



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 22, 2017

Breanna McKay, Administrator  
Lewiston of Cascadia  
3315 8th Street  
Lewiston, ID 83501-4966

Provider #: 135021

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

Dear Ms. McKay:

On **December 12, 2017**, a Facility Fire Safety and Construction survey was conducted at **Lewiston 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**

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completion date for each federal and state tag in column (X5) Completion Date to signify when you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office. 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 **January 4, 2018**. Failure to submit an acceptable PoC by **January 4, 2018**, may result in the imposition of civil monetary penalties by **January 24, 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 16, 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 16, 2018**. A change in the seriousness of the deficiencies on **January 16, 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 16, 2018**, includes the following:

Denial of payment for new admissions effective **March 12, 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 12, 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 12, 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:

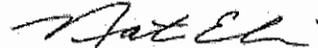
BFS Letters (06/30/11)

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

This request must be received by **January 4, 2018**. If your request for informal dispute resolution is received after **January 4, 2018**, 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: 12/21/2017  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135021</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ <b>RECEIVED</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/12/2017</b>
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NAME OF PROVIDER OR SUPPLIER <b>LEWISTON OF CASCADIA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3315 8TH STREET LEWISTON, ID 83501</b> <b>JAN 08 2018</b> <b>FACILITY STANDARDS</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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E 000	<p>Initial Comments</p> <p>The facility is a single story Type V (111) building with a finished basement built in 1965, is fully sprinklered with smoke detection throughout. The facility is situated in a municipal fire district and is currently licensed for 96 SNF/NF beds with a census of 54 on the day of the survey.</p> <p>The following deficiencies were cited during the Emergency Preparedness survey conducted on December 12, 2017. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.</p> <p>The Survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	E 000	<p><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></p>	
E 007 SS=F	<p>EP Program Patient Population CFR(s): 483.73(a)(3)</p> <p>[(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:]</p> <p>(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.**</p> <p>*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:</p>	E 007	<p>E007</p> <p><b>1. SPECIFIC ISSUE:</b> The facility has reviewed the Emergency Management Plan and it will be updated on or before January 31, 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.</p> <p><b>2. OTHER RESIDENTS:</b> All residents are potentially affected by deficient practice.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>BMG Lay</i> 1/4/2018	TITLE <i>ED</i>	(X6) DATE <i>1/4/17</i>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 007	<p>Continued From page 1</p> <p>Based on record review and interview, it was determined the facility failed to provide current policies, procedures and an emergency plan that addressed 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 updated policies, procedures and succession plan, potentially hinders continuation of resident care during an emergency. This deficient practice affected 54 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>1) On 12/12/17 review of provided policies, 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 2008 to 2017 and the section(s) which were found to relate to delegation, were flow charts that were not complete, or indicating specified personnel and their duties.</p> <p>2) Interviews conducted of 5 of 5 staff members on 12/12/17 from 11:00 AM - 2:00 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. Further interview established none of the staff had been trained on the duties for succession in the event of a disaster.</p> <p>Reference: 42 CFR 483.73 (a) (3)</p>	E 007	<p>3. <b>SYSTEMIC CHANGES:</b> Staff was educated by Executive Director and/ or designee regarding facilities residents' population including persons at risk, staff succession planning, and facilities ability to provide in an emergency.</p> <p>4. <b>MONITOR:</b> Upon completion of initial education with staff, Executive Director and/ or designee will monitor the effectiveness of the emergency management through staff interview and provide outcome to QAPI committee on a monthly basis. Additional education will be provided as necessary. Plan to be updated as indicated.</p> <p>5. <b>DATE OF COMPLIANCE:</b> January 31, 2018</p>	
E 009 SS=F	Local, State, Tribal Collaboration Process CFR(s): 483.73(a)(4)	E 009		

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E 009	Continued From page 2  [(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 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.  * [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. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to develop current 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 54	E 009	<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>  E009  1. <b>SPECIFIC ISSUE:</b> Lewiston Transitional Care of Cascadia Emergency Management plan was reviewed and updated on or before January 31, 2018 by facility QAPI committee and community emergency personnel to include comprehensive collaboration with local emergency planning authorities.  2. <b>OTHER RESDIENTS:</b> All residents are potentially affected by deficient practice  3. <b>SYSTEMIC CHANGES:</b> Staff was educated by the Executive Director and / or designee regarding facilities updated all hazard risk assessment developed in collaborations with local emergency authorities.	

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E 009	Continued From page 3 residents in the facility on the day of survey.  Findings include:  On 12/12/17 from 8:30 AM to 3:00 PM, review of provided policies and procedures revealed no documentation indicating a plan for collaboration with 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 12/12/17 from 10:30 - 12:00 PM, confirmed the facility had not been in contact with local emergency officials for development of a comprehensive collaboration plan and community based risk assessment and that the majority of the plan was carried over from previous management.  42 CFR 483.73, (a) (4)	E 009	4. <b>MONTIOR:</b> Upon completion of initial education with staff, Executive Director and/ or designee will monitor the effectiveness of the emergency management through staff interview. Provided outcomes will be given to QAPI committee on a monthly basis. Additional education will be provided as necessary  5. <b>DATE OF COMPLIANCE:</b> January 31, 2018  <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 013 SS=C	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	E 013	<i>E013</i>  1. <b>SPECIFIC ISSUE</b> Lewiston Transitional Care of Cascadia was reviewed and updated on or before January 31, 2018-by facility QAPI committee and community emergency personnel to include collaboration of facility risk assessment and communication with local emergency management officials.	

