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 23, 2020

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 **July 15, 2020**, 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 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 5, 2020**. Failure to submit an acceptable PoC by **August 5, 2020**, may result in the imposition of civil monetary penalties by **August 27, 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 19, 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 13, 2020**. A change in the seriousness of the deficiencies on **August 29, 2020**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **August 19, 2020**, includes the following:

Denial of payment for new admissions effective **October 15, 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 15, 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 15, 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:

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 5, 2020**. If your request for informal dispute resolution is received after **August 5, 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	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE NF B. WING	(X3) DATE SURVEY COMPLETED
	135076		07/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW VIEW NURSING AND REHABILITATION	46 NORTH MIDLAND BOULEVARD NAMPA, ID 83651

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The facility is a single-story Type V (111), originally constructed in 1964 with a 7,438 square foot addition in 2019. There is a partial basement housing the boiler room, maintenance shop and storage areas. The Essential Electrical System is supplied by a natural gas powered, on-site automatic generator. 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 101 on the date of the survey. The following deficiencies were cited during the annual fire/life safety survey conducted on July 15, 2020. 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: Linda Chaney Health Facility Surveyor Facility Fire Safety and Construction	K 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. RECEIVED AUG 12 2020 FACILITY STANDARDS	
K 232 SS=F	Aisle, Corridor, or Ramp Width CFR(s): NFPA 101 Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5	K 232		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: EXECUTIVE DIRECTOR — (X6) DATE: 8/7/20

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

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K 232	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain corridor exit access free of obstruction/storage. Failure to maintain exit access could hinder the safe evacuation of residents during a fire or other emergency. This deficient practice affected 19 residents in the 100 hallway and residents in the physical therapy area on the date of the survey. Findings include: During the facility tour on July 15, 2020, from approximately 2:30 PM to 4:00 PM, observation of the exit access corridor adjacent to the 100 hallway and physical therapy area, revealed the corridor was being used for storage of wheeled and non-wheeled equipment obstructing full access to the exit door. When asked, the Maintenance Director and Administrator stated the facility was aware items were being stored in the corridor but had not yet moved them. Actual NFPA standard: NFPA 101 19.2.1 General Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7, unless otherwise modified by 19.2.2 through 19.2.11. 19.2.3.4* Any required aisle, corridor, or ramp shall be not less than 48 in. (1220 mm) in clear width where serving as means of egress from patient sleeping rooms, unless otherwise permitted by one of the following: (1) Aisles, corridors, and ramps in adjunct areas	K 232	K 232 Corrective Action: Removed all obstructions from hallways and in front of exits. Educated staff on obstructing hallways and exits. Identification of others affected: Anyone needing to exit through that hallway may have been affected. Systemic Changes to ensure Deficient Practice Doesn't Repeat: Educated staff on obstructing hallways and exits. Removed all obstructions and created storage area for all items on hallway and in front of exits. Monitor of corrective action Maintenance director will conduct daily walk around corridors to ensure all are free from obstructions. During Covid outbreak nursing staff will ensure exits and hallways are unobstructed in all positive Covid areas. Corrective Action Completed:	7/15/2020

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K 232	Continued From page 2 not intended for the housing, treatment, or use of inpatients shall be not less than 44 in. (1120 mm) in clear and unobstructed width. (2)*Where corridor width is at least 6 ft (1830 mm), noncontinuous projections not more than 6 in. (150 mm) from the corridor wall, above the handrail height, shall be permitted. (3) Exit access within a room or suite of rooms complying with the requirements of 19.2.5 shall be permitted. (4) Projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in.(1525 mm). (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c)*The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment (5)*Where the corridor width is at least 8 ft (2440 mm), projections into the required width shall be permitted for fixed furniture, provided that all of the following conditions are met: (a) The fixed furniture is securely attached to the floor or to the wall. (b) The fixed furniture does not reduce the clear unobstructed corridor width to less than 6 ft (1830 mm), except as permitted by 19.2.3.4(2). (c) The fixed furniture is located only on one side of the corridor. (d) The fixed furniture is grouped such that each grouping does not exceed an area of 50 ft2 (4.6 m2).	K 232		

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K 232	Continued From page 3 (e) The fixed furniture groupings addressed in 19.2.3.4(5)(d) are separated from each other by a distance of at least 10 ft (3050 mm). (f)*The fixed furniture is located so as to not obstruct access to building service and fire protection equipment. (g) Corridors throughout the smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the fixed furniture spaces are arranged and located to allow direct supervision by the facility staff from a nurses' station or similar space. (h) The smoke compartment is protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.8.	K 232		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure fire alarm systems were maintained in accordance with NFPA 72. Failure to conduct sensitivity testing on non-addressable fire alarm systems could hinder system response during a fire event. This deficient practice affected 101 residents on the date of the survey.	K 345	K-345 Corrective Action: Facility will ensure and maintain a quarterly fire alarm system testing and will also conduct a sensitivity test as soon as possible, a sensitivity test on the new wing in 2022, and a sensitivity test for the entire facility before August 2025. Identification of others affected: Anyone may have been affected by missed sensitivity test. Systemic Changes to ensure Deficient Practice Doesn't Repeat: All fire alarm and sensitivity testing will be scheduled and audited to ensure all tests are completed timely. Monitor of corrective action: Maintenance director will keep records of all fire alarm system inspections and audit quarterly for completion. Corrective Action Completed:	8/3/2020

