



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

August 14, 2018

Debbie Mills, 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 Ms. Mills:

On **August 9, 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 **August 27, 2018**. Failure to submit an acceptable PoC by **August 27, 2018**, may result in the imposition of civil monetary penalties by **September 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 **September 13, 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 **September 13, 2018**. A change in the seriousness of the deficiencies on **September 13, 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 **September 13, 2018**, includes the following:

Denial of payment for new admissions effective **November 9, 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 **February 9, 2019**, 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 **August 9, 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:

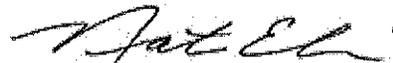
BFS Letters (06/30/11)

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

This request must be received by **August 27, 2018**. If your request for informal dispute resolution is received after **August 27, 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,



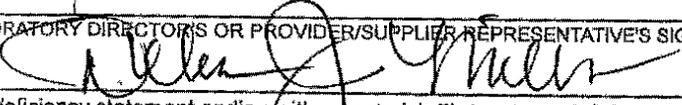
Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosures

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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 08/09/2018 |
|--|---|---|---|

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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 |
|---|---|

| (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) | (X6) COMPLETION DATE |
|--------------------|---|---------------|--|----------------------|
| 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 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 48 on the dates of the survey.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on August 8-9, 2017. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70 and 42 CFR 483.80.</p> <p>The Survey was conducted by:</p> <p>Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction</p> | K 000 | <p style="text-align: center;">RECEIVED</p> <p style="text-align: center;">AUG 27 2018</p> <p style="text-align: center;">FACILITY STANDARDS</p> <p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Wellspring Health and Rehabilitation of Cascadia does not admit that the deficiencies listed on the CMS Form 2567 exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.</p> | |
| K 291 SS=F | <p>Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9.18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by:</p> | K 291 | <p>K 291 Emergency Lighting</p> <p>Specific Issue: Facility failed to test emergency lighting for thirty seconds during June 2018. No documentation could be produced or an annual 90 minute test of the emergency lighting.</p> | |

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  | TITLE CEO | (X8) DATE 8/24/18 |
|---|---------------------|-----------------------------|

Deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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.

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

PRINTED: 08/09/2018
FORM APPROVED
OMB NO. 0938-0391

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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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| K 291 | <p>Continued From page 1</p> <p>Based on record review and interview the facility failed to provide monthly and annual emergency lighting test documentation. Failure to test the emergency lighting could inhibit egress of residents during an emergency. This deficient practice affected 48 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During review of the emergency lighting test logs on August 8, 2018, from approximately 11:30 AM to 2:00 PM, records revealed the facility failed to test emergency lighting for thirty (30) seconds during the month of June 2018. No documentation could be produced for an annual ninety (90) minute test of the emergency lighting. When asked, the visiting Environmental Services Managers stated the facility was unaware the tests were not completed or documentation maintained.</p> <p>Actual NFPA standard:</p> <p>NFPA 101 19.2.9 Emergency Lighting. 19.2.9.1 Emergency lighting shall be provided in accordance with Section 7.9. 7.9.3 Periodic Testing of Emergency Lighting Equipment. 7.9.3.1 Required emergency lighting systems shall be tested in accordance with one of the three options offered by 7.9.3.1.1, 7.9.3.1.2, or 7.9.3.1.3. 7.9.3.1.1 Testing of required emergency lighting systems shall be permitted to be conducted as follows: (1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5</p> | K 291 | <p>Other Residents: All residents could potentially be affected by deficient practice.</p> <p>Facility Systems: Staff educated on or before 8/31/18 by Executive Director or designee regarding monthly testing of emergency lighting and annual 90 minute emergency lighting testing.</p> <p>Monitor: Upon completion of education with staff, Executive Director and/or designee will monitor the effectiveness of the emergency lighting testing and provide a report to QAPI committee for the next 6 months. Any concerns will be addressed immediately and discussed with the QAPI committee.</p> <p>Date of Compliance:</p> | 8/31/14 |

