emergency Plan; facility and community based risk assessment; and the communication plan.</p> <p>e. Refer to E 0015 as it relates to the policies and procedures for the subsistence needs for residents and staff members during a disaster.</p> <p>f. Refer to E 0018 as it relates to the policies and procedures for tracking residents and staff in the event of a disaster.</p> <p>g. Refer to E 0024 as it relates to the facility use of volunteers</p> <p>h. Refer to E 0026 as it relates to the facility role under 1135 waiver as declared by the Secretary and the provision of care at an alternate site identified by emergency management officials.</p> <p>i. Refer to E 0029 as it relates to the development and annual update of the communication plan.</p> <p>j. Refer to E 0030 as it relates to the information and content of the communication plan.</p> <p>k. Refer to E 0033 as it relates to the methods for the facility to share information and medical documentation of residents with other facilities.</p> <p>l. Refer to E 0034 as it relates to the facility's means of providing information of occupancy needs and its ability to provide assistance during an emergency.</p> <p>m. Refer to E 0035 as it relates to the facility's ability to share information with family or representatives of residents and/or clients.</p>	E 004		

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E 004	Continued From page 5 n. Refer to E 0036 as it relates to the development and implementation of an annual training and testing program as it relates to the emergency preparedness plan. o. Refer to E 0037 as it relates to the emergency training program and the staff knowledge of emergency procedures. p. Refer to E 0039 as it relates to the emergency plan testing requirement. The cumulative effect of these systemic deficient practices, impeded the facility's ability to meet the emergency preparedness standard(s) and the needs of the residents during a disaster. Reference: 42 CFR 483.73 (a) Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2)	E 004	E 006 1. SPECIFIC ISSUE: The Orchards of Cascadia's all hazard risk assessment was reviewed and updated on or before Jan 5, 2018 by facility QAPI committee and community emergency personnel to include but not limited to community based risk assessment with local empirical data for the community based component, current and comprehensive policy and procedures and updated site-specific all-hazards risk assessment.	
E 006 SS=F	[(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* *[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. *[For ICF/IIDs at §483.475(a)(1):] (1) Be based on	E 006	2. OTHER RESIDENTS: All residents are potentially affected by deficient practice. 3. SYSTEMIC CHANGES: Staff educated on or before 1/5/2018 by Executive Director or designee regarding updated all-hazard risk assessment.	

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E 006	<p>Continued From page 6</p> <p>and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients.</p> <p>(2) Include strategies for addressing emergency events identified by the risk assessment.</p> <p>* [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to conduct a facility-based and community-based risk assessment which includes identified strategies for response. Failure to conduct a facility and community based risk assessment hinders facility response to localized disasters and emergencies. This deficient practice affected 75 residents, staff and visitors on the date of the survey. Findings include:</p> <p>On 11/30/17 from 8:30 AM to 2:00 PM, review of provided policies, procedures and the emergency plan revealed a risk assessment had been conducted, but when asked how the facility had determined the types of risks relevant to the facility, the Administrator stated the facility had based their risk assessment on staff choice during a management meeting.</p> <p>Further interview of the Administrator revealed the facility had not contacted any emergency management officials to obtain empirical data for</p>	E 006	<p>4. MONITOR: Upon completion of initial education with staff, Executive Director or designee will monitor the effectiveness of the emergency management plan through staff interview and provide outcomes to QAPI committee on a monthly basis. Additional education will be provided as necessary. Plan to be updated as indicated.</p> <p>5. Date of Compliance:</p>	1/5/2018	

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E 006	Continued From page 7 the community based component of the risk assessment, identifying actual risks the facility may encounter. Review of the actual policies, procedures, and plan established the plan identified such risks as hurricanes, tsunami's and landslides, none of which are geographically relevant to the facility, or supported as identified community based risks due to location.	E 006		
E 007 SS=F	Reference: 42 CFR 483.73 (a) (1) - (2) EP Program Patient Population CFR(s): 483.73(a)(3) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to provide current policies, procedures and an emergency plan that address the resident population including persons at risk, the facility's ability to provide in an emergency and included continuity of operations with staff succession planning. Failure to provide	E 007	E 007 1. SPECIFIC ISSUE: The Orchards of Cascadia's Emergency Management Plan was reviewed and updated on or before Jan 5, 2018 by facility QAPI committee and community emergency personnel to address resident population including persons at risk, staff succession planning, and facilities ability to provide in an emergency. 2. OTHER RESIDENTS: All residents are potentially affected by deficient practice. 3. SYSTEMIC CHANGES: Staff educated on or before 1/5/2018 by Executive Director or designee regarding facilities resident population including persons at risk, staff succession planning, and facilities ability to provide in an emergency.	

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E 007	Continued From page 8 updated policies, procedures and succession plan, potentially hinders continuation of resident care during an emergency. This deficient practice affected 75 residents, staff and visitors on the date of the survey. Findings include: 1) On 11/30/17 review of provided policies and procedures and the emergency plan did not reveal a current, updated plan which included delegations of authority and succession planning. Policies, procedures and the emergency plans provided varied in dates ranging from 2007 to 2016 and the section(s) which were found to relate to delegation, were flow charts that were not complete, but only generic examples. 2) Interviews conducted of 5 of 5 staff members on 11/30/17 from 1:00 PM - 2:45 PM, revealed staff members were unfamiliar with any plan, policies, or procedures for the succession planning of staff, or procedures for facility continuity of operations during a disaster. Reference: 42 CFR 483.73 (a) (3) Local, State, Tribal Collaboration Process CFR(s): 483.73(a)(4)	E 007	4. MONITOR Upon completion of initial education with staff, Executive Director or designee will monitor the effectiveness of the emergency management plan through staff interview and provide outcomes to QAPI committee on a monthly basis. Additional education will be provided as necessary. Plan to be updated as indicated.	
E 009 SS=E	Local, State, Tribal Collaboration Process CFR(s): 483.73(a)(4) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts	E 009	5. Date of Compliance:	1/5/2018