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K 345	Continued From page 4 Findings include: During review of facility fire alarm inspection records conducted on July 15, 2020, from approximately 9:15 AM to 11:00 AM, no record of sensitivity testing of the smoke detectors within the last five years could be produced. The last known sensitivity test was done in August of 2014. Additionally, smoke detectors in the 7,438 square foot addition constructed in 2019, require first year sensitivity testing. Interview of the Maintenance Director revealed the facility was aware the sensitivity test was past due, and already scheduled the test for later in the month. Actual NFPA standard: NFPA 72 Chapter 14 Inspection, Testing, and Maintenance 14.4.5.3.1 Sensitivity shall be checked within 1 year after installation. 14.4.5.3.2 Sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with 14.4.5.3.3. 14.4.5.3.3 After the second required calibration test, if sensitivity tests indicate that the device has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years.	K 345		
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors	K 374	K 374 Corrective Action: Smoke doors have been fixed and now shut properly.	

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K 374	Continued From page 5 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to maintain doors protecting smoke compartments. Failure to ensure smoke barrier doors limit the transfer of smoke, has the potential to hinder egress and the ability to shelter in place. This deficient practice affected 22 residents in the B (200) hallway on the date of survey. Findings include: During the facility tour on July 15, 2020, from approximately 2:30 PM to 4:00 PM, observation and operational testing of the smoke doors to the B Hallway, revealed the doors did not close all the way. The leaf on the right hit the top of the left leaf when closing, leaving an approximately 1/2" gap. When asked, the Maintenance Director stated the facility was aware the doors were not closing properly, but due to staff manually closing the two doors together to get a tight fit, had not repaired it yet. Actual NFPA Standards:	K 374	Identification of others affected: Anyone in an area with ineffective smoke doors may have been affected. Measures to ensure Deficient Practice Doesn't Repeat: Audits will be performed quarterly to ensure all doors are tested and maintained. Monitor of corrective action Audits will be completed quarterly to ensure completion and reported to the executive director and safety committee. Corrective Action Completed:	8/3/2020

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K 374	Continued From page 6 19.3.7.8* Doors in smoke barriers shall comply with 8.5.4 and all of the following: (1) The doors shall be self-closing or automatic-closing in accordance with 19.2.2.2.7. (2) Latching hardware shall not be required (3) The doors shall not be required to swing in the direction of egress travel. 8.5.4.4* Doors in smoke barriers shall be self-closing or automatic-closing in accordance with 7.2.1.8 and shall comply with the provisions of 7.2.1. 7.2.1.8.2 In any building of low or ordinary hazard contents, as defined in 6.2.2.2 and 6.2.2.3, or where approved by the authority having jurisdiction, door leaves shall be permitted to be automatic-closing, provided that all of the following criteria are met: (1) Upon release of the hold-open mechanism, the leaf becomes self-closing. (2) The release device is designed so that the leaf instantly releases manually and, upon release, becomes self-closing, or the leaf can be readily closed. (3) The automatic releasing mechanism or medium is activated by the operation of approved smoke detectors installed in accordance with the requirements for smoke detectors for door leaf release service in NFPA 72, National Fire Alarm and Signaling Code. (4) Upon loss of power to the hold-open device, the hold-open mechanism is released and the door leaf becomes self-closing. (5) The release by means of smoke detection of one door leaf in a stair enclosure results in closing all door leaves serving that stair.	K 374		
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101	K 761	K 761 <u>Corrective Action:</u> Maintenance director will inspect and test all smoke doors and hardware to ensure that these doors release and close as per N.F.P.A. requirements and record findings.	

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K 761	Continued From page 7 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure fire and smoke rated assemblies were inspected in accordance with NFPA 80 and NFPA 105. Failure to inspect and test fire rated assemblies annually, has the potential to hinder operation of these components and affect resident evacuation/defend in place during a fire or other emergency. This deficient practice affected 101 residents on the date of the survey. Findings include: During review of provided facility annual inspection records conducted on July 15, 2020, from approximately 11:00 AM to 2:00 PM, documentation for an annual inspection and operational testing of fire/smoke rated assemblies could not be produced. Further observation during the facility tour revealed fire and smoke rated doors installed throughout. When asked,	K 761	Identification of others affected: Anyone in an area with ineffective smoke doors or hardware may have been affected. Systemic Changes to ensure Deficient Practice Doesn't Repeat Maintenance director will schedule annual check of all smoke doors and hardware and audit results and completion. Monitor of corrective action Maintenance director will audit for completion and report findings to Executive Director and safety committee. Corrective Action Completed:	8/3/2020

