



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

March 21, 2019

Chase Gunderson, Administrator  
Meadow View Nursing And Rehabilitation  
46 North Midland Boulevard  
Nampa, ID 83651

Provider #: 135076

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

Dear Mr. Gunderson:

On **March 12, 2019**, a Facility Fire Safety and Construction survey was conducted at **Meadow View Nursing And Rehabilitation** 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

Form in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **April 3, 2019**. Failure to submit an acceptable PoC by **April 3, 2019**, may result in the imposition of civil monetary penalties by **April 25, 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 **April 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 . A change in the seriousness of the deficiencies on **May 5, 2019**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **April 16, 2019**, includes the following:

Denial of payment for new admissions effective **June 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 **September 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 **March 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

Chase Gunderson, Administrator

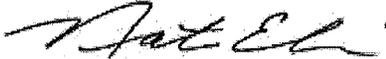
March 21, 2019

Page 4 of 4

This request must be received by **April 3, 2019**. If your request for informal dispute resolution is received after **April 3, 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

Printed: 03/20/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135076</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - ENTIRE NF</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/12/2019</b>
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NAME OF PROVIDER OR SUPPLIER <b>MEADOW VIEW NURSING AND REHABILITATION</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>46 NORTH MIDLAND BOULEVARD NAMPA, ID 83651</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	INITIAL COMMENTS  The facility is a single story Type V(111), originally constructed in 1964. There is a partial basement area that houses the boiler room, maintenance shop and storage areas. The building is fully sprinklered and is equipped with an interconnected fire alarm/smoke detection system. The facility is currently licensed for 112 SNF/NF beds and had a census of 86 on the date of the survey.  The following deficiencies were cited during the annual fire/life safety survey conducted on March 12, 2019. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.  The Survey was conducted by:  Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	K 000		
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101  Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9.18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure doors equipped with special locking arrangements, were provided with battery powered emergency lighting. Failure to provide emergency lighting for doors equipped with delayed egress potentially hinders identification of exits utilized for resident egress during an emergency. This deficient practice affected 86	K 291	<p style="text-align: center;"><b>RECEIVED</b> APR 02 2019</p> <p style="text-align: right;">WARDS</p> <p>K291</p> <p><u>Corrective Action:</u> Meadow View Nursing and Rehabilitation has all emergency lighting connected to the generator for backup emergency power. The emergency lights will be tested under generator power monthly for a minimum of 30 seconds and annually as required.</p> <p><u>Identification of others affected:</u> This deficiency had the potential to affect all residents, new admissions, staff including new hires, and visitors.</p> <p><u>Systemic Changes to ensure Deficient Practice Doesn't Repeat:</u> Meadow View Nursing and Rehabilitation will test and document all monthly and annual tests of the emergency lighting under generator power.</p> <p><u>Monitor of corrective action:</u> Maintenance director or designee will test and document emergency lighting test results monthly and annually as required.</p> <p><u>Corrective Action Completed:</u> 3/20/19</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>ADMINISTRATOR</b>	(X6) DATE <b>4/2/19</b>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135076</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b> - ENTIRE NF  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/12/2019</b>
NAME OF PROVIDER OR SUPPLIER <b>MEADOW VIEW NURSING AND REHABILITATI</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>46 NORTH MIDLAND BOULEVARD NAMPA, ID 83651</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 291	<p>Continued From page 1 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 3/12/19 from 10:30 AM - 3:00 PM, observation of the exit doors revealed all primary exits on both floors were equipped with magnetic locking arrangements, which included a delayed egress component. However, several of these doors were not provided with battery powered emergency lighting. These doors are listed as follows:</p> <p>Main Entrance door(s) East and West exit doors off day room and "B" wing North exit door off of "A" wing and Physical Therapy North exit off SCU day room</p> <p>Actual NFPA standard:</p> <p>19.2.9 Emergency Lighting. 19.2.9.1 Emergency lighting shall be provided in accordance with Section 7.9.</p> <p>7.9 Emergency Lighting. 7.9.1 General. 7.9.1.1* Emergency lighting facilities for means of egress shall be provided in accordance with Section 7.9 for the following: (1) Buildings or structures where required in Chapters 11 through 43 (2) Underground and limited access structures as addressed in Section 11.7 (3) High-rise buildings as required by other sections of this Code (4) Doors equipped with delayed-egress locks (5) Stair shafts and vestibules of smokeproof</p>	K 291		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135076</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - ENTIRE NF</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/12/2019</b>
NAME OF PROVIDER OR SUPPLIER <b>MEADOW VIEW NURSING AND REHABILITATI</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>46 NORTH MIDLAND BOULEVARD NAMPA, ID 83651</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 291	Continued From page 2 enclosures, for which the following also apply: (a) The stair shaft and vestibule shall be permitted to include a standby generator that is installed for the smokeproof enclosure mechanical ventilation equipment. (b) The standby generator shall be permitted to be used for the stair shaft and vestibule emergency lighting power supply.	K 291		