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| K 291 | <p>Continued From page 2</p> <p>weeks between tests, for not less than 30 seconds, except as otherwise permitted by 7.9.3.1.1(2).</p> <p>(2)*The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction.</p> <p>(3) Functional testing shall be conducted annually for a minimum of 1-172 hours if the emergency lighting system is battery powered.</p> <p>(4) The emergency lighting equipment shall be fully operational for the duration of the tests required by 7.9.3.1.1(1) and (3).</p> <p>(5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction.</p> <p>7.9.3.1.2 Testing of required emergency lighting systems shall be permitted to be conducted as follows:</p> <p>(1) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall be provided.</p> <p>(2) Not less than once every 30 days, self-testing/self-diagnostic battery-operated emergency lighting equipment shall automatically perform a test with a duration of a minimum of 30 seconds and a diagnostic routine.</p> <p>(3) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall indicate failures by a status indicator.</p> <p>(4) A visual inspection shall be performed at intervals not exceeding 30 days.</p> <p>(5) Functional testing shall be conducted annually for a minimum of 1-172 hours.</p> <p>(6) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall be fully operational for the duration of the 1-172-hour test.</p> <p>(7) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction.</p> | K 291 | <p>Facility Systems: Staff educated on or before 8/31/18 regarding hazardous areas enclosure by Executive Director. Room 526 door closure installed.</p> <p>Monitor: Executive Director or designee will ensure all corridor doors are audited for compliance of NFPA 101. Audits will be presented to QAPI committee for the next 3 months.</p> | 8/31/18 | |

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| K 291 | Continued From page 3 7.9.3.1.3 Testing of required emergency lighting systems shall be permitted to be conducted as follows: (1) Computer-based, self-testing/self-diagnostic battery-operated emergency lighting equipment shall be provided. (2) Not less than once every 30 days, emergency lighting equipment shall automatically perform a test with a duration of a minimum of 30 seconds and a diagnostic routine. (3) The emergency lighting equipment shall automatically perform annually a test for a minimum of 1-172 hours. (4) The emergency lighting equipment shall be fully operational for the duration of the tests required by 7.9.3.1.3(2) and (3). (5) The computer-based system shall be capable of providing a report of the history of tests and failures at all times. | K 291 | | |
| K 321 SS=D | <p>Hazardous Areas - Enclosure CFR(s): NFPA 101</p> <p>Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.</p> | K 321 | <p>K321 Hazardous Areas -- Enclosure</p> <p>Specific Issue: Facility failed to ensure corridor doors entering hazardous areas would fully close and latch when activated. Room 526 was converted to storage space that is greater than 200 square feet in size and housed combustible storage was not equipped with self-closing device.</p> <p>Other Residents: The deficient practice affected 20 residents, staff and visitors on the date of the survey.</p> | |

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| K 321 | <p>Continued From page 4 19.3.2.1, 19.3.5.9</p> <p>Area Automatic Sprinkler Separation N/A</p> <p>a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)</p> <p>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 20 residents, staff and visitors in on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on August 8, 2018, observation and operational testing of the doors entering room 526 was found not to be equipped with self-closing devices. Further observation of the room revealed it had been converted to a storage space that is greater than 200 square feet in size and housed combustible storage. *Note: This is a repeat citation from the previous survey on January 4, 2018.*</p> <p>Actual NFPA standard:</p> | K 321 | | |

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| K 321 | Continued From page 5 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 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 19.3.2.1.3 The doors shall be self-closing or automatic-closing. | K 321 | | | |
| K 353 SS=D | 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 | K 353 | K 353 Sprinkler System Specific Issue: Facility failed to ensure fire suppression system sprinkler pendants were maintained properly. Theater Room and Shower Room showed signs of paint on sprinkler head pendants. | | |

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| K 353 | <p>Continued From page 6</p> <p>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 were maintained properly. Failure to perform proper maintenance of suppression system has the potential to hinder system response and leave the building unprotected during a fire. This deficient practice affected residents, staff and visitors utilizing the Theater Room and the shower room on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on August 8, 2018 from 11:30 AM - 2:00 PM, observation of the Theater Room and the Shower Room adjacent to room #502 showed signs of paint on the sprinkler head pendants.</p> <p>Actual NFPA standard:</p> <p>NFPA 25 5.2* Inspection. 5.2.1 Sprinklers.</p> | K 353 | <p>Other Residents: This deficient practice affected residents, staff and visitors utilizing the Theater Room and the shower room on the date of the survey.</p> <p>Facility Changes: Maintenance Director will have affected sprinkler heads replaced by contractor as well as an audit of other sprinkler heads by 8/31/18. Maintenance Director will educate assistant to NFPA 25 to ensure during painting sprinkler heads are protected from paint.</p> <p>Monitor: Maintenance director will inspect sprinkler heads monthly and report findings to the QAPI committee for the next 3 months. Annual inspections will be completed by contractor and reported to the QAPI committee.</p> | 8/31/18 |

