



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – 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

February 19, 2019

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

Provider #: 135094

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Ms. Mills:

On **February 12, 2019**, a Facility Fire Safety and Construction survey was conducted at **Wellspring Health & Rehabilitation of Cascadia** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. Please provide **ONLY ONE** completion date for each federal and state tag in column (X5) Completion Date to signify when

Debbie Mills, Administrator
February 19, 2019
Page 3 of 4

The remedy, which will be recommended if substantial compliance has not been achieved by **March 19, 2019**, includes the following:

Denial of payment for new admissions effective **May 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 **August 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 **February 12, 2019**, 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:

Debbie Mills, Administrator
February 19, 2019
Page 4 of 4

<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:

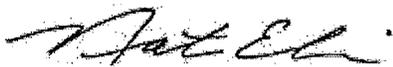
BFS Letters (06/30/11)

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

This request must be received by **March 4, 2019**. If your request for informal dispute resolution is received after **March 4, 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

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

PRINTED: 02/19/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135094	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 02/12/2019
--------------------------------------------------	-------------------------------------------------------------------------	--------------------------------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER WELLSPRING HEALTH & REHABILITATION OF CASCADIA	STREET ADDRESS, CITY, STATE, ZIP CODE 2105 12TH AVENUE ROAD NAMPA, ID 83686
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	<p>INITIAL COMMENTS</p> <p>The facility is a single story Type V (III) structure built in 1998 with an addition of 60 beds in March 2001 and a vent unit expansion in 2014. The facility is equipped with two (2) diesel powered emergency generators as part of the facility EES (Emergency Electrical System); one (1) for the main existing portion of the facility and one (1) which was added for the vent unit expansion. The facility is located in a municipal fire and county emergency district with full sprinkler protection throughout and smoke detection coverage in corridors, sleeping rooms, and open spaces. The facility is currently licensed for 120 SNF/NF beds and had a census of 51 on the dates of the survey.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on February 11 - 12, 2019. The facility was surveyed under the Life Safety Code, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70, and 42 CFR 483.80.</p> <p>The Survey was conducted by:</p> <p>Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction</p>	K 000	<p style="text-align: center;">RECEIVED MAR 04 2019 FACILITY STANDARDS</p>	
K 363 SS=D	<p>Corridor - Doors CFR(s): NFPA 101</p> <p>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</p>	K 363		<p>1. SPECIFIC ISSUE: Gap in resident rooms #110 and #304 between face of door and frame of door when fully closed.</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *Administrator* (X6) DATE: *3/4/19*

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 363	<p>Continued From page 1</p> <p>at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided 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 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation, operational testing, and interview the facility failed to maintain doors that protect corridor openings. Failure to maintain corridor doors could allow smoke and dangerous gases to pass freely, preventing defend in place. This deficient practice has the potential to affect 1</p>	K 363	<p>2. OTHER RESIDENTS: Facility wide audit performed by Maintenance Director on or before 3/15/19 to ensure facility maintained safe doors to resist the passage of smoke.</p> <p>3. SYSTEMIC CHANGES: Staff educated on or before 2/13/19 by Executive Director or 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 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>	3/15/19

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

PRINTED: 02/19/2019
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OMB NO. 0938-0391

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K 363	Continued From page 2 resident, staff, and visitors on the dates of the survey. Findings include: During the facility tour on February 12, 2019, from approximately 12:00 PM to 2:00 PM, observation and operational testing of the resident room doors revealed resident room #110 had an approximately 3/4" gap, and resident room #304 had an approximately 5/8" gap between the face of the door and the frame of the door when fully closed. When asked, the Director of Facilities stated the facility was unaware the doors were out of compliance. Actual NFPA Standards: NFPA 101 19.3.6.3* Corridor Doors. 19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be doors constructed to resist the passage of smoke and shall be constructed of materials such as the following: (1) 1-3/4 in. (44 mm) thick, solid-bonded core wood (2) Material that resists fire for a minimum of 20 minutes Additional Reference: Centers for Medicare/Medicaid Services S&C Letter 07-18, Permittable Door Gaps.	K 363		
K 374 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101	K 374		

