



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 29, 2018

Shon Shuldberg, Administrator  
Ashton Memorial Living Center  
PO Box 838  
Ashton, ID 83420-0838

Provider #: 135097

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

Dear Mr. Shuldberg:

On **August 21, 2018**, a Facility Fire Safety and Construction survey was conducted at Ashton Memorial Living Center by the Bureau of Facility Standards/Department of Health & Welfare 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. Your facility was found to be in substantial compliance with Federal regulations during this survey.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, which states that the facility complies with the requirements of CFR 42, 483.70(a) of the federal requirements. This form is for your records only and does not need to be returned.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact this office at (208) 334-6626, option 3.

Sincerely,

Nate Elkins, Supervisor  
Facility Fire Safety and Construction

NE/lj  
Enclosures

FILE COPY

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

Printed: 08/28/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135097</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/21/2018</b>
NAME OF PROVIDER OR SUPPLIER <b>ASHTON MEMORIAL LIVING CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>700 NORTH SECOND STREET ASHTON, ID 83420</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	<p><b>INITIAL COMMENTS</b></p> <p>The facility is a single story, Type V(111) construction. The building was completed in 2002 and is fully sprinklered with quick response heads. There is smoke detection coverage throughout, including sleeping rooms, corridors and open spaces to corridors. The facility incorporates a propane fueled, spark ignited Emergency Power Supply System (EPSS) generator. Currently the facility is licensed for 38 SNF/NF beds, with a census of 17 on the date of the survey.</p> <p>The facility was found to be in substantial compliance during the annual Fire/Life Safety survey conducted on August 21, 2018. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy and in accordance with 42 CFR, 483.70.</p> <p>The Survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	K 000	<p style="text-align: center;"><b>RECEIVED</b></p> <p style="text-align: center;"><b>SEP 10 2018</b></p> <p style="text-align: center;"><b>FACILITY STANDARDS</b></p>	

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

*Sam Burbank*

TITLE

*Administrator*

(X8) DATE

*9/10/18*

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



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3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0009  
PHONE 208-334-6626  
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August 29, 2018

Shon Shuldberg, Administrator  
Ashton Memorial Living Center  
PO Box 838  
Ashton, ID 83420-0838

FILE COPY

Provider #: 135097

**RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER**

Dear Mr. Shuldberg:

On **August 21, 2018**, an Emergency Preparedness survey was conducted at **Ashton Memorial Living Center** 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, 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 **September 11, 2018**. Failure to submit an acceptable PoC by **September 11, 2018**, may result in the imposition of civil monetary penalties by **October 3, 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 25, 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 25, 2018**. A change in the seriousness of the deficiencies on **September 25, 2018**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **September 25, 2018**, includes the following:

Denial of payment for new admissions effective **November 21, 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 21, 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 21, 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>

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

BFS Letters (06/30/11)

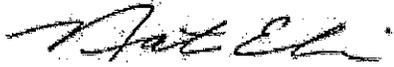
2001-10 Long Term Care Informal Dispute Resolution Process  
2001-10 IDR Request Form

Shon Shuldberg, Administrator  
August 29, 2018  
Page 4 of 4

This request must be received by **September 11, 2018**. If your request for informal dispute resolution is received after **September 11, 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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NAME OF PROVIDER OR SUPPLIER <b>ASHTON MEMORIAL LIVING CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>700 NORTH SECOND STREET ASHTON, ID 83420</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments  The facility is a single story, Type V(111) construction. The building was completed in 2002 and is fully sprinklered with quick response heads. There is smoke detection coverage throughout, including sleeping rooms, corridors and open spaces to corridors. The facility is located in a rural fire district with volunteer services, along with state and regional EMS support. The facility incorporates a 2500 gallon water storage system, along with a propane fueled, spark ignited Emergency Power Supply System (EPSS) generator. Currently the facility is licensed for 38 SNF/NF beds, with a census of 17 on the date of the survey.  The following deficiencies were cited during the Emergency Preparedness survey conducted on August 21, 2018. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.  The Survey was conducted by:  Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	E 000	<p>RECEIVED</p> <p>SEP 10 2018</p> <p>FACILITY STANDARDS</p> <p>Preparation and/or execution of the plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies.</p>	
E 006 SS=F	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2)  [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:]  (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.*  *[For LTC facilities at §483.73(a)(1):] (1) Be	E 006		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE Administrator (X6) DATE 9/6/18

