



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

September 17, 2018

Benjamin Roedel, Administrator  
Shaw Mountain of Cascadia  
909 Reserve Street  
Boise, ID 83712-6508

Provider #: 135090

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

Dear Mr. Roedel:

On **September 4, 2018**, a Facility Fire Safety and Construction survey was conducted at **Shaw Mountain 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 **October 1, 2018**. Failure to submit an acceptable PoC by **October 1, 2018**, may result in the imposition of civil monetary penalties by **October 22, 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 **October 9, 2018**, (Opportunity to Correct). Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **October 9, 2018**. A change in the seriousness of the deficiencies on **October 9, 2018**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **October 9, 2018**, includes the following:

Denial of payment for new admissions effective **December 4, 2018**.  
42 CFR §488.417(a)

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **March 4, 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 **September 4, 2018**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

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

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

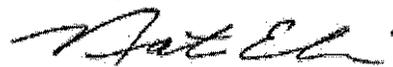
BFS Letters (06/30/11)

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

This request must be received by **October 1, 2018**. If your request for informal dispute resolution is received after **October 1, 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

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

Printed: 09/14/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135090</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/04/2018</b>
NAME OF PROVIDER OR SUPPLIER <b>SHAW MOUNTAIN OF CASCADIA</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>909 RESERVE STREET BOISE, ID 83712</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	INITIAL COMMENTS  The facility is a Type V(111) single story building originally constructed in 1963, with an addition completed in 1971. The east portion of the building was further re-modeled in 2007 with a special care unit set-up in that portion of the facility. The building is fully sprinklered with an interconnected fire alarm/smoke detection system installed that includes corridors, open spaces and resident rooms. The facility is equipped with an on-site, diesel-fired Emergency Power Supply System generator and exit corridors are supplied with battery-powered, emergency backup lighting. The facility is currently licensed for 98 SNF/NF beds with a census of 82 on the date of the survey.  The following deficiencies were cited during the annual fire/life safety survey conducted on September 4, 2018. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.  The Survey was conducted by:  Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	K 000	This plan of correction is submitted as required under Federal and State regulations and statues applicable to long-term care providers. The plan of correction does not constitute agreement by the facility that the surveyor's findings constitute a deficiency and / or that the scope and severity of the deficiencies cited are correctly applied.	
K 161 SS=D	Building Construction Type and Height CFR(s): NFPA 101  Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5	K 161		
	Construction Type			

**RECEIVED**  
OCT 02 2018  
FACILITY STANDARDS

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

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

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K 161	Continued From page 1 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the fire and smoke resistive properties of the structure were maintained. Failure to maintain rated construction assemblies, has the potential to allow fire, smoke and dangerous gases to pass into unprotected concealed spaces and between compartments.	K 161		

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K 161	<p>Continued From page 2</p> <p>This deficient practice potentially affected residents staff and visitors in 1 of 5 smoke compartments on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 9/4/18 from approximately 1:00 - 3:00 PM, observation of the interior wall of the Treatment Supplies storage revealed a 67 inch by 20 inch hole in the wall that separated the storage room from the Activities Director office. When asked about the open hole, the Environmental Services Director stated there was a leak in the wall and the repair of the drywall had not yet been completed.</p> <p>Actual NFPA standard:</p> <p>NFPA 101</p> <p>19.1.6 Minimum Construction Requirements. 19.1.6.1 Health care occupancies shall be limited to the building construction types specified in Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7. (See 8.2.1.)</p> <p>8.2 Construction and Compartmentation. 8.2.1 Construction. 8.2.1.1 Buildings or structures occupied or used in accordance with the individual occupancy chapters, Chapters 11 through 43, shall meet the minimum construction requirements of those chapters.</p> <p>8.2.2.2 Fire compartments shall be formed with fire barriers that comply with Section 8.3.</p> <p>8.3.5.6 Membrane Penetrations. 8.3.5.6.1 Membrane penetrations for cables, cable trays, conduits, pipes, tubes, combustion</p>	K 161	<ol style="list-style-type: none"> <li><u>Corrective Action:</u> The interior wall of the treatment room that revealed a hole was corrected by adding new drywall / patched.</li> <li><u>Identification of others affected:</u> Residents' staff and visitors in 1 of 5 smoke compartments on the date of the survey.</li> <li><u>Systemic Changes to ensure deficient practice does not recur:</u> Staff educated on or before 10/5/2018 by Executive Director or designee regarding facilities requirement / fire safety / smoke and fire compartments. Staff directed to report any areas of concern for fire safety.</li> <li><u>Monitor of Corrective Action:</u> Facility Environmental Service Director and Administrator or designee to walk facility monthly to ensure all smoke compartments are working properly and report to QAPI committee. QAPI will follow fire / smoke compartment issues until they are no longer a concern to the IDT.</li> </ol>	10/5/18

