



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

January 16, 2018

James Elton, Administrator
Wellspring Health & Rehabilitation of Cascadia
2105 12th Avenue Road
Nampa, ID 83686-6312

Provider #: 135094

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Mr. Elton:

On **January 4, 2018**, a Facility Fire Safety and Construction survey was conducted at **Wellspring Health & Rehabilitation of Cascadia** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. Please provide **ONLY ONE** completion date for each federal and state tag in column (X5) Completion Date to signify when

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **January 29, 2018**. Failure to submit an acceptable PoC by **January 29, 2018**, may result in the imposition of civil monetary penalties by **February 18, 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 **March 9, 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 **March 9, 2018**. A change in the seriousness of the deficiencies on **March 9, 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 **March 9, 2018**, includes the following:

Denial of payment for new admissions effective **April 4, 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 **July 4, 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 **January 4, 2018**, 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:

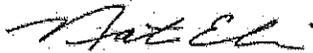
BFS Letters (06/30/11)

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

This request must be received by **January 29, 2018**. If your request for informal dispute resolution is received after **January 29, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135094	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/04/2018
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NAME OF PROVIDER OR SUPPLIER WELLSPRING HEALTH & REHABILITATION OF	STREET ADDRESS, CITY, STATE, ZIP CODE 2105 12TH AVENUE ROAD NAMPA, ID 83686
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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 Initial Comments

The facility is a single story Type V (III) structure built in 1998 with an addition of 60 beds in March 2001 and a vent unit expansion in 2014. The facility is equipped with two (2) diesel powered emergency generators as part of the facility EES (Emergency Electrical System); one (1) for the main existing portion of the facility and one (1) which was added for the vent unit expansion. The facility is located in a municipal fire and county emergency district with full sprinkler protection throughout and smoke detection coverage in corridors, sleeping rooms, and open spaces. The facility is currently licensed for 120 SNF/NF beds and had a census of 54 on the dates of the survey.

The following deficiencies were cited during the emergency preparedness survey conducted on January 3 and 4, 2017. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.

The Survey was conducted by:

Sam Burbank
Health Facility Surveyor
Facility Fire Safety & Construction

E 000

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 correctly applied.

RECEIVED
JAN 30 2018
FACILITY STANDARDS

E 006
SS=F Plan Based on All Hazards Risk Assessment
CFR(s): 483.73(a)(1)-(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:]

(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.*

E 006 1. **SPECIFIC ISSUE:**
Wellspring Health and Rehabilitation of Cascadia's all hazard risk assessment was reviewed and updated on or before 2/14/18 by facility QAPI committee and community emergency personnel to include but not limited to community based risk assessment with local

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE ED	(X6) DATE 1/29/18
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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 006	<p>Continued From page 1</p> <p>*[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents.</p> <p>*[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients.</p> <p>(2) Include strategies for addressing emergency events identified by the risk assessment.</p> <p>* [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to conduct a facility-based and community-based risk assessment which includes identified strategies for response. Failure to conduct a facility and community based risk assessment hinders facility response to localized disasters and emergencies. This deficient practice affected 54 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>On 1/3/18 and 1/4/18 from 9:30 AM to 5:00 PM, review of provided policies, procedures and the emergency plan located at the nursing station did not reveal a current facility and community based</p>	E 006	<p>empirical data for the community based component, current and comprehensive policy, and procedures and updated site-specific all-hazards risk assessment.</p> <p>2. OTHER RESIDENTS: All residents are potentially affected by deficient practice.</p> <p>3. SYSTEMIC CHANGES: Staff educated on or before 2/14/18 by Executive Director and/or designee regarding updated all-hazard risk assessment.</p> <p>4. MONITOR: Upon completion of initial education with staff, Executive Director and/or designee will monitor the effectiveness of the emergency management plan through staff interview and provide outcomes to QAPI committee monthly for the next 3 months. Additional education will be provided as necessary. Plan to be updated as needed.</p> <p>5. Date of Compliance:</p>	2/14/18

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E 006	Continued From page 2 risk assessment had been conducted. Interview of the Administrator and Environmental Services Manager on 1/3/18 from 10:30 - 11:00 AM found the facility had not yet contacted or conducted a facility and community based risk assessment. Reference: 42 CFR 483.73 (a) (1) - (2)	E 006		
E 007 SS=C	EP Program Patient Population CFR(s): 483.73(a)(3) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to provide current policies, procedures and an emergency plan that had been reviewed annually, addressing 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 potentially affected 54 residents, staff and visitors	E 007	1. SPECIFIC ISSUE: Wellspring Health and Rehabilitation of Cascadia's Emergency Management Plan was reviewed and updated on or before 2/14/18 by facility QAPI committee and community emergency personnel to address resident population including persons at risk, staff succession planning, delegation of authority, and facility's ability to provide services in an emergency. 2. OTHER RESIDENTS: All residents are potentially affected by deficient practice. 3. SYSTEMIC CHANGES: Staff educated on or before 2/14/18 Executive Director and/or designee regarding facilities resident population including persons at risk, staff succession planning, delegation of authority and facility's ability to provide services in an emergency.	

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E 007	Continued From page 3 on the date of the survey. Findings include: 1) On 1/3/18 from 9:30 AM - 5:00 PM review of provided policies and procedures and the emergency plan from the nursing station did not reveal a plan which included delegations of authority and succession planning. 2) Interviews conducted of 5 of 5 staff members on 1/4/18 from 9:00 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. Reference: 42 CFR 483.73 (a) (3)	E 007	4. MONITOR: Upon completion of initial education with staff, Executive Director and/or designee will monitor the effectiveness of the emergency management plan through staff interview and provide outcomes to QAPI committee monthly for the next 3 months. Additional education will be provided as necessary. Plan to be updated as indicated. 5. Date of Compliance:	2/14/18
E 009 SS=F	Local, State, Tribal Collaboration Process CFR(s): 483.73(a)(4) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts 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	E 009	1. SPECIFIC ISSUE: Wellspring Health and Rehabilitation of Cascadia's Emergency Management Plan was reviewed and updated on or before 2/14/18 by facility QAPI committee and community emergency personnel to include comprehensive collaboration with local emergency planning authorities including documentation of the facility's efforts to contact such officials. 2. OTHER RESIDENTS: All residents are potentially affected by deficient practice.	

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E 009	Continued From page 4 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 a current plan for cooperation and collaboration with local, tribal, regional, State and Federal EP officials. Failure to develop a collaborative planning effort with multi-jurisdictional entities, has the potential to limit the facilities options during a disaster. This deficient practice affected 54 residents, staff and visitors on the date of the survey. Findings include: On 1/3/18 from 9:30 AM - 5:00 PM, review of provided policies, procedures and the emergency plan revealed the emergency policies and plan did not indicate collaborative involvement with local, tribal, regional State and Federal EP officials. Interview of the Environmental Services Manager established he had not yet completed contacting county emergency management personnel to incorporate collaborative arrangements into the emergency plan. Reference: 42 CFR 483.73 (a) (4)	E 009	3. SYSTEMIC CHANGES: Staff educated on or before 2/14/18 by Executive Director and/or designee regarding facility's updated all hazard risk assessment developed in collaboration with local emergency authorities. 4. MONITOR: Upon completion of initial education with staff, Executive Director and/or designee will monitor the effectiveness of the emergency management plan through staff interview and provide outcomes to QAPI committee monthly for the next 3 months. Additional education will be provided as necessary. Plan to be updated as indicated. 5. Date of Compliance:	2/14/18	
E 013 SS=F	Development of EP Policies and Procedures CFR(s): 483.73(b)	E 013	1. SPECIFIC ISSUE: Wellspring Health and Rehabilitation		

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E 013	Continued From page 5 (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical 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. *[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	E 013	of Cascadia's Emergency Management Plan was reviewed and updated on or before 2/14/18 by facility QAPI committee and community emergency personnel to include updated and site-specific policy and procedures for all identified areas of the facility risk assessment and communication. 2. OTHER RESIDENTS: All residents are potentially affected by deficient practice. 3. SYSTEMIC CHANGES: Staff educated on or before 2/14/18 by Executive Director and/or designee regarding facility's updated policies per the facility assessment and communications plan. 4. MONITOR: Upon completion of initial education with staff, Executive Director and/or designee will monitor the effectiveness of the emergency management plan through staff interview and provide outcomes to QAPI committee monthly for the next 3 months. Additional education will be provided as necessary. Plan to be updated as indicated. 5. Date of Compliance:	2/14/18

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

Printed: 01/11/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135094	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/04/2018
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E 013	<p>Continued From page 6</p> <p>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:</p> <p>Based on record review, it was determined the facility failed to develop policies and procedures based on the Emergency Plan. Failure to develop current policies and procedures based on the emergency plan, a facility and community based risk assessment and the facility communications plan, limits the facility response capabilities in the protection of residents during a disaster. This deficient practice affected 54 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>On 1/3/18 from 9:30 AM to 5:00 PM, review of provided policies and procedures revealed the current copy located at the nursing station had been reviewed annually, however it was established these policies and plan were based on other locations in other cities and counties and even other states for its development of contact information; staffing needs; emergency management personal and even containing facility identification which was inconsistent with the facility location.</p> <p>Some of the examples revealed inconsistent with the facility are:</p> <p>Page 42 identifies the police department as "Boise Police" when the facility is located in the city of Nampa.</p> <p>The facility is located in Canyon County, yet the phone number listed on page 58 is for the Ada</p>	E 013		

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E 013	Continued From page 7 County Emergency Management office. Page 58 identifies the city of Boise City Hall telephone number for the fire department and this is not the fire district the facility is located in. Page 70 identifies the phone number of Boise City Hall as the contact for the fire department in response to floods. Page 59 identifies both "Wellspring of Cascadia" and "Wellspring of Mt. Tabor" when identifying the facility's response to external fires. Page 73 identifies only one (1) emergency generator ("a") and the facility is equipped with two. Page 73 also fails to identify that at least one of the two emergency generators is equipped with a minimum 96 hour fuel supply based on the life support needs of a high-risk, oxygen-dependent population. Reference: 42 CFR 483.73 (b)	E 013		
E 015 SS=D	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies	E 015	1. SPECIFIC ISSUE: Wellspring Health and Rehabilitation of Cascadia's Emergency Management Plan was reviewed and updated on or before 2/14/18 by facility QAPI committee and community emergency personnel to include updated and site-specific policy and procedures to include provision of subsistence needs for staff and patients whether they evacuate or shelter in place. Including food, water, medical and pharmaceutical supplies and alternate sources of energy.	