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NAME OF PROVIDER OR SUPPLIER ORCHARDS OF CASCADIA, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH HORTON STREET NAMPA, ID 83651		
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E 009	<p>Continued From page 9</p> <p>to maintain an integrated response during a disaster or emergency situation, including documentation of the facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts.</p> <p>* [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the dialysis facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, it was determined the facility failed to develop current updated policies and procedures based on the Emergency Plan. Failure to develop current policies and procedures based on the emergency plan, a facility and community based risk assessment and the facility communications plan, limits the facility response capabilities to protect the 75 residents in the facility on the day of survey.</p> <p>Findings include:</p> <p>On 11/30/17 from 8:30 AM to 3:00 PM, review of provided policies and procedures revealed no records indicating a plan for collaboration with</p>	E 009	<p>E 009</p> <ol style="list-style-type: none"> SPECIFIC ISSUE: The Orchards of Cascadia's Emergency Management Plan was reviewed and updated on or before Jan 5, 2018 by facility QAPI committee and community emergency personnel to include comprehensive collaboration with local emergency planning authorities. OTHER RESIDENTS: All residents are potentially affected by deficient practice. SYSTEMIC CHANGES: Staff educated on or before 1/5/2018 by Executive Director or designee regarding facilities updated all hazard risk assessment with collaboration with local emergency authorities. 	

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E 009	Continued From page 10 local, tribal, regional, State or Federal emergency officials. Further review of the policies and procedures established contact information for the State emergency management office was a disconnected number and not a current contact. Interview of the Administrator on 11/30/17 from 8:30 - 10:00 AM, confirmed the facility had not been in contact with local emergency officials for development of a comprehensive collaboration plan and that this plan was carried over from previous management.	E 009		
E 013 SS=F	42 CFR 483.73. (a) (4) Development of EP Policies and Procedures CFR(s): 483.73(b) (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical	E 013	4. MONITOR: Upon completion of initial education with staff, Executive Director or designee will monitor the effectiveness of the emergency management plan through staff interview and provide outcomes to QAPI committee on a monthly basis. Additional education will be provided as necessary. Plan to be updated as indicated. 5. Date of Compliance:	1/5/2018

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E 013	<p>Continued From page 11</p> <p>emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least annually.</p> <p>*[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to develop current updated policies and procedures based on the Emergency Plan. Failure to develop current policies and procedures based on the emergency plan, a facility and community based risk assessment and the facility communications plan, limits the facility response capabilities in the protection of residents during a disaster. This deficient practice affected 75 residents, staff and visitors on the date of the survey.</p> <p>Findings include: On 11/30/17 from 8:30 AM to 3:00 PM, review of provided policies and procedures revealed the</p>	E 013	<p>E 013</p> <ol style="list-style-type: none"> 1. SPECIFIC ISSUE: The Orchards of Cascadia's Emergency Management Plan was reviewed and updated on or before Jan 5, 2018 by facility QAPI committee and community emergency personnel to include updated and site-specific policy and procedures for all identified areas of the facility risk assessment and communication. 2. OTHER RESIDENTS: All residents are potentially affected by deficient practice. 3. SYSTEMIC CHANGES: Staff educated on or before 1/5/2018 by Executive Director or designee regarding facilities updated policies per the facility assessment and communications plan. 4. MONITOR: Upon completion of initial education with staff, Executive Director or designee will monitor the effectiveness of the emergency management plan through staff 	

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E 013	Continued From page 12 current copy ranged in date from 2007 to 2016. Further review of the policy established the annual review was dated 10/1/17, however the plan included natural disasters such as hurricanes, tsunamis and landslides, which were not reflected by the the risk assessment. Interview of the Administrator on 11/30/17 from 8:30 - 10:00 AM, confirmed the facility risk assessment was not reflective of the emergency policies, procedures or plan as the risk assessment was conducted by staff during a management meeting and the policies and plan were from a former management group.	E 013	interview and provide outcomes to QAPI committee on a monthly basis. Additional education will be provided as necessary. Plan to be updated as indicated. 5. Date of Compliance:	1/1/2018
E 015 SS=D	42 CFR 483.73 (b) Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and	E 015	E 015 1. SPECIFIC ISSUE: The Orchards of Cascadia's Emergency Management Plan was reviewed and updated on or before Jan 5, 2018 by facility QAPI committee and community emergency personnel to include updated and site-specific policy and procedures to include provision of subsistence needs for staff and patients when sheltering in place including water storage on-site to equal one (1) gallon per person. See also E 007. 2. OTHER RESIDENTS: All residents are potentially affected by deficient practice.	

