



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

December 20, 2018

Gary "Paul" Arnell, Administrator
The Orchards of Cascadia
404 North Horton Street
Nampa, ID 83651-6541

Provider #: 135019

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Mr. Arnell:

On **December 12, 2018**, a Facility Fire Safety and Construction survey was conducted at **The Orchards 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 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).

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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 **January 2, 2019**. Failure to submit an acceptable PoC by **January 2, 2019**, may result in the imposition of civil monetary penalties by **January 24, 2019**.

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 **January 16, 2019**, (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 **March 12, 2019**. A change in the seriousness of the deficiencies on **January 26, 2019**, 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 **January 16, 2019**, includes the following:

Denial of payment for new admissions effective **March 12, 2019**.
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 **June 12, 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 **December 12, 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:

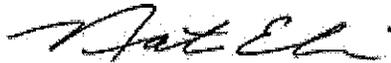
BFS Letters (06/30/11)

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

This request must be received by **January 2, 2019**. If your request for informal dispute resolution is received after **January 2, 2019**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosures

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|--|---|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135019 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____ | (X3) DATE SURVEY COMPLETED 12/12/2018 |
| NAME OF PROVIDER OR SUPPLIER ORCHARDS OF CASCADIA, THE | | STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH HORTON STREET NAMPA, ID 83651 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
| K 000 | INITIAL COMMENTS The facility is a single story Type V (111) occupancy, originally constructed in 1959. There is an automatic fire sprinkler system and interconnected fire alarm/smoke detection system. There have been multiple renovations conducted in the building, the last of which was completed in 2017. There is an on-site spark-fired Emergency Electrical System (EES) generator which provides backup emergency power. The facility is currently licensed for 100 beds and had a census of 78 on the day of the survey. The following deficiencies were cited during the annual fire/life safety survey conducted on December 12, 2018. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70 and 483.80. The Survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction | K 000 | <i>This plan of correction is submitted as required under Federal and State regulations and statutes applicable to long-term care providers. The plan of Correction does not constitute agreement by the facility that the surveyors findings constitute a deficiency and/or that the scope and severity of the deficiencies cited are correct applied.</i> RECEIVED DEC 31 2018 | |
| K 211 SS=F | Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on operational testing and interview, the facility failed to exit doors were maintained in | K 211 | 1. SPECIFIC ISSUE: FACILITY STANDARDS The front door, north exit door from therapy, the exit door leading out of the 500 hall and the front dining room door with the overhang impediment have all been repaired, tested, and found functional by the maintenance director on or before 1/2/2019. 2. OTHER RESIDENTS: Facility wide audit performed by Maintenance Director on or before 12/26/2018 to ensure facility maintained safe and appropriate delayed egress doors. 3. SYSTEMIC CHANGES: Staff educated on or before 12/28/2018 by Executive Director or | |

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

TITLE

(X6) DATE



CEO

12/27/19

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 211 | <p>Continued From page 1</p> <p>accordance with NFPA 101. Failure to ensure exit doors were not impeded to use and magnetic locking arrangements equipped with delayed egress would release as designed has the potential to hinder evacuation of residents during an emergency. This deficient practice affected 34 residents in the 400/500 wings and residents, staff and visitors using the front exit and the east dining room exit on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 12/12/18 from 1:00 - 3:30 PM, operational testing of facility exit doors revealed the following:</p> <p>Testing of the delayed egress function of the front door, the north exit door from the Therapy and the east exit door leading out of the 500 hall, revealed these doors would not initiate the irreversible process of releasing the magnet with 5 lbs of pressure applied to the engaged magnetic locking arrangement.</p> <p>Interview of the Maintenance Director established these doors had recently had the keypad system worked on and were fully functional prior to that work being done.</p> <p>Testing of the east exit door from the front dining room revealed the door was impeded by the overhang outside of the building when opened and provided approximately 24 inches in clear width for exit.</p> <p>Actual NFPA standard:</p> <p>7.1.10 Means of Egress Reliability. 7.1.10.1* General. Means of egress shall be continuously maintained free of all obstructions or</p> | K 211 | <p>designee regarding preventative maintenance policy and applicable NFPA standards.</p> <p>4. MONITOR: Executive Director or designee will validate that all doors are functioning per NFPA guidelines for egress. Facility to audits all doors to ensure compliance, then weekly x 3, then monthly x 3. Additional education will be provided as necessary. Results of audit will be reviewed in PI to ensure systems being followed. Plan to be updated as indicated.</p> <p>5. Date of Compliance:</p> | 1/4/2019 |

