



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

Brantley Shattuck, Administrator  
Cascadia of Nampa  
900 N. Happy Valley Rd.  
Nampa, ID 83687

Provider #: 135144

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

Dear Mr. Shattuck:

On **February 14, 2019**, a Facility Fire Safety and Construction survey was conducted at **Cascadia Of Nampa** 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

Brantley Shattuck, Administrator  
February 19, 2019  
Page 2 of 4

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 **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 21, 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 **May 15, 2019**. A change in the seriousness of the deficiencies on **March 31, 2019**, may result in a change in the remedy.

Brantley Shattuck, Administrator  
February 19, 2019  
Page 3 of 4

The remedy, which will be recommended if substantial compliance has not been achieved by **March 21, 2019**, includes the following:

Denial of payment for new admissions effective **May 14, 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 14, 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 14, 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:

Brantley Shattuck, 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:

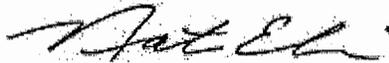
BFS Letters (06/30/11)

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:  <b>135144</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - ENTIRE BUILDING</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/14/2019</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CASCADIA OF NAMPA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>900 N HAPPY VALLEY RD NAMPA, ID 83687</b>
--	---

**RECEIVED**  
**MAR 04 2019**  
**FACILITY STANDARDS**

(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	INITIAL COMMENTS  The facility is a single story, Type V (111) structure with a special feature of two Won-Doors located in areas A and B. The building is fully sprinklered and has a complete addressable fire alarm/smoke detection system including open areas to include audible/visual notification throughout. Emergency Power is provided by a Type 1 EPSS with an annunciator and emergency stop. Currently the facility is licensed for 99 SNF/NF beds, and had a census of 68 on the dates of the survey.  The following deficiencies were cited during the annual fire/life safety survey conducted on February 13 - 14, 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.  The Survey was conducted by:  Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction	K 000		
K 223 SS=E	Doors with Self-Closing Devices CFR(s): NFPA 101  Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: *Required manual fire alarm system; and *Local smoke detectors designed to detect	K 223	<p><b>1. Specific Issue:</b> The facility failed to ensure that doors equipped with self-closing devices were maintained in accordance with NFPA 101 as applicable.</p> <p><b>2. Other Residents:</b> 48 residents are potentially affected by deficient practice.</p> <p><b>3. Systemic changes:</b> Maintenance Director will coordinate with licensed door contractor to ensure door is properly repaired by 5/03/2019 and meets NFPA regulations.</p> <p><b>4. Monitor:</b> Executive Director or designee will audit the Maintenance Director's Quarterly door inspections monthly for 3 months. Results will be presented at QAPI meeting monthly to ensure systems are being followed.</p> <p><b>5. Date of Compliance:</b> 3/4/2019</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  	TITLE  <i>Executive Director</i>	(X6) DATE  <i>3/4/19</i>
---	--	--------------------------------

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

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER  <b>CASCADIA OF NAMPA</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>900 N HAPPY VALLEY RD NAMPA, ID 83687</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 223	<p>Continued From page 1</p> <p>smoke passing through the opening or a required smoke detection system; and</p> <ul style="list-style-type: none"> <li>*Automatic sprinkler system, if installed; and</li> <li>*Loss of power.</li> </ul> <p>18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and operational testing, the facility failed to ensure that doors equipped with self-closing devices were maintained in accordance with NFPA 101. Failure of self-closing doors to operate as designed could allow smoke and dangerous gases to pass between compartments during a fire. This deficient practice affected 48 residents, staff and visitors in the B Unit on the dates of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on February 14, 2019 from approximately 1:30 PM to 3:00 PM, observation and operational testing of the smoke barrier doors at the entrance to the B Unit revealed the doors did not close and latch when released from the magnetic hold open devices, leaving an approximately 5/8-inch gap between the doors.</p> <p>Actual NFPA standard:</p> <p>NFPA 101 19.2.2.2.7* Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier, or hazardous area enclosure shall be permitted to be held open only by an automatic release device that complies with 7.2.1.8.2. The automatic sprinkler system, if provided, and the fire alarm system, and the systems required by 7.2.1.8.2, shall be arranged to initiate the closing action of</p>	K 223		