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K 161	Continued From page 3 vents and exhaust vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a membrane of a wall, floor, or floor/ceiling assembly constructed as a fire barrier shall be protected by a firestop system or device and shall comply with 8.3.5.1 through 8.3.5.2.	K 161		
K 324 SS=D	<p><b>Cooking Facilities</b> CFR(s): NFPA 101</p> <p><b>Cooking Facilities</b> Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:</p> <ul style="list-style-type: none"> <li>* residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2</li> <li>* cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or</li> <li>* cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.</li> </ul> <p>Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure</p>	K 324	<ol style="list-style-type: none"> <li>1. <u>Corrective Action:</u> Shaw Mountain of Cascadia contacted facility fire response / hood suppression company before Oct 5, 2018. Replaced and installed new flame guards to ensure grease laden vapors do not bypass hood filters.</li> <li>2. <u>Identification of others affected:</u> All kitchen staff have the potential to be affected by deficient practice.</li> <li>3. <u>Systemic Changes to ensure deficient practice does not recur:</u> Kitchen Staff educated on or before 10/5/2018 by Executive Director or designee regarding kitchen hood system and prevention of grease fires. Also, facility vendor that completes the hood inspection was notified and made aware of findings. Vendor to ensure the hood is in proper working order, with Environmental Service Director to monitor the work of the vendor.</li> <li>4. <u>Monitor of Corrective Action:</u> QAPI will follow hood filter / maintenance issues until they are no longer a concern to the IDT.</li> </ol>	10/5/18

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K 324	Continued From page 4 kitchen hood systems were maintained in accordance with NFPA 96. Failure to ensure grease laden vapors do not bypass hood filters could allow grease build-up inside the exhaust system, increasing the risk of grease fires. This deficient practice affected staff and visitors of the main Kitchen on the date of the survey.  Findings include:  During the facility tour conducted on 9/4/18 from approximately 1:00 - 4:00 PM, observation of the main Kitchen hood system revealed a gap of approximately 3/4 inch between the filter on the left hand side and the stationary panel when facing the hood, allowing exhaust air to bypass the filters.  Actual NFPA standard:  NFPA 96  6.2.3 Grease Filters. 6.2.3.3 Grease filters shall be arranged so that all exhaust air passes through the grease filters.	K 324		
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	K 363	1. <u>Corrective Action:</u> Facility Environmental Service Director has ordered 4 clear oak fire rated doors on 9/28/18 as needed. Vendor to install doors upon arrival.  2. <u>Identification of others affected:</u> All residents and staff are potentially affected by deficient practice.	10/5/18

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K 363	<p>Continued From page 5</p> <p>requirements do not apply to auxiliary spaces that do not contain flammable or combustible material.</p> <p>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 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, the facility failed to ensure corridor doors would resist the passage of smoke. Failure to ensure corridor doors are not undercut more than 1 inch from the floor, or provided with transfer grilles, has the potential to allow fire, smoke and dangerous gases to pass into the corridor hindering resident egress. This deficient practice affected 2 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p>	K 363	<p>3. <u>Systemic Changes to ensure deficient practice does not recur:</u> Staff educated on or before 10/5/2018 by Executive Director or designee regarding fire doors and ensuring corridor doors resist the passage of smoke. Facility Environmental Service Director and Administrator or designee to walk facility monthly to ensure all smoke compartments are working properly.</p> <p>4. <u>Monitor of Corrective Action:</u> Facility Environmental Service Director and Administrator or designee to walk facility monthly to ensure all smoke compartments are working properly and report back to QAPI committee. QAPI will follow fire / smoke compartment issues until they are no longer a concern to the IDT.</p>	10/5/18

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K 363	Continued From page 6 During the facility tour conducted on 9/4/18 from 1:00 - 3:00 PM, the following doors were observed to be undercut from the floor level in excess of 1 inch:  Shower room #8 in the 300 east hallway was undercut 1-7/8 inches to 2-1/2 inches from the floor to the bottom of the door. Storage room across from shower room #8 was undercut 2-1/4 inches to 2-1/2 inches from the floor to the bottom of the door. Shower room #10, abutting room #8, was undercut 2-1/2 inches from the floor. The door to the oxygen storage and transfill area located outside the Laundry service corridor, was equipped with a transfer grille that measured 10 inches tall by twenty-six inches wide.  Actual NFPA standard:  NFPA 101  19.3.6.3* Corridor Doors. 19.3.6.3.4 A clearance between the bottom of the door and the floor covering not exceeding 1 in. (25 mm) shall be permitted for corridor doors.  19.3.6.4 Transfer Grilles. 19.3.6.4.1 Transfer grilles, regardless of whether they are protected by fusible link-operated dampers, shall not be used in corridor walls or doors.	K 363		
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101  Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing	K 511		