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E 013	<p>Continued From page 4</p> <p>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 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 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</p>	E 013	<p>2. <b>OTHER RESIDENTS</b> All residents are potentially affected by deficient practice.</p> <p>3. <b>SYSTEMIC CHANGES:</b> Staff was educated by Executive Director and/ or designee regarding facilities updated policies and facility risk assessment from collaboration of community emergency response management team.</p> <p>4. <b>MONITOR</b> Upon completion of facility risk assessment and initial staff education, Executive Director and/ or designee will monitor the effectiveness of the emergency management through staff interview and provide outcomes to QAPI committee on a monthly basis. Additional education will be provided as necessary.</p> <p>5. <b>DATE OF COMPLIANCE:</b> January 31, 2018</p>	

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E 013	Continued From page 5 has the potential to affect 54 residents, staff and visitors on the date of the survey.  Findings include:  On 12/12/17 from 8:30 AM to 3:00 PM, review of provided policies and procedures revealed the current copy ranged in date from 2008 to 2017. Further review of the policy established an annual review had been conducted, however the plan's risk assessment had been done internally at a staff meeting and not a community based assessment with local emergency management officials.  Interview of the Administrator on 12/12/17 from 10:30 - 12:00 PM, confirmed the facility risk assessment was not in collaboration with emergency management officials.  42 CFR 483.73 (b)	E 013	<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 018 SS=C	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 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	E 018	<i>E018</i>  1. <b>SPECIFIC ISSUE</b> Lewiston Transitional Care of Cascadia's Emergency Management Plan was reviewed and updated on or before January 31, 2018 by facility QAPI committee and community emergency personnel to include updated and site specific policy and procedures for staff and resident tracking system during an evacuation.  2. <b>OTHER RESDIENTS:</b> All residents are potentially affected by deficient practice.		

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E 018	<p>Continued From page 6</p> <p>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 responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.</p>	E 018	<p>3. <b>SYSTEMIC CHANGES:</b> Staff education was provided by Executive Director and / or designee regarding facilities updated polices regarding on-duty staff and resident tracking systems for evacuation.</p> <p>4. <b>MONITOR:</b> Upon completion of initial education with staff, Executive Director and / or designee will monitor the effectiveness of the emergency management 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. <b>DATE OF COMPLIANCE:</b> January 31, 2018</p>	

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NAME OF PROVIDER OR SUPPLIER <b>LEWISTON OF CASCADIA</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3315 8TH STREET LEWISTON, ID 83501</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 018	<p>Continued From page 7</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: 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 54 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>On 12/12/17 from 8:30 AM to 3:00 PM, review of the provided policies, procedures and emergency plan, 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 12/12/17 from 11:00 AM - 2:00 PM, revealed staff were not aware of any tracking policies or procedures or plan for staff and sheltered residents during an emergency.</p> <p>Reference:</p>	E 018		

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E 018  E 023 SS=C	Continued From page 8  42 CFR 483.73 (b) (2)  Policies/Procedures for Medical Documentation CFR(s): 483.73(b)(5)  [(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:]  (5) A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. [(5) or (3),(4),(6)] A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. This is what's in SOM.  *[For RNHCIs at §403.748(b):] Policies and procedures. (5) A system of care documentation that does the following: (i) Preserves patient information. (ii) Protects confidentiality of patient information. (iii) Secures and maintains the availability of records.  *[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.	E 018  E 023	<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>  E023  1. <b>SPECIFIC ISSUE:</b> Lewiston Transitional Care of Cascadia was reviewed and updated on or before January 31, 2018 Emergency Management Plan by QAPI committee and to include updated and site specific policy and procedure on attaining medical records during emergency.  2. <b>OTHER RESDIENTS</b> All residents are potentially affected by deficient practice.  3. <b>SYSTEMIC CHANGES:</b> Staff education was provided by Executive Director and/ or designee regarding facilities updated policy and procedure regarding preservation and confidentiality of resident medical records during an emergency.

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E 023	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to develop and implement policies and procedures in conjunction with the emergency plan that ensures preservation and confidentiality of medical records and information of residents during a disaster. Failure to provide policies, procedures and a plan which preserves and protects information and medical records has the potential to hinder continuity of care during a disaster for the 54 residents housed in the facility on the date of the survey.  Findings include:  On 12/12/17 from 8:30 AM to 3:00 PM, review of policies, procedures and the emergency plan indicated the plan for Medical Records was dated 2008 and stated the facility would gather the records in a portable cart, but failed to demonstrate how medical records and information were to be protected to ensure confidentiality during a disaster.  During interview of 2 of 2 nurse's from 11:00 AM to 2:00 PM, both nurse's stated the facility used electronic documentation of records which they could retrieve from a laptop, however no plan, policy or procedure was directly related to how the facility would protect and secure this electronically transmitted information during a disaster.  Reference:  42 CFR 483.73 (b) (5)	E 023	4. <b>MONITOR</b> Upon completion of initial education with staff, Executive Director and / or designee will monitor the effectiveness through staff interview and provide outcomes to QAPI committee on a monthly basis. Additional education will be provided as necessary.  5. <b>DATE OF COMPLIANCE:</b> January 31, 2018  <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>  E024  1. <b>SPECIFIC ISSUE</b> Lewiston Transitional Care of Cascadia's Emergency Management was reviewed and updated on or before January 31, 2018-by facility QAPI committee and community emergency personnel to include updated and site specific policy and procedures to include facility response to surge capacity needs and utilizing volunteers	
E 024 SS=C	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6)	E 024		

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E 024	<p>Continued From page 10</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>(6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.</p> <p>*[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to develop, 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 provide continuity of care during a disaster. This deficient practice has the potential to affect 54 residents, staff and visitors on the date of the survey.</p> <p>Findings include:  On 12/12/17 from 8:30 AM to 3:00 PM, review of</p>	E 024	<p>2. <b>OTHER RESIDENTS:</b> All residents are potentially affected by deficient practice</p> <p>3. <b>SYSTEMIC CHANGES:</b> Staff was educated by Executive Director and / or designee regarding facilities updated polices regarding surge capacity needs and the use of volunteers.</p> <p>4. <b>MONITOR:</b> Upon completion of initial education with staff, Executive Director and / or designee will monitor the effectives of the emergency management through staff interview and provide outcomes to QAPI committee on a monthly basis. Additional education will be provided as needed. Plan to be updated as indicated.</p> <p>5. <b>DATE OF COMPLIANCE:</b> January 31, 2018</p>	

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E 024	Continued From page 11 provided policies, procedures, and the emergency preparedness plan 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 2008 to 2017 with no indication of the use of volunteers or the risk of surge needs.  Interview of 5 of 5 staff members on 12/12/17 from 11:00 AM to 2:00 PM, did not indicate any knowledge of the use of volunteers during an emergency. Interview of the Administrator on 12/12/17 from 10:30 AM - 12:00 PM did not reveal the facility had a policy on the use of volunteers or reaction to surge events.  Reference: 42 CFR 483.73 (b) (6)	E 024			
E 026 SS=C	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8)  [(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:]  (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	E 026	<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>  E026  1. <b>SPECIFIC ISSUE:</b> Lewiston Transitional Care of Cascadia's Emergency Management Plan was reviewed and updated on or before January 31, 2018-by facility QAPI committee to include updated site- specific policy and procedures to include facility role and responsibilities established by the 1135 waiver.		