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3232 Elder Street  
P.O. Box 83720  
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PHONE 208-334-6626  
FAX 208-364-1888

March 21, 2019

Chase Gunderson, Administrator  
Meadow View Nursing and Rehabilitation  
46 North Midland Boulevard  
Nampa, ID 83651

Provider #: 135076

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

Dear Ms. Gunderson:

On **March 12, 2019**, an Emergency Preparedness survey was conducted at **Meadow View Nursing and Rehabilitation** 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

Chase Gunderson, Administrator  
March 21, 2019  
Page 2 of 4

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 **April 3, 2019**. Failure to submit an acceptable PoC by **April 3, 2019**, may result in the imposition of civil monetary penalties by **April 25, 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 **April 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 **June 10, 2019**. A change in the seriousness of the deficiencies on **April 26, 2019**, may result in a change in the remedy.

Chase Gunderson, Administrator  
March 21, 2019  
Page 3 of 4

The remedy, which will be recommended if substantial compliance has not been achieved by **April 16, 2019**, includes the following:

Denial of payment for new admissions effective **June 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 **September 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 **March 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:

Chase Gunderson, Administrator  
March 21, 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:

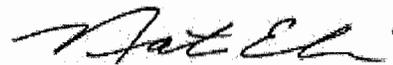
BFS Letters (06/30/11)

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

This request must be received by **April 3, 2019**. If your request for informal dispute resolution is received after **April 3, 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: 03/20/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135076</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/12/2019</b>
NAME OF PROVIDER OR SUPPLIER <b>MEADOW VIEW NURSING AND REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>46 NORTH MIDLAND BOULEVARD NAMPA, ID 83651</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
E 000	Initial Comments  The facility is a single story Type V(111) structure, originally constructed in 1964. It is located within a municipal fire district with both state and county EMS services available. Emergency backup power is provided with an on-site, natural gas Emergency Power Supply System (EPSS) generator. There is a partial basement area which houses the boiler room, maintenance shop and storage. The building is fully sprinklered and is equipped with an interconnected fire alarm/smoke detection system. The facility is currently licensed for 112 SNF/NF beds, and had a census of 86 on the date of the survey.  The following deficiencies were cited during the Emergency Preparedness (EP) Survey conducted on March 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:  Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	E 000	'The plan of correction is prepared and submitted as required by law. By submitting this Plan of Correction, Meadow View Nursing and Rehabilitation does not admit that the deficiency listed on this form exists, nor does the center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.	
E 009 SS=D	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	E 009		