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K 761	Continued From page 8 the Maintenance Director stated the facility tests the doors monthly but was not aware they were required to document the inspection and testing of the rated doors. Actual NFPA standard: NFPA 101 19.2.2.2 Doors. 19.2.2.2.1 Doors complying with 7.2.1 shall be permitted. 7.2.1 Door Openings. 7.2.1.15 Inspection of Door Openings. 7.2.1.15.1* Where required by Chapters 11 through 43, the following door assemblies shall be inspected and tested not less than annually in accordance with 7.2.1.15.2 through 7.2.1.15.8: (1) Door leaves equipped with panic hardware or fire exit hardware in accordance with 7.2.1.7 (2) Door assemblies in exit enclosures (3) Electrically controlled egress doors (4) Door assemblies with special locking arrangements subject to 7.2.1.6 7.2.1.15.2 Fire-rated door assemblies shall be inspected and tested in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Smoke door assemblies shall be inspected and tested in accordance with NFPA 105, Standard for Smoke Door Assemblies and Other Opening Protectives. NFPA 80 5.2* Inspections. 5.2.1* Fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept	K 761		

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K 761	Continued From page 9 for inspection by the AHJ. NFPA 105 5.2 Specific Requirements. 5.2.1* Inspections. 5.2.1.1 Smoke door assemblies shall be inspected annually. 5.2.1.2 Doors shall be operated to confirm full closure. 5.2.1.3 Hardware and gaskets shall be inspected annually, and any parts found to be damaged or inoperative shall be replaced.	K 761		

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 23, 2020

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 Mr. Gunderson:

On **July 15, 2020**, 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 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 5, 2020**. Failure to submit an acceptable PoC by **August 5, 2020**, may result in the imposition of civil monetary penalties by **August 27, 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 19, 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 6, 2020**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **August 19, 2020**, includes the following:

Denial of payment for new admissions effective **October 15, 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 15, 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 15, 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:

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 5, 2020**. If your request for informal dispute resolution is received after **August 5, 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	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135076		07/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW VIEW NURSING AND REHABILITATION	46 NORTH MIDLAND BOULEVARD NAMPA, ID 83651

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E 000	Initial Comments	E 000		
	The facility is a single-story Type V (111), originally constructed in 1964 with a 7,438 square foot addition in 2019. There is a partial basement housing the boiler room, maintenance shop and storage areas. The Essential Electrical System is supplied by a natural gas powered, on-site automatic generator. 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 101 on the date of the survey. The following deficiency was cited during the annual Emergency Preparedness Survey conducted on July 15, 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		RECEIVED AUG 12 2020 FACILITY STANDARDS	
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 every 2 years. 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.* (2) Include strategies for addressing emergency	E 006	E 006 Corrective Action: Emergency preparedness plan will include an annual facility hazards review. All missing documentation will be updated and plans put in to provide the missing strategies. Facility developed and included strategies to address all emergency events identified by the facility-based risk assessment. Identification of others affected:	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 8/7/20

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

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E 006	Continued From page 1 events identified by the risk assessment. *[For LTC facilities at §483.73(a)(1):] Emergency Plan. The LTC 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, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a)(1):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. 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, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. 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. (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	E 006	Anyone in the facility may have been affected by a lack of thorough hazard plan. <u>Systemic Changes to ensure Deficient Practice Doesn't Repeat:</u> Emergency preparedness plan will be audited annually which will include an audit of facility hazards. Facility will ensure thorough plans are in place for each hazard. <u>Monitor of corrective action:</u> Maintenance director will review emergency plan with executive director and safety committee annually to ensure plan is thorough and complete. <u>Corrective Action Completed:</u>	8/3/2020

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E 006	Continued From page 2 emergencies that would affect the hospice's ability to provide care. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to include strategies to address all emergency events identified by the facility-based and community-based risk assessment. Failure to develop strategies for response to all hazards identified by the facility risk assessment hinders the facility's ability to respond to localized disasters and emergencies. This deficient practice affected 101 residents on the date of the survey. Findings include: On July 15, 2020, from approximately 8:00 AM to 9:15 AM, review of the provided emergency preparedness plan, including the facility Hazard Vulnerability Assessment (HVA) revealed some of the hazards identified on the HVA did not have strategies for response. They were Wildland/Urban Fire; Severe Weather; Influenza Outbreak; Biological Epidemic; and Transportation Failure. The facility also had not added "Emerging Infectious Diseases" to the facility HVA as required. When asked, the Administrator stated the facility was unaware of the missing strategies and would add Emerging Infectious Diseases to the HVA immediately. Reference: 42 CFR 483.73 (a) (1) - (2)	E 006		