



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

March 30, 2018

Rachel Zimmerman, Administrator  
Aspen Park of Cascadia  
420 Rowe Street  
Moscow, ID 83843-9319

Provider #: 135093

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

Dear Ms. Zimmerman:

On **March 22, 2018**, a Facility Fire Safety and Construction survey was conducted at **Aspen Park 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

Rachel Zimmerman, Administrator  
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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 **April 12, 2018**. Failure to submit an acceptable PoC by **April 12, 2018**, may result in the imposition of civil monetary penalties by **May 2, 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 **April 26, 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 **April 26, 2018**. A change in the seriousness of the deficiencies on **April 26, 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 **April 26, 2018**, includes the following:

Denial of payment for new admissions effective **June 22, 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 **September 22, 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 **March 22, 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:

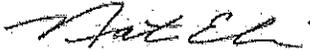
BFS Letters (06/30/11)

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

This request must be received by **April 12, 2018**. If your request for informal dispute resolution is received after **April 12, 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

2018-04-12 17:58

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P 3/14  
PRINTED: 03/29/2018  
FORM APPROVED  
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135093	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  03/22/2018
NAME OF PROVIDER OR SUPPLIER  ASPEN PARK OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 420 ROWE STREET MOSCOW, ID 83043	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS  The facility is a single-story Type V (111) building, with two partial basements. The facility is fully sprinklered, with smoke detectors in corridors and open spaces. It was built in 1985, is currently licensed for 70 SNF/NF beds, and had a census of 48 on the dates of the survey.  The following deficiencies were cited at the above facility during the annual fire/life safety code survey conducted on March 21 - 22, 2018. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Chapter 19, Existing Healthcare Occupancies, in accordance with 42 CFR 483.70, 42 CFR 483.80 and 42 CFR 483.65.  The survey was conducted by:  Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction	K 000		
K 324 SS-D	Cooking Facilities CFR(s): NFPA 101  Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with	K 324		
			K 324  1. SPECIFIC ISSUE: Facility failed to ensure cooking equipment was protected in accordance with NFPA 96.  2. OTHER RESIDENTS: All staff and visitors in the kitchen were potentially affected by deficient practice.	

RECEIVED  
APR 12 2018  
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *R. Summer* TITLE *ED* (X6) DATE *4/20/18*

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 30 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 324	<p>Continued From page 1</p> <p>30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.</p> <p>Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor.</p> <p>18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the kitchen hood system, specifically, grease filters, in accordance with NFPA 96. Failure to maintain grease filters could increase the risk of fires due to excessive build-up of grease laden vapors. This deficient practice affected staff and visitors in the kitchen on the dates of the survey.</p> <p>Findings include:</p> <p>During the facility tour on March 22, 2018, from approximately 1:30 PM to 3:30 PM, inspection of the hood system revealed one baffle filter was broken, allowing grease laden vapors to enter the duct system unfiltered. When asked, the Maintenance Supervisor stated the facility was unaware the grease filter was broken.</p> <p>Actual NFPA standard: NFPA 96</p> <p>4.1 General, 4.1.1 Cooking equipment used in processes</p>	K 324	<p>3. <b>SYSTEMIC CHANGES:</b> All baffle filters in the kitchen hood system were inspected and the broken baffle filter was replaced on or before 4/12/18. The facility will maintain the kitchen hood system, specifically grease filters, in accordance with NFPA 96. Dietary and Maintenance staff educated by Executive Director or designee on or before 4/12/18 to ensure monthly inspections of kitchen hood system are within NFPA 96 guidelines.</p> <p>4. <b>MONITOR:</b> Executive Director or designee will audit kitchen hood inspections monthly for 3 months. Executive Director or designee will ensure monthly inspection and maintenance is completed. Results of audit will be reviewed in QAPI to ensure systems being followed. Plan to be updated as indicated.</p> <p>5. <b>Date of Compliance:</b> 4/26/18</p>

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K 324	Continued From page 2 producing smoke or grease-laden vapors shall be equipped with an exhaust system that complies with all the equipment and performance requirements of this standard. 4.1.2 All such equipment and its performance shall be maintained in accordance with the requirements of this standard during all periods of operation of the cooking equipment. 4.1.3 The following equipment shall be kept in working condition: (1) Cooking equipment (2) Hoods (3) Ducts (if applicable) (4) Fans (5) Fire-extinguishing equipment (6) Special effluent or energy control equipment 4.1.3.1 Maintenance and repairs shall be performed on all components at intervals necessary to maintain good working condition. 6.2.3 Grease Filters. 6.2.3.2 Grease filters shall be of rigid construction that will not distort or crush under normal operation, handling, and cleaning conditions.	K 324		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101  Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked  b) Who provided system test	K 353	K 353  1. <b>SPECIFIC ISSUE:</b> Facility failed to ensure fire suppression system sprinkler pendants was maintained in accordance with NFPA 25.  2. <b>OTHER RESIDENTS:</b> All residents are potentially affected by deficient practice.	