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E 015	<p>Continued From page 8</p> <p>(ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal.</p> <p>*[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the facility failed to develop and maintain current policies, procedures and plan to provide subsistence needs of residents and staff should they need to evacuate or shelter in place during a disaster. Lack of subsistence policies limits the facility's ability to provide continuing care and</p>	E 015	<p>2. OTHER RESIDENTS: All residents are potentially affected by deficient practice.</p> <p>3. SYSTEMIC CHANGES: Staff educated on or before 2/14/18 by Executive Director and/or designee regarding facilities updated policies regarding provision of subsistence needs and alternate energy sources.</p> <p>4. MONITOR: Upon completion of initial education with staff, Executive Director and/or designee will monitor the effectiveness of the emergency management through staff interview and observation of subsistence needs. Outcomes will be presented to QAPI committee monthly for the next 3 months. Additional education will be provided as necessary. Plan to be updated as indicated.</p> <p>5. Date of Compliance:</p>	2/14/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135094	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/04/2018
NAME OF PROVIDER OR SUPPLIER WELLSPRING HEALTH & REHABILITATION OF		STREET ADDRESS, CITY, STATE, ZIP CODE 2105 12TH AVENUE ROAD NAMPA, ID 83686		
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E 015	Continued From page 9 services for residents during an emergency. This deficient practice affected 54 residents, staff and visitors on the date of the survey. Findings include: On 1/3/18 from 9:30 AM to 5:00 PM, review of provided policies and procedures for the facility did not indicate the ability of the facility to provide subsistence for residents and staff in the event of evacuation or choose to shelter in place during a disaster. Documentation of contracted services to be provided for outside vendors to provide food were not signed and dated. Review of emergency generator records revealed deficiencies in the maintenance and testing of emergency power systems (Reference K-914 and K-918). In addition, no records were provided demonstrating subsistence provisions for temperature, sanitation such as laundry and sewage and waste disposal. Reference: 42 CFR 483.73 (b) (1)	E 015		
E 018 SS=F	Procedures for Tracking of Staff and Patients CFR(s): 483.73(b)(2) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:] (2) A system to track the location of on-duty staff	E 018	1. SPECIFIC ISSUE: Wellspring Health and Rehabilitation of Cascadia's Emergency Management Plan was reviewed and updated on or before 2/14/18 by facility QAPI committee and community emergency personnel to include updated and site-specific policy and procedures to include staff and resident tracking system and tools for both evacuation and shelter-in-place scenarios.	

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E 018	<p>Continued From page 10 and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location.</p> <p>*[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location.</p> <p>*[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location.</p> <p>*[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of</p>	E 018	<p>2. OTHER RESIDENTS: All residents are potentially affected by deficient practice.</p> <p>3. SYSTEMIC CHANGES: Staff educated on or before 2/14/18 by Executive Director and/or designee regarding facilities updated policies regarding tracking systems for both evacuation and shelter-in-place scenarios.</p> <p>4. MONITOR: Upon completion of initial education with staff, Executive Director and/or designee will monitor the effectiveness of the emergency management plan through staff interview and provide outcomes to QAPI committee monthly for the next 3 months. Additional education will be provided as necessary. Plan to be updated as indicated.</p> <p>5. Date of Compliance:</p>	2/14/18	

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E 018	<p>Continued From page 11</p> <p>evacuation location(s); and primary and alternate means of communication with external sources of assistance.</p> <p>*[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records.</p> <p>*[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to provide a 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 1/3/18 from 9:30 AM to 3:00 PM, review of provided policies, procedures and emergency plan, failed to demonstrate the facility had in place a system to track the location of on-duty staff and sheltered residents during an emergency. Further review revealed identification was to be completed for residents and resident "care" needs at admission and added to arm bands, but no policy or plan was provided to</p>	E 018		

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E 018	Continued From page 12 identify and track residents and on-duty staff either in the facility if sheltering in place, or a receiving facility during evacuation. Interview of 5 of 5 staff members on 1/4/18 from 9:00 AM - 3:00 PM, revealed none were aware of any policies for the tracking procedures of staff and residents during an emergency. Reference: 42 CFR 483.73 (b) (2)	E 018		
E 020 SS=C	Policies for Evac. and Primary/Alt. Comm. CFR(s): 483.73(b)(3) [(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:] Safe evacuation from the [facility], 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. *[For RNHCs at §403.748(b)(3) and ASCs at §416.54(b)(2):] Safe evacuation from the [RNHCI or ASC] which includes the following: (i) Consideration of care needs of evacuees. (ii) Staff responsibilities. (iii) Transportation. (iv) Identification of evacuation location(s).	E 020	1. SPECIFIC ISSUE: Wellspring Health and Rehabilitation of Cascadia's Emergency Management Plan was reviewed and updated on or before 2/14/18 by facility QAPI committee and community emergency personnel to include safe evacuation from the facility, 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. 2. OTHER RESIDENTS: All residents are potentially affected by deficient practice. 3. SYSTEMIC CHANGES: Staff educated on or before 2/14/18 by Executive Director and/or	

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E 020	<p>Continued From page 13</p> <p>(v) Primary and alternate means of communication with external sources of assistance.</p> <p>* [For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at §494.62(b)(2):] Safe evacuation from the [CORF; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services; and ESRD Facilities], which includes staff responsibilities, and needs of the patients.</p> <p>* [For RHCs/FQHCs at §491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients. 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 and procedure for evacuation which included care, treatment and needs of evacuees; staff responsibilities; transportation and identification of locations and primary/alternate means of communication. Lack of a current policy and procedure for evacuations and communications, both primary and alternate, has the potential to create confusion and misinformation during an emergency, hindering care for the 54 residents, staff and visitors in the care of the facility on the date of the survey.</p> <p>Findings include:</p> <p>On 1/3/18 from 9:30 AM - 5:00 PM, review of the provided policies, procedures and emergency plan, found no policies procedures or plan for</p>	E 020	<p>designee regarding facilities updated policies regarding safe evacuation from the facility.</p> <p>4. MONITOR: Upon completion of initial education with staff, Executive Director and/or designee will monitor the effectiveness of the emergency management plan through staff interview and provide outcomes to QAPI committee monthly for the next 3 months. Additional education will be provided as necessary. Plan to be updated as indicated.</p> <p>5. Date of Compliance:</p>	2/14/18

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E 020	<p>Continued From page 14</p> <p>evacuation which included both primary and alternate methods of communication and a specific transportation provision.</p> <p>Examples:</p> <p>No specific section was found for transportation, but the references found on page 56 stated the facility would "contract with a designated company", however no company was defined and no contract was present. Further reference found on page 86 identified the ambulance company as one located in another county, with no information if a mutual aid agreement was present during emergencies.</p> <p>The Communication Plan found on pages 21 to 28 showed focus was on external communications with media, social media and information to provide to staff outside of media alerts, but did not show alternate communication methods which would assist contacting outside resources such as emergency management personnel; EMS; Police; Fire or assisting facilities and volunteer organizations should landlines be disabled.</p> <p>On 1/4/18 from 2:00 PM - 2:30 PM, interview of the Environmental Services Manager revealed he was not aware of any specific policy, procedure, or equipment the facility had available for alternative communication.</p> <p>Reference: 42 CFR 483.73 (b) (3)</p>	E 020		
E 022 SS=F	<p>Policies/Procedures for Sheltering in Place CFR(s): 483.73(b)(4)</p> <p>[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness</p>	E 022	<p>1. SPECIFIC ISSUE: Wellspring Health and Rehabilitation of Cascadia's Emergency Management Plan was reviewed and</p>	

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E 022	<p>Continued From page 15</p> <p>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>(4) A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility].</p> <p>*[For Inpatient Hospices at §418.113(b):] Policies and procedures.</p> <p>(6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following:</p> <p>(i) A means to shelter in place for patients, hospice employees who remain in the hospice. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, it was determined the facility failed to provide a policy procedure or plan for sheltering in place. Failure to provide a plan for sheltering in place has the potential to leave residents and staff without resources to continue 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>On 1/3/18 from 9:30 AM to 5:00 PM, review of provided policies, procedures and emergency plan, found the facility had several policies and procedures relating to both a temporary and</p>	E 022	<p>updated on or before 2/14/18 by facility QAPI committee and community emergency personnel to include policies and procedures or plans for sheltering in place</p> <p>2. OTHER RESIDENTS: All residents are potentially affected by deficient practice.</p> <p>3. SYSTEMIC CHANGES: Staff educated on or before 2/14/18 by Executive Director and/or designee regarding facilities updated policies and procedures for sheltering in place.</p> <p>4. MONITOR: Upon completion of initial education with staff, Executive Director and/or designee will monitor the effectiveness of the emergency management plan through staff interview and provide outcomes to QAPI committee monthly for the next 3 months. Additional education will be provided as necessary. Plan to be updated as indicated.</p> <p>5. Date of Compliance:</p>	2/14/18

