

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

PRINTED: 08/22/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135144	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2018
NAME OF PROVIDER OR SUPPLIER CASCADIA OF NAMPA			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N HAPPY VALLEY RD NAMPA, ID 83687		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 000	<p>INITIAL COMMENTS</p> <p>The facility is a single story, Type V (111) structure with a special feature of two Won-Doors located in areas A and B. The building is fully sprinklered and has a complete addressable fire alarm/smoke detection system including open areas to include audible/visual notification throughout. Emergency Power is provided by a Type 1 EPSS with an annunciator and emergency stop. Currently the facility is licensed for 99 SNF/NF beds.</p> <p>The facility was found to be in substantial compliance during the initial federal certification survey conducted on March 6, 2018. The facility was surveyed under the LIFE SAFETY CODE, 2012 edition, Existing Healthcare Occupancies, in accordance with 42 CFR 483.70</p> <p>The survey was conducted by:</p> <p>Nate Elkins, Supervisor Facility Fire Safety & Construction Program</p>	K 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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 000	<p>Initial Comments</p> <p>The facility is a single story, Type V (111) structure with a special feature of two Won-Doors located in areas A and B. The building is fully sprinklered and has a complete addressable fire alarm/smoke detection system including open areas to include audible/visual notification throughout. Emergency Power is provided by a Type 1 EPSS with an annunciator and emergency stop. Currently the facility is licensed for 99 SNF/NF beds.</p> <p>The facility was found to be in substantial compliance during the initial Emergency Preparedness federal certification survey completed on March 6, 2018. The facility was surveyed in accordance with 42 CFR 483.73.</p> <p>The survey was conducted by:</p> <p>Nate Elkins, Supervisor Facility Fire Safety & Construction Program</p>	E 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE	(X6) DATE	

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