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K 511	<p>Continued From page 7</p> <p>installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure safe electrical equipment installations in accordance with NFPA 70. Failure to enclose live electrical installations with a protective cover, has the potential of exposing residents to electrical shock and/or arc fires. This deficient practice affected residents using the social center, staff and visitors, on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 9/4/18 from approximately 1:30 - 3:00 PM, observation of the installed electrical installations, revealed the following:</p> <p>1) A light switch on the west wall of the Activities storage room was missing a protective cover, allowing possible physical contact with energized parts.</p> <p>2) Observation of the med room off the 200 hall, revealed an outlet located behind the refrigerator was missing the protective cover, allowing possible physical contact to the energized parts.</p> <p>3) Observation of the Social Center revealed a three to one, multiple plug extension cord used to supply power to the audio visual equipment. Further observation of this cord revealed the cord ran under an area rug from the wall to the energized equipment.</p> <p>4) Observation of the Kitchen storage room</p>	K 511	<p>1. <u>Corrective Action:</u> 1) Cover on light switch in the activity's storage room was replaced with new cover. 2) Med room outlet cover replaced with new cover. 3) Multiple plug extension cord in the Social Center was removed from facility. 4) Kitchen storage room, both outlets that were charred were replaced with new outlets by a certified electrician.</p> <p>2. <u>Identification of others affected:</u> All staff that utilize those specific areas are potentially affected by deficient practice.</p> <p>3. <u>Systemic Changes to ensure deficient practice does not recur:</u> Staff educated on or before 10/5/2018 by Executive Director or designee regarding safe electrical equipment and importance of enclosing live electrical outlets. Staff educated to report these items if seen to the Environmental Service Director and or Administrator.</p> <p>4. <u>Monitor of Corrective Action:</u> Facility Environmental Service Director and Administrator or designee to walk facility monthly to ensure all electrical enclosures are in place and are working properly. Findings to be reported back to QAPI committee. QAPI will follow safe electrical equipment issues until they are no longer a concern to the IDT.</p>	10/5/18

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K 511	<p>Continued From page 8</p> <p>located off the southwest service corridor exit, revealed a refrigerator and a freezer both plugged into an outlet with black char from apparent electrical arcing.</p> <p>Actual NFPA standard:</p> <p>NFPA 70</p> <p>Finding 1 and 2</p> <p>110.12 Mechanical Execution of Work. Electrical equipment shall be installed in a neat and workmanlike manner.</p> <p>Informational Note: Accepted industry practices are described in ANSI/NECA 1-2006, Standard Practices for Good Workmanship in Electrical Contracting, and other ANSI-approved installation standards.</p> <p>(A) Unused Openings. Unused openings, other than those intended for the operation of equipment, those intended for mounting purposes, or those permitted as part of the design for listed equipment, shall be closed to afford protection substantially equivalent to the wall of the equipment. Where metallic plugs or plates are used with nonmetallic enclosures, they shall be recessed at least 6 mm (1/4 in.) from the outer surface of the enclosure.</p> <p>400.8 Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following:</p> <p>(1) As a substitute for the fixed wiring of a structure</p> <p>(2) Where run through holes in walls, structural ceilings,</p>	K 511		

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K 511	Continued From page 9 suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces Exception to (4): Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of 368.56(B) (5) Where concealed by walls, floors, or ceilings or located above suspended or dropped ceilings (6) Where installed in raceways, except as otherwise permitted in this Code (7) Where subject to physical damage	K 511		
K 521 SS=D	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, observation and interview, the facility failed to ensure installed fire dampers were maintained in accordance with NFPA 80. Failure to ensure fire dampers installed in fuel-fired Heating Ventilation and Air Conditioning (HVAC) equipment are maintained, <del>has the potential to allow smoke, fire and</del> dangerous gases to pass between compartments	K 521		

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K 521	<p>Continued From page 10 during a fire. This deficient practice affected those residents, staff and visitors utilizing the southeast section of the facility.</p> <p>Findings include:</p> <p>1) During review of facility maintenance records conducted on 9/4/18 from 8:30 to 10:30 AM, no records were available indicating the date of the last fire damper inspection. When asked if he knew of the last time the dampers had been inspected, the Environmental Services Director stated he was not aware of that inspection having been completed.</p> <p>2) During the facility tour conducted on 9/4/18 from 1:00 to 4:00 PM, inspection of the fuel-fired equipment installed in the mechanical space on the southeast side of the facility, revealed one (1) fire damper installed on the return air side of the system.</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 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems, or</p>	K 521	<ol style="list-style-type: none"> <li>1. <u>Corrective Action:</u> Facility Environmental Service Director notified Western Heating and Cooling (HVAC vendor) and vendor completed inspection on all fire dampers on 9/25/2018.</li> <li>2. <u>Identification of others affected:</u> All residents and staff are potentially affected by deficient practice.</li> <li>3. <u>Systemic Changes to ensure deficient practice does not recur:</u> HVAC vendor to perform inspections on all fire dampers in accordance with NFPA 80. Vendor to communicate with Environmental Service Director and or Administrator to ensure inspections are completed timely in accordance with NFPA 80.</li> <li>4. <u>Monitor of Corrective Action:</u> Environmental Service Director on or before 10/5/2018 to add to his calendar to ensure inspection occurs at minimum every 4 years.</li> </ol>	10/5/18