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K 374	<p>Continued From page 3</p> <p>Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING</p> <p>Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors.</p> <p>19.3.7.6, 19.3.7.8, 19.3.7.9</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, operational testing, and interview the facility failed to maintain doors that separate smoke compartments. Failure to maintain smoke barrier doors could allow smoke and dangerous gases to pass freely, preventing defend in place. This deficient practice has the potential to affect 18 residents housed in the 300 and 500 hallways, staff, and visitors on the dates of survey.</p> <p>Findings include:</p> <p>During the facility tour on February 12, 2019, from approximately 12:00 PM to 2:00 PM, observation and operational testing of the smoke barrier doors adjacent to resident rooms #512 and #514, revealed the doors would not self-close when released from the magnetic hold open devices. One of the doors appeared to be rubbing on the top of the door frame, slowing the door and preventing it from closing, leaving an approximately 1" gap. When asked, the Director</p>	K 374		

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K 374	<p>Continued From page 4</p> <p>of Facilities stated the facility was unaware the door was rubbing on the frame preventing it from closing. The Director of Facilities further stated the door and/or frame may have swelled due to the recent influx of moisture to the building from a sprinkler pipe that broke in the 400 hallway.</p> <p>Actual NFPA Standards:</p> <p>19.3.7.8* Doors in smoke barriers shall comply with 8.5.4 and all of the following: (1) The doors shall be self-closing or automatic-closing in accordance with 19.2.2.7. (2) Latching hardware shall not be required (3) The doors shall not be required to swing in the direction of egress travel.</p> <p>8.5.4.4* Doors in smoke barriers shall be self-closing or automatic-closing in accordance with 7.2.1.8 and shall comply with the provisions of 7.2.1.</p> <p>7.2.1.8.2 In any building of low or ordinary hazard contents, as defined in 6.2.2.2 and 6.2.2.3, or where approved by the authority having jurisdiction, door leaves shall be permitted to be automatic-closing, provided that all of the following criteria are met: (1) Upon release of the hold-open mechanism, the leaf becomes self-closing. (2) The release device is designed so that the leaf instantly releases manually and, upon release, becomes self-closing, or the leaf can be readily closed. (3) The automatic releasing mechanism or medium is activated by the operation of approved smoke detectors installed in accordance with the requirements for smoke detectors for door leaf release service in NFPA 72, National Fire Alarm and Signaling Code. (4) Upon loss of power to the hold-open device,</p>	K 374	<p>K 374</p> <ol style="list-style-type: none"> SPECIFIC ISSUE: Smoke barrier doors adjacent to rooms #512 and #514, would not self-close when released from magnetic hold open devices OTHER RESIDENTS: Facility wide audit performed by Maintenance Director on or before 3/15/19 to ensure facility maintain doors that separate smoke compartments. SYSTEMIC CHANGES: Staff educated on or before 2/13/19 by Executive Director or designee regarding preventative maintenance policy and applicable NFPA standards. MONITOR: Executive Director or designee will validate that all doors are functioning per NFPA guidelines. Facility to audits all doors to ensure compliance 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. 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135094	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 02/12/2019
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K 374	Continued From page 5 the hold-open mechanism is released and the door leaf becomes self-closing. (5) The release by means of smoke detection of one door leaf in a stair enclosure results in closing all door leaves serving that stair.	K 374	5. Date of Compliance:	3/15/19
K 712 SS=F	Fire Drills CFR(s): NFPA 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 record review and interview, the facility failed to provide documentation of fire drills on all shifts quarterly. Failure to perform fire drills on each shift quarterly could result in confusion and hinder the safe evacuation of residents during a fire event. This deficient practice affected 51 residents, staff and visitors on the dates of survey. Findings Include: During record review on February 11, 2019, from approximately 1:30 PM to 4:30 PM, review of fire drill reports revealed the facility was missing fire drill documentation on third shift, first quarter 2018 and all shifts for second quarter 2018.	K 712	K 712 1. SPECIFIC ISSUE: Missing fire drill documentation. 2. OTHER RESIDENTS: All residents, staff and visitors have the potential to be affected. 3. SYSTEMIC CHANGES: Staff educated on or before 2/13/19 by Executive Director or designee regarding conducting fire drills at per NFPA standards. 4. MONITOR: Executive Director or designee will validate that fire drills are conducted per NFPA guidelines. Facility to audits all drills are conducted x 3 months. 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. 5. Date of Compliance:	3/15/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135094	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 02/12/2019
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K 712	<p>Continued From page 6</p> <p>When asked, the Director of Facilities stated he was new to his position as of third quarter 2018, and was unaware fire drills had not been performed during those time frames.</p> <p>Actual NFPA Standard:</p> <p>NFPA 101</p> <p>19.7.1.4* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions.</p> <p>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.</p>	K 712		