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E 015	<p>Continued From page 13 safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal.</p> <p>*[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to implement current policies and procedures, which could then be reviewed annually, to provide subsistence needs of residents and staff should they need to evacuate or shelter in place during a disaster. Failure to follow policies for subsistence potentially limits the facility's ability to provide continuing care and services for the 75</p>	E 015	<p>3. SYSTEMIC CHANGES: Staff educated on or before 1/5/2018 by Executive Director or designee regarding facilities updated policies regarding provision of subsistence needs and alternate energy sources.</p> <p>4. MONITOR: Upon completion of initial education with staff, Executive Director or designee will monitor the effectiveness of the emergency management plan through staff interview and provide outcomes to QAPI committee on a monthly basis. Additional education will be provided as necessary. Plan to be updated as indicated.</p> <p>5. Date of Compliance:</p>	1/1/2018

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E 015	Continued From page 14 residentsts during an emergency on the day of survey. Findings include: On 11/30/17 from 8:00 AM to 2:00 PM, review of provided policies and procedures for the facility indicated policies and procedures for emergency food and water supplies to be stored on site for use in the event of a disaster. Further review of the plan established the facility had an outdated contract dated 2/15/2011 from a non-local water vendor. The plan did not indicate provisions for water to be stored on site to equal one (1) gallon per person. Interview of 5 of 5 staff on 11/30/17 from 1:00 - 3:00 PM, revealed the facility had no stored water on site. Reference: 42 CFR 483.73 (b) (1)	E 015	E 018 1. SPECIFIC ISSUE: The Orchards of Cascadia's Emergency Management Plan was reviewed and updated on or before Jan 5, 2018 by facility QAPI committee and community emergency personnel to include updated and site-specific policy and procedures to include staff and resident tracking system and tools for both evacuation and shelter-in-place scenarios. 2. OTHER RESIDENTS: All residents are potentially affected by deficient practice. 3. SYSTEMIC CHANGES:	
E 018 SS=F	Procedures for Tracking of Staff and Patients CFR(s): 483.73(b)(2) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following: (2) A system to track the location of on-duty staff	E 018	Staff educated on or before 1/5/2018 by Executive Director or designee regarding facilities updated policies regarding tracking systems for both evacuation and shelter-in-place scenarios.	

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E 018	<p>Continued From page 15 and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location.</p> <p>*[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location.</p> <p>*[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location.</p> <p>*[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff</p>	E 018	<p>4. MONITOR Upon completion of initial education with staff, Executive Director or designee will monitor the effectiveness of the emergency management plan through staff interview and provide outcomes to QAPI committee on a monthly basis. Additional education will be provided as necessary. Plan to be updated as indicated.</p> <p>5. Date of Compliance:</p>	1/5/2018	

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E 018	<p>Continued From page 16</p> <p>responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.</p> <p>*[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records.</p> <p>*[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, it was determined the facility failed to provide a current policy for tracking of staff and sheltered residents during an emergency, or if relocated, a policy for documentation of the receiving facility or other location for those relocated individuals. Lack of a tracking policy has the potential to hinder the facility's ability to provide care and continuation of services during an emergency. This deficient practice affected 75 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>On 11/30/17 from 8:30 AM to 3:00 PM, review of the records, policies and procedures provided failed to demonstrate a system in place to track the location of on-duty staff and sheltered residents during an emergency.</p> <p>Interview of 5 of 5 staff members on 11/30/17</p>	E 018			

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E 024	<p>Continued From page 18</p> <p>document and maintain current emergency policies, procedures and operational plans for the use of volunteers to address surge needs during an emergency. Lack of current plans and policies for the use of volunteers has the potential to hinder the facility's ability to care for residents and provide continuation of care during a disaster. This deficient practice has the potential to affect 75 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>On 11/30/17 from 8:30 AM to 3:00 PM, review of provided policies, procedures, and emergency preparedness records failed to demonstrate a current plan, which addressed the use of volunteers, or integration of State and Federally designated health care professionals to address surge needs during an emergency. Facility policy, procedures and emergency plan records provided, ranged in date from 2007 to 2016 with no indication of the use of volunteers or the risk of surge needs.</p> <p>Interview of 5 of 5 staff members on 11/30/17 from 1:00 to 3:00 PM, did not indicate any knowledge of the use of volunteers during an emergency. Interview of the Administrator on 11/29/17 from 8:30 - 10:00 AM revealed the facility did not have a policy on the use of volunteers and did not establish any plan for the facility reaction to surge events.</p> <p>Reference: 42 CFR 483.73 (b) (6)</p>	E 024	<p>4. MONITOR: Upon completion of initial education with staff, Executive Director or designee will monitor the effectiveness of the emergency management plan through staff interview and provide outcomes to QAPI committee on a monthly basis. Additional education will be provided as necessary. Plan to be updated as indicated.</p> <p>5. Date of Compliance:</p>	1/5/2018
E 026 SS=C	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8)	E 026		

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E 026	<p>Continued From page 19</p> <p>[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:]</p> <p>(8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.</p> <p>*[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the facility failed to document a current plan for the facility role under an 1135 waiver as declared by the Secretary and the provisions of care at an alternate site if identified by emergency management officials. Failure to plan for alternate means of care and the role under an 1135 waiver has the potential to limit facility options during an emergency.</p> <p>Findings include:</p>	E 026	<p>E 026</p> <ol style="list-style-type: none"> SPECIFIC ISSUE: The Orchards of Cascadia's Emergency Management Plan was reviewed and updated on or before Jan 5, 2018 by facility QAPI committee and community emergency personnel to include updated and site-specific policy and procedures to include facility role and responsibilities established by 1135 waiver. OTHER RESIDENTS: All residents are potentially affected by deficient practice. SYSTEMIC CHANGES: Staff educated on or before 1/5/2018 by Executive Director or designee regarding facilities updated policies regarding facility role and responsibilities under 1135 waiver.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 026	Continued From page 20 On 11/30/17 from 8:30 AM to 3:00 PM, review of the provided policies and procedures revealed the facility did not have a current policy or procedure that addressed the facility role during a disaster event under the 1135 waiver. Policies, procedures and emergency plans provided ranged in date from 2007 to 2016, without representation of the facility's responsibilities under a declaration by the Secretary. Reference: 42 CFR 483.73 (b) (8)	E 026	4. MONITOR: Upon completion of initial education with staff, Executive Director or designee will monitor the effectiveness of the emergency management plan through staff interview and provide outcomes to QAPI committee on a monthly basis. Additional education will be provided as necessary. Plan to be updated as indicated.	
E 029 SS=F	Development of Communication Plan CFR(s): 483.73(c) (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to document a current plan for facility communications. Communication plans are an essential component during an emergency. Failure to have a current communication plan has the potential to hinder both internal and external emergency response by personnel. This deficient practice affected 75 residents, staff and visitors on the date of the survey. Findings include: On 11/30/17 from 8:30 AM to 3:00 PM, review of provided disaster and emergency policies and	E 029	5. Date of Compliance: E 029 1. SPECIFIC ISSUE: The Orchards of Cascadia's Emergency Management Plan was reviewed and updated on or before Jan 5, 2018 by facility QAPI committee and community emergency personnel to include updated and site-specific policy and procedures to include an updated communications plan. 2. OTHER RESIDENTS: All residents are potentially affected by deficient practice.	1/5/2018