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| K 353 | Continued From page 7 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 363 SS=D | Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided | K 363 | K 363 Corridor – Doors Specific Issue: The facility failed to maintain doors that protect corridor openings. Doors leading to rooms #110, #520 and #532 did not close and seal properly leaving approximately 5/8" gap between the door and frame. Other residents: This deficient practice had the potential to affect 4 residents, staff and visitors. Facility Systems: Maintenance Director and Assistant will be educated to NFPA 101 on or before 8/31/18 by Executive Director. Doors #110, #520 and #532 will be repaired to ensure proper closure and seal by 8/31/18. | |

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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 08/09/2018 |
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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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| K 363 | <p>Continued From page 8</p> <p>with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.</p> <p>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485</p> <p>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, operational testing, and interview, the facility failed to maintain doors that protect corridor openings. Failure to maintain corridor doors could allow smoke and dangerous gases to pass freely, preventing defend in place. This deficient practice has affected four (4) residents, staff, and visitors on the date of survey.</p> <p>Findings include:</p> <p>During the facility tour on August 8, 2018 from approximately 11:30 AM to 2:00 PM, observation and operational testing of the doors leading to resident room #110, resident room #520, and resident room #532 revealed the doors did not close and seal properly leaving an approximately 5/8" gap between the door and the door frame.</p> | K 363 | <p>Monitor</p> <p>Maintenance will audit door closures monthly with preventive maintenance program. This will be monitored by the QAPI committee for the next 3 months.</p> | 8/31/18 |

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| NAME OF PROVIDER OR SUPPLIER WELLSPRING HEALTH & REHABILITATION OF CASCADIA | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2106 12TH AVENUE ROAD NAMPA, ID 83686 | |
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| K 363 | Continued From page 9 Actual NFPA standard: NFPA 101 19.3.6.3* Corridor Doors. 19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be doors constructed to resist the passage of smoke and shall be constructed of materials such as the following: (1) 1 3/4 in. (44 mm) thick, solid-bonded core wood (2) Material that resists fire for a minimum of 20 minutes | K 363 | | |
| K 521 SS=F | HVAC CFR(s): NFPA 101 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 This REQUIREMENT is not met as evidenced by: Based on record review the facility failed to show corrective actions from a fire damper inspection dated March 2, 2018. Failure to correct deficient fire dampers could allow the spread of smoke/fire from the space of fire origin to other compartments. This deficient practice has the potential to affect all residents, staff, and visitors on the date of survey. Findings include: | K 521 | K521 HVAC Specific Issue: Facility failed to show corrective actions from a fire damper inspection dated 3/2/18 showing deficiencies. Other Residents: This deficient practice has the potential to affect all residents, staff and visitors. Facility Systems: Maintenance is working with contractor to repair dampers in systems 2,3,6,7, 11, 12, and 13 on or by 10/1/18 Monitor: Executive Director will monitor to ensure repairs are made to system. Maintenance director will ensure that dampers are tested and inspected 1 year after installation and every 4 years. | 8/31/18 |

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| K 521 | <p>Continued From page 10</p> <p>1) During the review of facility inspection records on August 8, 2018, found an inspection record for the fire damper testing dated March 2, 2018 showing deficiencies in the following areas that were not corrected: System 2 and 3 - Found return damper installed in the wrong direction System 6 and 7 - Found chain section and needs to be replaced with correct fusible link System 11, 12, 13 - Found return damper installed in the wrong direction</p> <p>Actual NFPA standard:</p> <p>NFPA 101 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 90 A, Standard for the Installation of 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.</p> <p>NFPA 90 A 5.4.8.1 Fire dampers and ceiling dampers shall</p> | K 521 | | |