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E 026	Continued From page 12 officials.  *[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.  Findings include:  On 12/12/17 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 2008 to 2017, without representation of the facility's responsibilities under a declaration by the Secretary.  Reference:  42 CFR 483.73 (b) (8)	E 026	2. <b>OTHER RESIDENTS</b> All residents are potentially affected by deficient practice.  3. <b>SYSTEMIC CHANGES:</b> Staff education was provided by Executive Director and/ or designee regarding facility role and responsibilities under 1135 waiver.  4. <b>MONITOR:</b> Upon completion of initial education with staff, Executive Director will monitor the effectiveness of the emergency management plan and provide outcomes to QAPI committee on a monthly basis. Additional education will be provided as necessary. Plan to be updated as indicated.  5. <b>DATE OF COMPLIANCE</b> January 31, 2018	
E 030 SS=C	Names and Contact Information CFR(s): 483.73(c)(1)  [(c) The [facility, except RNHCIs, hospices, transplant centers, and HHAs] must develop and	E 030		

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E 030	<p>Continued From page 13</p> <p>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>(1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers.</p> <p>*[For RNHCIs at §403.748(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) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers.</p> <p>*[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.</p> <p>*[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.</p>	E 030	<p><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></p> <p><i>E030</i></p> <ol style="list-style-type: none"> <li><b>SPECIFIC ISSUE:</b> Lewiston Transitional Care of Cascadia's Emergency Management Plan was reviewed and updated on or before January 31, 2018 by the QAPI committee and community emergency personnel to include updated and site specific contact list that includes staff, entities providing services, resident physicians, other facilities, and current volunteers.</li> <li><b>OTHER RESIDENTS</b> All residents are potentially affected by deficient practice.</li> <li><b>SYSTEMIC CHANGES:</b> Staff education was provided by Executive Director and / or designee regarding facilities updated-contact list.</li> </ol>		

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E 030	<p>Continued From page 14</p> <p>(ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices.</p> <p>*[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 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 54 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>On 12/30/17 from 8:30 AM to 3:00 PM, review of provided disaster and emergency policies and procedures revealed undated page for contact information to be used during an emergency, however the page contained in the plan had no information as to the contact policy or procedure for volunteers.</p> <p>Interview of 5 of 5 staff members from 11:00 AM to 2:00 PM indicated they were not aware of any</p>	E 030	<p>4. <b>MONITOR:</b> Upon completion of initial education with staff, Executive Director and/ or designee will monitor the effectiveness of the emergency management through staff interview and review of contact list to validate numbers are correct. Outcomes will be provided to QAPI committee on a monthly basis. Additional education will be provided as necessary. Plan to be updated as indicated.</p> <p>5. <b>DATE OF COMPLIANCE:</b> January 31, 2018</p>	

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E 030	Continued From page 15 communication plan and contact information for the facility to use during an emergency and had not been made aware of the contact information for volunteers.  Reference:  42 CFR 483.73 (c) (1)	E 030	<p><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></p> <p><i>E031</i></p> <ol style="list-style-type: none"> <li><b>SPECIFIC ISSUE</b> Lewiston Transitional Care of Cascadia's emergency management plan was reviewed and updated on or before January 31, 2018 through facility QAPI committee to include current –Contact list for emergency management office, Ombudsman and state licensing agency.</li> <li><b>OTHER RESDIENTS</b> All residents are potentially affected by deficient practice.</li> <li><b>SYSTEMIC CHANGES:</b> Staff was educated by Executive Director and / or designee regarding updated contact list of emergency management office, Ombudsman and state licensing agency.</li> </ol>	
E 031 SS=C	Emergency Officials Contact Information CFR(s): 483.73(c)(2)  [(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:  (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance.  *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, or local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance.  *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. This REQUIREMENT is not met as evidenced	E 031		

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E 031	Continued From page 16 by: Based on record review, the facility failed to ensure current contact information for emergency management official and other resources of assistance was provided in the emergency communication plan. Failure to provide updated information for resources available to the facility has the potential to hinder facility response and continuity of care for the 54 residents in the facility on the date of the survey.  Findings include:  On 12/12/17 from 8:30 AM - 12:00 PM, review of the emergency plan, policies and procedures demonstrated the plans listed for contacts in the event of an emergency, did not include numbers for the Ombudsman, State Licensing agency and the area listed for the State Emergency Management contact was a disconnected number.  Reference: 42 CFR 483.73 (c) (2)	E 031	4. <b>MONITOR:</b> Upon completion of initial education with staff, Executive Director and / or designee will monitor the effectiveness of the emergency management through staff interview and review of the current contact list and provide outcomes to QAPI committee on a monthly basis. Additional education will be provided as necessary. Plan to be updated as indicated.  5. <b>DATE OF COMPLIANCE:</b> January 31, 2018  <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 035 SS=C	LTC and ICF/IID Sharing Plan with Patients 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:	E 035	<i>E035</i>  1. <b>SPECIFIC ISSUE:</b> Lewiston Transitional Care of Cascadia's emergency management program will be posted and available for all visitors and residents to review on or before January 31, 2018. Additionally, emergency plan will be discussed upon admissions with all new residents and their advocate. Emergency management plan will be discussed ongoing with residents during resident council and education provided as needed.	