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E 030	Continued From page 22 (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to document a current plan which included contact information for staff, entities providing services, physicians, other facilities and volunteers. Failure to have	E 030	2. OTHER RESIDENTS: All residents are potentially affected by deficient practice. 3. SYSTEMIC CHANGES: Staff educated on or before 1/5/2018 by Executive Director or designee regarding facilities updated contact list. 4. MONITOR: Upon completion of initial education with staff, Executive Director or designee will monitor the effectiveness of the emergency management plan through staff interview and provide outcomes to QAPI committee on a monthly basis. Additional education will be provided as necessary. Plan to be updated as indicated. 5. Date of Compliance:	1/5/2018	

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E 030	Continued From page 23 current contact information available has the potential to hinder staff response, leaving residents without continuation of care during an emergency. This deficient practice could potentially affect 75 residents, staff and visitors on the date of the survey. Findings include: On 11/30/17 from 8:30 AM to 3:00 PM, review of provided disaster and emergency policies and procedures revealed policies dated 8/31/2012 which included pages for contact information to be used during an emergency, however the pages were left blank. Interview of 5 of 5 staff members from 1:00 to 3:00 PM indicated they were not aware of any communication plan and contact information for the facility to use during an emergency. Reference: 42 CFR 483.73 (c) (1)	E 030		
E 033 SS=F	Methods for Sharing Information CFR(s): 483.73(c)(4)-(6) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care.	E 033	E 033 1. SPECIFIC ISSUE: The Orchards of Cascadia's Emergency Management Plan was reviewed and updated on or before Jan 5, 2018 by facility QAPI committee and community emergency personnel to include updated and site-specific policies regarding method of sharing information and medical documentation with other health providers including, in the event of an evacuation, release of patient information including general condition and transfer location, if indicated. See also E 018. 2. OTHER RESIDENTS: All residents are potentially affected by deficient practice. 3. SYSTEMIC CHANGES: Staff educated on or before 1/5/2018 by Executive Director or designee regarding facilities policy for sharing information regarding patient condition and location and method of sharing information with other health providers as indicated.	

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E 033	Continued From page 24 (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.22(c), CORFs under §485.68(c), and RHCs/FQHCs under §491.12(c).] (6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4). *[For RNHCs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHC's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative. *[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to document a current plan for sharing information during an emergency. Lack of a current plan for sharing information with other health care providers has the potential to hinder the facility's ability to continue care during a disaster. This deficient practice affected 75 residents, staff and visitors on the date of the survey. Findings include:	E 033	4. MONITOR Upon completion of initial education with staff, Executive Director or designee will monitor the effectiveness of the emergency management plan through staff interview and provide outcomes to QAPI committee on a monthly basis. Additional education will be provided as necessary. Plan to be updated as indicated. 5. Date of Compliance:	1/5/2018	

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E 033	<p>Continued From page 25</p> <p>On 11/30/17 from 8:30 AM to 3:00 PM, review of provided disaster and emergency policies and procedures which ranged in date from 2007 to 2016, failed to demonstrate a current policy which could be implemented by the facility to share information for the care of residents with other healthcare providers during an emergency.</p> <p>Interview of 5 of 5 staff members from 1:00 to 3:00 PM revealed they had no knowledge of a policy or plan for the sharing of information with other healthcare providers.</p> <p>Reference: Information on Occupancy/Needs CFR(s): 483.73(c)(7)</p> <p>[(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following:</p> <p>(7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.</p> <p>*[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.</p> <p>*[For Inpatient Hospice at §418.113:] (7) A means</p>	E 033	<p>E 034</p> <ol style="list-style-type: none"> SPECIFIC ISSUE: The Orchards of Cascadia's Emergency Management Plan was reviewed and updated on or before Jan 5, 2018 by facility QAPI committee and community emergency personnel to include updated and site-specific policies regarding means of providing information about the facilities occupancy, needs and ability to provide assistance with Incident Commander or designee. OTHER RESIDENTS: All residents are potentially affected by deficient practice. SYSTEMIC CHANGES: Staff educated on or before 1/5/2018 by Executive Director or designee regarding facilities procedure to provide facility information to incident commander or designee. 	
E 034 SS=D		E 034		

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E 034	Continued From page 26 of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to document a current plan for sharing information on needs, occupancy and its ability to provide assistance with emergency management officials. Lack of a current plan for providing information to emergency personnel on the facility's needs and abilities to provide assistance during an emergency has the potential to hinder response assistance and continuation of care for the residents that require specialized care. Findings include: On 11/30/17 from 8:30 AM to 3:00 PM, review of provided policies, procedures and emergency plans revealed a range of dates from 2007 to 2016, with no indication of what method the facility would use to share information on its needs or capabilities with emergency management officials. Interview of the Administrator from 8:30 to 10:00 AM revealed the facility had not met or contacted local or regional emergency management officials prior to the date of the survey. Reference: 42 CFR 483.73 (c) (7)	E 034	4. MONITOR: Upon completion of initial education with staff, Executive Director or designee will monitor the effectiveness of the emergency management plan through staff interview and provide outcomes to QAPI committee on a monthly basis. Additional education will be provided as necessary. Plan to be updated as indicated. 5. Date of Compliance:	1/5/2018
E 035	LTC and ICF/IID Sharing Plan with Patients	E 035		