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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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| K 521 | Continued From page 11 be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. 5.4.8.2 Smoke dampers shall be maintained in accordance with NFPA 105, Standard for Smoke Door Assemblies and Other Opening Protectives. NFPA 80 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 751 SS=E | Draperies, Curtains, and Loosely Hanging Fabr CFR(s): NFPA 101 Draperies, Curtains, and Loosely Hanging Fabrics Draperies, curtains including cubicle curtains and loosely hanging fabric or films shall be in accordance with 10.3.1. Excluding curtains and draperies: at showers and baths; on windows in patient sleeping room located in sprinklered compartments; and in non-patient sleeping rooms in sprinklered compartments where individual drapery or curtain panels do not exceed 48 square feet or total area does not exceed 20 percent of the wall. 18.7.5.1, 18.3.5.11, 19.7.5.1, 19.3.5.11, 10.3.1 This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to provide documentation for flame rating for loosely hanging fabrics. Failure to treat loosely hanging fabrics increases the charring and decomposition of the material when exposed to flame or high temperature. This deficient practice affected residents, staff, and visitors that utilize the theater room. | K 751 | K751 Draperies, Curtains and Loosely Hanging Fabrics Specific Issue: Facility failed to provide documentation for flame rating for loosely hanging fabrics. No records could be produced to provide evidence the hanging curtains in Theater room met the flame propagation performance criteria contained in NFPA701 Other Residents: All residents are potentially affected by deficient practice that utilize the theater room. Facility Systems: Maintenance will ensure the fabric in the theater room is treated to meet flame rating criteria contained in NFPA701. Treatment shall be completed and documented by 8/31/18 | | |

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| K 751 | <p>Continued From page 12</p> <p>During the record review on August 8, 2018 from 9:00 AM - 10:00 AM, no records were maintained to provide evidence the loosely hanging curtains in the Theater room met the flame propagation performance criteria contained in NFPA701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. Upon further observation during the tour it was determined that no tags or other markings on the curtains contained information of flame spread rating.</p> <p>Actual NFPA standard:</p> <p>10.3 Contents and Furnishings. 10.3.1* Where required by the applicable provisions of this Code, draperies, curtains, and other similar loosely hanging furnishings and decorations shall meet the flame propagation performance criteria contained in NFPA701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films.</p> | K 751 | <p>Monitor: Treatment will be reported to QAPI Committee. Executive Director or Maintenance to monitor any drapes or loose fabric installed shall meet the standard.</p> | 8/31/18 |
| K 914 SS=F | <p>Electrical Systems - Maintenance and Testing CFR(s): NFPA 101</p> <p>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 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,</p> | K 914 | <p>K914 Electrical Systems – Maintenance and Testing</p> <p>Specific Issue: Facility failed to provide records of testing hospital grade outlets.</p> <p>Other Residents: The residents, staff and visitors in rooms 400 and 500 halls had the potential to be affected.</p> | |

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| K 914 | <p>Continued From page 13</p> <p>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.</p> <p>6.3.4 (NFPA 99)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview the facility failed to provide records of testing the hospital grade outlets. Failure to the minimum acceptable documentation should identify what was tested, when it was tested, and whether it performed successfully could result in failure in achieving maximum reliability affecting 14 residents in the 400 and 500 wings, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During review of facility maintenance and inspection records provided on August 8, 2018 from approximately 11:30 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. Upon further observation of the facility electrical installations in resident rooms revealed the facility was equipped with hospital grade outlets in the 400 and 500 wing rooms.</p> <p>Actual NFPA standard:</p> <p>NFPA 99 6.3.4.1 Maintenance and Testing of Electrical</p> | K 914 | <p>Facility Systems:</p> <p>Maintenance will test hospital grade outlets on 400 and 500 halls on or before 8/31/18. Testing shall also be performed after initial installation, replacement or servicing of the device. Maintenance director and assistant will be in serviced to NFPA 99 on or before 8/31/18 by Executive Director.</p> <p>Monitor:</p> <p>Maintenance will present inspection outlets to QAPI committee by 8/31/18.</p> | 8/31/18 | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135094 | (X2) MULTIPLE CONSTRUCTION A. BUILDING D1 - ENTIRE BUILDING B. WING _____ | (X3) DATE SURVEY COMPLETED 08/09/2018 |
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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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| K 914 | Continued From page 14 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 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 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. 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 | K 918 | F918 Electrical Systems Specific Issue: The facility failed to provide weekly generator inspection logs for 4 weeks in April and May. Also missing were monthly load tests for March, April and May. Other Residents: All residents, staff and visitors had the potential to be affected. Facility Systems: Maintenance director and assistant will be educated to NFPA110 before 8/31/18. Maintenance director or designee will ensure that the generator is inspected weekly and load tests completed monthly. Monitor: Generator inspections and testing will be presented to the QAPI committee monthly for the next 6 months. | 8/31/18 |