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NAME OF PROVIDER OR SUPPLIER <b>LEWISTON OF CASCADIA</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3315 8TH STREET LEWISTON, ID 83501</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 035	Continued From page 17 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 54 residents, staff and visitors on the date of the survey.  Findings include:  On 12/12/17 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 2008 to 2017. No documentation was provided demonstrating the facility policy for sharing information with residents, their families or representatives.  Reference:  42 CFR 483.73 (c) (8)	E 035	2. <b>OTHER RESIDENTS:</b> All residents are potentially affected by deficient practice  3. <b>SYSTEMIC CHANGES:</b> Staff was educated by Executive Director and/ or designee regarding communication of the emergency management program plan to visitors and residents.  4. <b>MONITOR</b> Upon completion of initial education with staff, Executive Director and/ or designee will monitor the effectiveness of the emergency management through resident advocate 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 036 SS=F	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	E 036	5. <b>DATE OF COMPLIANCE</b> January 31, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135021</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/12/2017</b>
NAME OF PROVIDER OR SUPPLIER <b>LEWISTON OF CASCADIA</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3315 8TH STREET LEWISTON, ID 83501</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 036	<p>Continued From page 18</p> <p>testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h).</p> <p>*[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review 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 54 residents, staff and visitors on the date of the survey.</p> <p>Findings include:  On 12/12/17 from 8:30 AM to 3:00 PM, review of</p>	E 036	<p><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></p> <p><i>E036</i></p> <p><b>1. SPECIFIC ISSUE:</b> Lewiston Transitional Care of Cascadia's emergency management plan was reviewed and updated on or before January 31, 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.</p> <p><b>2. OTHER RESIDENTS</b> All residents are potentially affected by deficient practice.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135021</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>12/12/2017</b>
NAME OF PROVIDER OR SUPPLIER <b>LEWISTON OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3315 8TH STREET LEWISTON, ID 83501</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
E 036	Continued From page 19 provided disaster plans and emergency policies and procedures, revealed a range of dates for policies, procedures and emergency plans from 2008 to 2017. No documentation was provided demonstrating the facility had a current training and testing program for staff based on a specific plan.  Interview of 5 of 5 staff conducted on 12/12/17 from 11:00 AM to 2:00 PM established staff had not participated or had knowledge of any specific training and testing program in relation to emergency preparedness.  Further interview of the Staff Development Coordinator on 12/12/17 from 1:00 to 1:30 PM substantiated the facility did not have any current training and testing program to meet the standard.  Reference:  42 CFR 483.73 (d)	E 036	<p>3. <b>SYSTEMIC CHANGES:</b> Staff was educated by Executive Director and / or designee to validate understanding of current emergency preparedness plan. Additional education to be provided as indicated. Staff Development Coordinator was educated by Executive Director and / or designee to validate training and testing program is available and offered upon orientation and annually to employees. Annual training calendar includes updated educational sessions for emergency preparedness plan.</p> <p>4. <b>MONITOR:</b> Upon completion of initial education with staff, Executive Director and / or designee will monitor the effectiveness of the emergency management through staff interview and disaster drill. Outcomes will be provided to QAPI committee on a monthly basis. Additional education will be provided as necessary. Plan to be updated as indicated.</p> <p>5. <b>DATE OF COMPLIANCE:</b> January 31, 2018</p>		
E 037 SS=F	EP Training Program CFR(s): 483.73(d)(1)  (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] 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 role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures.	E 037			

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NAME OF PROVIDER OR SUPPLIER <b>LEWISTON OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3315 8TH STREET LEWISTON, ID 83501</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
E 037	<p>Continued From page 20</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:</p> <p>(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.</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.</p> <p>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:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing 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:</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 roles.</p>	E 037	<p><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></p> <p><i>E037</i></p> <p><b>1. SPECIFIC ISSUE</b> Lewiston Transitional Care of Cascadia's Emergency Management Plan was reviewed and updated on or before January 31, 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 includes documentation and staff competency completion.</p> <p><b>2. OTHER RESIDENTS:</b> All residents are potentially affected by deficient practice.</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135021</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/12/2017</b>
NAME OF PROVIDER OR SUPPLIER <b>LEWISTON OF CASCADIA</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3315 8TH STREET LEWISTON, ID 83501</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 037	<p>Continued From page 21</p> <p>(ii) After initial training, provide emergency preparedness training at least annually.</p> <p>(iii) Demonstrate staff knowledge of emergency procedures.</p> <p>(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:</p> <p>(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.</p> <p>(ii) Provide emergency preparedness training at least annually.</p> <p>(iii) Demonstrate staff knowledge of emergency 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>	E 037	<p>3. <b>SYSTEMIC CHANGES:</b> Staff educated by Executive director and or designee to validate understanding of current emergency preparedness plan. Additional education to be provided as indicated. Staff Development Coordinator was educated by Executive Director to validate training and testing program is available and offered upon orientation and annually to employees.</p> <p>4. <b>MONITOR</b> Upon completion of initial education with staff, Executive Director and / or designee will monitor the effectiveness of the emergency management through staff interview and disaster drills. Outcomes will be provided to QAPI committee on a monthly basis. Additional education will be provided as necessary. Plan to be updated as indicated.</p> <p>5. <b>DATE OF COMPLIANCE</b> January 31, 2018</p>	

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NAME OF PROVIDER OR SUPPLIER <b>LEWISTON OF CASCADIA</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3315 8TH STREET LEWISTON, ID 83501</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 037	<p>Continued From page 22</p> <p>*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:</p> <ul style="list-style-type: none"> <li>(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.</li> <li>(ii) Provide emergency preparedness training at least annually.</li> <li>(iii) Maintain documentation of the training.</li> <li>(iv) Demonstrate staff knowledge of emergency procedures.</li> </ul> <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.</p> <p>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 54 residents, staff and visitors on the date of the survey.</p>	E 037		

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NAME OF PROVIDER OR SUPPLIER <b>LEWISTON OF CASCADIA</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3315 8TH STREET LEWISTON, ID 83501</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 037	Continued From page 23  Findings include:  On 12/12/17 from 8:30 AM to 3:00 PM, review of provided emergency policy, procedures and plan revealed the plan ranged in date from 2008 to 2017, without substantiating documentation demonstrating the facility had a training program for staff based on the plan.  Interview of 5 of 5 staff members on 12/12/17 from 11:00 AM - 3:00 PM revealed no specific training was conducted on the emergency plan or its contents. During interview, 3 of 5 staff stated they understood the facility was in the process of developing a new plan.  Further interview of the Staff Development Coordinator on 12/12/17 indicated she was in the process of developing a new specified training program to be provided which focused on the emergency plan.  Reference:  42 CFR 483.73 (d) (1)	E 037		
E 039 SS=F	EP Testing Requirements CFR(s): 483.73(d)(2)  (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following:  *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the	E 039	<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>  E039  1. <b>SPECIFIC ISSUE</b> Lewiston Transitional Care of Cascadia's Emergency Management Plan was reviewed and updated on or before January 31, 2018-by facility QAPI committee and community emergency personnel to include participation in full scale exercise.	