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E 035 SS=D	Continued From page 27 CFR(s): 483.73(c)(8) [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the facility failed to provide a current plan for sharing information on the emergency plan with residents, families or representatives. Lack of a current plan for sharing information to residents, families or representatives has the potential to create confusion and lack of understanding of the facility's response during a disaster. This deficient practice could potentially affect 75 residents, staff and visitors on the date of the survey. Findings include: On 11/30/17 from 8:30 AM to 3:00 PM, review of provided disaster and emergency policies and procedures revealed a range of dates for policies, procedures and emergency plans from 2007 to 2016. No documentation was provided demonstrating the facility policy for sharing information with residents, their families or representatives. Reference:	E 035	E 035 1. SPECIFIC ISSUE: The Orchards of Cascadia's emergency management plan will be posted and available for all visitors and residents to review on or before Jan. 5, 2018. Additionally, emergency plan will be discussed upon admission with all new residents and their advocates. Emergency management plan will be discussed ongoing with residents during resident council and education provided as needed. 2. OTHER RESIDENTS: All residents are potentially affected by deficient practice. 3. SYSTEMIC CHANGES: Staff educated on or before 1/5/2018 by Executive Director or designee regarding communication of the emergency management plan to visitors and residents. 4. MONITOR: Upon completion of initial education with staff, Executive Director or		

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E 035 E 036 SS=F	Continued From page 28 42 CFR 483.73 (c) (8) EP Training and Testing CFR(s): 483.73(d) (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at	E 035 E 036	designee will monitor the effectiveness of the emergency management plan through staff interview and provide outcomes to QAPI committee on a monthly basis. Additional education will be provided as necessary. Plan to be updated as indicated. 5. Date of Compliance: E 036 1. SPECIFIC ISSUE: The Orchards of Cascadia's Emergency Management Plan was reviewed and updated on or before Jan 5, 2018 by facility QAPI committee and community emergency personnel to include updated and site-specific policy regarding training and testing of employees for Emergency Management plan upon orientation and annually and will include documentation and staff competency completion. See also E 037. 2. OTHER RESIDENTS: All residents are potentially affected by deficient practice. 3. SYSTEMIC CHANGES:	1/5/2018	

Staff educated on or before 1/5/2018 by Executive Director or designee to validate understanding of current emergency preparedness plan. Additional education to be provided

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E 036	<p>Continued From page 29 paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, it was determined the facility failed to provide a current emergency prep training and testing program. Lack of an emergency training and testing program covering the emergency preparedness plan and policies for the facility, has the potential to hinder staff response during a disaster. This deficient practice affected 75 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>On 11/30/17 from 8:30 AM to 3:00 PM, review of provided disaster plans and emergency policies and procedures, revealed a range of dates for policies, procedures and emergency plans from 2007 to 2016. No documentation was provided demonstrating the facility had a current training and testing program for staff based on a specific plan.</p> <p>Interview of 5 of 5 staff conducted on 11/30/17 from 1:00 to 3:00 PM established staff had not participated or had knowledge of any specific training and testing program in relation to emergency preparedness.</p> <p>Further interview of the Staff Development Coordinator on 12/1/17 from 1:00 to 1:30 PM substantiated the facility did not have any current training and testing program to meet the standard.</p> <p>Reference:</p>	E 036	<p>as indicated. Staff Development Coordinator educated on or before 1/5/2018 by Executive Director to validate training and testing program is available and offered upon orientation and annually to employees (annual training calendar to include updates).</p> <p>4. MONITOR: Upon completion of initial education with staff, Executive Director or designee will monitor the effectiveness of the emergency management plan through staff interview and provide outcomes to QAPI committee on a monthly basis. Additional education will be provided as necessary. Plan to be updated as indicated.</p> <p>5. Date of Compliance:</p>	1/5/2018

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E 036	Continued From page 30	E 036	E 037	
E 037 SS=F	<p>42 CFR 483.73 (d) EP Training Program CFR(s): 483.73(d)(1)</p> <p>(1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures.</p> <p>*[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. This is what's in SOM but is missing here.</p> <p>*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing</p>	E 037	<p>1. SPECIFIC ISSUE: The Orchards of Cascadia's Emergency Management Plan was reviewed and updated on or before Jan 5, 2018 by facility QAPI committee and community emergency personnel to include updated and site-specific policy regarding training and testing of employees for Emergency Management plan upon orientation and annually and will include documentation and staff competency completion. See also E 036.</p> <p>2. OTHER RESIDENTS: All residents are potentially affected by deficient practice.</p> <p>3. SYSTEMIC CHANGES: Staff educated on or before 1/5/2018 by Executive Director or designee to ensure understanding of current emergency preparedness plan. Additional education to be provided as indicated. Staff Development Coordinator educated on or before</p>	

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E 037	<p>Continued From page 31</p> <p>hospice employees, and individuals providing services under arrangement, consistent with their expected roles.</p> <p>(ii) Demonstrate staff knowledge of emergency procedures.</p> <p>(iii) Provide emergency preparedness training at least annually.</p> <p>(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.</p> <p>*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training.</p> <p>*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency</p>	E 037	<p>ensure training and testing program is available and offered upon orientation and annually to employees (annual training calendar to include updates).</p> <p>1/5/2018 by Executive Director to</p> <p>4. MONITOR: Upon completion of initial education with staff, Executive Director or designee will monitor the effectiveness of the emergency management plan through staff interview and provide outcomes to QAPI committee on a monthly basis. Additional education will be provided as necessary. Plan to be updated as indicated.</p> <p>5. Date of Compliance:</p>	1/5/2018	