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K 521	Continued From page 11 NFFPA 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.  NFFPA 90A 5.4.8 Maintenance. 5.4.8.1 Fire dampers and ceiling dampers shall be maintained in accordance with NFFPA 80, Standard for Fire Doors and Other Opening Protectives.  NFFPA 80 19.4* Periodic Inspection and Testing. 19.4.1 Each damper shall be tested and inspected 1 year after installation. 19.4.1.1 The test and inspection frequency shall then be every 4 years, except in hospitals, where the frequency shall be every 6 years.	K 521		
K 712 SS=F	Fire Drills CFR(s): NFFPA 101  Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure fire drills were conducted in accordance with NFFPA 101. Failure to perform	K 712		

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K 712	Continued From page 12 fire drills quarterly for each shift has the potential to hinder staff response in the event of a fire. This deficient practice affected 82 residents, staff and visitors on the date of the survey.  Findings include:  1) During review of provided facility maintenance records conducted on 9/4/18 from 8:30 to 10:30 AM, no records were provided demonstrating fire drills were performed on the following shifts: PM (three o'clock pm to eleven o'clock pm) shift during the second quarter of 2018 NOC (eleven o'clock pm to seven o'clock am) shift during the third quarter of 2017 AM (seven o'clock am to three o'clock pm)  2) Interview of the Environmental Services Manager revealed he was not aware of the missing fire drills.  Actual NFPA standard:  19.7* Operating Features. 19.7.1 Evacuation and Relocation Plan and Fire Drills.  19.7.1.6 Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions.	K 712	1. <u>Corrective Action:</u> Facility Environmental Service Director completed 3 separate fire drills. One fire drill per shift (Day, Evening, and NOC) before 10/5/2018.  2. <u>Identification of others affected:</u> All residents and staff are potentially affected by deficient practice.  3. <u>Systemic Changes to ensure deficient practice does not recur:</u> All Staff educated on or before 10/5/2018 by Executive Director or designee regarding fire drills and the policy and procedure for the facility.  4. <u>Monitor of Corrective Action:</u> Facility Administrator to ensure with the Environmental Service Director that all drills are completed. A minimum of 1 fire drill per shift per quarter. All drills reported to QAPI, and committee will follow safe fire drills issues until they are no longer a concern to the IDT.	
K 916 SS=F	Electrical Systems - Essential Electric System CFR(s): NFPA 101  Electrical Systems - Essential Electric System Alarm Annunciator <del>A remote annunciator that is storage battery</del> powered is provided to operate outside of the	K 916		10/5/18

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K 916	<p>Continued From page 13</p> <p>generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, the facility failed to ensure the Essential Electrical System (EES) was equipped with a remote annunciator that was readily observable in a regular work station in accordance with NFPA 99. Failure to provide an annunciator that is readily observed has the potential to hinder facility staff awareness to system failures during a power outage or other emergency. This deficient practice affected 82 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 9/4/18 from approximately 1:00 - 3:00 PM, a remote annunciator for the EES was observed installed in the rear of the Kitchen Storage area, behind a support column. When asked about the staff who had access to this area and the normal work hours of those staff, the Dietary Manager stated the storage area was primarily accessed by dietary staff whose normal working hours were eight o'clock am to six o'clock pm.</p> <p>Actual NFPA standard:</p> <p>NFPA 99 6.4.1.1 On-Site Generator Set. 6.4.1.1.17 Alarm Annunciator. A remote annunciator that is storage battery powered shall</p>	K 916	<ol style="list-style-type: none"> <li><u>Corrective Action:</u> On 9/14/2018 Environmental Service Director had a licensed electrician install a remote annunciator to the generator located in the 100-chart room to allow all staff to be aware of any alarm conditions for the emergency or auxillary power source.</li> <li><u>Identification of others affected:</u> All residents and staff are potentially affected by deficient practices.</li> <li><u>Systemic Changes to ensure deficient practice does not recur:</u> Facility staff educated on or before 10/5/2018 by Executive Director or designee regarding the location and the purpose of the generator annunciator. Staff educated to report any alarms or lights to either the Environmental Service Director and or Administrator.</li> <li><u>Monitor of Corrective Action:</u> Executive Director or designee will audit at random to ensure staff are aware / purpose of the annunciator, and to ensure annunciator is working properly. Findings to be reported to QAPI committee. QAPI will follow essential electrical system issues until they are no longer a concern to the IDT.</li> </ol>	