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E 022	Continued From page 16 indefinite evacuation of the facility, but these documents did not contain information or procedures for sheltering in place. In addition, review of the Community Disaster section of the plan found on page 12, stated: "responsible parties of ambulatory residents will be requested to remove them from the facility for the duration of the emergency condition", nullifying the ability for those residents in need of care to shelter in place. When interviewed on 1/4/18 from 9:00 AM - 3:00 PM, 5 of 5 staff members could not identify a facility policy, procedure or plan for sheltering in place. Reference: 42 CFR 483.73 (b) (4)	E 022		
E 023 SS=D	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	E 023	<p>1. SPECIFIC ISSUE: Wellspring Health and Rehabilitation of Cascadia's Emergency Management Plan was reviewed and updated on or before 2/14/18 by facility QAPI committee and community emergency personnel to include policies and procedures for the transfer of medical documentation of residents, which both secures the information and protects confidentiality.</p> <p>2. OTHER RESIDENTS: All residents are potentially affected by deficient practice.</p>	

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E 023	<p>Continued From page 17 and maintains availability of records. This is what's in SOM.</p> <p>*[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.</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. This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to provide emergency plan, policies and procedures for the transfer of medical documentation of residents, which both secured the information and protected confidentiality. Failure to provide procedures for the secure transfer of medical records during an emergency has the potential to affect the continuity of care for the 54 housed residents on the date of the survey.</p> <p>Findings include: During review of provided emergency policies, procedures and plan on 1/3/18 from 9:30 AM - 5:00 PM, a section in the Table of Contents of the Emergency Plan was found indicating "Electronic Medical Records", however no policy or procedure regarding this practice was found.</p> <p>On 1/4/18 from 9:00 AM - 2:00 PM Interview of the DON and SDC established the facility</p>	E 023	<p>3. SYSTEMIC CHANGES: Staff educated on or before 2/14/18 by Executive Director and/or designee regarding facilities updated policies and procedures for the transfer of medical documentation of residents, which both secures the information and protects confidentiality.</p> <p>4. MONITOR: Upon completion of initial education with staff, Executive Director and/or designee will monitor the effectiveness of the emergency management plan through staff interview and provide outcomes to QAPI committee monthly for the next 3 months. Additional education will be provided as necessary. Plan to be updated as indicated.</p> <p>5. Date of Compliance: 2/14/18</p>	

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E 023	Continued From page 18 maintained electronic medical records, but did not have any policy or procedure for the transfer of these records during a disaster. Reference: 42 CFR 483.73	E 023		
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 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 their 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	E 026	<ol style="list-style-type: none"> SPECIFIC ISSUE: Wellspring Health and Rehabilitation of Cascadia's Emergency Management Plan was reviewed and updated on or before 2/14/18 by facility QAPI committee and community emergency personnel to include updated and site-specific policy and procedures to include facility role and responsibilities established by 1135 waiver. OTHER RESIDENTS: All residents are potentially affected by deficient practice. SYSTEMIC CHANGES: Staff educated on or before 2/14/18 by Executive Director and/or designee regarding facility's updated policies regarding facility role and responsibilities under 1135 waiver. MONITOR: Upon completion of initial education with staff, Executive Director will monitor the effectiveness of the emergency management plan and 	

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: 135094	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/04/2018
NAME OF PROVIDER OR SUPPLIER WELLSPRING HEALTH & REHABILITATION OF		STREET ADDRESS, CITY, STATE, ZIP CODE 2105 12TH AVENUE ROAD NAMPA, ID 83686		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 026	Continued From page 19 plan for alternate means of care and the role under an 1135 waiver has the potential to limit facility options during an emergency. This deficient practice potentially affects reimbursement and continuity of care for the 54 residents, staff and visitors housed on the date of the survey along with the available surge needs of the community during a disaster. Findings include: On 1/3/18 from 9:30 AM to 5:00 PM, review of the provided emergency plan, policies and procedures, revealed a section defining what an 1135 waiver was and how that process was enacted by the Secretary, but no information as to what the facility's role was if such conditions existed. Reference: 42 CFR 483.73 (b) (8)	E 026	provide outcomes to QAPI committee on a monthly basis. Additional education will be provided as necessary. Plan to be updated as indicated.	
E 029 SS=F	Development of Communication Plan CFR(s): 483.73(c) (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the facility failed to provide the method of communication which would support coordination of care for residents during a disaster and how that communication would meet federal, state and local laws. How the facility provides communication during a disaster and interacts with local emergency management personnel is essential to providing continuing care for	E 029	5. Date of Compliance: 1. SPECIFIC ISSUE: Wellspring Health and Rehabilitation of Cascadia's Emergency Management Plan was reviewed and updated on or before 2/14/18 by facility QAPI committee and community emergency personnel to include updated and site-specific policy and procedures to include an updated communications plan. 2. OTHER RESIDENTS: All residents are potentially affected by deficient practice.	2/14/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135094	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/04/2018
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E 029	Continued From page 20 residents during a disaster. This deficient practice affected 54 residents, staff and visitors on the date of the survey. Findings include: On 1/3/18 from 9:30 AM to 5:00 PM, review of provided emergency plan, policies and procedures revealed the communication plan focus was the release of information to media officials and release of information on social media as related to a crisis. However the plan did not describe what method of transmission the facility intended to use for delivering information such as landline telephones; Internet connectivity; cellular telephones; two-way radio systems or other systems and if the method used by the facility was in compliance with local, state and federal laws as applicable. Reference: 42 CFR 483.73 (c)	E 029	3. SYSTEMIC CHANGES: Staff educated on or before 2/14/18 by Executive Director and/or designee regarding facility's updated communication plan. 4. MONITOR: 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 monthly for the next 3 months. Additional education will be provided as necessary. Plan to be updated as indicated. 5. Date of Compliance: 2/14/18	
E 030 SS=F	Names and Contact Information CFR(s): 483.73(c)(1) [(c) The [facility, except RNHCIs, hospices, transplant centers, and HHAs] 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:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers.	E 030	1. SPECIFIC ISSUE: Wellspring Health and Rehabilitation of Cascadia's Emergency Management Plan was reviewed and updated on or before 2/14/18 by facility QAPI committee and community emergency personnel to include updated and site-specific contact list that includes staff, entities providing services, patient physicians, other facilities, and volunteers. 2. OTHER RESIDENTS: All residents are potentially affected	

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E 030	<p>Continued From page 21</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. (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</p>	E 030	<p>by deficient practice.</p> <p>3. SYSTEMIC CHANGES: Staff educated on or before 2/14/18 by Executive Director and/or designee regarding facility's updated contact list.</p> <p>4. MONITOR: 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 current. Outcomes will be provided to QAPI committee monthly for the next 3 months. Additional education will be provided as necessary. Plan to be updated as indicated.</p> <p>5. Date of Compliance:</p>	2/14/18

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E 030	Continued From page 22 Donation Service Area (DSA). This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the facility failed to document a communication plan which included contact information for staff, resident physicians, other facilities and volunteers. Failure to have a communication plan which includes contact information for those parties assisting in the facility's response and recovery during a disaster, has the potential to hinder both internal and external emergency response efforts. This deficient practice affected 54 residents, staff and visitors on the date of the survey. Findings include: On 1/3/18 from 9:30 AM - 5:00 PM, review of provided emergency plan, policies and procedures revealed the communication plan did not include contact information for resident physicians and volunteers and that the staff contact information for the DON and Kitchen on page 42 of the plan was not current. Reference: 42 CFR 483.73 (c) (1)	E 030			
E 031 SS=E	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	E 031	1. SPECIFIC ISSUE: Wellspring Health and Rehabilitation of Cascadia's Emergency Management Plan was reviewed and updated on or before 2/14/18 by facility QAPI committee and community emergency personnel to include current contact information for emergency management officials and other resources of assistance.		