**RECEIVED**

MAR 04 2019

F. [unclear] 3

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K 223	Continued From page 2	K 223	<p><b>K 914</b></p> <p><b>1. Specific Issue:</b> Facility failed to ensure outlets in resident care areas were tested in accordance with NFPA 99.</p> <p><b>2. Other Residents:</b> All residents are potentially impacted by this issue.</p> <p><b>3. Systemic Changes:</b> Facility wide audit performed by Maintenance Director on or before 3/4/2019 to ensure all hospital grade outlets meet NFPA 99 regulations. Maintenance Staff educated by Executive Director or designee on or before 3/4/2019 to ensure continued compliance with NFPA regulations.</p> <p><b>4. Monitor:</b> Executive Director or designee will audit the Maintenance Director's annual testing for 3 months. Results will be presented at QAPI meeting monthly to ensure systems are being followed.</p> <p><b>5. Date of Compliance:</b> 3/4/2019</p>	
K 914 SS=F	<p>Electrical Systems - Maintenance and Testing CFR(s): NFPA 101</p> <p>Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to one 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, observation and interview, the facility failed to ensure outlets in resident care areas were maintained and tested. Failure to perform maintenance and testing on electrical systems has the potential of electrical outlet failure and/or exposing residents to the risks of arc fires. This deficient practice affected 68 residents staff and visitors on the dates of the survey.</p>	K 914		

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K 914	Continued From page 3  Findings include:  During review of facility records on February 13, 2019, from approximately 9:00 AM - 11:30 AM, documents revealed the testing of hospital grade outlets in resident rooms had not been completed since the initial testing over a year ago when the facility was built. When asked, The Director of Facilities stated the facility was aware of the requirement for annual testing of hospital grade outlets and was in process, but had not yet completed the testing.  Actual NFPA standard:  NFPA 99 6.3.4.1 Maintenance and Testing of Electrical Systems 6.3.4.1.1 Where hospital-grade receptacles are required at patient bed locations and in locations where deep sedation or general anesthesia is administered, testing shall be performed after initial installation, replacement, or servicing of the device. 6.3.4.1.2 Additional testing of receptacles in patient care rooms shall be performed at intervals defined by documented performance data. 6.3.4.1.3 Receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months.	K 914			



IDAHO DEPARTMENT OF  
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3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0009  
PHONE 208-334-6626  
FAX 208-364-1888

February 19, 2019

Brantley Shattuck, Administrator  
Cascadia of Nampa  
900 N. Happy Valley Rd.  
Nampa, ID 83687

Provider #: 135144

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

Dear Mr. Shattuck:

On **February 14, 2019**, an Emergency Preparedness survey was conducted at **Cascadia of Nampa** 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 21, 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 21, 2019**, includes the following:

Denial of payment for new admissions effective **May 14, 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 14, 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 14, 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)

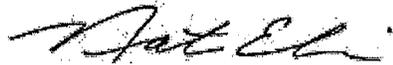
2001-10 Long Term Care Informal Dispute Resolution Process  
2001-10 IDR Request Form

Brantley Shattuck, 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,

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

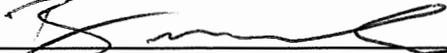
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NAME OF PROVIDER OR SUPPLIER  <b>CASCADIA OF NAMPA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>900 N HAPPY VALLEY RD NAMPA, ID 83687</b>	
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E 000	Initial Comments  The facility is a single story, Type V (111) structure with a special feature of two Won-Doors located in areas A and B. The building is fully sprinklered and has a complete addressable fire alarm/smoke detection system including open areas to include audible/visual notification throughout. Emergency Power is provided by a Type 1 EPSS with an annunciator and emergency stop. Currently the facility is licensed for 99 SNF/NF beds, and had a census of 68 on the dates of the survey.  The following deficiencies were cited during the annual emergency preparedness survey conducted on February 13 - 14, 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 SS=F	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2)  [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:]  (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.*  *[For LTC facilities at §483.73(a)(1):] (1) Be based	E 006	<b>RECEIVED</b>  <b>MAR 04 2019</b>  <b>FACILITY STANDARDS</b>  E 006  1. <b>SPECIFIC ISSUE:</b> Cascadia of Nampa did not develop specific strategies for response to all risks identified in the facility and community-based risk assessment.  2. <b>OTHER RESIDENTS:</b> All residents and staff are potentially affected by deficient practice.  3. <b>SYSTEMIC CHANGES:</b> Cascadia of Nampa will review and develop strategic responses within the emergency manual that address all risks within the facility All Hazards Vulnerability Assessment.  4. <b>MONITOR:</b> Cascadia of Nampa will report updates of the emergency manual to Qapi and provide ongoing education to staff.  5. <b>Date of Compliance:</b> 3/21/2019	