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February 19, 2019

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

Provider #: 135094

RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER

Dear Ms. Mills:

On **February 12, 2019**, an Emergency Preparedness survey was conducted at **Wellspring Health & Rehabilitation of Cascadia** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. Please provide **ONLY ONE** completion date for each federal and state tag in column (X5) Completion Date to signify when you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, 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 **March 4, 2019**. Failure to submit an acceptable PoC by **March 4, 2019**, may result in the imposition of civil monetary penalties by **March 26, 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 **March 19, 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 . A change in the seriousness of the deficiencies on **April 5, 2019**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **March 19, 2019**, includes the following:

Denial of payment for new admissions effective **May 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 **August 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 **February 12, 2019**, 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

Debbie Mills, Administrator
February 19, 2019
Page 4 of 4

This request must be received by **March 4, 2019**. If your request for informal dispute resolution is received after **March 4, 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

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Enclosures

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135094	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/12/2019
NAME OF PROVIDER OR SUPPLIER WELLSPRING HEALTH & REHABILITATION OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 2105 12TH AVENUE ROAD NAMPA, ID 83686	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments The facility is a single story Type V (III) structure built in 1998 with an addition of 60 beds in March 2001 and a vent unit expansion in 2014. The facility is equipped with two (2) diesel powered emergency generators as part of the facility EES (Emergency Electrical System); one (1) for the main existing portion of the facility and one (1) which was added for the vent unit expansion. The facility is located in a municipal fire and county emergency district with full sprinkler protection throughout and smoke detection coverage in corridors, sleeping rooms, and open spaces. The facility is currently licensed for 120 SNF/NF beds, and had a census of 51 on the dates of the survey. The following deficiencies were cited during the emergency preparedness survey conducted on February 11 - 12, 2019. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73. The Survey was conducted by: Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction	E 000	E 006 1. SPECIFIC ISSUE: Facility failed to provide strategies for response to all of the risks identified in the facility and community-based risk assessment. 2. OTHER RESIDENTS: All residents, staff and visitors have the potential to be affected. 3. SYSTEMIC CHANGES: Staff educated on or before 2/13/19 by Executive Director or designee risk strategies for all identified risks. RECEIVED MAR 04 2019 4. MONITOR: FACILITY STANDARDS Executive Director or designee will validate that risk assessments are completed. Facility Safety committee will review monthly for 3 months . 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. 5. Date of Compliance:	
E 006 SS=F	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (1) Be based on and include a documented,	E 006		3/15/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *Administrator* (X6) DATE: *3/4/19*

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

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E 006	<p>Continued From page 1 facility-based and community-based risk assessment, utilizing an all-hazards approach.*</p> <p>*[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents.</p> <p>*[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients.</p> <p>(2) Include strategies for addressing emergency events identified by the risk assessment.</p> <p>* [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to provide strategies for response to all of the risks identified in the facility and community-based risk assessment. Failure to provide strategies for response could hinder the facilities ability to respond in a timely manner to disasters and emergencies. This deficient practice affected 51 residents, staff and visitors on the dates of the survey.</p> <p>Findings include: On February 11, 2019 from approximately 11:30 AM to 1:30 PM, review of the facility emergency</p>	E 006		

