



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

September 2, 2020

Rachel Zimmerman, Administrator  
Aspen Park of Cascadia  
420 Rowe Street  
Moscow, ID 83843-9319

Provider #: 135093

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

Dear Ms. Zimmerman:

On **August 20, 2020**, a Facility Fire Safety and Construction survey was conducted at **Aspen Park Of Cascadia** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be an isolated 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.

Rachel Zimmerman, Administrator  
September 2, 2020  
Page 2 of 4

**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 **September 15, 2020**. Failure to submit an acceptable PoC by **September 15, 2020**, may result in the imposition of civil monetary penalties by **October 7, 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 **September 24, 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 **November 18, 2020**. A change in the seriousness of the deficiencies on **October 4, 2020**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been

Rachel Zimmerman, Administrator  
September 2, 2020  
Page 3 of 4

achieved by **September 24, 2020**, includes the following:

Denial of payment for new admissions effective **November 20, 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 **February 20, 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 **August 20, 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>

Rachel Zimmerman, Administrator  
September 2, 2020  
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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 **September 15, 2020**. If your request for informal dispute resolution is received after **September 15, 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:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - ENTIRE BUILDING</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/20/2020</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ASPEN PARK OF CASCADIA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET MOSCOW, ID 83843</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	<p><b>INITIAL COMMENTS</b></p> <p>The facility is a single-story Type V (111) building, with two partial basements. The facility is fully sprinklered, with an interconnected fire alarm/smoke detection system installed in common areas and halls. The building was originally constructed in 1965. Emergency power is provided through an on-site, spark-ignited Emergency Power Supply System (EPSS) generator set. Currently the facility is licensed for 70 SNF/NF beds, and had a census of 47 on the date of the survey.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on August 20, 2020. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Chapter 19, Existing Healthcare Occupancies, in accordance with 42 CFR 483.70</p> <p>The survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety &amp; Construction</p>	K 000		
K 324 SS=D	<p><b>Cooking Facilities</b> CFR(s): NFPA 101</p> <p><b>Cooking Facilities</b> Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:</p> <ul style="list-style-type: none"> <li>* residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2</li> <li>* cooking facilities open to the corridor in smoke</li> </ul>	K 324		

**RECEIVED**  
**SEP 24 2020**  
**FACILITY STANDARDS**

*9/19/2020*

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>R. Zimmerman</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>9/19/2020</i>
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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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/20/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>ASPEN PARK OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET MOSCOW, ID 83843</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 324	<p>Continued From page 1</p> <p>compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or</p> <p>* cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.</p> <p>Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor.</p> <p>18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure kitchen hood systems were maintained in accordance with NFPA 96. Failure to ensure grease laden vapors do not bypass hood filters could allow grease build-up inside the exhaust system, increasing the risk of grease fires. This deficient practice affected staff of the main Kitchen on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 8/20/2020 from 10:00 AM - 12:00 PM, observation of the main Kitchen hood system revealed a section of broken vent louvers in the hood grease filters, on the back, or east side of the hood, providing an approximately one to two-inch gap between the vent louvers.</p> <p>Actual NFPA standard:</p>	K 324	<p>1. <b>SPECIFIC ISSUE:</b> Facility failed to ensure cooking equipment was protected in accordance with NFPA 96.</p> <p>2. <b>OTHER RESIDENTS:</b> All staff and visitors in the kitchen were potentially affected by deficient practice.</p> <p>3. <b>SYSTEMIC CHANGES:</b> All kitchen hood filters were inspected and the broken baffle filter was replaced on or before 9/15/2020. The facility will maintain the kitchen hood system, specifically grease filters, in accordance with NFPA 96. Dietary and Maintenance staff educated by Executive Director or designee on or before 9/15/2020 to ensure monthly inspections of kitchen hood system are within NFPA 96 guidelines.</p> <p>4. <b>MONITOR:</b> Executive Director or designee will audit kitchen hood inspections monthly for 3 months. Executive Director or designee will ensure monthly inspection and maintenance is completed. Results of audit will be reviewed in QAPI to ensure systems being followed. Plan to be updated as indicated.</p> <p>5. <b>Date of Compliance:</b> 9/24/2020</p>		