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| K 211 | Continued From page 2 impediments to full instant use in the case of fire or other emergency. 7.2.1.6* Special Locking Arrangements. 7.2.1.6.1 Delayed-Egress Locking Systems. 7.2.1.6.1.1 Approved, listed, delayed-egress locking systems shall be permitted to be installed on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6 or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 11 through 43, provided that all of the following criteria are met: (1) The door leaves shall unlock in the direction of egress upon actuation of one of the following: (a) Approved, supervised automatic sprinkler system in accordance with Section 9.7 (b) Not more than one heat detector of an approved, supervised automatic fire detection system in accordance with Section 9.6 (c) Not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6 (2) The door leaves shall unlock in the direction of egress upon loss of power controlling the lock or locking mechanism. (3)*An irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions: (a) The force shall not be required to exceed 15 lbf (67 N). (b) The force shall not be required to be continuously applied for more than 3 seconds. (c) The initiation of the release process shall | K 211 | | |

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| K 211 | Continued From page 3 activate an audible signal in the vicinity of the door opening. (d) Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only. (4)*A readily visible, durable sign in letters not less than 1 in. (25 mm) high and not less than 1.8 in. (3.2 mm) in stroke width on a contrasting background that reads as follows shall be located on the door leaf adjacent to the release device in the direction of egress: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS (5) The egress side of doors equipped with delayed-egress locks shall be provided with emergency lighting in accordance with Section 7.9. | K 211 | | |
| K 353 SS=F | Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced | K 353 | K 353 1. SPECIFIC ISSUE: The one corroded pendant in the bathroom abutting room 209 and the additional pendant in the conference room with paint on it were replaced on or before 12/26/2018 by Director of Maintenance. 2. OTHER RESIDENTS: All sprinkler heads were inspected and repaired as needed on or before 12/26/2018 by Director of Maintenance. 3. SYSTEMIC CHANGES: Staff educated on or before 12/28/2018 by Executive Director or designee regarding preventative maintenance policy and applicable NFPA standards. 4. MONITOR: Executive Director or designee will monitor for sprinkler head corrosion/paint weekly x 3, then monthly x 3. Additional education will be provided as necessary. | |

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| K 353 | Continued From page 4 by: Based on observation, the facility failed to ensure fire suppression systems were maintained in accordance with NFPA 25. Failure to replace fire suppression pendants which are corroded or painted has the potential to hinder system response during a fire event. This deficient practice affected 34 residents, staff and visitors on the date of the survey. Findings include: During the facility tour conducted on 12/12/18 from 1:00 - 3:30 PM, observation of the installed fire suppression pendants revealed one (1) corroded head in the bathroom abutting room 209 and one (1) painted head in the conference room. Actual NFPA standard: 5.2* Inspection. 5.2.1 Sprinklers. 5.2.1.1* Sprinklers shall be inspected from the floor level annually. 5.2.1.1.1* Sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., upright, pendent, or sidewall). 5.2.1.1.2 Any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical damage (4) Loss of fluid in the glass bulb heat responsive element (5)*Loading (6) Painting unless painted by the sprinkler manufacturer | K 353 | Results of audit will be reviewed in PI to ensure systems being followed. Plan to be updated as indicated. 5. Date of Compliance: 1/4/2019 | |
| K 511 | Utilities - Gas and Electric | K 511 | | |

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| K 511 SS=D | <p>Continued From page 5 CFR(s): NFPA 101</p> <p>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 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 installation of electrical systems in accordance with NFPA 70. Failure to secure live electrical connections in enclosed housings has the potential to allow accidental contact with live parts or damaged wires, increasing the risk of arc fires. This deficient practice affected staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 12/12/18 from 1:10 - 3:30 PM, observation of the facility fire suppression riser area revealed an unsealed four inch by four inch electrical junction box on the east wall, with a portable worklight hanging by a hook from one of the exposed wires.</p> <p>Actual NFPA standard: NFPA 70 110.27 Guarding of Live Parts. (A) Live Parts Guarded Against Accidental</p> | K 511 | <p>K 511</p> <ol style="list-style-type: none"> SPECIFIC ISSUE: Electrical junction box in fire suppression riser area was covered and the portable work light was removed. OTHER RESIDENTS: Facility wide audit performed by Maintenance Director on or before 12/26/2018 to ensure facility maintained safe electrical installations. SYSTEMIC CHANGES: Facility staff educated by Executive Director or designee on or before 12/28/2018 to ensure understanding of safe electrical installations throughout the facility. MONITOR: Executive Director or designee will audit random electrical installations weekly x 3 then monthly x 3 to ensure ongoing compliance. Additional education will be provided as necessary. Results of audit will be reviewed in PI to ensure systems being followed. Plan to be updated as indicated. Date of Compliance: | 1/4/2019 |