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E 031	<p>Continued From page 23 emergency preparedness staff. (ii) Other sources of assistance.</p> <p>*[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.</p> <p>*[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 by: Based on record review, the facility failed to ensure current contact information for emergency management officials 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.</p> <p>Findings include: On 1/3/18 from 9:30 AM - 5:00 PM, review of the emergency plan, policies and procedures, revealed the plan did not include the number for the Ombudsman and listed contacts for emergency management officials, along with police and fire contacts which were from another city and county than where the facility was</p>	E 031	<p>2. OTHER RESIDENTS: All residents are potentially affected by deficient practice.</p> <p>3. SYSTEMIC CHANGES: Staff educated on or before 2/14/18 by Executive Director and/or designee regarding facility's updated emergency officials contact information.</p> <p>4. MONITOR: 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 emergency officials contact information list to validate numbers are current. Outcomes will be provided to QAPI committee monthly for the next 3 months. Additional education will be provided as necessary. Plan to be updated as indicated.</p> <p>5. Date of Compliance:</p>	2/14/2018

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E 031	Continued From page 24 located.	E 031		
E 032 SS=D	<p>Reference: 42 CFR 483.73 (c) (2)</p> <p>Primary/Alternate Means for Communication CFR(s): 483.73(c)(3)</p> <p>[(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following:</p> <p>(3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies.</p> <p>*[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to document the primary and alternate means of communicating with staff, federal, state, tribal, regional and local emergency management agencies during an emergency. Failure to identify alternative communication options has the potential to hinder response efforts by staff and emergency management agencies. This deficient practice affected 54 residents, staff and visitors on the date of the survey.</p> <p>Findings include: On 1/3/17 from 9:30 AM to 5:00 PM, review of</p>	E 032	<p>1. SPECIFIC ISSUE: Wellspring Health and Rehabilitation of Cascadia's Emergency Management Plan was reviewed and updated on or before 2/14/18 by facility QAPI committee and community emergency personnel to include primary and alternate means for communicating with facility staff, Federal, State, tribal, regional, and local emergency management agencies.</p> <p>2. OTHER RESIDENTS: All residents are potentially affected by deficient practice.</p> <p>3. SYSTEMIC CHANGES: Staff educated on or before 2/14/18 by Executive Director and/or designee regarding facility's primary and alternate means for communicating with facility staff, Federal, State, tribal, regional, and local emergency management agencies.</p> <p>4. MONITOR: Upon completion of initial education with staff, Executive Director and/or</p>	

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E 032	Continued From page 25 provided emergency plan, policies and procedures, revealed no provision for alternate communication procedures during an emergency. Interview of the Environmental Services Manager on 1/4/18 from 2:00 - 2:30 PM found he was unaware of any plan for alternate communications. Reference: 42 CFR 483.73 (c) (3)	E 032	designee will monitor the effectiveness of the emergency management plan through staff interview. Outcomes will be provided to QAPI committee monthly for the next 3 months. Additional education will be provided as necessary. Plan to be updated as indicated.	2/14/18
E 033 SS=F	Methods for Sharing Information CFR(s): 483.73(c)(4)-(6) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care. (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.22(c), CORFs under §485.68(c), and RHCs/FQHCs under §491.12(c).] (6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4). *[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for	E 033	5. Date of Compliance: 1. SPECIFIC ISSUE: Wellspring Health and Rehabilitation of Cascadia's Emergency Management Plan was reviewed and updated on or before 2/14/18 by facility QAPI committee and community emergency personnel to include updated and site-specific policies regarding method of sharing information and medical documentation with other health providers including, in the event of an evacuation, release of patient information including general condition and transfer location, if indicated. See also E 018. 2. OTHER RESIDENTS: All residents are potentially affected by deficient practice. 3. SYSTEMIC CHANGES: Staff educated on or before 2/14/18 by Executive Director and/or	

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E 033	<p>Continued From page 26</p> <p>patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative.</p> <p>*[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4).</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 document a plan demonstrating the method for sharing information during an emergency. Failure to share information with other health care providers has the potential to hinder the facility's ability to continue care during a disaster. This deficient practice affected 54 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>On 1/3/18 from 9:30 AM to 5:00 PM, review of provided emergency plan, policies and procedures, failed to demonstrate a policy which identified how the facility would share information for the care of residents with other healthcare providers, release resident information in the event of an evacuation and provide information about the condition and location of residents as required during an emergency.</p> <p>Interview of 5 of 5 staff members on 1/4/18 from 9:00 AM to 3:00 PM, revealed they had no knowledge of a policy or plan for the sharing of information with other healthcare providers.</p>	E 033	<p>designee regarding facility's policy for sharing information regarding patient condition and location and method of sharing information with other health providers as indicated.</p> <p>4. MONITOR: Upon completion of initial education with staff, Executive Director and/or designee will monitor the effectiveness of the emergency management plan through staff interview and provide outcomes to QAPI committee monthly for the next 3 months. Additional education will be provided as necessary. Plan to be updated as indicated.</p> <p>5. Date of Compliance:</p>	2/14/18

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E 033	Continued From page 27 Reference: 42 CFR 483.73 (c) (4)-(6)	E 033		
E 034 SS=D	Information on Occupancy/Needs CFR(s): 483.73(c)(7) [(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: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For Inpatient Hospice at §418.113:] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide a communication plan for sharing information on needs, occupancy and its ability to provide assistance with emergency management officials. Failure to provide a plan to share information with emergency personnel on the facility's needs and abilities to provide assistance during a disaster, has the potential to	E 034	<p>1. SPECIFIC ISSUE: Wellspring Health and Rehabilitation of Cascadia's Emergency Management Plan was reviewed and updated on or before 2/14/18 by facility QAPI committee and community emergency personnel to include updated and site-specific policies regarding means of providing information about the facilities occupancy, needs and/or ability to provide assistance with Incident Commander or designee.</p> <p>2. OTHER RESIDENTS: All residents are potentially affected by deficient practice.</p> <p>3. SYSTEMIC CHANGES: Staff educated on or before 2/14/18 by Executive Director and/or designee regarding facility's procedure to provide facility information to incident commander or designee.</p> <p>4. MONITOR: Upon completion of initial education with staff, Executive Director will monitor the effectiveness of the emergency management plan and</p>	

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E 034	<p>Continued From page 28</p> <p>hinder response assistance and continuation of care for the 54 residents housed on the date of the survey.</p> <p>Findings include:</p> <p>On 1/3/18 from 9:30 AM to 5:00 PM, review of provided policies, procedures and emergency plans failed to indicate what method the facility would use to share information on its needs or capabilities when communicating with emergency management officials.</p> <p>Interview of the Environmental Services Manager from 2:00 PM - 2:30 PM revealed the facility had not met or contacted local or regional emergency management officials prior to the date of the survey.</p> <p>Reference: 42 CFR 483.73 (c) (7)</p>	E 034	<p>provide outcomes to QAPI committee on a monthly basis. Additional education will be provided as necessary. Plan to be updated as indicated.</p> <p>5. Date of Compliance: 2/14/18</p>	
E 035 SS=C	<p>LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8)</p> <p>[(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:</p> <p>(8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the facility failed to provide policies, procedure or plan identifying the method of sharing information on</p>	E 035	<p>1. SPECIFIC ISSUE: Wellspring Health and Rehabilitation of Cascadia's emergency management plan will be posted and available for all visitors and residents to review on or before 2/14/18. The location of the emergency plan will be discussed upon admission with all new residents and/or their families or responsible parties. Additional education to families or residents will be provided as needed.</p> <p>2. OTHER RESIDENTS: All residents are potentially affected by deficient practice.</p>	

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E 035	Continued From page 29 the emergency plan with residents, families or representatives. Failure to share the emergency plan and its contents with 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 potentially affected 54 residents, staff and visitors on the date of the survey. Findings include: On 1/3/18 from 9:30 AM to 5:00 PM, review of provided emergency plan, policies and procedures, no documentation was provided demonstrating the facility policy and method for sharing information with residents, their families or representatives. Reference: 42 CFR 483.73 (c) (8)	E 035	3. SYSTEMIC CHANGES: Staff educated on or before 2/14/18 by Executive Director and/or designee regarding communication of the emergency management plan to residents and the families or representatives. 4. MONITOR: Upon completion of initial education with staff, Executive Director and/or designee will monitor the effectiveness of the emergency management through resident and/or resident representative interview and provide outcomes to QAPI committee monthly for the next 3 months. Additional education will be provided as necessary. Plan to be updated as indicated.	2/14/18	
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 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,	E 036			
			5. Date of Compliance: 1. SPECIFIC ISSUE: Wellspring Health and Rehabilitation of Cascadia's Emergency Management Plan was reviewed and updated on or before 2/14/18 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		

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NAME OF PROVIDER OR SUPPLIER WELLSPRING HEALTH & REHABILITATION OF		STREET ADDRESS, CITY, STATE, ZIP CODE 2105 12TH AVENUE ROAD NAMPA, ID 83686		
(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 30</p> <p>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 emergency prep training and testing program. Lack of a facility emergency training and testing program covering the emergency preparedness plan, policies and procedures, 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:</p> <p>On 1/3/18 from 9:30 AM to 5:00 PM, review of provided emergency plan, policies and procedures, found no documentation demonstrating the facility had a current training and testing program for staff based on the plan.</p>	E 036	<p>documentation and staff competency completion. See also E 037.</p> <p>2. OTHER RESIDENTS: All residents are potentially affected by deficient practice.</p> <p>3. SYSTEMIC CHANGES: Staff educated on or before 2/14/18 by Executive Director and/or designee to validate understanding of current emergency preparedness plan. Additional education to be provided as indicated. Staff Development Coordinator educated on or before 2/14/18 by Executive Director to validate training and testing program is available and offered upon orientation and annually to employees (annual training calendar to include updates).</p> <p>4. MONITOR: Upon completion of initial education with staff, Executive Director and/or designee will monitor the effectiveness of the emergency management through staff interview and disaster drills. Outcomes will be provided to QAPI committee monthly for the next 3 months. Additional education will be provided as necessary. Plan to be updated as indicated.</p>	

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E 036	Continued From page 31 Interview of 5 of 5 staff conducted on 1/4/18 from 9:00 AM to 2:30 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 1/4/18 from 11:00 AM to 2:00 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	5. Date of Compliance:	2/14/18
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. *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at	E 037	1. SPECIFIC ISSUE: Wellspring Health and Rehabilitation of Cascadia's Emergency Management Plan was reviewed and updated on or before 2/14/18 by facility QAPI committee and community emergency personnel to include updated and site-specific policy regarding training and testing of employees for Emergency Management plan upon orientation and annually and will include documentation and staff competency completion. See also E 036. 2. OTHER RESIDENTS: All residents are potentially affected by deficient practice. 3. SYSTEMIC CHANGES: Staff educated on or before 2/14/18	