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| K 918 | <p>Continued From page 15</p> <p>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 EES (Essential Electrical System) 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 dates of the survey.</p> <p>Findings Include:</p> <p>During review of the facility generator inspection and testing records on August 8, 2018, from approximately 11:30 AM to 2:00 PM, the facility failed to provide weekly generator inspection logs for the weeks of 4/15/18 - 4/21/18, 4/22/18 - 4/28/18, 4/29/18 - 5/5/18, and 5/20/18 - 5/26/18. They were also missing monthly load tests for March, April, and May of 2018. When asked, the Administrator explained the previous Environmental Services Manager had neglected many of his responsibilities, and was terminated.</p> | K 918 | | |
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| K 918 | <p>Continued From page 16</p> <p>Actual NFPA standard</p> <p>NFPA 110</p> <p>8.4 Operational Inspection and Testing.</p> <p>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:</p> <p>(1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer</p> <p>(2) Under operating temperature conditions and at not less than 30 percent of the EPS nameplate kW rating</p> <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> | K 918 | | |



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
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August 14, 2018

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

Provider #: 135094

RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER

Dear Ms. Mills:

On **August 9, 2018**, an Emergency Preparedness 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 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. 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 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,

Debbie Mills, Administrator
August 14, 2018
Page 2 of 4

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.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **August 27, 2018**. Failure to submit an acceptable PoC by **August 27, 2018**, may result in the imposition of civil monetary penalties by **September 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 **September 13, 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 **September 13, 2018**. A change in the seriousness of the deficiencies on **September 13, 2018**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **September 13, 2018**, includes the following:

Debbie Mills, Administrator
August 14, 2018
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Denial of payment for new admissions effective **November 9, 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 **February 9, 2019**, 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 **August 9, 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:

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

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

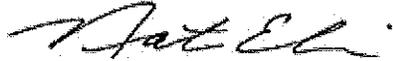
BFS Letters (06/30/11)

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

This request must be received by **August 27, 2018**. If your request for informal dispute resolution is received after **August 27, 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

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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 08/09/2018 |
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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 |
|---|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| E 000 | <p>Initial Comments</p> <p>The facility is a single story Type V (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 48 on the dates of the survey.</p> <p>The following deficiencies were cited during the emergency preparedness survey conducted on August 8-9, 2017. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.</p> <p>The Survey was conducted by:</p> <p>Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction</p> | E 000 | <p style="text-align: center;">RECEIVED</p> <p style="text-align: center;">AUG 27 2018</p> <p style="text-align: center;">FACILITY STANDARDS</p> <p>SPECIFIC ISSUE: Wellspring Health and Rehabilitation of Cascadia's all hazard risk assessment was reviewed and updated on or before 8/31/18 by facility QAPI committee to include strategies for response with current and comprehensive policy and procedures.</p> | |
| E 006 SS=F | <p>Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2)</p> <p>[(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:]</p> <p>(1) Be based on and include a documented,</p> | E 006 | | |

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  | TITLE CEO | (X6) DATE 8/24/18 |
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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.