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NAME OF PROVIDER OR SUPPLIER ORCHARDS OF CASCADIA, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH HORTON STREET NAMPA, ID 83651		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 037	<p>Continued From page 32</p> <p>procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.</p> <p>(iv) Maintain documentation of all training.</p> <p>*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:</p> <p>(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.</p> <p>(ii) Provide emergency preparedness training at least annually.</p> <p>(iii) Maintain documentation of the training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.</p> <p>*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.</p> <p>(ii) Provide emergency preparedness training at least annually.</p>	E 037		

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E 037	<p>Continued From page 33</p> <p>(iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures.</p> <p>*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to provide a current emergency prep training program. Lack of a training program on the emergency preparedness plan and policies for the facility, has the potential to hinder staff response during a disaster. This deficient practice affected 75 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>On 11/30/17 from 8:30 AM to 3:00 PM, review of provided emergency policy, procedures and plan revealed the plan ranged in date from 2007 to 2016, without substantiating documentation demonstrating the facility had a training program for staff based on the plan.</p> <p>Interview of 5 of 5 staff members on 11/30/17 from 1:00 - 3:00 PM revealed no specific training was conducted on the emergency plan or its contents. During interview, 2 of 5 staff stated the</p>	E 037			

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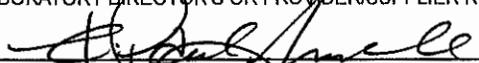
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E 039	<p>Continued From page 35</p> <p>include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, facility-based.</p> <p>(B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.</p> <p>*[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following:</p> <p>(i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, it was determined the facility failed to participate in any exercises which tested the emergency preparedness readiness of the facility. Failure to participate in full-scale or tabletop events has the potential to reduce the facility's effectiveness to</p>	E 039	<p>4. MONITOR: Executive Director will monitor the effectiveness of the emergency management plan through evaluation of full scale drill and table-top exercises. Outcomes will be provide to QAPI committee. Additional education will be provided as necessary. Results of audit will be reviewed in QAPI to validate systems followed. Plan to be updated as indicated.</p> <p>5. Date of Compliance:</p>	1/5/2018

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E 039	Continued From page 36 provide continuation of care to residents during an emergency. This deficient practice affected 75 residents, staff and visitors on the date of the survey. Findings include: On 11/30/17 from 8:30 AM to 3:00 PM, review of provided emergency plan documents revealed no documentation demonstrating the facility had participated in at least two (2) exercises of the emergency preparedness policies and procedures. Interview of the Administrator on 11/30/17 from 8:30 to 10:00 AM substantiated the facility had not participated in any full-scaled exercises, or tabletop events to test the emergency plan. Reference: 42 CFR 483.73 (d) (1)	E 039		

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K 000	INITIAL COMMENTS The facility is a single story Type V (111) building built in 1959; an automatic fire sprinkler system was installed in 1973 as a retrofit and a new fire alarm/smoke detection system was installed in 2002. There had been an addition to the building in 1962. A remodel and extensions of A & B wing occurred in 1995 with a rehabilitation wing added in October 1995. The current rehab wing was remodeled extensively in 2006. The facility is currently licensed for 100 beds and had a census of 68 on the day of the survey. The following deficiencies were cited during the annual fire/life safety survey conducted on November 30 and December 1, 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: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	K 000	RECEIVED DEC 26 2017 FACILITY STANDARDS <i>This plan of correction is submitted as required under Federal and State regulations and statutes applicable to long-term care providers. The plan of Correction does not constitute agreement by the facility that the surveyors findings constitute a deficiency and/or that the scope and severity of the deficiencies cited are correct applied.</i>	
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 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 REQUIREMENT is not met as evidenced by: Based on record review and observation, the facility failed to provide emergency lighting in accordance with NFPA 101. Failure to provide emergency lighting for doors equipped with	K 291	1. SPECIFIC ISSUE: All doors leading to outside of facility have been designated as delayed egress. All doors will be outfitted with emergency lighting compliant with NFPA 101 standards. 2. OTHER RESIDENTS: All residents have the potential to be affected by deficient practice. 3. SYSTEMIC CHANGES: Licensed electrician to install lighting per NFPA guidelines on or before March 1 st , 2018.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE
 Executive Director 12/22/17

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.

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K 291	<p>Continued From page 1</p> <p>delayed egress potentially hinders identification of exits affecting resident egress during an emergency. This deficient practice affected 75 residents staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on November 30, 2017 from 10:30 AM to 3:30 PM, observation of exit doors revealed all exits were equipped with Wanderguard system and a delayed egress component for the magnetic locking arrangements. Further observation established the facility was not providing battery backup emergency lighting for these exits.</p> <p>Actual NFPA standard:</p> <p>19.2.9 Emergency Lighting. 19.2.9.1 Emergency lighting shall be provided in accordance with Section 7.9.</p> <p>7.9 Emergency Lighting. 7.9.1 General. 7.9.1.1* Emergency lighting facilities for means of egress shall be provided in accordance with Section 7.9 for the following: (1) Buildings or structures where required in Chapters 11 through 43 (2) Underground and limited access structures as addressed in Section 11.7 (3) High-rise buildings as required by other sections of this Code (4) Doors equipped with delayed-egress locks (5) Stair shafts and vestibules of smokeproof enclosures, for which the following also apply: (a) The stair shaft and vestibule shall be</p>	K 291	<p>4. MONITOR: Executive Director or designee will validate that all doors are equipped with appropriate lighting and battery back-up per NFPA guidelines for egress. Monitoring of this system will be added to the preventative maintenance check. Additional education will be provided as necessary. Results of audit will be reviewed in PI to ensure systems being followed. Plan to be updated as indicated.</p> <p>5. Date of Compliance:</p>	1/5/2018	