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E 037	<p>Continued From page 32 least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. This is what's in SOM but is missing here.</p> <p>*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least annually. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.</p> <p>*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training.</p> <p>*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:</p>	E 037	<p>by Executive Director and/or designee to validate understanding of current emergency preparedness plan. Additional education to be provided as indicated. Staff Development Coordinator educated on or before 2/14/18 by Executive Director to validate training and testing program is available and offered upon orientation and annually to employees (annual training calendar to include updates).</p> <p>4. MONITOR: Upon completion of initial education with staff, Executive Director and/or designee will monitor the effectiveness of the emergency management through staff interview and disaster drills. Outcomes will be provided to QAPI committee monthly for the next 3 months. Additional education will be provided as necessary. Plan to be updated as indicated.</p> <p>5. Date of Compliance:</p>	2/14/18

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E 037	<p>Continued From page 33</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> <p>*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster</p>	E 037		

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E 037	<p>Continued From page 34</p> <p>authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.</p> <p>(ii) Provide emergency preparedness training at least annually.</p> <p>(iii) Maintain documentation of the training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures.</p> <p>*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, it was determined the facility failed to provide a current 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> <p>Findings include:</p> <p>On 1/3/18 from 9:30 AM to 5:00 PM, review of provided emergency plan, policy and procedures, revealed no substantiating documentation demonstrating the facility had a training program for staff based on the plan.</p>	E 037		

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E 037	Continued From page 35 Interview of 5 of 5 staff members on 1/4/18 from 9:00 AM - 2:30 PM revealed no specific training was conducted on the emergency plan or its contents. Further interview of the Staff Development Coordinator on 1/4/18 indicated she was in the process of developing a new specified training program to be provided which included 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, RNHCs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCs 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 following:] (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. (ii) Conduct an additional exercise that may	E 039	<p>1. SPECIFIC ISSUE: Wellspring Health and Rehabilitation of Cascadia's Emergency Management Plan was reviewed and updated on or before 2/14/18 by facility QAPI committee and community emergency personnel to include participation in a full-scale exercise and additional full-scale or table top exercise for two (2) exercises annually.</p> <p>2. OTHER RESIDENTS: All residents are potentially affected by deficient practice.</p> <p>3. SYSTEMIC CHANGES: Executive Director to coordinate a full scale disaster drill with Southwest District Health annually. An additional table-top exercise will be completed annually at the center.</p>	

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E 039	<p>Continued From page 36</p> <p>include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, facility-based.</p> <p>(B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.</p> <p>*[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following:</p> <p>(i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, it was determined the facility failed to participate in 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</p>	E 039	<p>Outcomes of drill will be evaluated and additional education provided as indicated.</p> <p>4. MONITOR: Executive Director and/or designee will monitor the effectiveness of the emergency management through evaluation of full scale drill and table-top exercises. 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. Date of Compliance:</p>	2/14/18

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E 039	Continued From page 37 residents during an emergency. This deficient practice affected 54 residents, staff and visitors on the date of the survey. Findings include: On 1/3/18 from 9:30 AM to 5:00 PM, review of provided emergency plan documents revealed no documentation demonstrating the facility had participated in any type of exercise challenging the emergency preparedness plan, policies and procedures. Interview of the Administrator Environmental Services Manager on 1/3/18 from 9:30 to 11:00 AM substantiated the facility had not participated in any full-scale events. Reference: 42 CFR 483.73 (d) (1)	E 039		
E 041 SS=D	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location	E 041	1. SPECIFIC ISSUE: Wellspring Health and Rehabilitation of Cascadia's Emergency Management Plan was reviewed and updated on or before 2/14/18 by facility QAPI committee and community emergency personnel to include required emergency and standby power systems are maintained and provided subsistence. 2. OTHER RESIDENTS: All residents are potentially affected by deficient practice.	

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E 041	<p>Continued From page 38</p> <p>requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated.</p> <p>482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code.</p> <p>482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates.</p> <p>*[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of</p>	E 041	<p>3. SYSTEMIC CHANGES: Environmental Services Director educated on or before 2/14/18 by Executive Director to update emergency preparedness plan, perform weekly inspections and monthly testing of the emergency generator.</p> <p>4. MONITOR: Upon completion of initial education with staff, Executive Director and/or designee will monitor compliance of the facility maintenance and weekly inspection records and monthly testing of the emergency generators. Findings will be reviewed by the QAPI committee monthly for the next 3 months. Additional education will be provided as necessary. Plan to be updated as indicated.</p> <p>5. Date of Compliance:</p>	2/14/18

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E 041	<p>Continued From page 39 _federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes.</p> <p>(1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000.</p> <p>(i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011.</p> <p>(ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011.</p> <p>(iii) TIA 12-3 to NFPA 99, issued August 9, 2012.</p> <p>(iv) TIA 12-4 to NFPA 99, issued March 7, 2013.</p> <p>(v) TIA 12-5 to NFPA 99, issued August 1, 2013.</p> <p>(vi) TIA 12-6 to NFPA 99, issued March 3, 2014.</p> <p>(vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011.</p> <p>(viii) TIA 12-1 to NFPA 101, issued August 11, 2011.</p> <p>(ix) TIA 12-2 to NFPA 101, issued October 30, 2012.</p> <p>(x) TIA 12-3 to NFPA 101, issued October 22, 2013.</p> <p>(xi) TIA 12-4 to NFPA 101, issued October 22, 2013.</p> <p>(xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure the emergency and standby power systems were maintained and provided subsistence as required under the rule. Failure to ensure emergency generators are maintained and tested in accordance with NFPA 99 and NFPA 110, hinders the facility ability to provide continuity of care during an emergency, to the 54</p>	E 041		

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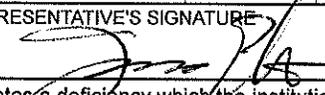
E 041	<p>Continued From page 40 residents housed in the facility on the date of the survey.</p> <p>Findings include:</p> <p>During review of the facility maintenance and inspection records and facility emergency plan, policies and procedures on 1/3/18 from 9:30 AM to 5:00 PM, records provided for the emergency generators revealed missing documentation for weekly inspections and monthly testing (Reference K-918 on CMS 2567).</p> <p>Further review of the emergency preparedness plan, policies and procedures revealed the documentation mis-identified the quantity and type of generator(s) the facility had, listing a single propane generator when in fact the facility had two (2) diesel generators.</p> <p>When asked about the missing documentation and the discrepancy of the generator information in the plan, the Environmental Services Manager stated he was unaware of the finding prior to the date of the survey.</p> <p>Reference: 42 CFR 483.73 (e) (1)</p>	E 041		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135094	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 01/04/2018
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NAME OF PROVIDER OR SUPPLIER WELLSPRING HEALTH & REHABILITATION OF CASCADIA	STREET ADDRESS, CITY, STATE, ZIP CODE 2105 12TH AVENUE ROAD NAMPA, ID 83686
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	<p>INITIAL COMMENTS</p> <p>The facility is a single story Type V (III) structure built in 1998 with an addition of 60 beds in March 2001. The facility is equipped with two (2) diesel powered emergency generators as part of the facility EES (Emergency Electrical System); one (1) for the main existing portion of the facility and one (1) which was added for the vent unit expansion in 2014. The facility is sprinklered throughout with smoke detection coverage in corridors, sleeping rooms, and open spaces. The facility is currently licensed for 120 SNF/NF beds.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on January 3 and 4, 2017. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.</p> <p>The Survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction</p>	K 000	<p style="text-align: center;">RECEIVED JAN 30 2018 FACILITY STANDARDS</p>	
K 161 SS=D	<p>Building Construction Type and Height CFR(s): NFPA 101</p> <p>Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1. I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2. II (111) One story non-sprinklered. Maximum 3</p>	K 161		<p>1. SPECIFIC ISSUE: The facility failed to ensure that the fire and smoke resistive properties of the structure were maintained. Specifically failure to seal penetrations in rated construction areas.</p> <p>2. OTHER RESIDENTS: All residents are potentially affected by deficient practice.</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE ED	(X6) DATE 1/29/18
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 161	<p>Continued From page 1</p> <p>stories sprinklered</p> <p>3. II (000) Not allowed non-sprinklered</p> <p>4. III (211) Maximum 2 stories sprinklered</p> <p>5. IV (2HH)</p> <p>6. V (111)</p> <p>7. III (200) Not allowed non-sprinklered</p> <p>8. V (000) Maximum 1 story sprinklered</p> <p>Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5)</p> <p>Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, the facility failed to ensure that the fire and smoke resistive properties of the structure were maintained. Failure to seal penetrations in rated construction assemblies has the potential to allow fire, smoke and dangerous gases to pass between compartments during a fire. 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 1/3/189 from approximately 2:30 - 3:30 PM, two (2) unsealed data cabling conduits approximately three inch by three inch were observed in the electrical room across from the Kitchen.</p> <p>When asked about the unsealed penetrations, the Environmental Services Manager stated he</p>	K 161	<p>3. SYSTEMIC CHANGES: Noted penetrations were repaired on or before 2/14/18. Maintenance Staff educated by Executive Director or designee on or before 2/14/2018 to ensure smoke resistive properties of the structure are maintained in accordance with NFPA 101.</p> <p>4. MONITOR: Executive Director or designee will ensure quarterly audits of potential smoke penetrations in compliance with NFPA 101 thru monthly audits. Results of audits will be reviewed in QAPI.</p> <p>5. Date of Compliance:</p>	2/14/18