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K 916	Continued From page 14 be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station (see 700.12 of NFPA 70, National Electrical Code). The annunciator shall be hard-wired to indicate alarm conditions of the emergency or auxiliary power source as follows: (1) Individual visual signals shall indicate the following: (a) When the emergency or auxiliary power source is operating to supply power to load (b) When the battery charger is malfunctioning (2) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate the following: (a) Low lubricating oil pressure (b) Low water temperature (below that required in 6.4.1.1.11) (c) Excessive water temperature (d) Low fuel when the main fuel storage tank contains less than a 4-hour operating supply (e) Overcrank (failed to start) (f) Overspeed	K 916		
K 926 SS=E	Gas Equipment - Qualifications and Training CFR(s): NFPA 101  Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: <del>Based on record review, and interview, the facility</del> failed to ensure continuing education and staff	K 926		

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K 926	<p>Continued From page 15</p> <p>training was provided on the risks associated with the storage, handling and use of medical gases and their cylinders. Failure to provide training of safety and the risks associated with medical gases, potentially increases risks associated, hindering staff response on the use and handling of oxygen. This deficient practice potentially affected oxygen dependent residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During review of provided training records on 9/4/18 from 8:30 - 10:30 AM, records provided did not demonstrate continuing training was performed for the risks associated with oxygen and its use.</p> <p>Interview of 4 of 4 staff members revealed none had participated in a facility provided, continuing education program, on the risks associated with the storage, handling or use of medical gases such as oxygen.</p> <p>Actual NFPA standard:</p> <p>NFPA 99 11.5.2 Gases in Cylinders and Liquefied Gases in Containers. 11.5.2.1 Qualification and Training of Personnel. 11.5.2.1.1* Personnel concerned with the application and maintenance of medical gases and others who handle medical gases and the cylinders that contain the medical gases shall be trained on the risks associated with their handling and use. 11.5.2.1.2 Health care facilities shall provide programs of continuing education for their personnel. 11.5.2.1.3 Continuing education programs shall</p>	K 926	<ol style="list-style-type: none"> <li><u>Corrective Action:</u> Facility education calendar updated to include annual training of application, maintenance and handling of medical gases and cylinders including associated risks. Additionally, same training program updated for facility orientation of new employees.</li> <li><u>Identification of others affected:</u> All residents and staff are potentially affected by deficient practice.</li> <li><u>Systemic Changes to ensure deficient practice does not recur:</u> Staff Development Coordinator educated by Executive Director or Director of Nursing on or before 10/5/2018 to ensure oxygen training and education of above-mentioned requirements are provided upon orientation and annually to employees.</li> <li><u>Monitor of Corrective Action:</u> Executive Director or designee will audit facility orientation and annual training monthly x3 to ensure ongoing compliance. Additional education will be provided as necessary. Results of audit will be reported to QAPI committee. QAPI will follow oxygen training issues until they are no longer a concern to the IDT.</li> </ol>	10/5/18

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K 926	Continued From page 16 include periodic review of safety guidelines and usage requirements for medical gases and their cylinders.	K 926		
K 927 SS=D	Gas Equipment - Transfilling Cylinders CFR(s): NFPA 101  Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99), 11.5.2.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure that transfilling procedures and the storage of cryogenic medical gas cylinders, was in accordance with NFPA 99. Failure to transfill or transfer liquid oxygen (LOX) over the appropriate substrate and secure cylinders containing LOX, has the potential to expose residents to explosions and accelerated fire conditions. This deficient practice affected staff and visitors on the date of the survey.  Findings include:  During the facility tour conducted on 9/4/18 from 1:00 - 3:00 PM, observation of the oxygen storage and transfill room located in main Laundry corridor, revealed the flooring of the transfill area was vinyl composite tile (VCT) glued down over concrete. Further observation revealed	K 927	<ol style="list-style-type: none"> <li><u>Corrective Action:</u> Environmental Service Director secured all 5 LOX cylinders by chaining them to the wall and placing them on rollers. Facility Oxygen Storage room VCT flooring was removed. Ceramic tile will be installed on or before 10/5/2018.</li> <li><u>Identification of others affected:</u> All staff working with O2 are potentially affected by deficient practice.</li> <li><u>Systemic Changes to ensure deficient practice does not recur:</u> Facility staff educated by Administrator or designee on or before 10/5/2018 to ensure understanding that oxygen cylinders need to be secured per NFPA regulations.</li> <li><u>Monitor of Corrective Action:</u> Executive Director or designee will audit designated oxygen holding areas weekly. Results of audit will be reported to QAPI committee. QAPI will follow oxygen training issues until they are no longer a concern to the IDT.</li> </ol>	10/5/18