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

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E 006	<p>Continued From page 1</p> <p>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: Based on record review and interview, it was determined the facility failed to develop an EP plan that included a geographically relevant facility based and community based risk assessment. Failure to provide a relevant facility and community based risk assessment, has the potential to focus staff training and resources on hazards that are not consistent with the facility location. This deficient practice affected 17 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>1) On 8/21/18 from 10:30 AM - 12:00 PM, review of the provided emergency plan, policies and procedures, revealed the facility HVA (Hazard Vulnerability Analysis) failed to provide relevant</p>	E 006	<p>E006 Specific Residents - No specific residents were identified.</p> <p>Other Residents - All Residents have the ability to be affected. HVA was reviewed for relevant information for both floods and dam failure. It will be aligned with the county all hazard mitigation plan.</p>	

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E 006	Continued From page 2 information for both floods and dam failure. Further review of the county all-hazard mitigation plan which was finalized in January of 2016, revealed the county determined both hazards were of a medium threat to the facility location. Furthermore, the facility itself had suffered from an internal flood requiring the full evacuation of the facility in that same year.  2) On 8/21/18 from 1:00 - 3:30 PM, interview with the Administrator revealed the facility risk assessment was developed during an internal management meeting and the county HVA was not reflected in its formation.  Reference: 42 CFR 483.73 (a) (1) - (2)	E 006	Systemic Changes - Ashton Living Center EOP will reflect any potential for flooding from an outside source, a dam failure that could cause service issues and equipment failure/extreme weather that could cause internal flooding and be aligned with the county's all hazard mitigation plan. Facility staff will be trained on any changes.  Monitor - Administrator and Committee will review changes to Facility HVA and Facility EOP and will be reviewed annually after that.	9/24/2018
E 007 SS=D	EP Program Patient Population CFR(s): 483.73(a)(3)  [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:]  (3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency, and continuity of operations, including delegations of authority and succession plans.**  *Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the facility failed to provide an emergency plan, policies and procedures, addressing the types of	E 007		

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E 007	Continued From page 3 services the facility has the ability to provide during an emergency. Failure to address the available services the facility can provide during an emergency, has the potential to hinder continuity of care and emergency management response. This deficient practice affected 17 residents, staff and visitors on the date of the survey.  Findings include:  On 8/21/18 from 8:30 - 10:00 AM, review of provided emergency plan, policies and procedures, revealed the plan failed to define what types of services the facility had the ability to provide during an emergency.  Reference: 42 CFR 483.73 (a) (3)	E 007	E007  Specific Residents - 17 residents, staff and visitors were identified on the date of survey.  Other Residents - All Residents have the ability to be affected.  Systemic changes - Facility EOP now includes what types of services the facility has the ability to provide during an emergency.  Monitor - Administrator reviewed these services with management team and added it to the Facility EOP. This will be reviewed annually.	9/24/2018
E 013 SS=D	Development of EP Policies and Procedures CFR(s): 483.73(b)  (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.  *Additional Requirements for PACE and ESRD Facilities:  *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this	E 013		

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E 013	<p>Continued From page 4</p> <p>section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least annually.</p> <p>*[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to develop policies and procedures based on the Emergency Plan, that aligned with a facility and community based risk assessment. Failure to align policies and procedures with a facility and community based risk assessment has the potential to develop training and practices that are not reflective of relevant hazards. This deficient practice affected 17 residents, staff and visitors on the date of the survey.</p>	E 013		