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K 161	Continued From page 2 had not noticed these penetrations prior to the survey. Actual NFPA standard: 19.1.6 Minimum Construction Requirements. 19.1.6.1 Health care occupancies shall be limited to the building construction types specified in Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7. (See 8.2.1.) 8.2 Construction and Compartmentation. 8.2.1 Construction. 8.2.1.1 Buildings or structures occupied or used in accordance with the individual occupancy chapters, Chapters 11 through 43, shall meet the minimum construction requirements of those chapters. 8.2.2.2 Fire compartments shall be formed with fire barriers that comply with Section 8.3. 8.3.5.6 Membrane Penetrations. 8.3.5.6.1 Membrane penetrations for cables, cable trays, conduits, pipes, tubes, combustion vents and exhaust vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a membrane of a wall, floor, or floor/ceiling assembly constructed as a fire barrier shall be protected by a firestop system or device and shall comply with 8.3.5.1 through 8.3.5.2.	K 161			
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges,	K 211			

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K 211	<p>Continued From page 3</p> <p>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</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, observation and interview, the facility failed to ensure that rated assemblies were inspected in accordance with NFPA 80 and/or NFPA 105, as applicable. Failure to inspect and test rated assemblies has the potential to hinder system performance as designed. This deficient practice affected 54 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>1) During review of provided facility annual inspection records conducted on 1/3/18 from approximately 9:30 AM - 10:00 AM, no records were available demonstrating an initial or annual inspection and testing of rated assemblies had been conducted. When asked about the missing documentation, the Environmental Services Manager stated he was not aware of this requirement.</p> <p>2) During the facility tour conducted on 1/3 and 1/4/18 from approximately 9:30 AM to 5:00 PM, observation of installed doors revealed doors in 4 of 4 smoke compartments were labeled as smoke or fire resistive, and ranged in fire/smoke protective ratings from 20 minutes to 90 minutes.</p> <p>Actual NFPA standard:</p>	K 211	<p>K 211</p> <ol style="list-style-type: none"> SPECIFIC ISSUE: The facility failed to ensure that rated assemblies were inspected in accordance with NFPA 80 and/or NFPA 105 as applicable. OTHER RESIDENTS: All residents are potentially affected by deficient practice. SYSTEMIC CHANGES: Facility will have its annual Fire Door inspection by 2/14/18 by licensed contractor. Inspection will include a detailed map of the facility with fire ratings. MONITOR: Executive Director or designee will ensure that the inspection and corrections are completed by 2/14/18. Any issues will be reported in QAPI. Date of Compliance: 	2/14/18

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K 211	<p>Continued From page 4 NFPA 101</p> <p>19.2 Means of Egress Requirements 19.2.2.2 Doors. 19.2.2.2.1 Doors complying with 7.2.1 shall be permitted.</p> <p>7.2.1 Door Openings. 7.2.1.15 Inspection of Door Openings. 7.2.1.15.1* Where required by Chapters 11 through 43, the following door assemblies shall be inspected and tested not less than annually in accordance with 7.2.1.15.2 through 7.2.1.15.8: (1) Door leaves equipped with panic hardware or fire exit hardware in accordance with 7.2.1.7 (2) Door assemblies in exit enclosures (3) Electrically controlled egress doors (4) Door assemblies with special locking arrangements subject to 7.2.1.6</p> <p>7.2.1.15.2 Fire-rated door assemblies shall be inspected and tested in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Smoke door assemblies shall be inspected and tested in accordance with NFPA 105, Standard for Smoke Door Assemblies and Other Opening Protectives.</p> <p>NFPA 80 5.2* Inspections. 5.2.1* Fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ.</p> <p>NFPA 105 5.2 Specific Requirements. 5.2.1* Inspections. 5.2.1.1 Smoke door assemblies shall be</p>	K 211		

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K 321	<p>Continued From page 6 Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and operational testing, the facility failed to ensure corridor doors entering hazardous areas would fully close and latch when activated. Failure to protect hazardous areas could allow smoke, fires and dangerous gases to pass into corridors, hindering egress during a fire. 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 1/3/18 from approximately 2:00 - 3:00 PM, observation and operational testing of the doors entering room 221 and room 526 were found not to be equipped with self-closing devices. Further observation of these two rooms revealed they had been converted to storage spaces, ranging in size from 200 square feet (sf) to 250 sf and housed combustible storage such as cartoned materials and foam beds.</p> <p>Actual NFPA standard: NFPA 101 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.7.1. 19.3.2.1.5 Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3</p>	K 321			

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K 321	Continued From page 7 m2) (3) Paint shops (4) Repair shops (5) Rooms with soiled linen in volume exceeding 64 gal (242 L) (6) Rooms with collected trash in volume exceeding 64 gal (242 L) (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard	K 321		
K 325 SS=F	19.3.2.1.3 The doors shall be self-closing or automatic-closing. Alcohol Based Hand Rub Dispenser (ABHR) CFR(s): NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source	K 325	K 325 1. SPECIFIC ISSUE: The facility alcohol based hand rub dispensers were not maintained in accordance with NFPA 101. 2. OTHER RESIDENTS: All residents are potentially affected by deficient practice. 3. SYSTEMIC CHANGES: Maintenance Staff educated by Executive Director or designee on or before 2/14/2018 to ensure Alcohol based hand rub dispensers are maintained in accordance with NFPA 101.	

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K 325	<p>Continued From page 8</p> <ul style="list-style-type: none"> * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure automatically operated Alcohol Based Hand Rub Dispensers (ABHR) were maintained in accordance with NFPA 101. Failure to test and document operation of ABHR dispensers could result in inadvertently spilling flammable liquids increasing the risk of fires. This deficient practice affected 54 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1) During the review of provided facility inspection records conducted on 1/3/18 from approximately 9:30 - 11:00 AM, records indicated refills and inspections of ABHR dispensers was performed, but no documentation was provided as to what actions were performed during that inspection as required under the standard. 2) During the facility tour conducted on 1/3/18 from 1:30 - 3:45 PM, observation of installed ABHR dispensers revealed automatic dispensers had been installed in four of four smoke compartments. Interview of the Housekeeping Supervisor in the Housekeeping storage area across from the Kitchen established that the log for refilling did not include any specific testing of 	K 325	<p>1. MONITOR: Executive Director or designee will ensure Alcohol based hand rub dispenser are maintained in accordance with NFPA 101 thru monthly audits. Results of audit will be reviewed in QAPI monthly for 3 months to ensure systems being followed. Plan to be updated as indicated.</p> <p>5. Date of Compliance:</p>	2/14/2018

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K 325	<p>Continued From page 9</p> <p>the devices other than battery replacement and operation and initial activation. She further stated she was not aware of any specific required inspection and testing, or the requirements under manufacturer's specifications as to refill directions, such as type, size or any color coding of the refill unit.</p> <p>Actual NFPA standard:</p> <p>NFPA 101</p> <p>19.3.2.6* Alcohol-Based Hand-Rub Dispensers. Alcohol-based hand-rub dispensers shall be protected in accordance with 8.7.3.1, unless all of the following conditions are met:</p> <p>(1) Where dispensers are installed in a corridor, the corridor shall have a minimum width of 6 ft (1830 mm).</p> <p>(2) The maximum individual dispenser fluid capacity shall be as follows:</p> <p>(a) 0.32 gal (1.2 L) for dispensers in rooms, corridors, and areas open to corridors</p> <p>(b) 0.53 gal (2.0 L) for dispensers in suites of rooms</p> <p>(3) Where aerosol containers are used, the maximum capacity of the aerosol dispenser shall be 18 oz. (0.51 kg) and shall be limited to Level 1 aerosols as defined in NFPA30B, Code for the Manufacture and Storage of Aerosol Products.</p> <p>(4) Dispensers shall be separated from each other by horizontal spacing of not less than 48 in. (1220 mm).</p> <p>(5) Not more than an aggregate 10 gal (37.8 L) of alcohol-based hand-rub solution or 1135 oz (32.2</p>	K 325			

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K 325	<p>Continued From page 10</p> <p>kg) of Level 1 aerosols, or a combination of liquids and Level 1 aerosols not to exceed, in total, the equivalent of 10 gal (37.8 L) or 1135 oz (32.2 kg), shall be in use outside of a storage cabinet in a single smoke compartment, except as otherwise provided in 19.3.2.6(6).</p> <p>(6) One dispenser complying with 19.3.2.6 (2) or (3) per room and located in that room shall not be included in the aggregated quantity addressed in 19.3.2.6(5).</p> <p>(7) Storage of quantities greater than 5 gal (18.9 L) in a single smoke compartment shall meet the requirements of NFPA 30, Flammable and Combustible Liquids Code.</p> <p>(8) Dispensers shall not be installed in the following locations:</p> <p>(a) Above an ignition source within a 1 in. (25 mm) horizontal distance from each side of the ignition source</p> <p>(b) To the side of an ignition source within a 1 in. (25mm) horizontal distance from the ignition source</p> <p>(c) Beneath an ignition source within a 1 in. (25 mm) vertical distance from the ignition source</p> <p>(9) Dispensers installed directly over carpeted floors shall be permitted only in sprinklered smoke compartments.</p> <p>(10) The alcohol-based hand-rub solution shall not exceed 95 percent alcohol content by volume.</p> <p>(11) Operation of the dispenser shall comply with the following criteria:</p> <p>(a) The dispenser shall not release its contents except when the dispenser is activated, either manually or automatically by touch-free activation.</p> <p>(b) Any activation of the dispenser shall occur only when an object is placed within 4 in. (100 mm) of the sensing device.</p>	K 325		