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NAME OF PROVIDER OR SUPPLIER <b>LEWISTON OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3315 8TH STREET LEWISTON, ID 83501</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
E 039	<p>Continued From page 24 following:]</p> <p>(i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event.</p> <p>(ii) Conduct an additional exercise that may 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</p>	E 039	<p>2. <b>OTHER RESIDENTS</b> All residents are potentially affected by deficient practice.</p> <p>3. <b>SYSTEMIC CHANGES:</b> Executive director and/ or designee to coordinate a full scale disaster drill with Northwest Coalition. Outcomes of drill will be evaluated and additional education provided as indicated.</p> <p>4. <b>MONITOR</b> Executive Director and/ or designee will monitor the effectiveness of the emergency management through evaluation of full scale drill. Outcomes will be provided 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. <b>DATE OF COMPLIANCE:</b> January 31, 2018</p>		

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NAME OF PROVIDER OR SUPPLIER <b>LEWISTON OF CASCADIA</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3315 8TH STREET LEWISTON, ID 83501</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	<p>Continued From page 25</p> <p>to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHC'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 two exercises which tested the emergency preparedness readiness of the facility. Failure to participate in full-scale, actual, or tabletop events has the potential to reduce the facility's effectiveness to provide continuation of care to residents during an emergency. This deficient practice affected 54 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>On 12/12/17 from 8:30 AM to 3:00 PM, review of provided emergency plan documents revealed documentation demonstrating the facility had participated in one (1) exercise of the emergency preparedness plan, policies and procedures.</p> <p>Interview of the Administrator on 12/12/17 from 8:30 to 10:00 AM substantiated the facility had only participated in one tabletop event on a procedure identified in the emergency plan.</p> <p>Reference:</p> <p>42 CFR 483.73 (d) (1)</p>	E 039		

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NAME OF PROVIDER OR SUPPLIER <b>LEWISTON OF CASCADIA</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3315 8TH STREET LEWISTON, ID 83501</b>		
		<b>JAN 08 2018</b>		
		<b>FACILITY STANDARDS</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS  The facility is a single story Type V(111) building with a finished basement. The structure was built in 1965 with a complete renovation in 1998. It is fully sprinklered with smoke detection provided in corridors, open spaces and resident sleeping rooms. The facility is currently licensed for 96 SNF/NF beds with a census of 54 on the day of the survey.  The following deficiencies were cited during the annual fire/life safety survey conducted on December 12, 2017. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70 and 42 CFR 483.80  The survey was conducted by:  Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction	K 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>	
K 100 SS=F	General Requirements - Other CFR(s): NFPA 101  General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to demonstrate implementation of a water management program for waterborne pathogens such as Legionella, in accordance with 42 CFR 483.80. Failure to implement a water management program to avert transmission of	K 100	<b>K100</b>  <b>1. SPECIFIC ISSUE:</b> Facility water management program was reviewed and updated prior to January 31, 2018. The facility risk assessment, identification of control measures to be implemented, and water testing has occurred to avert transmission of waterborne pathogens.  <b>2. OTHER RESIDENTS:</b> All residents have potential to be affected by deficient practice.  <b>3. SYSTEMIC CHANGES:</b> Facility will implement facility risk assessment for water management and control measures per ASHRAE 188 guidelines.	

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

TITLE

(X6) DATE

*Bmg Kay*

*ED*

*1/4/18*

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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NAME OF PROVIDER OR SUPPLIER <b>LEWISTON OF CASCADIA</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3315 8TH STREET LEWISTON, ID 83501</b>		
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K 100	Continued From page 1 waterborne pathogens, which considers CDC standards and the guidance of ASHRAE 188, has the potential to expose residents to Legionella and other water source bacterium. This deficient practice affected 54 residents, staff and visitors on the date of the survey.  Findings include:  During review of provided maintenance and inspection records conducted on December 12, 2017 from approximately 8:30 AM to 10:00 AM, records provided for the facility's water management plan, failed to demonstrate it had completed the facility risk assessment, and identify the control measures to be implemented for the prevention of waterborne pathogens such as Legionella.  When asked about the missing documentation, the Maintenance Director stated he was aware of the requirement and had not been aware of the missing components prior to the date of the survey.  CFR standard:  42 CFR 483.80  § 483.80 Infection control. The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection.  Additional reference: Center for Medicaid/Medicare Services S & C letter 17-30	K 100	4. <b>MONITOR:</b> Executive director and/or designee will validate that facility water management program is complete with facility risk assessment, and identifying control measures per ASHRAE guidelines are completed monthly for 3 months. Monitoring of this system will be added to the preventative maintenance check. Results of audit will be reviewed in PI to ensure systems being followed. Plan to be updated as indicated.  5. <b>DATE OF COMPLIANCE:</b> January 31, 2018	
K 211	Means of Egress - General	K 211		