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K 291	Continued From page 2 permitted to include a standby generator that is installed for the smokeproof enclosure mechanical ventilation equipment. (b) The standby generator shall be permitted to be used for the stair shaft and vestibule emergency lighting power supply. (6) New access-controlled egress doors in accordance with 7.2.1.6.2.	K 291		
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to maintain safe electrical installations in accordance with NFPA 70 and the equipment respective listing. Use of non-grounded connections for electrical appliances and lighting has the potential to increase the risk of arc fires. This deficient practice affected staff and visitors on the date of the survey. Findings include: During the facility tour conducted on November 30, 2017 from approximately 8:30 AM to 3:00 PM,	K 511	K 511 1. SPECIFIC ISSUE: Christmas tree in lobby had lights and non-grounded relocatable power tap removed. 2. OTHER RESIDENTS: Facility wide audit performed by Maintenance Director on or before 1/5/2018 to ensure facility maintained safe electrical installations. 3. SYSTEMIC CHANGES: Facility staff educated by Executive Director or designee on or before 1/5/2018 to ensure understanding of safe electrical installations throughout the facility. 4. MONITOR: Executive Director or designee will audit random electrical installations weekly x 3 then monthly x 3 to ensure ongoing compliance. Additional education will be provided as necessary. Results of audit will be reviewed in PI to ensure systems being followed.	

5. **Date of Compliance:**

1/5/2018

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K 511	<p>Continued From page 3</p> <p>observation of the Christmas tree and its lighting decorations at the front lobby revealed the lights were daisy-chained together in a combination of 5 sets, plugged into a non-grounded relocatable power tap and then into the facility outlet.</p> <p>Actual NFPA standard:</p> <p>NFPA 70</p> <p>110.2 Approval. The conductors and equipment required or permitted by this Code shall be acceptable only if approved.</p> <p>Informational Note: See 90.7, Examination of Equipment for Safety, and 110.3, Examination, Identification, Installation, and Use of Equipment. See definitions of Approved, Identified, Labeled, and Listed.</p> <p>110.3 Examination, Identification, Installation, and Use of Equipment.</p> <p>(A) Examination. In judging equipment, considerations such as the following shall be evaluated:</p> <p>(1) Suitability for installation and use in conformity with the provisions of this Code Informational Note: Suitability of equipment use may be identified by a description marked on or provided with a product to identify the suitability of the product for a specific purpose, environment, or application. Special conditions of use or other limitations and other pertinent information may be marked on the equipment, included in the product instructions, or included in the appropriate listing and labeling information. Suitability of equipment may be evidenced by listing or labeling.</p> <p>(2) Mechanical strength and durability, including,</p>	K 511		

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K 511	Continued From page 4 for parts designed to enclose and protect other equipment, the adequacy of the protection thus provided (3) Wire-bending and connection space (4) Electrical insulation (5) Heating effects under normal conditions of use and also under abnormal conditions likely to arise in service (6) Arcing effects (7) Classification by type, size, voltage, current capacity, and specific use (8) Other factors that contribute to the practical safeguarding of persons using or likely to come in contact with the equipment (B) Installation and Use. Listed or labeled equipment shall be installed and used in accordance with any instructions included in the listing or labeling. Reference UL 1363 XBYS.GuidelInfo Relocatable Power Taps	K 511	<p>K 923</p> <p>1. SPECIFIC ISSUE: Oxygen cylinder found in oxygen storage area immediately removed.</p> <p>2. OTHER RESIDENTS: Facility wide audit performed by Maintenance Director on or before 1/5/2018 to ensure additional oxygen cylinders were removed from facility oxygen area or other potential areas.</p> <p>3. SYSTEMIC CHANGES: Facility staff educated by Executive Director or designee on or before 1/5/2018 to ensure understanding that any oxygen cylinder needs to be secured per NFPA regulations.</p> <p>4. MONITOR: Executive Director or designee will audit designated oxygen holding area and other potential areas weekly x 3 then monthly x 3 to ensure ongoing compliance. Additional education will be provided as necessary. Results of audit will be reviewed in PI to ensure systems being followed. Plan to be updated as indicated.</p> <p>5. Date of Compliance:</p>	
K 923 SS=D	Gas Equipment - Cylinder and Container Storage CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum	K 923		

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K 923	<p>Continued From page 5</p> <p>1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure medical gases were stored in accordance with NFPA 99. Failure to secure compressed medical gas cylinders with either a rack or chain has the potential of damaging cylinders from falling, increasing the risk of fires or explosion. This deficient practice affected staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on November 30, 2017 from approximately 12:45 PM to 2:15 PM, observation of the oxygen storage area on the northwest side of the facility, revealed one</p>	K 923		

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K 923	Continued From page 6 unsecured oxygen cylinder set between two racks for storing cylinders. Inquiry of the Maintenance Director established he was aware of the standard requiring all cylinders to be secured. Actual NFPA standard: NFPA 99 11.6.2.3 Cylinders shall be protected from damage by means of the following specific procedures: (1) Oxygen cylinders shall be protected from abnormal mechanical shock, which is liable to damage the cylinder, valve, or safety device. (2) Oxygen cylinders shall not be stored near elevators or gangways or in locations where heavy moving objects will strike them or fall on them. (3) Cylinders shall be protected from tampering by unauthorized individuals. (4) Cylinders or cylinder valves shall not be repaired, painted, or altered. (5) Safety relief devices in valves or cylinders shall not be tampered with. (6) Valve outlets clogged with ice shall be thawed with warm - not boiling - water. (7) A torch flame shall not be permitted, under any circumstances, to come in contact with a cylinder, cylinder valve, or safety device. (8) Sparks and flame shall be kept away from cylinders. (9) Even if they are considered to be empty, cylinders shall not be used as rollers, supports, or for any purpose other than that for which the supplier intended them. (10) Large cylinders (exceeding size E) and containers larger than 45 kg (100 lb) weight shall be transported on a proper hand truck or cart	K 923		