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E 013	Continued From page 5 Findings include:  On 8/21/18 from 8:30 - 10:00 AM, review of provided policies and procedures revealed the risk of flood or dam failure was not included in the HVA, but the facility procedures included policies for risks associated with flooding. Further evaluation of the local county all-hazard mitigation plan found the county plan listed flooding as the most likely hazard for the area.  Interview with the Administrator revealed he had not included flooding or dam failure in the HVA due to the location of the facility's elevation, but had not used the information in the county assessment during the plan's development.  Reference: 42 CFR 483.73 (b)  Additional Reference: E - 0006	E 013	E013  Specific Residents - 17 residents, staff and visitors were identified on the date of survey.  Other Residents - All Residents have the ability to be affected.  Systemic Changes - Ashton Living Center EOP with reflect any potential for a dam failure that could cause service issues and be aligned with the county's all hazard mitigation plan. Facility staff will be trained on any changes to current flood policy that was in place at time of survey.  Monitor - Administrator and Committee will review Facility EOP and will be reviewed annually.	9/24/2018
E 031 SS=D	Emergency Officials Contact Information CFR(s): 483.73(c)(2)  [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following:  (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance.  *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, or local	E 031		

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NAME OF PROVIDER OR SUPPLIER <b>ASHTON MEMORIAL LIVING CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>700 NORTH SECOND STREET ASHTON, ID 83420</b>		
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E 031	Continued From page 6 emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance.  *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to ensure contact information for emergency management officials and other resources of assistance was provided in the emergency communication plan. Failure to provide information for resources available to the facility has the potential to hinder facility response and continuity of care for the 17 residents, staff and visitors in the facility on the date of the survey.  Findings include:  On 8/21/18 from 8:30 - 10:00 AM, review of the emergency plan, policies and procedures, revealed the plan did not include contact information for State Licensing and Certification Agency or the Long Term Care Ombudsman.  Reference: 42 CFR 483.73 (c) (2)	E 031	E031  Specific Residents - Specific Residents - No specific residents were identified.  Other Residents - All Residents have the ability to be affected.  Systemic changes - Facility EOP now includes The state Licensing and Certification Agency E-mail fsb@dhw.idaho.gov Office Phone (208) 334-6626 then Option 5 Fax Number (208) 364-1888  Mailing Address Bureau of Facility Standards PO Box 83720 Boise, ID 83720-0009  Physical Address 3232 W. Elder Street Boise, ID 83705  and  The office of the state Long-Term Care Ombudsman Cathy Hart, State Long Term Care Ombudsman 208-577-2855 cathy.hart@aging.idaho.gov  Monitor - Facility EOP will be reviewed annually.	9/24/2018
E 036 SS=D	EP Training and Testing CFR(s): 483.73(d)  (d) Training and testing. The [facility] must develop and maintain an emergency	E 036		

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

Printed: 08/28/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135097</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/21/2018</b>
NAME OF PROVIDER OR SUPPLIER <b>ASHTON MEMORIAL LIVING CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>700 NORTH SECOND STREET ASHTON, ID 83420</b>		
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E 036	<p>Continued From page 7</p> <p>preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.</p> <p>*[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h).</p> <p>*[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to provide an emergency prep training and testing program.</p>	E 036		

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E 036	<p>Continued From page 8</p> <p>Lack of a facility emergency training and testing program covering the emergency preparedness plan, policies and procedures, has the potential to hinder staff response during a disaster. This deficient practice affected 17 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>On 8/21/18 from 8:30 - 10:00 AM, review of provided emergency plan, policies and procedures, along with associated inservices, found no documentation demonstrating the facility had a current testing program for staff based on training conducted on the contents of the emergency plan.</p> <p>Interview of the Human Resources manager established the facility had not yet implemented a testing program for staff on the contents of the Emergency Plan.</p> <p>Reference: 42 CFR 483.73 (d)</p>	E 036	<p>E036</p> <p>Specific Residents - No specific residents were identified.</p> <p>Other Residents - All Residents have the ability to be affected. Testing program will be implemented.</p> <p>Systemic Changes - Staff will be tested for understanding the contents of the Emergency Plan using Quarterly trainings, 1 on 1 interviews with staff, Role playing and Practice Drills and activities.</p> <p>Monitor - Suzanne Brady, HR will track in training logs demonstrations of competency of staffs knowledge of the Emergency Plan. Progress will be reported to QAPI committee.</p>	9/24/2018