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K 211 SS=F	<p>Continued From page 2 CFR(s): NFPA 101</p> <p><b>Means of Egress - General</b> Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that means of egress were provided in accordance with NFPA 101. Failure to maintain means of egress free of obstructions has the potential to hinder evacuation of residents during an emergency. This deficient practice affected 54 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on December 12, 2017 from 10:30 AM to 3:00 PM, observation of exit doors revealed the following:</p> <p>1) The entrance door of the "A" wing found the door was equipped with keyed, hookbolt lock and magnetic locking arrangements which activated under the operation of the Wanderguard system. Operational testing of door revealed that when the hookbolt was activated at the same time the magnetic locking arrangement was engaged, the delayed egress operation would not release and the lock would prohibit the doors from breaking away as designed.</p> <p>2) The rehab and therapy gym area was observed to have a magnetic locking</p>	K 211	<p><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></p> <p><i>K211</i></p> <p><b>1. SPECIFIC ISSUE:</b> All doors leading to the outside are free of hook bolt locks. All doors leading to the outside are compliant with NFPA 101 egress standards.</p> <p><b>2. OTHER RESIDENTS:</b> All residents have the potential to be affective by deficient practice.</p> <p><b>3. SYSTEMIC CHANGES:</b> Maintenance director removed hook bolt lock from A wing entrance, removed lock and throw bolt from kitchen back door, and provided manual release to therapy/ gym door per NFPA guidelines.</p>	

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K 211	<p>Continued From page 3</p> <p>arrangement without a delayed egress component and equipped with a motion detector on the egress side, but without a manual release, providing one of the two requirements to meet allowable access controlled arrangements. When asked about the missing panic or push button release component, the Maintenance Director stated he was not aware of the two methods required under access control.</p> <p>3) The back door of the Kitchen was equipped with a keyed passage lock and throwbolt.</p> <p>Actual NFPA standard:</p> <p>Findings 1-3</p> <p>NFPA 101 19.2 Means of Egress Requirements. 19.2.1 General. Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7, unless otherwise modified by 19.2.2 through 19.2.11.</p> <p>19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side, unless otherwise permitted by one of the following: (1) Locks complying with 19.2.2.2.5 shall be permitted. (2)*Delayed-egress locks complying with 7.2.1.6.1 shall be permitted (3)*Access-controlled egress doors complying with 7.2.1.6.2 shall be permitted. (4) Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted. (5) Approved existing door-locking installations shall be permitted.</p>	K 211	<p><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></p> <p><b>K211</b></p> <ol style="list-style-type: none"> <li><b>SPECIFIC ISSUE:</b> All doors leading to the outside are free of hook bolt locks. All doors leading to the outside are compliant with NFPA 101 egress standards.</li> <li><b>OTHER RESIDENTS:</b> All residents have the potential to be affective by deficient practice.</li> <li><b>SYSTEMIC CHANGES:</b> Maintenance director removed hook bolt lock from A wing entrance, removed lock and throw bolt from kitchen back door, and provided manual release to therapy/ gym door per NFPA guidelines.</li> </ol>	

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K 211	Continued From page 4  7.1.10 Means of Egress Reliability. 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.  7.2.1.5.3 Locks, if provided, shall not require the use of a key, a tool, or special knowledge or effort for operation from the egress side.  Finding 2  NFPA 101 7.2.1.6* Special Locking Arrangements.  7.2.1.6.1.2 The provisions of 7.2.1.6.2 for access-controlled egress door assemblies shall not apply to door assemblies with delayed-egress locking systems. 7.2.1.6.2* Access-Controlled Egress Door Assemblies. Where permitted in Chapters 11 through 43, door assemblies in the means of egress shall be permitted to be equipped with electrical lock hardware that prevents egress, provided that all of the following criteria are met: (1) A sensor shall be provided on the egress side, arranged to unlock the door leaf in the direction of egress upon detection of an approaching occupant. (2) Door leaves shall automatically unlock in the direction of egress upon loss of power to the sensor or to the part of the access control system that locks the door leaves. (3) Door locks shall be arranged to unlock in the direction of egress from a manual release device complying with all of the following criteria: (a) The manual release device shall be located on the egress side, 40 in. to 48 in. (1015 mm to	K 211	4. <b>MONITOR</b> Executive director and/or designee will validate that egress doors are free of hook bolt lock per NFPA guidelines monthly for 3 months. Monitoring of this system will be added to preventive 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.  5. <b>DATE OF COMPLIANCE:</b> January 31, 2018	

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K 211	Continued From page 5 1220 mm ) vertically above the floor, and within 60 in. (1525 mm) of the secured door openings. (b) The manual release device shall be readily accessible and clearly identified by a sign that reads as follows: PUSH TO EXIT. (c) When operated, the manual release device shall result in direct interruption of power to the lock - independent of the locking system electronics-and the lock shall remain unlocked for not less than 30 seconds. (4) Activation of the building fire-protective signaling system, if provided, shall automatically unlock the door leaves in the direction of egress, and the door leaves shall remain unlocked until the fire-protective signaling system has been manually reset. (5) The activation of manual fire alarm boxes that activate the building fire-protective signaling system specified in 7.2.1.6.2(4) shall not be required to unlock the door leaves. (6) Activation of the building automatic sprinkler or fire detection system, if provided, shall automatically unlock the door leaves in the direction of egress, and the door leaves shall remain unlocked until the fire-protective signaling system has been manually reset. (7) The egress side of access-controlled egress doors, other than existing access-controlled egress doors, shall be provided with emergency lighting in accordance with Section 7.9.	K 211	<p><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></p> <p><b>K291</b></p> <p><b>1. SPECIFIC ISSUE:</b> All doors leading to outside of the facility have been designated as delayed egress. All doors will be equipped with emergency exit lighting complaint with NFPA 101 standards.</p> <p><b>2. OTHER RESIDENTS:</b> All residents have the potential to be affected by deficient practice.</p>	
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:	K 291		

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K 291	<p>Continued From page 6</p> <p>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 delayed egress potentially hinders identification of exits affecting resident egress during an emergency. This deficient practice affected 54 residents staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on December 12, 2017 from 10:30 AM to 3:00 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</p>	K 291	<p>3. <b>SYSTEMIC CHANGES:</b> Facility has installed lighting per NFPA guidelines.</p> <p>4. <b>MONITOR:</b> Executive Director and/or designee will validate that all doors are equipped with appropriate lighting and battery back-up per NFPA guidelines for egress monthly for 3 months. 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. <b>DATE OF COMPLIANCE:</b> January 31, 2018</p>	