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E 006	Continued From page 2 preparedness plan and hazard vulnerability assessment (HVA) revealed the facility had not provided strategies/procedures to address all hazards identified on the facility HVA. The following hazards were identified on the facility HVA without corresponding strategies/procedures to address in the EP plan: Drought, Generator Failure, Fuel Shortage, Natural Gas Failure, Information System Failure, Medical Gas Failure, Internal Haz-Mat exposure, External Haz-Mat exposure, Workplace Violence, Security Threat, Hostage Situation, and Man Made Threat (angry family member, disgruntled employee, etc.) When asked, the Administrator stated the facility believed this deficiency had been corrected when cited on the 2018 Life Safety Survey, and was unaware documentation had been removed/added to the EP plan and/or HVA to bring them out of compliance.	E 006		
E 009 SS=E	Reference: 42 CFR 483.73 (a) (1) - (2) Local, State, Tribal Collaboration Process CFR(s): 483.73(a)(4) [(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:] (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	E 009	E 009 1. SPECIFIC ISSUE: Facility failed to collaborate with local, Regional, State, and Federal officials in an effort to maintain an integrated response to emergency events. 2. OTHER RESIDENTS: All residents, staff and visitors have the potential to be affected.	

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E 009	<p>Continued From page 3 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. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility had not implemented policy by contacting other entities and emergency responders within their community to promote an integrated response to emergency events. This deficient practice had the potential to affect 51 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>Review of the facility EP plan on February 11, 2019, from approximately 11:30 AM to 1:30 PM, revealed the facility failed to collaborate with local, regional, State, and Federal officials in an effort to maintain an integrated response. When asked, the Administrator stated the facility was in the process of connecting their new Maintenance Director with the local Healthcare Coalition and other emergency response entities and</p>	E 009	<p>3. SYSTEMIC CHANGES: Staff educated on or before 2/13/19 by Executive Director or designee to work with local, Regional, State and Federal officials in an effort to maintain an integrated response to emergency events.</p> <p>4. MONITOR: Executive Director or designee will validate that facility is represented and participating with local, Regional, State and Federal officials. Facility Safety committee will review monthly for 3 months . Additional education will be provided as necessary. Results will be reviewed in PI to ensure systems being followed. Plan to be updated as indicated.</p> <p>5. Date of Compliance:</p>	3/15/19	

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E 009	Continued From page 4 organizations to participate in the planning and/or training.	E 009			
E 036 SS=F	<p>Reference: 42 CFR 483.73 (a) (4) 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 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</p>	E 036	<p>E 036</p> <ol style="list-style-type: none"> SPECIFIC ISSUE: Facility failed to provide written training And testing program for emergency preparedness to instruct staff, contractors and facility volunteers on their role during an emergency event. OTHER RESIDENTS: All residents, staff and visitors have the potential to be affected. SYSTEMIC CHANGES: Staff, educated on or before 3/15/19 by Executive Director or Designee and then annually to provide written and testing to staff, contractors and facility volunteers their role during an emergency. MONITOR: Executive Director or designee will validate that facility has conducted training and testing in emergency 		

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E 036	<p>Continued From page 5</p> <p>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:</p> <p>Based on record review and interview, it was determined the facility failed to provide a written training and testing program for emergency preparedness (EP). Lack of a training and testing program covering the EP plan, policies and procedures for the facility, has the potential to hinder staff response during a disaster. This deficient practice affected 51 residents, staff and visitors on the dates of the survey.</p> <p>Findings include:</p> <p>On February 11, 2019, from approximately 11:30 AM to 1:30 PM, review of provided EP plans, policies and procedures, revealed the facility had not included a written training and testing program in their EP plan to educate and instruct staff, contractors, and facility volunteers on their role during an emergency event. Additionally, facility did not have a written plan to test the effectiveness of the training and/or overall emergency preparedness program. When asked, the Administrator stated the facility was unaware the written training and testing program for EP was not included in the EP plan.</p> <p>Reference:</p> <p>42 CFR 483.73 (d)</p>	E 036	<p>preparedness an review in safety committee . Additional education will be provided as necessary. Results will be reviewed in PI to ensure systems being followed. Plan to be updated as indicated.</p> <p>5. Date of Compliance:</p>	3/15/19