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K 353	Continued From page 3  c) Water system supply source  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 and interview, the facility failed to ensure fire suppression system pendants were maintained free of obstructions such as paint or corrosion. Failure to maintain fire sprinkler pendants free of obstructions could hinder system performance during a fire event. This deficient practice affected 48 residents, staff and visitors on the dates of the survey.  Findings include:  During the facility tour on March 22, 2018, from approximately 1:30 PM to 3:30 PM, observation of sprinkler pendants throughout the facility revealed many sprinkler heads had been painted with non-factory applied paint and/or overspray. There were also several corroded sprinkler heads throughout the facility. Below is a sampling of areas where obstructed sprinkler heads were identified: 1.) Corroded sprinkler heads were found in the 300 hall shower room, behind the dryers in the laundry room, in the 300 hall storage room (once a shower room), in the corridor outside of room 304 and in the 100 hall shower room. 2.) Painted sprinkler heads were found in the corridor outside of the 300 hall shower room, in resident room 312 and 312 bath, in the corridor outside of room 304, in Physical Therapy, the 300 hall storage room (was once a shower), the 100	K 353	3. <b>SYSTEMIC CHANGES:</b> All sprinkler pendants were visually inspected and those needing replacement were replaced on or before 2/26/18 by licensed contractor. Fire suppression system pendants are maintained free of obstructions such as paint or corrosion in accordance with NFPA 25. Maintenance Staff educated by Executive Director or designee on or before 4/26/18 to ensure future annual inspections of sprinkler heads are within NFPA 25 guidelines.  4. <b>MONITOR:</b> Executive Director or designee will audit sprinkler head inspections monthly 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 followed. Plan to be updated as indicated.  5. <b>Date of Compliance:</b>	4/26/18

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K 353	Continued From page 4 hall shower room, and the basement stairwell. Based on the quantity found in multiple locations, the condition was deemed widespread and further documentation was unnecessary. When asked, the Maintenance Supervisor stated the facility was unaware of the corroded and painted sprinkler heads.  Actual NFPA standard:  NFPA 25 5.2.1 Sprinklers. 5.2.1.1* Sprinklers shall be inspected from the floor level annually. 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). 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	K 353		
K 918 SS=F	Electrical Systems - Essential Electric System 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	K 918	K 918  1. <b>SPECIFIC ISSUE:</b> Facility failed to ensure Emergency Power Supply systems were maintained in accordance to NFPA 110.	

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NAME OF PROVIDER OR SUPPLIER  ASPEN PARK OF CASCADIA	STREET ADDRESS, CITY, STATE, ZIP CODE 420 ROWE STREET MOSCOW, ID 83843
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K 918	<p>Continued From page 5</p> <p>process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.</p> <p>Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.</p> <p>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure the generator for the Essential Electrical System (EES) was maintained in accordance with NFPA 110. Failure to inspect and test EES generators could result in a lack of system reliability during a power loss. This deficient practice affected 48 residents, staff and visitors on the date of the survey.</p>	K 918	<p>2. <b>OTHER RESIDENTS:</b> All residents at risk to be affected by deficient practice.</p> <p>3. <b>SYSTEMIC CHANGES:</b> Diesel powered Emergency Generator will be tested per NFPA standards monthly for 30 minutes under load 20- 40 day intervals, and exercised once every 36 months for 4 continuous hours, including documented conditions, in addition to weekly inspections. Facility Maintenance Director educated by Executive Director on or before 4/12/18 to ensure routine testing is completed weekly, monthly and yearly.</p> <p>4. <b>MONITOR:</b> Executive Director or designee will audit facility testing monthly for 3 months. Results to be reviewed and addressed in QAPI meetings.</p> <p>5. <b>Date of Compliance:</b></p>	4/26/18
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K 918	<p>Continued From page 6</p> <p>Findings include:</p> <p>During review of the facility generator inspection and testing records on March 21 - 22, 2018, the facility failed to provide a 3-year, 4-hour load test of the generator for the assigned class. When asked, the Maintenance Supervisor stated that the facility was unaware of the requirement for a 3-year, 4-hour load test.</p> <p>Actual NFPA standard:</p> <p>NFPA 110</p> <p>8.4 Operational Inspection and Testing.</p> <p>8.4.9* Level 1 EPSS shall be tested at least once within every 36 months.</p> <p>8.4.9.1 Level 1 EPSS shall be tested continuously for the duration of its assigned class (see Section 4.2).</p> <p>8.4.9.2 Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 continuous hours.</p> <p>8.4.9.3 The test shall be initiated by operating at least one transfer switch test function and then by operating the test function of all remaining ATSS, or initiated by opening all switches or breakers supplying normal power to all ATSS that are part of the EPSS being tested.</p> <p>8.4.9.4 A power interruption to non-EPSS loads shall not be required.</p> <p>8.4.9.5 The minimum load for this test shall be as specified in 8.4.9.5.1, 8.4.9.5.2, or 8.4.9.5.3</p> <p>8.4.9.5.3 For spark-ignited EPSSs, loading shall be the available EPSS load.</p> <p>4.2* Class. The class defines the minimum time, in which the EPSS is designed to operate at its rated load being refueled or recharged. [See</p>	K 918		

2018-04-12 18:00

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P 10/14  
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K 918	Continued From page 7 Table 4.1(a).]	K 918		

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E 000	<p>Initial Comments</p> <p>The facility is a single-story Type V (111) building, with two partial basements. The facility is fully sprinklered, with smoke detectors in corridors and open spaces. It was built in 1965, is currently licensed for 70 SNF/NF beds, and had a census of 48 on the dates of the survey.</p> <p>The facility was found to be in substantial compliance during the initial Emergency Preparedness Survey conducted on March 21 - 22, 2018. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.</p> <p>The survey was conducted by:</p> <p>Linda Chaney                  Health Facility Surveyor                  Facility Fire Safety &amp; Construction</p>	E 000		

APR 12 2018  
 FACILITY VALIDATION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X8) DATE  
*R. Zimmerman, Executive Director* 4/12/18

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