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K 927	Continued From page 17 five (5) unsecured LOX cylinders.  NFPA 99  11.5.2.3 Transfilling Liquid Oxygen. Transfilling of liquid oxygen shall comply with 11.5.2.3.1 or 11.5.2.3.2, as applicable.  11.5.2.3.1 Transfilling to liquid oxygen base reservoir containers or to liquid oxygen portable containers over 344.74 kPa (50 psi) shall include the following: (1) A designated area separated from any portion of a facility wherein patients are housed, examined, or treated by a fire barrier of 1 hour fire-resistive construction. (2) The area is mechanically ventilated, is sprinklered, and has ceramic or concrete flooring. (3) The area is posted with signs indicating that transfilling is occurring and that smoking in the immediate area is not permitted. (4) The individual transfilling the container(s) has been properly trained in the transfilling procedures.  11.7.3.3* Liquid oxygen base reservoir containers shall be secured by one of the following methods while in storage or use to prevent tipping over caused by contact, vibration, or seismic activity: (1) Securing to a fixed object with one or more restraints (2) Securing within a framework, stand, or assembly designed to resist container movement (3) Restraining by placing the container against two points of contact	K 927		



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

September 17, 2018

Benjamin Roedel, Administrator  
Shaw Mountain of Cascadia  
909 Reserve Street  
Boise, ID 83712-6508

Provider #: 135090

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

Dear Mr. Roedel:

On **September 4, 2018**, an Emergency Preparedness survey was conducted at **Shaw Mountain 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, 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 **October 1, 2018**. Failure to submit an acceptable PoC by **October 1, 2018**, may result in the imposition of civil monetary penalties by **October 22, 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 **October 9, 2018**, (Opportunity to Correct). Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **October 9, 2018**. A change in the seriousness of the deficiencies on **October 9, 2018**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **October 9, 2018**, includes the following:

Denial of payment for new admissions effective **December 4, 2018**.  
42 CFR §488.417(a)

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **March 4, 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 **September 4, 2018**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

<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

Benjamin Roedel, Administrator

September 17, 2018

Page 4 of 4

This request must be received by **October 1, 2018**. If your request for informal dispute resolution is received after **October 1, 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,

A handwritten signature in black ink, appearing to read "Nate Elkins".

Nate Elkins, Supervisor  
Facility Fire Safety and Construction

NE/lj

Enclosures

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

Printed: 09/14/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135090</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/04/2018</b>
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NAME OF PROVIDER OR SUPPLIER <b>SHAW MOUNTAIN OF CASCADIA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>909 RESERVE STREET BOISE, ID 83712</b>
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E 000	<p>Initial Comments</p> <p>The facility is a Type V(111) single story building originally constructed in 1963, with an addition completed in 1971. The east portion of the building was further re-modeled in 2007 with a special care unit set-up in that portion of the facility. The facility is located in a municipal fire district with support from county and state EMS services.</p> <p>The building is fully sprinklered with an interconnected fire alarm/smoke detection system installed that includes corridors, open spaces and resident rooms. The facility is equipped with an on-site, diesel-fired Emergency Power Supply System generator and exit corridors are supplied with battery-powered, emergency backup lighting. The facility is currently licensed for 98 SNF/NF beds with a census of 82 on the date of the survey.</p> <p>The following deficiencies were cited during the annual Emergency Preparedness survey conducted on September 4, 2018. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73..</p> <p>The Survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	E 000	<p>This plan of correction is submitted as required under Federal and State regulations and statues applicable to long-term care providers. The plan of correction does not constitute agreement by the facility that the surveyor's findings constitute a deficiency and / or that the scope and severity of the deficiencies cited are correctly applied.</p> <p style="text-align: center;"><b>RECEIVED</b> OCT 02 2018 FACILITY STANDARDS</p>	
E 009 SS=F	<p>Local, State, Tribal Collaboration Process CFR(s): 483.73(a)(4)</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>	E 009		10/5/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>Sam Burbank</i>	TITLE  Executive Director	(X8) DATE  10/1/18
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 009	<p>Continued From page 1</p> <p>(4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts.</p> <p>* [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the dialysis facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the facility failed to document collaboration with local, tribal, regional, State and Federal EP officials and integrated emergency response efforts. Failure to develop a collaborative planning effort with multi-jurisdictional entities, has the potential to limit the facilities options during a disaster. This deficient practice affected 82 residents, staff and visitors on the date of the survey.</p> <p>Findings include: On 9/4/18 from 8:30 - 3:00 PM, review of</p>	E 009	<ol style="list-style-type: none"> <li><u>Corrective Action:</u> Shaw Mountain of Cascadia's Emergency Management Plan was reviewed and updated on or before Oct 5, 2018 by facility QAPI committee to include comprehensive collaboration with local emergency planning authorities. Facility administrator or designee to attend and participate in community / regional healthcare coalition meetings.</li> <li><u>Identification of others affected:</u> All residents are potentially affected by deficient practice.</li> <li><u>Systemic Changes to ensure deficient practice does not recur:</u> Staff educated on or before 10/5/2018 by Executive Director or designee regarding facilities updated emergency plan and policy and procedures specific to community partners and collaboration with local emergency authorities. Facility Administrator or designee to be attend next coalition meeting held October 4<sup>th</sup>.</li> <li><u>Monitor of Corrective Action:</u> QAPI will follow emergency preparedness issues until they are no longer a concern to the IDT.</li> <li><u>Corrective Action Completed:</u> 10/5/2018</li> </ol>	10/5/18