**RECEIVED**  
APR 02 2019  
**FACILITY STANDARDS**

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

*Chris [Signature]*

TITLE

ADMINISTRATOR

(X6) DATE

4/1/19

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135076</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/12/2019</b>
NAME OF PROVIDER OR SUPPLIER <b>MEADOW VIEW NURSING AND REHABILITATI</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>46 NORTH MIDLAND BOULEVARD NAMPA, ID 83651</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
E 009	<p>Continued From page 1 documentation of the facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts.</p> <p>* [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the dialysis facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to document collaboration with local, tribal, regional, State and Federal EP officials and integrated emergency response efforts. Failure to develop a collaborative planning effort with multi-jurisdictional entities, has the potential to limit the facilities options during a disaster. This deficient practice affected 86 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>On 3/12/18 from 9:00 AM - 12:00 PM, review of provided policies, procedures and the emergency plan, failed to establish documentation indicating collaborative involvement with local, tribal, regional State and Federal EP officials, including such involvement as participation in county EMS</p>	E 009	<p>E 009</p> <p><u>Corrective Action:</u> Meadow View Nursing and Rehabilitation reached out and joined the local coalition group.</p> <p><u>Identification of others affected:</u> The deficiency had the potential to affect all residents, new admissions, staff including new hires, and visitors may be affected.</p> <p><u>Systemic Changes to ensure Deficient Practice Doesn't Repeat:</u> The Administrator and Maintenance Director were educated on the requirements of local cooperation and collaboration with emergency preparedness. The facility joined the local coalition and will participate on an ongoing basis.</p> <p><u>Monitor of corrective action:</u> Administrator and/or designee will attend local coalition meetings and keep a log of all meetings attended.</p> <p><u>Corrective Action Completed:</u> 4/1/2019</p>	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 009	Continued From page 2 or regional healthcare coalition meetings. When asked about efforts of collaboration made, the Administrator stated he had made attempts to contact local healthcare coalition personnel, but had not received any return contact.  Reference: 42 CFR 483.73 (a) (4)	E 009		
E 015 SS=D	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1)  [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:  (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal.  *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for	E 015	E 015  <u>Corrective Action:</u> Meadow View Nursing and Rehabilitation developed and implemented an emergency preparedness policy and procedure for sewage and waste disposal.  <u>Identification of others affected:</u> This deficiency had the potential to affect all residents, new admissions, staff including new hires, and visitors.  <u>Systemic Changes to ensure Deficient Practice Doesn't Repeat:</u> Meadow View Nursing and Rehabilitation will continue to review the emergency preparedness plan policies and procedures no less than quarterly and as needed to ensure the plan is a living document to include all necessary components and policies and procedures.  <u>Monitor of corrective action:</u> Maintenance director or designee will review emergency plan quarterly to ensure the plan contains all required components and policies and procedures.  <u>Corrective Action Completed:</u> 3/20/19	

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

Printed: 03/20/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135076</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/12/2019</b>
NAME OF PROVIDER OR SUPPLIER <b>MEADOW VIEW NURSING AND REHABILITATI</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>46 NORTH MIDLAND BOULEVARD NAMPA, ID 83651</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
E 015	<p>Continued From page 3</p> <p>hospice-operated inpatient care facilities only. The policies and procedures must address the following:</p> <p>(iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following:</p> <p>(A) Food, water, medical, and pharmaceutical supplies.</p> <p>(B) Alternate sources of energy to maintain the following:</p> <p>(1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.</p> <p>(2) Emergency lighting.</p> <p>(3) Fire detection, extinguishing, and alarm systems.</p> <p>(C) Sewage and waste disposal.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, it was determined the facility failed to develop policies and procedures in the Emergency Operations Plan (EOP), which identified the steps or methods for providing sewage and waste disposal should those utilities become compromised in a disaster requiring the need to shelter in place. Lack of policies and procedures for sewage and waste disposal during a disaster, has the potential to limit the ability to provide continuing care for residents housed in the facility. This deficient practice affected 86 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>On 3/12/19 from 9:00 AM - 12:00 PM, review of provided policies and procedures did not reveal a policy or procedure for utilities loss that was relevant to the loss of sewage and waste disposal</p>	E 015		

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E 015	Continued From page 4 during a disaster.  Reference: 42 CFR 483.73 (b) (1)	E 015			