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| K 511 | Continued From page 6 Contact. Except as elsewhere required or permitted by this Code, live parts of electrical equipment operating at 50 volts or more shall be guarded against accidental contact by approved enclosures or by any of the following means: (1) By location in a room, vault, or similar enclosure that is accessible only to qualified persons. (2) By suitable permanent, substantial partitions or screens arranged so that only qualified persons have access to the space within reach of the live parts. Any openings in such partitions or screens shall be sized and located so that persons are not likely to come into accidental contact with the live parts or to bring conducting objects into contact with them. (3) By location on a suitable balcony, gallery, or platform elevated and arranged so as to exclude unqualified persons. (4) By elevation of 2.5 m (8 ft) or more above the floor or other working surface. (B) Prevent Physical Damage. In locations where electrical equipment is likely to be exposed to physical damage, enclosures or guards shall be so arranged and of such strength as to prevent such damage. | K 511 | K 914 1. SPECIFIC ISSUE: Electrical outlets found in residents rooms were manually tested on or before 12/26/2018 by Director of Maintenance. 2. OTHER RESIDENTS: All electrical outlets were tested per NFPA 99 standard on or before 12/26/2018 by Director of Maintenance. 3. SYSTEMIC CHANGES: Staff educated on or before 12/28/2018 by Executive Director or designee regarding testing and applicable NFPA standards. Additionally, annual inspection log was added to online preventative maintenance schedule to ensure ongoing compliance. 4. MONITOR: In the event the facility needs to change any details of the residents outlets, we will ensure all NFPA standards are followed. Additional education will be provided as necessary. | |
| K 914 SS=F | Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at | K 914 | | |

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| K 914 | <p>Continued From page 7</p> <p>intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results.</p> <p>6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that electrical outlets installed in resident rooms were maintained in accordance with NFPA 99. Failure to test resident room outlets at least every 12 months has the potential to limit the availability of reliable power sources and hinder the ability to shelter in place during a power outage or other emergency. This deficient practice affected 78 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During review of facility maintenance and inspection records conducted on 12/12/18 from 8:45 AM - 12:00 PM, provided records did not indicate the facility was testing the resident room outlets within the last 12 months. When asked if he had any documentation of the facility testing of resident room outlets, the Maintenance Director stated he had not been documenting any testing of the outlets.</p> <p>Actual NFPA standard:</p> <p>NFPA 99</p> | K 914 | <p>Results of audit will be reviewed in PI to ensure systems being followed. Plan to be updated as indicated.</p> <p>5. Date of Compliance: 1/4/2019</p> | |

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| K 914 | Continued From page 8 6.3.4.1.3 Receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months. | K 914 | | |



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

December 20, 2018

Gary "Paul" Arnell, Administrator
The Orchards of Cascadia
404 North Horton Street
Nampa, ID 83651-6541

Provider #: 135019

RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER

Dear Mr. Arnell:

On **December 12, 2018**, an Emergency Preparedness survey was conducted at The Orchards of Cascadia by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with 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,

A handwritten signature in black ink that reads "Nate Elkins". The signature is written in a cursive, flowing style.

Nate Elkins, Supervisor
Facility Fire Safety and Construction

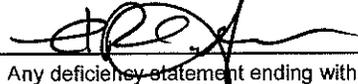
NE/lj
Enclosures

| | | | | | |
|--|--|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135019 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 12/12/2018 |
| NAME OF PROVIDER OR SUPPLIER ORCHARDS OF CASCADIA, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH HORTON STREET NAMPA, ID 83651 | | |
| (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 | <p>Initial Comments</p> <p>The facility is a single story Type V (111) occupancy, originally constructed in 1959. There is an automatic fire sprinkler system and interconnected fire alarm/smoke detection system. There have been multiple renovations conducted in the building, the last of which was completed in 2017. There is an on-site spark-fired Emergency Electrical System (EES) generator which provides backup emergency power. The facility is located in a municipal fire district with both county and state EMS services available. The facility is currently licensed for 100 beds and had a census of 78 on the day of the survey.</p> <p>The facility was found to be in substantial compliance during the Emergency Preparedness survey conducted on December 12, 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 style="text-align: center;">RECEIVED DEC 31 2018 FACILITY STANDARDS</p> | | |

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

TITLE

(X6) DATE



CEO

12/27/18

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.