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E 009	Continued From page 2 provided policies, procedures and the emergency plan, failed to establish documentation indicating collaborative involvement with local, tribal, regional State and Federal EP officials, including such involvement as participation in county EMS or regional healthcare coalition meetings.	E 009		
E 030 SS=D	Reference: 42 CFR 483.73 (a) (4) Names and Contact Information CFR(s): 483.73(c)(1)  [(c) The [facility, except RNHCs, hospices; transplant centers, and HHAs] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:]  (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers.  *[For RNHCs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCs. (v) Volunteers.  *[For ASCs at §416.45(c):] The communication	E 030	1. <u>Corrective Action:</u> Shaw Mountain of Cascadia's Emergency Management Plan was reviewed and updated on or before 10/5/2018 by facility QAPI committee to include updated and site-specific contact list that includes staff, entities providing services, patient physicians, other facilities, and volunteers.  2. <u>Identification of others affected:</u> All residents are potentially affected by deficient practice.  3. <u>Systemic Changes to ensure deficient practice does not recur:</u> Staff educated on or before 10/5/2018 by Executive Director or designee regarding facilities updated contact list.  4. <u>Monitor of Corrective Action:</u> QAPI will follow emergency preparedness issues until they are no longer a concern to the IDT.  5. <u>Corrective Action Completed:</u> 10/5/2018	10/5/18

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

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E 030	Continued From page 3 plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers.	E 030			
	<p>*[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices.</p> <p>*[For OPOs at §486.360(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the facility failed to document a communication plan which included contact information for volunteers or volunteer organizations. Failure to have a communication plan which includes contact information for those parties assisting in the facility's response and recovery during a disaster, has the potential to hinder both internal and external emergency response efforts. This deficient practice affected 82 residents, staff and</p>				

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E 030	Continued From page 4 visitors on the date of the survey.  Findings include:  On 9/4/18 from 8:30 AM - 3:00 PM, review of provided emergency plan, policies and procedures, failed to reveal a communication plan that included contact information for resident volunteers  Reference: 42 CFR 483.73 (c) (1)	E 030		
E 031 SS=F	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 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.	E 031	1. <u>Corrective Action:</u> Contact list in Emergency Preparedness Binder / Emergency Plan was updated on or before 10/5/2018 to include all contact information required for federal, state, and county, emergency management, state licensing and certification agency, and the state ombudsman.  2. <u>Identification of others affected:</u> All residents are potentially affected by deficient practice.  3. <u>Systemic Changes to ensure deficient practice does not recur:</u> Staff educated on or before 10/5/2018 by Executive Director or designee regarding facilities updated contact list.  4. <u>Monitor of Corrective Action:</u> QAPI will follow emergency preparedness issues until they are no longer a concern to the IDT.  5. <u>Corrective Action Completed:</u> 10/5/2018	10/5/18

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E 031	<p>Continued From page 5</p> <p>(ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to ensure current contact information for emergency management officials and other resources of assistance was provided in the emergency communication plan. Failure to provide information for resources available to the facility has the potential to hinder facility response and continuity of care for the 28 residents, staff and visitors in the facility on the date of the survey.</p> <p>Findings include:</p> <p>On 9/4/18 from 8:30 AM - 3:00 PM, review of the emergency plan, policies and procedures, revealed the plan did not include contact information for Federal, State, and County emergency management, as well as State Licensing and Certification Agency and the State Ombudsman. Review of the section having these areas for points of contact, revealed all sections for those related agencies were left blank and no contact information was entered.</p> <p>Reference: 42 CFR 483.73 (c) (2)</p>	E 031		
E 036 SS=F	<p>EP Training and Testing CFR(s): 483.73(d)</p> <p>(d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and</p>	E 036		