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K 923	Continued From page 7 complying with 11.4.3.1. (11) Freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. (12) Cylinders shall not be supported by radiators, steam pipes or heat ducts.	K 923	<p>K 926</p> <ol style="list-style-type: none"> SPECIFIC ISSUE: Facility education calendar updated to include annual training of application, maintenance and handling of medical gases and cylinders including associated risks. Additionally, same training program updated for facility orientation of new employees. OTHER RESIDENTS: All residents at risk to be affected by deficient practice. SYSTEMIC CHANGES: Staff Development Coordinator educated by Executive Director on or before 1/5/2018 to ensure oxygen training and education of above mentioned requirements are provided upon orientation and annually to employees. MONITOR: Executive Director or designee will audit facility orientation and annual trainings weekly x 3 then monthly x 3 to ensure ongoing compliance. Additional education will be provided as necessary. Results of audit will be reviewed in PI to ensure systems being followed. Plan to be updated as indicated. 	
K 926 SS=E	Gas Equipment - Qualifications and Training CFR(s): NFPA 101 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on record review, and interview, the facility failed to ensure continuing education and staff training was provided on the risks associated with the storage, handling and use of medical gases and their cylinders. Failure to provide training of safety and the risks associated with medical gases, hinders staff response and affects those residents utilizing supplemental oxygen. This deficient practice potentially affected oxygen dependent residents, staff and visitors on the date of the survey. Findings include: Interview of 5 of 5 staff members conducted on November 30, 2017 from approximately 1:00 PM to 3:00 PM, 5 of 5 staff stated they had not	K 926		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135019	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 12/01/2017
NAME OF PROVIDER OR SUPPLIER ORCHARDS OF CASCADIA, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH HORTON STREET NAMPA, ID 83651	
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K 926	Continued From page 8 participated in any continuing education program on the risks associated with the storage, handling or use of medical gases. Further interview of the Staff Development Coordinator conducted on December 1, 2017 from approximately 1:00 PM to 1:15 PM, revealed she was not aware of any current program of continued education for the handling, use and storage of medical gases. Actual NFPA standard: NFPA 99 11.5.2 Gases in Cylinders and Liquefied Gases in Containers. 11.5.2.1 Qualification and Training of Personnel. 11.5.2.1.1* Personnel concerned with the application and maintenance of medical gases and others who handle medical gases and the cylinders that contain the medical gases shall be trained on the risks associated with their handling and use. 11.5.2.1.2 Health care facilities shall provide programs of continuing education for their personnel. 11.5.2.1.3 Continuing education programs shall include periodic review of safety guidelines and usage requirements for medical gases and their cylinders.	K 926		
K 930 SS=E	Gas Equipment - Liquid Oxygen Equipment CFR(s): NFPA 101 Gas Equipment - Liquid Oxygen Equipment The storage and use of liquid oxygen in base reservoir containers and portable containers comply with sections 11.7.2 through 11.7.4 (NFPA 99). 11.7 (NFPA 99) This REQUIREMENT is not met as evidenced	K 930	<p>K 930</p> <ol style="list-style-type: none"> SPECIFIC ISSUE: Liquid oxygen cylinder found in oxygen storage area and outside 300 wing were immediately secured per NFPA guidelines (chained). OTHER RESIDENTS: Facility wide audit performed by Maintenance Director on or before 1/5/2018 to ensure ongoing securement of liquid oxygen cylinders. SYSTEMIC CHANGES: Facility staff educated by Executive Director or designee on or before 1/5/2018 to ensure understanding that any oxygen cylinder needs to be secured per NFPA regulations. MONITOR: Executive Director or designee will audit designated oxygen holding areas weekly x 3 then monthly x 3 to ensure ongoing compliance. Additional education will be provided as necessary. Results of audit will be reviewed in PI to ensure systems being followed. Plan to be updated as indicated. 	

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

PRINTED: 12/11/2017
FORM APPROVED
OMB NO. 0938-0391

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K 930	<p>Continued From page 9</p> <p>by:</p> <p>Based on observation, the facility failed to ensure liquid oxygen base reservoir containers were secured in accordance with NFPA 99. Failure to secure liquid oxygen containers has the potential to damage of the cylinder due to falling and spilling a cryogenic liquid, which may come in contact with grease, dirt or oils, increasing its explosive nature.</p> <p>Findings include:</p> <p>During the facility tour conducted on November 30, 2017 from approximately 1:30 PM to 3:30 PM, observation of liquid oxygen containers stored outside the 300 wing and the 400 wing revealed one (1) unsecured liquid oxygen cylinder at the 400 wing transfill area and four (4) unsecured liquid oxygen containers at the oxygen storage area outside the 300 wing.</p> <p>Actual NFPA standard:</p> <p>NFPA 99 11.7.3.3* Liquid oxygen base reservoir containers shall be secured by one of the following methods while in storage or use to prevent tipping over caused by contact, vibration, or seismic activity: (1) Securing to a fixed object with one or more restraints (2) Securing within a framework, stand, or assembly designed to resist container movement (3) Restraining by placing the container against two points of contact</p>	K 930		