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

TITLE

(X6) DATE

 *Executive Director* 3/4/2019

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135144</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/14/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>CASCADIA OF NAMPA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>900 N HAPPY VALLEY RD NAMPA, ID 83687</b>		
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E 006	<p>Continued From page 1</p> <p>on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents.</p> <p>*[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients.</p> <p>(2) Include strategies for addressing emergency events identified by the risk assessment.</p> <p>* [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, it was determined the facility failed to provide strategies for response to all risks identified in the facility &amp; 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 68 residents, staff and visitors on the dates of the survey.</p> <p>Findings include:</p> <p>On February 13, 2019 from approximately 11:30 AM to 4:00 PM, review of the facility emergency preparedness plan and hazard vulnerability assessment (HVA) revealed the facility had not provided strategies/procedures to address all the hazards identified on the facility HVA. The</p>	E 006			

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E 006	<p>Continued From page 2</p> <p>following hazards were identified on the facility HVA without corresponding strategies/procedures in the EP plan: Wildfire, Tornado, Generator Failure, Drought, Chemical Terrorism, Biological Terrorism, HVAC Failure, Structural Damage, Volcano, Internal Haz-Mat exposure, Explosion/munitions, External Haz-Mat exposure, Civil Disturbance/Community Violence, Information Systems Failure, Fuel Shortage, Severe Thunderstorm, Epidemic/Pandemic, Workplace Violence, Labor Action, Transportation Failure and Unavailability of Supplies.</p> <p>When asked, the Administrator stated his interpretation of an "All Hazards Approach" meant it wasn't necessary to detail every strategy for all hazards, because there was a system in place to address any potential hazard. The facility only developed specific strategies for hazards that reached a threshold of 10 or greater in probability, and believed this met the CMS requirement.</p> <p>Reference: 42 CFR 483.73 (a) (1) - (2)</p>	E 006	E 037	
E 037 SS=F	<p>EP Training Program CFR(s): 483.73(d)(1)</p> <p>(1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] 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 role.</p> <p>(ii) Provide emergency preparedness training at</p>	E 037	<p>1. <b>SPECIFIC ISSUE:</b> Cascadia of Nampa failed to implement site-specific training and testing of employees for Emergency Management plan upon orientation and annually.</p> <p>2. <b>OTHER RESIDENTS:</b> All residents and staff are potentially affected by deficient practice.</p> <p>3. <b>SYSTEMIC CHANGES:</b> New training specific to facility policy and procedures for the emergency management manual will be implemented and provided to all staff upon orientation and annually. The education will be provided ongoing as updates and modifications are made to the emergency manual.</p> <p>4. <b>MONITOR:</b> Executive Director and/or designee will provide education to staff. Effectiveness of training will be evaluated based upon testing, drills, and mock disaster training. Additional education/results will be reported to Qapi.</p> <p>5. <b>Date of Compliance:</b></p>	3/21/2018

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E 037	<p>Continued From page 3</p> <p>least annually.</p> <p>(iii) Maintain documentation of the training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures.</p> <p>*[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:</p> <p>(i) Initial training in emergency preparedness 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>	E 037			

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E 037	<p>Continued From page 4</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 preparedness training.</p> <p>*[For PACE at §460.84(d):] (1) The PACE organization 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 on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.</p> <p>(ii) Provide emergency preparedness training at least annually.</p> <p>(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.</p> <p>(iv) Maintain documentation of all training.</p> <p>*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:</p> <p>(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.</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</p>	E 037			

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E 037	<p>Continued From page 5</p> <p>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 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. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures.</p> <p>*[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.</p>	E 037			

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E 037	<p>Continued From page 6</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 implement the facility EP training program as outlined in the Emergency Preparedness (EP) Plan. Failure to implement training on the EP plan, has the potential to hinder staff response during a disaster. This deficient practice affected 68 residents, staff and visitors on the dates of the survey.</p> <p>Findings include:</p> <p>On February 13, 2019, from 11:30 AM to 4:00 PM, review of the facility EP documentation revealed a written training plan, to include training on the EP plan at the time of hire as part of the new hire orientation. There was also a plan for annual training for existing staff and individuals providing services under arrangement. However, no documentation could be produced to support the training had taken place. Interview of the Director of Facilities and the Administrator confirmed the facility had not fully implemented and documented their training program for EP. The Administrator stated they had recently hired a new training manager and believed this deficiency had already been addressed with a plan in place to correct it.</p> <p>Reference:</p> <p>42 CFR 483.73 (d) (1)</p>	E 037		
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