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K 325	Continued From page 11 (c) An object placed within the activation zone and left in place shall not cause more than one activation. (d) The dispenser shall not dispense more solution than the amount required for hand hygiene consistent with label instructions. (e) The dispenser shall be designed, constructed, and operated in a manner that ensures that accidental or malicious activation of the dispensing device is minimized. (f) The dispenser shall be tested in accordance with the manufacturer ' s care and use instructions each time a new refill is installed.	K 325		
K 331 SS=F	Interior Wall and Ceiling Finish CFR(s): NFPA 101 Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). <u>This REQUIREMENT</u> is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure interior finishes were in accordance with NFPA 101. Failure to install textile wall coverings which meet or exceed flame and smoke spread requirements of Class A or Class B, as determined by testing documentation under NFPA 286. This deficient practice affected 54 residents, staff and visitors	K 331	<p>K 331</p> <ol style="list-style-type: none"> SPECIFIC ISSUE: Facility failed to ensure interior finish accordance with NFPA 101. Failure wall coverings which meet or exceed smoke spread requirements of Class A determined by testing documentation 286. OTHER RESIDENTS: All residents are potentially affected by deficient practice. SYSTEMIC CHANGES: The wall coverings have been treated or verified to comply with NFPA 101 guidelines. Maintenance Staff educated by Executive Director or designee on or before 2/14/2018 to ensure future installations are within NFPA guidelines. 	

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K 331	<p>Continued From page 12 on the date of the survey.</p> <p>Findings include:</p> <p>During review of the facility records conducted on 1/3/18 from approximately 9:30 AM to 1:00 PM, the facility failed to provide documentation of the flame resistive properties of the floor to ceiling wall covering in the Theatre room and below the hand rail in the 100, 200 and 500 corridors. Further observation revealed the wall coverings in all locations were a textile carpeting and the material in the corridors measured 27 inches from the floor. When asked for documentation confirming the carpet was a Class A, B or Type 1 or 2 flame and smoke propagation compliant material, the Environmental Services Manager was not able to provide such documentation.</p> <p>Actual NFPA standard:</p> <p>NFPA 101 19.3.3 Interior Finish. 19.3.3.1 General. Interior finish shall be in accordance with Section 10.2.</p> <p>10.2.4.1* Textile Wall and Textile Ceiling Materials. The use of textile materials on walls or ceilings shall comply with one of the following conditions: (1) Textile materials meeting the requirements of Class A when tested in accordance with ASTM E 84, Standard Test Method for Surface Burning Characteristics of Building Materials, or ANSI/UL 723, Standard for Test for Surface Burning Characteristics of Building Materials, using the specimen preparation and mounting method of ASTM E 2404, Standard Practice for Specimen Preparation and Mounting of Textile,</p>	K 331	<p>4. MONITOR: Executive Director or designee will ensure any new additions meet NFPA guidelines monthly for the next 3 months. Results of audit will be reviewed in QAPI to ensure systems being followed. Plan to be updated as indicated.</p> <p>5. Date of Compliance:</p>	2/4/18

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K 331	Continued From page 13 Paper or Vinyl Wall or Ceiling Coverings to Assess Surface Burning Characteristics (see 10.2.3.4), shall be permitted on the walls or ceilings of rooms or areas protected by an approved automatic sprinkler system. (2) Textile materials meeting the requirements of Class A when tested in accordance with ASTM E 84 or ANSI/UL 723, using the specimen preparation and mounting method of ASTM E 2404 (see 10.2.3.4), shall be permitted on partitions that do not exceed three-quarters of the floor-to-ceiling height or do not exceed 8 ft (2440mm) in height, whichever is less. (3) Textile materials meeting the requirements of Class A when tested in accordance with ASTM E 84 or ANSI/UL 723, using the specimen preparation and mounting method of ASTM E 2404 (see 10.2.3.4), shall be permitted to extend not more than 48 in. (1220 mm) above the finished floor on ceiling-height walls and ceiling-height partitions. (4) Previously approved existing installations of textile material meeting the requirements of Class A when tested in accordance with ASTM E 84 or ANSI/UL 723 (see 10.2.3.4) shall be permitted to be continued to be used. (5) Textile materials shall be permitted on walls and partitions where tested in accordance with NFPA 265, Standard Methods of Fire Tests for Evaluating Room Fire Growth Contribution of Textile or Expanded Vinyl Wall Coverings on Full Height Panels and Walls. (See 10.2.3.7.) (6) Textile materials shall be permitted on walls, partitions, and ceilings where tested in accordance with NFPA 286, Standard Methods of Fire Tests for Evaluating Contribution of Wall and Ceiling Interior Finish to Room Fire Growth. (See 10.2.3.7.)	K 331		

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K 353 SS=F	<p>Sprinkler System - Maintenance and Testing CFR(s): NFPA 101</p> <p>Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure fire suppression system sprinkler pendants was maintained in accordance with NFPA 25. Failure to perform annual inspection and maintenance suppression system and provide the correct amount of spare system pendants, has the potential to hinder system response and leave the building unprotected during a fire. This deficient practice affected 54 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>1) During review of the facility fire suppression system inspection records conducted on 1/3/18 from approximately 9:30 AM to 2:00 PM, no</p>	K 353	<p>1. SPECIFIC ISSUE: Facility failed to ensure fire suppression system sprinkler pendants was maintained in accordance with NFPA 25.</p> <p>2. OTHER RESIDENTS: All residents are potentially affected by deficient practice.</p> <p>3. SYSTEMIC CHANGES: All sprinkler pendants were visually inspected and those needing replacement were replaced on or before 2/14/18 by licensed contractor. Adequate spare sprinkler pendants are maintained in inventory in accordance with NFPA 25. Maintenance Staff educated by Executive Director or designee on or before 2/14/2018 to ensure future annual testing are within NFPA 25 guidelines.</p> <p>4. MONITOR: Executive Director or designee will audit availability of spare sprinkler pendants monthly in riser room for 3 months. Executive Director or designee will ensure annual inspection and maintenance is completed. Results of audit will be reviewed in QAPI to ensure systems being</p>	

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K 353	<p>Continued From page 15</p> <p>records were available for the replacement or testing for dry system pendants within the last ten years.</p> <p>2) During the facility tour conducted on 1/4/18 from approximately 2:00 - 3:00 PM, observation of the main Kitchen fire suppression system pendants revealed the installed pendant over the dishwashing area was corroded. Further observation of the riser room revealed only eleven spare pendants and no replacement wrenches.</p> <p>Actual NFPA standard:</p> <p>NFPA 25</p> <p>4.1.1.2 Inspection, testing, and maintenance shall be performed by personnel who have developed competence through training and experience.</p> <p>4.3 Records.</p> <p>4.3.1* Records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request.</p> <p>4.3.2 Records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date.</p> <p>5.2* Inspection.</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>	K 353	<p>followed. Plan to be updated as indicated.</p> <p>5. Date of Compliance:</p>	2/14/2018

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K 353	Continued From page 16 5.2.1.1.2 Any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical damage (4) Loss of fluid in the glass bulb heat responsive element (5)*Loading (6) Painting unless painted by the sprinkler manufacturer 5.2.1.4 The supply of spare sprinklers shall be inspected annually for the following: (1) The correct number and type of sprinklers as required by 5.4.1.4 and 5.4.1.5 (2) A sprinkler wrench for each type of sprinkler as required by 5.4.1.6 5.3.1.1.1.6* Dry sprinklers that have been in service for 10 years shall be replaced or representative samples shall be tested and then retested at 10-year intervals. 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 5.4.1.6* A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. 5.4.1.6.1 One sprinkler wrench shall be provided	K 353			

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K 511	Continued From page 18 they supplied power. Interview of the Environmental Services Manager established he was not aware of the missing labeling prior to the date of the survey. Actual NFPA standard: NFPA 70 110.22 Identification of Disconnecting Means. (A) General. Each disconnecting means shall be legibly marked to indicate its purpose unless located and arranged so the purpose is evident. The marking shall be of sufficient durability to withstand the environment involved.	K 511	<p>K 521</p> <ol style="list-style-type: none"> SPECIFIC ISSUE: The facilities failure to periodically test fire damp has the potential to allow fires, smoke, and dangerous gases to pass between smoke compartments during a fire. OTHER RESIDENTS: All residents are potentially affected. SYSTEMIC CHANGES: The 4 year inspection was completed on or before 2/14/18 by licensed contractor. The facility Maintenance Director will be educated by Executive Director or designee on or before 2/14/2018 to ensure that the HVAC Dampers system is inspected every 4 years per NFPA 101 MONITOR: Executive Director or designee will audit that the fire dampers are inspected per NFPA 105 regulations by 2/14/18. Date of Compliance: 		
K 521 SS=F	<p>HVAC CFR(s): NFPA 101</p> <p>HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure fire dampers were inspected and tested in accordance with NFPA 105. Failure to periodically test fire dampers has the potential to allow fires, smoke and dangerous gases to pass between smoke compartments during a fire. This deficient practice affected 54 residents, staff and visitors on the date of the survey.</p>	K 521			