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K 291	Continued From page 7 (5) Stair shafts and vestibules of smokeproof enclosures, for which the following also apply: (a) The stair shaft and vestibule shall be 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	<p><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></p> <p><i>K293</i></p> <ol style="list-style-type: none"> <li><b>SPECIFIC ISSUE</b> Exit signs are installed above the bulkhead fire doors to clearly identify the path of egress during a fire or other emergency to ensure compliance of NFPA 101 standards.</li> <li><b>OTHER RESIDENTS</b> 20 residents have the potential to be affected by the deficient practice.</li> <li><b>SYSTEMIC CHANGES:</b> Facility installed additional exit lighting to provide clear, and identifiable exit pathways compliant with NFPA 101 standards.</li> </ol>	
K 293 SS=E	Exit Signage CFR(s): NFPA 101  Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure means of egress signage was provided in accordance with NFPA 101. Failure to provide exit signs which are clear and identifiable has the potential to confuse residents and hinder egress during an emergency. This deficient practice affected 20 residents in 2 of 5 smoke compartments on the date of the survey.  Findings include:  During the facility tour conducted on December 12, 2017 from approximately 10:30 AM to 3:00 PM, observation of installed exit signs, revealed the following locations were not equipped with	K 293		

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K 293	Continued From page 8 exit signs identifying the path of egress during a fire or other emergency:  The bulkhead above the north to south corridor smoke barrier located at rooms 311/312 and the east to west bulkhead above the smoke barrier at rooms 300/301 were missing exit signs. Further observation of these two locations revealed the path of travel would not be clearly identified when the smoke barrier doors activated with the fire alarm/smoke detection system or power loss.  Actual NFPA standard:  7.10.1.2 Exits. 7.10.1.2.1* Exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign that is readily visible from any direction of exit access.	K 293	4. <b>MONITOR:</b> Executive director and/or designee will validate appropriate exit signage to be clear and identifiable for all exit pathways monthly for 3 months. Monitoring of this system will be added to the preventative maintenance check. Results of audit will be reviewed in PI to ensure systems being followed. Plan to be updated as indicated.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101  Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____  Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler	K 353	<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>  K353  <b>1. SPECIFIC ISSUE</b> Sprinkler system has proper testing and documentation related to antifreeze levels. All sprinklers are free of paint, and correct amount of extra sprinkler heads are located in the facility for compliance with NFPA 25.	

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K 353	<p>Continued From page 9 system.          9.7.5, 9.7.7, 9.7.8, and NFPA 25          This REQUIREMENT is not met as evidenced by:          Based on record review, observation and interview, the facility failed to ensure the fire suppression system was maintained in accordance with NFPA 25. Failure to maintain fire suppression system components has the potential to hinder system performance during a fire event. This deficient practice affected 54 residents, staff and visitors in 4 of 6 smoke compartments on the date of the survey. The facility is currently licensed for 96 SNF/NF beds and had a census of 54 on the day of the survey.</p> <p>Findings include:</p> <p>1) During record review of provided facility fire suppression system inspection reports conducted on December 12, 2017 from approximately 8:30 AM to 10:30 AM, records indicated the suppression system was equipped with an antifreeze loop. Further examination of these reports failed to indicate the antifreeze solution installed was tested for concentration, only that it was tested for temperature range to inhibit freezing.</p> <p>2) During the facility tour conducted on December 12, 2017 from approximately 10:30 AM to 3:30 PM, observation of installed fire sprinkler pendants revealed the following:  Two (2) painted heads in the main Laundry          Only eleven (11) spare pendants in the spare sprinkler box</p> <p>Interview of the Maintenance Supervisor revealed he was not aware of these deficiencies prior to</p>	K 353	<p>2. <b>OTHER RESIDENTS</b>          All residents have the potential to be affected by deficient practice.</p> <p>3. <b>SYSTEMIC CHANGES:</b>          Fire Sprinkler Company tested antifreeze levels and provided proper documentation. Facility replaced sprinkler heads that had paint on them, and obtained proper amount of extra sprinkler heads per NFPA 25.</p> <p>4. <b>MONITOR:</b>          Executive director and/or designee will validate proper documentation of antifreeze levels, round to check sprinkler heads are free of paint after new paint projects, and validate proper amount of sprinklers are onsite for use monthly for 3 months. 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. Monitoring of this system will be added to the preventative maintenance check.</p> <p>5. <b>DATE OF COMPLAINE:</b>          January 31, 2018</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135021</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - ENTIRE BUILDING</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/12/2017</b>
NAME OF PROVIDER OR SUPPLIER <b>LEWISTON OF CASCADIA</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3315 8TH STREET LEWISTON, ID 83501</b>		
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K 353	<p>Continued From page 10 the date of the survey.</p> <p>Actual NFPA standard:</p> <p>NFPA 25</p> <p>5.2.1 Sprinklers.</p> <p>5.2.1.1* Sprinklers shall be inspected from the floor level annually.</p> <p>5.2.1.1.1* Sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., upright, pendent, or sidewall).</p> <p>5.2.1.1.2 Any sprinkler that shows signs of any of the following shall be replaced:</p> <p>(1) Leakage (2) Corrosion (3) Physical damage (4) Loss of fluid in the glass bulb heat responsive element (5)*Loading (6) Painting unless painted by the sprinkler manufacturer</p> <p>5.3.4* Antifreeze Systems. The freezing point of solutions in antifreeze shall be tested annually by measuring the specific gravity with a hydrometer or refractometer and adjusting the solutions if necessary.</p> <p>5.3.4.1* Solutions shall be in accordance with Table 5.3.4.1(a) and Table 5.3.4.1(b).</p> <p>Additional reference NFPA 25, 2011 Edition, TIA 11-1</p> <p>5.4.1.4* A supply of spare sprinklers (never fewer than six)</p>	K 353		

