



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

July 24, 2020

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 **July 14, 2020**, 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.

FILE COPY

Brantley Shattuck, Administrator
July 24, 2020
Page 2 of

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. 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 **August 6, 2020**. Failure to submit an acceptable PoC by **August 6, 2020**, may result in the imposition of civil monetary penalties by **August 28, 2020**.

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 **August 18, 2020**, (Opportunity to Correct). Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **October 12, 2020**. A change in the seriousness of the deficiencies on **August 28, 2020**, may result in a change in the remedy.

Brantley Shattuck, Administrator
July 24, 2020
Page 3 of

The remedy, which will be recommended if substantial compliance has not been achieved by **August 18, 2020**, includes the following:

Denial of payment for new admissions effective **October 14, 2020**.
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 **January 14, 2021**, 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 **July 14, 2020**, 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
July 24, 2020
Page 4 of

<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:

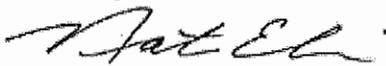
BFS Letters (06/30/11)

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

This request must be received by **August 6, 2020**. If your request for informal dispute resolution is received after **August 6, 2020**, 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: 07/23/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135144	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 07/14/2020
NAME OF PROVIDER OR SUPPLIER CASCADIA OF NAMPA			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N HAPPY VALLEY RD NAMPA, ID 83687	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	<p>INITIAL COMMENTS</p> <p>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 80 on the date of the survey.</p> <p>The following deficiency was cited during the annual fire/life safety survey conducted on July 14, 2020. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.</p> <p>The Survey was conducted by:</p> <p>Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction</p>	K 000		
K 918 SS=F	<p>Electrical Systems - Essential Electric System CFR(s): NFPA 101</p> <p>Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance</p>	K 918		

RECEIVED

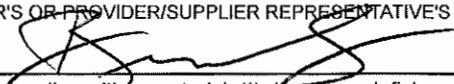
AUG 11 2020

FACILITY STANDARDS

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

TITLE

(X6) DATE



Administrator

8/6/2020

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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K 918	<p>Continued From page 1 with NFPA 110.</p> <p>Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.</p> <p>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure Emergency Power Supply Systems (EPSS) were maintained in accordance to NFPA 110. Failure to test diesel fuel annually for quality could hinder the performance of the equipment during an emergency. This deficient practice affected 80 residents on the date of the survey.</p> <p>Findings include:</p> <p>During review of the EPSS annual inspection and testing documentation provided on July 14, 2020,</p>	K 918			

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NAME OF PROVIDER OR SUPPLIER CASCADIA OF NAMPA			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N HAPPY VALLEY RD NAMPA, ID 83687		
(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 918	Continued From page 2 from approximately 8:30 AM to 10:00 AM, no documentation for a quality test of the diesel fuel could be located. When asked, the Maintenance Director stated the facility was not aware the generator inspection company failed to take a sample of diesel fuel for testing. Actual NFPA standard: NFPA 110 8.3 Maintenance and Operational Testing. 8.3.8 A fuel quality test shall be performed at least annually using tests approved by ASTM standards.	K 918			

Facility Fire Safety and Construction Survey Plan of Correction

K918

CORRECTIVE ACTION(S)

1. A fuel test has been scheduled and will be performed.

IDENTIFICATION OF OTHER RESIDENTS EFFECTED

2. All residents are potentially at risk

SYSTEMIC CHANGES/PREVENTION MEASURES

3. The annual EPSS inspection will now include a fuel test approved by astm standards.

MONITORING OF CORRECTIVE ACTION

4. The executive director and or designee will report the completion of this task to the qapi committee.

Date of Compliance 8/10/2020

RECEIVED

AUG - 6 2020

FACILITY STANDARDS



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July 24, 2020

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

FILE COPY

Provider #: 135144

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

Dear Mr. Shattuck:

On **July 14, 2020**, 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).

Brantley Shattuck, Administrator
July 24, 2020
Page 2 of 4

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 **August 6, 2020**. Failure to submit an acceptable PoC by **August 6, 2020**, may result in the imposition of civil monetary penalties by **August 28, 2020**.

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 **August 18, 2020**, (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 **September 7, 2020**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **August 18, 2020**, includes the following:

Denial of payment for new admissions effective **October 14, 2020**.
42 CFR §488.417(a)

Brantley Shattuck, Administrator
July 24, 2020
Page 3 of 4

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 **January 14, 2021**, 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 **July 14, 2020**, 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:

Brantley Shattuck, Administrator
July 24, 2020
Page 4 of 4

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 **August 6, 2020**. If your request for informal dispute resolution is received after **August 6, 2020**, 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

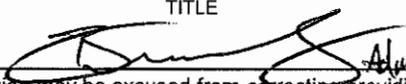
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER/CLIA ID NUMBER: 135144	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/14/2020
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NAME OF PROVIDER OR SUPPLIER CASCADIA OF NAMPA	STREET ADDRESS, CITY, STATE, ZIP CODE 900 N HAPPY VALLEY RD NAMPA, ID 83687
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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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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 80 on the date of the survey. The following deficiencies were cited during the annual emergency preparedness survey conducted on July 14, 2020. The facility was surveyed under the Emergency Preparedness Rule in accordance with 42 CFR 483.73. The Survey was conducted by: Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction	E 000		
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 every 2 years (annually for LTC facilities). 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.	E 009		

RECEIVED
AUG 11 2020
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
		August 6/2020