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K 521	<p>Continued From page 19</p> <p>Findings include:</p> <p>During review of facility inspection and testing records conducted on October 16, 2017 from approximately 9:00 AM to 10:30 AM, no records were available indicating smoke dampers had been inspected or tested within the last four years. Subsequent inspection above the ceiling at the North and East resident halls revealed electronic smoke dampers were installed on the return air ducting of the HVAC (Heating Ventilation and Air Conditioning) system.</p> <p>When asked if these dampers had been inspected, the interim Maintenance Director stated he was not sure of the last time the inspection had been conducted.</p> <p>Actual NFPA standard:</p> <p>NFPA 101</p> <p>19.5.2 Heating, Ventilating, and Air-Conditioning. 19.5.2.1 Heating, ventilating, and air-conditioning shall comply with the provisions of Section 9.2 and shall be installed in accordance with the manufacturer ' s specifications, unless otherwise modified by 19.5.2.2.</p> <p>9.2 Heating, Ventilating, and Air-Conditioning. 9.2.1 Air-Conditioning, Heating, Ventilating Ductwork, and Related Equipment. Air-conditioning, heating, ventilating ductwork, and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of</p>	K 521		

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K 521	Continued From page 20 Air-Conditioning and Ventilating Systems, or NFPA 90B, Standard for the Installation of Warm Air Heating and Air-Conditioning Systems, as applicable, unless such installations are approved existing installations, which shall be permitted to be continued in service. NFPA 90A 5.4.8 Maintenance. 5.4.8.1 Fire dampers and ceiling dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80 19.4* Periodic Inspection and Testing. 19.4.1 Each damper shall be tested and inspected 1 year after installation. 19.4.1.1 The test and inspection frequency shall then be every 4 years, except in hospitals, where the frequency shall be every 6 years.	K 521		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.	K 712	<p>K 712</p> <ol style="list-style-type: none"> SPECIFIC ISSUE: The facility failed to provide documentation of required fire drills, one per shift per quarter. OTHER RESIDENTS: All residents are potentially affected. SYSTEMIC CHANGES: The facility Maintenance Director will be educated by Executive Director or designee on or before 2/14/2018 to ensure that fire drills be conducted quarterly. MONITOR: Executive Director or designee will audit that fire drills are being conducted per NFPA quarterly and results reported monthly QAPI meeting for 3 months. Date of Compliance: 2/14/2018 	

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K 712	Continued From page 21 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to provide documentation of required fire drills, one per shift per quarter. Failure to perform fire drills on each shift quarterly could result in confusion, hindering the safe evacuation of residents during a fire. This deficient practice affected 54 residents, staff and visitors on the date of the survey. Findings include: During review of provided facility fire drills conducted on 1/3/18 from approximately 9:30 AM to 12:00 PM, fire drill documentation revealed the facility failed to perform the following drills: 1) Noc shift drill in the first quarter 2017. 2) Day shift and noc shift in the third quarter 2017. Actual NFPA standard: 19.7.1.6 Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions.	K 712			
K 914 SS=E	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial	K 914			

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K 914	Continued From page 22 installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on record review and observation, the facility failed to ensure outlets in resident care areas were tested in accordance with NFPA 99. Failure to perform maintenance and testing on electrical systems has the potential of electrical outlet failure, adversely affecting the safety and health of residents. This deficient practice affected 22 residents in the 400 and 500 wings, staff and visitors on the date of the survey. Findings include: 1) During review of facility maintenance and inspection records provided on 1/3/18 from approximately 9:30 AM to 2:00 PM, no records were provided indicating hospital grade outlets in resident rooms of the 400 and 500 wings were inspected and tested.	K 914	<p>K 914</p> <ol style="list-style-type: none"> SPECIFIC ISSUE: Facility failed to ensure outlets in resident care areas were tested in accordance with NFPA 99. OTHER RESIDENTS: All residents are potentially impacted by this issue. SYSTEMIC CHANGES: Facility wide audit performed by Maintenance Director on or before 2/14/2018 to ensure all hospital grade outlets meet NFPA 99 codes. Maintenance staff educated by Executive Director or designee on or before 2/14/2018 to ensure continued compliance with NFPA regulations. MONITOR: Executive Director or designee will audit the Maintenance Director's annual testing monthly for 3 months. QAPI to ensure systems being followed. Date of Compliance: 2/14/2018 		

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K 914	Continued From page 23 2) During the facility tour conducted on 1/3/18 from approximately 2:00 - 3:45 PM, observation of facility electrical installations in resident rooms revealed the facility was equipped with hospital grade outlets in the 400 and 500 wing rooms. Actual NFPA standard: NFPA 99 6.3.4.1 Maintenance and Testing of Electrical Systems 6.3.4.1.1 Where hospital-grade receptacles are required at patient bed locations and in locations where deep sedation or general anesthesia is administered, testing shall be performed after initial installation, replacement, or servicing of the device. 6.3.4.1.2 Additional testing of receptacles in patient care rooms shall be performed at intervals defined by documented performance data. 6.3.4.1.3 Receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months.	K 914			
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and	K 918			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135094	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED 01/04/2018
NAME OF PROVIDER OR SUPPLIER WELLSPRING HEALTH & REHABILITATION OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 2105 12TH AVENUE ROAD NAMPA, ID 83686		
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K 918	Continued From page 24 transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure Emergency Power Supply Systems (EPSS) were maintained in accordance to NFPA 110. Failure to inspect and test generators under load potentially fails to pre-act to possible system problems, hindering performance of the equipment during an emergency. This deficient practice affected 54 residents, staff and visitors on the date of the survey. Findings include:	K 918	1. SPECIFIC ISSUE: Facility failed to ensure Emergency Power Supply systems were maintained in accordance to NFPA 110. 2. OTHER RESIDENTS: All residents at risk to be affected by deficient practice. 3. SYSTEMIC CHANGES: Diesel powered Emergency Generator will be tested per NFPA standards monthly for 30 minutes under load including documented conditions, in addition to weekly inspections. Facility Maintenance Director educated by Executive Director on or before 2/14/2018 to ensure routine testing is completed weekly and monthly. 4. MONITOR: Executive Director or designee will audit facility testing monthly for 3 months. Results to be reviewed and addressed in QAPI meetings. 5. Date of Compliance:	2/14/2018	

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K 918	<p>Continued From page 25</p> <p>During review of the EPSS weekly inspection and monthly load testing documentation conducted on 1/3/18 from approximately 9:30 AM to 2:00 PM, the following deficiencies were noted:</p> <p>1) Weekly inspection documentation was not provided for the weeks of May 1 to July 19, 2017 and September 11 and 18 of 2017.</p> <p>2) Weekly inspections conducted on August 30 and September 6, 2017 did not indicate fuel level; coolant level; battery condition; condensate trap condition.</p> <p>3) Monthly load testing documentation records provided did not indicate the available load during the tests.</p> <p>Asked about the missing documentation, the Environmental Services Manager stated he was not aware of the missing documentation prior to the date of the survey.</p> <p>Actual NFPA standard:</p> <p>NFPA 110</p> <p>8.4 Operational Inspection and Testing. 8.4.1* EPSSs, including all appurtenant components, shall be inspected weekly and exercised under load at least monthly.</p> <p>8.4.2* Diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS nameplate kW rating</p>	K 918			

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K 918	Continued From page 26	K 918		
K 926 SS=F	<p>8.4.2.3 Diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS load and shall be exercised annually with supplemental loads at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours.</p> <p>Gas Equipment - Qualifications and Training CFR(s): NFPA 101</p> <p>Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on record review, and interview, the facility failed to ensure continuing education and staff training was provided on the risks associated with the storage, handling and use of medical gases and their cylinders. Failure to provide training of safety and the risks associated with medical gases, hinders staff response and affects those residents utilizing supplemental oxygen. This deficient practice potentially affected oxygen dependent residents, staff and visitors on the date of the survey.</p>	K 926		

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K 926	<p>Continued From page 27</p> <p>Findings include:</p> <p>During review of provided training records on 1/3/18 from approximately 9:30 - 11:00 AM, no records were provided for annual oxygen training. Interview of 5 of 5 staff members on 1/4/18 from 9:00 AM to 2:30 PM, revealed none had participated in any continuing education program on the risks associated with the storage, handling or use of medical gases. Further interview of the Staff Development Coordinator from approximately 1:00 - 2:00 PM, revealed she was not aware of any current program of continued education for the handling, use and storage of medical gases.</p> <p>Actual NFPA standard:</p> <p>NFPA 99 11.5.2 Gases in Cylinders and Liquefied Gases in Containers. 11.5.2.1 Qualification and Training of Personnel. 11.5.2.1.1* Personnel concerned with the application and maintenance of medical gases and others who handle medical gases and the cylinders that contain the medical gases shall be trained on the risks associated with their handling and use. 11.5.2.1.2 Health care facilities shall provide programs of continuing education for their personnel. 11.5.2.1.3 Continuing education programs shall include periodic review of safety guidelines and usage requirements for medical gases and their cylinders.</p>	K 926	<p>K 926</p> <ol style="list-style-type: none"> SPECIFIC ISSUE: Facility education calendar updated to include annual training of application, maintenance and handling of medical gases and cylinders including associated risks. Additionally, same training program updated for facility orientation of new employees. OTHER RESIDENTS: All residents at risk to be affected by deficient practice. SYSTEMIC CHANGES: Staff Development Coordinator educated by Executive Director on or before 1/5/2018 to ensure oxygen training and education of above mentioned requirements are provided upon orientation and annually to employees. MONITOR: Executive Director and/or designee will audit facility orientation and annual trainings weekly x 3 then monthly x 3 to ensure ongoing compliance. Additional education will be provided as necessary. Results of audit will be reviewed in PI to ensure systems being followed. Plan to be updated as indicated. 	2/14/18