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

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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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| E 006 | <p>Continued From page 1</p> <p>facility-based and community-based risk assessment, utilizing an all-hazards approach.*</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.</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 strategies for response to all of the risks identified in the facility-based/community-based risk assessment. Failure to provide strategies for response could hinder the facilities ability to respond in a timely manner to disasters and emergencies. This deficient practice affected 48 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>On August 8, 2018 from approximately 10:00 AM to 11:30 AM, review of the facility Hazard</p> | E 006 | <p>OTHER RESIDENTS: All residents are potentially affected by deficient practice.</p> <p>SYSTEMIC CHANGES: Staff educated on or before 8/31/18 by Executive Director or designee regarding updated all-hazard risk assessment.</p> <p>MONITOR: Upon completion of initial education with staff, Executive Director or designee will monitor the effectiveness of the emergency management plan through staff interview and provide outcomes to QAPI committee on a monthly basis. Additional education will be provided as necessary. Plan to be updated as indicated.</p> <p>Date of Compliance:</p> | 8/31/18 |

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| E 006 | Continued From page 2 Vulnerability Assessment (HVA) and EP plan, revealed the facility had not provided strategies for facility response to all of the risks identified on the HVA. When asked, the visiting Environmental Services Managers stated the facility was not aware of the missing strategies for response. Reference: 42 CFR 483.73 (a) (1) - (2) | E 006 | | |
| E 035 SS=E | LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to provide current information on the facility emergency preparedness plan with residents, their families or representatives. Not sharing information with residents, their families or representatives on the EP plan, has the potential to create confusion and lack of understanding of the facility's response during a disaster. This deficient practice could potentially affect 48 residents, staff and visitors on the date of the survey. Findings include: | E 035 | 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 8/31/18. Additionally, emergency plan will be discussed upon admission with all new residents and their advocates. Emergency management plan will be discussed ongoing with residents during resident council and education provided as needed. OTHER RESIDENTS: All residents are potentially affected by deficient practice. SYSTEMIC CHANGES: Staff educated on or before 8/31/18 by Executive Director or designee regarding communication of the emergency management plan to visitors and residents. | |

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| E 035 | Continued From page 3 On August 8, 2018 from approximately 10:00 AM to 11:30 AM, review of the facility Emergency Preparedness (EP) Plan and related documents revealed the facility did not have a plan to share information with residents, families or representatives about the EP no documentation was provided demonstrating the facility policy for sharing information with residents, their families or representatives, and no annual review or update had been conducted. Interview of the Supervisor for the Living Center on 11/15/17 from 11:15 - 11:45 AM revealed he was not aware of any policies or procedures for sharing the emergency plan with residents, family or representatives Reference: 42 CFR 483.73 (c) (8) 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. | E 035 | MONITOR: Upon completion of initial education with staff, Executive Director or designee will monitor the effectiveness of the emergency management plan through staff interview and provide outcomes to QAPI committee on a monthly basis. Additional education will be provided as necessary. Plan to be updated as indicated. Date of Compliance: | 8/31/18 | |
| E 041 SS=F | 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. | E 041 | Specific Issue: The facility failed to provide weekly generator inspection logs for 4 weeks in April and May. Also missing were monthly load tests for March, April and May. Other Residents: All residents, staff and visitors had the potential to be affected. Facility Systems: Maintenance director and assistant will be educated to NFPA 110 before 8/31/18. Maintenance director or designee will ensure that the generator is inspected weekly and load tests completed monthly. | | |

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| E 041 | <p>Continued From page 4</p> <p>§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 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</p> | E 041 | <p>Monitor: Generator inspections and testing will be presented to the QAPI committee monthly for the next 6 months.</p> | 8/31/18 |

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| E 041 | <p>Continued From page 5 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_federal_regulations/ibr_locations.html.</p> <p>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>(xii) 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 generator for the EES</p> | E 041 | | |
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| E 041 | <p>Continued From page 8</p> <p>(Essential Electrical System) 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 dates of the survey.</p> <p>Findings Include:</p> <p>During review of the facility generator inspection and testing records on August 8, 2018, from approximately 11:30 AM to 2:00 PM, the facility failed to provide weekly generator inspection logs for the weeks of 4/15/18 - 4/21/18, 4/22/18 - 4/28/18, 4/29/18 - 5/5/18, and 5/20/18 - 5/26/18. They were also missing monthly load tests for March, April, and May of 2018. When asked, the Administrator explained the previous Environmental Services Manager had neglected many of his responsibilities, and was terminated.</p> <p>Reference:</p> <p>42 CFR 483.73 (e) (2)</p> <p>Also, Refer to K Tag 0918</p> | E 041 | | |