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - ENTIRE BUILDING</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/20/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>ASPEN PARK OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET MOSCOW, ID 83843</b>		
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K 511	Continued From page 3  NFPA 70  110.3 Examination, Identification, Installation, and Use of Equipment. (A) Examination. In judging equipment, considerations such as the following shall be evaluated: (1) Suitability for installation and use in conformity with the provisions of this Code Informational Note: Suitability of equipment use may be identified by a description marked on or provided with a product to identify the suitability of the product for a specific purpose, environment, or application. Special conditions of use or other limitations and other pertinent information may be marked on the equipment, included in the product instructions, or included in the appropriate listing and labeling information. Suitability of equipment may be evidenced by listing or labeling. (2) Mechanical strength and durability, including, for parts designed to enclose and protect other equipment, the adequacy of the protection thus provided (3) Wire-bending and connection space (4) Electrical insulation (5) Heating effects under normal conditions of use and also under abnormal conditions likely to arise in service (6) Arcing effects (7) Classification by type, size, voltage, current capacity, and specific use (8) Other factors that contribute to the practical safeguarding of persons using or likely to come in contact with the equipment (B) Installation and Use. Listed or labeled equipment shall be installed and used in accordance with any instructions included in the	K 511	<p>1. <b>SPECIFIC ISSUE:</b> Facility failed to ensure safe electrical installation in accordance with NFPA 70.</p> <p>2. <b>OTHER RESIDENTS:</b> All staff and residents were potentially affected by deficient practice.</p> <p>3. <b>SYSTEMIC CHANGES:</b> All appliances were inspected and ensured safe electrical installations were in accordance with NFPA 70 on or before 9/15/2020. The facility will maintain the safe electrical installations in accordance with NFPA 70, specifically the use of RPTs to supply power to appliances. Management and Maintenance staff educated by Executive Director or designee on or before 9/15/2020 to ensure monthly inspections of RPTs and electrical installations in accordance of NFPA 70 guidelines.</p> <p>4. <b>MONITOR:</b> Executive Director or designee will audit RPTs inspections monthly for 3 months. Executive Director or designee will ensure monthly inspection are completed. Results of audit will be reviewed in QAPI to ensure systems being followed. Plan to be updated as indicated.</p> <p>5. <b>Date of Compliance:</b> 9/24/2020</p>		

RECEIVED

SEP 24 2020

FACILITY STANDARDS

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

PRINTED: 09/02/2020  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - ENTIRE BUILDING</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/20/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>ASPEN PARK OF CASCADIA</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET MOSCOW, ID 83843</b>		
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K 511	Continued From page 4 listing or labeling.  Additional reference UL 1363 XYBS	K 511		



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

September 2, 2020

Rachel Zimmerman, Administrator  
Aspen Park of Cascadia  
420 Rowe Street  
Moscow, ID 83843-9319

Provider #: 135093

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

Dear Ms. Zimmerman:

On **August 20, 2020**, an Emergency Preparedness survey was conducted at Aspen Park of Cascadia by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. Your facility was found to be in substantial compliance with Federal regulations during this survey.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, which states that the facility complies with the requirements of CFR 42, 483.70(a) of the federal requirements. This form is for your records only and does not need to be returned.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact this office at (208) 334-6626, option 3.

Sincerely,

Nate Elkins, Supervisor  
Facility Fire Safety and Construction

NE/lj

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

Printed: 08/28/2020  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/20/2020</b>
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NAME OF PROVIDER OR SUPPLIER <b>ASPEN PARK OF CASCADIA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET MOSCOW, ID 83843</b>
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E 000	<p>Initial Comments</p> <p>The facility is a single-story Type V (111) building, with two partial basements and located within a municipal fire district with both state and county EMS services available. The facility is fully sprinklered, with an interconnected fire alarm/smoke detection system installed in common areas and halls. The building was originally constructed in 1965. Emergency power is provided through an on-site, spark-ignited Emergency Power Supply System (EPSS) generator set. Currently the facility is licensed for 70 SNF/NF beds, and had a census of 47 on the date of the survey.</p> <p>The facility was found to be in substantial compliance during the Emergency Preparedness survey conducted on August 20, 2020. The facility was surveyed under the Emergency Preparedness Rule in accordance with 42 CFR 483.73.</p> <p>The survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety &amp; Construction</p>	E 000	<p><b>RECEIVED</b></p> <p><b>SEP 14 2020</b></p> <p><b>FACILITY STANDARDS</b></p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *R. Zimmerman* TITLE *Executive Director* (X6) DATE *9/9/2020*

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.