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K 353	Continued From page 11 shall be maintained on the premises so that any sprinklers that have operated or been damaged in any way can be promptly replaced.  5.4.1.5 The stock of spare sprinklers shall include all types and ratings installed and shall be as follows: (1) For protected facilities having under 300 sprinklers-no fewer than 6 sprinklers (2) For protected facilities having 300 to 1000 sprinklers - no fewer than 12 sprinklers (3) For protected facilities having over 1000 sprinklers - no fewer than 24 sprinklers	K 353	<p><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></p> <p><i>K511</i></p> <ol style="list-style-type: none"> <li><b>SPECIFIC ISSUE</b> Facility is free of non-compliant power taps throughout facility.</li> <li><b>OTHER RESIDENTS</b> All residents have potential to be affected by deficient practice.</li> <li><b>SYSTEMATIC CHANGES:</b> Power tap was removed from tech center. All areas of facility were inspected to validate that there are no power taps in use. Executive director and / or designee provided staff education to validate understanding of safe electrical installations throughout the facility.</li> </ol>	
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 relocatable power taps (RPT's) for electrical appliances such as microwaves, has the potential to increase the risk of arc fires. This deficient practice affected staff and visitors on the date of the survey.	K 511		

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K 511	<p>Continued From page 12</p> <p>Findings include:</p> <p>During the facility tour conducted on December 12, 2017 from approximately 10:30 AM to 3:30 PM, observation of the tech center revealed a microwave plugged into a 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. (A) Examination. In judging equipment, considerations such as the following shall be evaluated: (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</p>	K 511	<p><b>MONITOR</b></p> <p>Executive Director and / or designee will audit random electrical installations weekly x4 then monthly x3 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><b>4. DATE OF COMPLIANCE:</b></p> <p>January 31, 2018</p>	

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K 511	Continued From page 13 evidenced by listing or labeling. (2) Mechanical strength and durability, including, 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.	K 511		
K 781 SS=D	Reference UL 1363 XBYS.GuidelInfo Relocatable Power Taps  Portable Space Heaters CFR(s): NFPA 101  Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to prohibit the use of portable heating devices in accordance with NFPA 101. Portable heaters have been historically linked to facility fires. This deficient practice had the potential to	K 781	<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>  K781  1. <b>SPECIFIC ISSUE</b> Facility is free of space heaters compliant with NFPA 101 standards.  2. <b>OTHER RESIDENTS</b> This affects 8 residents, staff, and visitors. Facility wide inspection did not find any other space heaters in use.	

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K 781	Continued From page 14 affect 8 residents, staff and visitors on the date of the survey.  Findings include:  During the facility tour conducted on December 12, 2017 from approximately 10:30 AM to 3:30 PM, observation of the Beauty Shop located in the 300 south resident hall, revealed a portable heater plugged into the wall outlet.  Interview of the Maintenance Director revealed he was not aware of the presence of the portable heater prior to the date of the survey.  Actual NFPA standard:  19.7.8 Portable Space-Heating Devices. Portable spaceheating devices shall be prohibited in all health care occupancies, unless both of the following criteria are met: (1) Such devices are used only in nonsleeping staff and employee areas. (2) The heating elements of such devices do not exceed 212°F (100°C).	K 781	<p>3. <b>SYSTEMIC CHANGES</b> Executive director and/ or designee provided staff education on safety measures and not having space heaters within building.</p> <p>4. <b>MONITOR:</b> Executive director and/ or designee will audit weekly x4 and monthly x3 to no validate space heaters are present per NFPA guidelines. Monitoring of this system will be added to the preventive 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 indication.</p> <p>5. <b>DATE OF COMPLIANCE:</b> January 31, 2018</p> <p><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></p> <p><i>K927</i></p> <p>1. <b>SPECIFIC ISSUE:</b> The fan for the oxygen transfill storage area was adjusted to meet proper exhaust airflow per NFPA 99.</p>	
K 927 SS=D	Gas Equipment - Transfilling Cylinders CFR(s): NFPA 101  Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99).	K 927		

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K 927	<p>Continued From page 15 11.5.2.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and operational testing, the facility failed to ensure liquid oxygen transfilling was conducted in accordance with NFPA 99. Failure to transfill liquid oxygen with sufficient mechanical ventilation has the potential to create an oxygen rich environment, increasing the risk of combustion. 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 December 12, 2017 from approximately 10:30 AM to 3:30 PM, observation and operational testing of the fan for the oxygen storage/transfill area abutting the dining room, revealed the fan was operational, but lacked exhaust airflow when tested with a sheet of standard note paper and a single facial tissue placed within one inch of the exhaust vent.</p> <p>Actual NFPA standard: NFPA 99 11.5.2.3 Transfilling Liquid Oxygen. Transfilling of liquid oxygen shall comply with 11.5.2.3.1 or 11.5.2.3.2, as applicable. 11.5.2.3.1 Transfilling to liquid oxygen base reservoir containers or to liquid oxygen portable containers over 344.74 kPa (50 psi) shall include the following: (1) A designated area separated from any portion of a facility wherein patients are housed, examined, or treated by a fire barrier of 1 hour fire-resistive construction. (2) The area is mechanically ventilated, is sprinklered, and has ceramic or concrete flooring.</p>	K 927	<p>2. <b>OTHER RESIDENTS:</b> All residents have potential to be affected by deficient practice.</p> <p>3. <b>SYSTEMIC CHANGES</b> Maintenance Director was educated on the NFPA 99 regulations regarding proper airflow for oxygen transfill storage area. Monitoring is added to the preventative maintenance plan.</p> <p>4. <b>MONITOR</b> Executive Director and/ or designee will validate that mechanical ventilation is in compliance standards with NFPA 99 monthly for 3 months. Monitoring of this system will be added to the preventative maintenance check.</p> <p>5. <b>DATE OF COMPLIANCE</b> January 31, 2018</p>	

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K 927	Continued From page 16 (3) The area is posted with signs indicating that transfilling is occurring and that smoking in the immediate area is not permitted. (4) The individual transfilling the container(s) has been properly trained in the transfilling procedures.  9.3.7.5.3.2 Mechanical exhaust shall be at a rate of 1 L/sec of airflow for each 300 L (1 cfm per 5 ft3 of fluid) designed to be stored in the space and not less than 24 L/sec (50 cfm) nor more than 235 L/sec (500 cfm).	K 927		