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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E 009	Continued From page 1 * [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. 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, the facility failed to develop policies and procedures to collaborate with emergency management officials. Failure to develop current policies and procedures to work together with local emergency responders, has the potential to hinder an integrated response during an emergency. This deficient practice could potentially affect 80 residents on the date of the survey. Findings include: On July 14, 2020, from approximately 10:00 AM to 12:00 PM, review of provided emergency preparedness policies and procedures revealed the facility failed to have a written plan in place for collaboration with local, tribal, regional, State or Federal emergency officials. Interview of the Administrator and Maintenance Director revealed the facility does participate in local emergency preparedness groups and meetings but did not have a written policy/procedure.	E 009			
E 034	42 CFR 483.73. (a) (4) Information on Occupancy/Needs	E 034			

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E 034 SS=D	<p>Continued From page 2 CFR(s): 483.73(c)(7)</p> <p>[(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years (annually for LTC).] The communication plan must include all of the following:</p> <p>(7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.</p> <p>*[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.</p> <p>*[For Inpatient Hospice at §418.113(c):] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to document a current plan for sharing information on needs, occupancy and its ability to provide assistance with emergency management officials. Lack of a current plan for providing information to emergency personnel on the facility's needs and abilities to provide assistance during an emergency has the potential to hinder an integrated response and continuation of care. This deficient practice could potentially affect 80</p>	E 034		

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NAME OF PROVIDER OR SUPPLIER CASCADIA OF NAMPA			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N HAPPY VALLEY RD NAMPA, ID 83687		
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E 034	Continued From page 3 residents on the date of the survey. Findings include: On July 14, 2020, from approximately 10:00 AM to 12:00 PM, review of the facility emergency plan revealed no written method to share information on its needs or capabilities with emergency management officials. When asked, the Administrator stated the facility has communicated this information with local emergency preparedness groups at meetings but did not have a written plan. Reference: 42 CFR 483.73 (c) (7)	E 034			
E 036 SS=E	EP Training and Testing CFR(s): 483.73(d) *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, RHC/FHQs at §491.12:] (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 every 2 years.	E 036			

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

PRINTED: 07/23/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135144	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/14/2020
NAME OF PROVIDER OR SUPPLIER CASCADIA OF NAMPA			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N HAPPY VALLEY RD NAMPA, ID 83687		
(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 036	<p>Continued From page 4</p> <p>*[For LTC at §483.73(d):] (d) Training and testing. The LTC 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 every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i).</p> <p>*[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years.</p>	E 036			

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NAME OF PROVIDER OR SUPPLIER CASCADIA OF NAMPA			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N HAPPY VALLEY RD NAMPA, ID 83687		
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E 036	<p>Continued From page 5</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide a written emergency preparedness training and testing program. Failure to have a written plan to train staff and test the Emergency Preparedness plan, has the potential to hinder staff response during a disaster. This deficient practice affected 80 residents on the date of the survey.</p> <p>Findings include:</p> <p>On July 14, 2020, from approximately 10:00 AM to 12:00 PM, review of Emergency Preparedness policies and procedures revealed the facility did not have a written plan for training and testing. When asked, the Administrator stated the facility was unaware the Emergency Preparedness Plan did not include a written policy/procedure for training and testing.</p> <p>Reference:</p> <p>42 CFR 483.73 (d)</p>	E 036			

RECEIVED
AUG - 6 2020
FACILITY STANDARDS

Emergency Preparedness Survey Plan of Correction

E009

CORRECTIVE ACTION(S)

1. The emergency manual has been updated with a policy and procedure to collaborate with local emergency responders and community

IDENTIFICATION OF OTHER RESIDENTS EFFECTED

2. All residents are potentially at risk

SYSTEMIC CHANGES/PREVENTION MEASURES

3. This policy and procedure will be included in the emergency manual moving forward.

MONITORING OF CORRECTIVE ACTION

4. The Executive Director and or designee will review and report this change to the qapi committee. This policy and procedure will be reviewed at least annually by the qapi committee and modify it as needed.

Date of compliance 8/10/2020

E034

CORRECTIVE ACTION(S)

1. The emergency manual has been updated with a facility profile indicating the facility needs, and its ability to provide assistance, to the authority having jurisdiction, the incident command center, or designee as outlined in the communication plan.

IDENTIFICATION OF OTHER RESIDENTS EFFECTED

2. All residents are potentially at risk

SYSTEMIC CHANGES/PREVENTION MEASURES

3. This Facility Profile will be included in the emergency manual moving forward.

MONITORING OF CORRECTIVE ACTION

4. The Executive Director and or designee will review and report this change to the qapi committee. This policy and procedure will be reviewed at least annually by the qapi committee and modify it as needed.

Date of compliance 8/10/2020

RECEIVED

AUG -6 2020

FACILITY STANDARDS

E036

CORRECTIVE ACTION(S)

5. The emergency manual has been updated with a written plan and policy for training and testing.

IDENTIFICATION OF OTHER RESIDENTS EFFECTED

6. All residents are potentially at risk

SYSTEMIC CHANGES/PREVENTION MEASURES

7. The emergency manual will include the written plan and policy moving forward.

MONITORING OF CORRECTIVE ACTION

The Executive Director and or designee will review and report this change to the qapi committee. This policy and procedure will be reviewed at least annually by the qapi committee and modify it as needed.

Date of compliance 8/10/2020