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E 036	<p>Continued From page 6</p> <p>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. 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 82 residents, staff and</p>	E 036	<ol style="list-style-type: none"> <li><u>Corrective Action:</u> Shaw Mountain of Cascadia's Emergency Management Plan was reviewed and updated on or before Oct 5, 2018 by facility QAPI committee. Plan to include updated and site-specific policy regarding training and testing of employees for Emergency Management plan upon orientation and annually. Plan will include documentation and staff competency completion. See also E 037.</li> <li><u>Identification of others affected:</u> All residents are potentially affected by deficient practice.</li> <li><u>Systemic Changes to ensure deficient practice does not recur:</u> Staff educated on or before 10/5/2018 by Executive Director or designee regarding current emergency preparedness plan, and the policies and procedures. Additional education to be provided as directed. Staff Development Coordinator educated on or before 10/5/2018 by Executive Director to validate training and testing program is available and offered upon orientation and annually to employees (annual training calendar to include updates).</li> </ol>	10/5/18	

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E 036	Continued From page 7 visitors on the date of the survey.  Findings include:  On 9/4/18 from 8:30 AM - 3:00 PM, 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 over the contents of the emergency plan.  Interview of 4 of 4 staff members conducted on 9/4/18 from 10:30 AM - 12:45 PM, established the facility had not yet implemented a testing program for staff on the contents of the Emergency Plan.  Reference: 42 CFR 483.73 (d)	E 036	4. <u>Monitor of Corrective Action:</u> Staff interviews will be conducted randomly to ensure the effectiveness of the training and or areas that need to be a focus for training. Results of interviews to be reported to the QAPI committee. QAPI will follow emergency preparedness issues until they are no longer a concern to the IDT.  5. <u>Corrective Action Completed:</u> 10/5/2018	
E 037 SS=F	EP Training Program CFR(s): 483.73(d)(1)  (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following:  (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures.  *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following: (i) Initial training in emergency preparedness	E 037	1. <u>Corrective Action:</u> Shaw Mountain of Cascadia's Emergency Management Plan was reviewed and updated on or before Oct 5, 2018 by facility QAPI committee. Plan to include updated and site-specific policy regarding training and testing of employees for Emergency Management plan upon orientation and annually. Plan will include documentation and staff competency completion.  2. <u>Identification of others affected:</u> All residents are potentially affected by deficient practice.	10/5/18

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E 037	<p>Continued From page 8</p> <p>policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles.</p> <p>(ii) Provide emergency preparedness training at least annually.</p> <p>(iii) Maintain documentation of the training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures.</p> <p>*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.</p> <p>(ii) Demonstrate staff knowledge of emergency procedures.</p> <p>(iii) Provide emergency preparedness training at least annually.</p> <p>(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.</p> <p>*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.</p> <p>(ii) After initial training, provide emergency preparedness training at least annually.</p> <p>(iii) Demonstrate staff knowledge of emergency procedures.</p> <p>(iv) Maintain documentation of all emergency</p>	E 037	<p>3. <u>Systemic Changes to ensure deficient practice does not recur:</u> Staff educated on or before 10/5/2018 by Executive Director or designee regarding current emergency preparedness plan, and the policies and procedures. Additional random interviews and education to be provided as directed to ensure staff understanding on the current emergency plan. Staff Development Coordinator educated on or before 10/5/2018 by Executive Director to validate training and testing program is available and offered upon orientation and annually to employees (annual training calendar to include updates).</p> <p>4. <u>Monitor of Corrective Action:</u> Staff interviews will be conducted randomly to ensure the effectiveness of the training and or areas that need to be a focus for training. Results of interviews to be reported to the QAPI committee. QAPI will follow emergency preparedness issues until they are no longer a concern to the IDT.</p> <p>5. <u>Corrective Action Completed:</u> 10/5/2018</p>	10/5/18

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E 037	<p>Continued From page 9 preparedness training.</p> <p>*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training.</p> <p>*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.</p> <p>*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt</p>	E 037		

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E 037	<p>Continued From page 10 reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.</p> <p>(ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures.</p> <p><b>*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually.</b></p> <p><b>This REQUIREMENT is not met as evidenced by:</b> Based on record review and interview, it was determined the facility failed to provide an emergency prep training program. Lack of a training program on the emergency preparedness plan and policies for the facility, has the potential to hinder staff response during a disaster. This deficient practice affected 82 residents, staff and visitors on the date of the survey.</p> <p><b>Findings include:</b>  On 9/4/18 from 8:30 AM - 3:30 PM, review of provided emergency plan, policy and procedures,</p>	E 037		

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E 037	Continued From page 11 revealed no substantiating documentation demonstrating the facility had a training program for staff based on the plan.  Interview of 4 of 4 staff members on 9/4/18 from 10:30 AM - 12:45 PM revealed no specific training was conducted on the emergency plan or its contents.  Reference: 42 CFR 483.73 (d) (1)	E 037		