



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 12, 2019

Debbie Mills, Administrator  
Wellspring Health & Rehabilitation of Cascadia  
2105 12th Avenue Road  
Nampa, ID 83686-6312

Provider #: 135094

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

Dear Ms.. Mills:

On **September 4, 2019**, a Facility Fire Safety and Construction survey was conducted at **Wellspring Health & Rehabilitation 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 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.

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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 **September 25, 2019**. Failure to submit an acceptable PoC by **September 25, 2019**, may result in the imposition of civil monetary penalties by **October 17, 2019**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.
- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567. If a State Form was issued as well, it should also be signed, dated and returned.

All references to federal regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Remedies may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **October 9, 2019**, (Opportunity to Correct). Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **December 3, 2019**. A change in the seriousness of the deficiencies on **October 19, 2019**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **October 9, 2019**, includes the following:

Denial of payment for new admissions effective **December 4, 2019**.  
42 CFR §488.417(a)

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **March 4, 2020**, 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 **September 4, 2019**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

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<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:

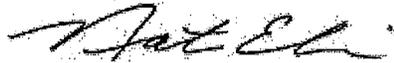
BFS Letters (06/30/11)

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

This request must be received by **September 25, 2019**. If your request for informal dispute resolution is received after **September 25, 2019**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



Nate Elkins, Supervisor  
Facility Fire Safety and Construction

NE/lj  
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135094</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/04/2019</b>
NAME OF PROVIDER OR SUPPLIER <b>WELLSPRING HEALTH &amp; REHABILITATION OF</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2105 12TH AVENUE ROAD NAMPA, ID 83686</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 000	<p><b>INITIAL COMMENTS</b></p> <p>The facility is a single story Type V (III) structure, originally constructed in 1998. There was an addition of 60 beds in March 2001 and a vent unit expansion in 2014. The facility is equipped with two (2) diesel powered, Emergency Power Supply System (EPSS) generators, one (1) for the main existing portion of the facility and one (1) for the vent unit. The facility is fully sprinklered with an interconnected fire alarm/smoke detection system. The facility is currently licensed for 120 SNF/NF beds, and had a census of 54 on the dates of the survey.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on September 3 - 4, 2019. 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>Sam Burbank Health Facility Surveyor Facility Fire Safety &amp; Construction</p>	K 000	<p><b>RECEIVED</b> SEP 25 2019 <b>FACILITY STANDARDS</b></p> <p><b>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Wellspring Health and Rehabilitation of Cascadia does not admit that the deficiencies listed on the CMS Form 2567 exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.</b></p>	
K 100 SS=D	<p><b>General Requirements - Other</b> CFR(s): NFPA 101</p> <p><b>General Requirements - Other</b> List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure compartmentation was</p>	K 100	<p><b>K100</b></p> <p><b>Specific Issue: Facility failed to ensure compartmentation was maintained.</b></p> <p><b>Other Residents: All residents, staff and visitors have the potential to be affected.</b></p> <p><b>Systemic Changes: Missing ceiling tiles have been replaced. Upon completion of projects by contractors, Maintenance Supervisor will inspect to ensure compartmentation is maintained.</b></p>	

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

TITLE

(X6) DATE

*William Mills*

*Administrator*

*9/24/19*

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

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K 100	<p>Continued From page 1</p> <p>maintained. Failure to maintain compartmentation has the potential to hinder installed fire suppression and fire alarm system response, by allowing heat and smoke to bypass these features. This deficient practice affected those residents and staff using the southside assist dining on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 9/3/19 from 2:00 - 4:45 PM, observation of suspended ceiling installations revealed the area outside the east entrance to the Kitchen from the Assist Dining had two (2) missing ceiling tiles approximately one foot by four feet and one foot by sixteen inches in size.</p> <p>Actual NFPA standard:</p> <p>19.1.1.3 Total Concept. 19.1.1.3.1 All health care facilities shall be designed, constructed, maintained, and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants.</p> <p>19.1.1.3.2 Because the safety of health care occupants cannot be ensured adequately by dependence on evacuation of the building, their protection from fire shall be provided by appropriate arrangement of facilities; adequate, trained staff; and development of operating and maintenance procedures composed of the following:</p> <p>(1) Design, construction, and compartmentation (2) Provision for detection, alarm, and extinguishment (3) Fire prevention procedures and planning, training, and drilling programs for the isolation of fire, transfer of occupants to areas of refuge, or</p>	K 100	<p><b>Monitor: Executive Director or designee will validate inspection has occurred. Facility Safety Committee will review monthly for 3 months. Additional Education will be provided as necessary. Results of audit will be reviewed in PI to ensure system is being followed. Plan to be updated as indicated.</b></p> <p><b>Date of Compliance: 9/24/19</b></p>	

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K 100	Continued From page 2 evacuation of the building	K 100		
K 353 SS=F	<p>Sprinkler System - Maintenance and Testing CFR(s): NFPA 101</p> <p>Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure control valves were secured in accordance with NFPA 25. Failure to ensure the Post Indicator Valve (PIV) for the fire suppression system is secure, has the potential to allow the system to be shut down unintentionally and render the facility unsprinklered during a fire event. This deficient practice affected 54 residents, staff and visitors on the dates of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 9/3/2019 from 2:00 - 4:00 PM, observation of the PIV</p>	K 353	<p><b>K 353</b></p> <p><b>Specific Issue: The facility failed to ensure control valves were secured.</b></p> <p><b>Other Residents: All residents, staff and visitors have the potential to be affected.</b></p> <p><b>Systemic Changes: Padlock on hasp was replaced 9/5/19. Monitoring the lock will be added to the TELS system for weekly inspection by Maintenance Director or designee.</b></p> <p><b>Monitor: Executive Director or designee will validate TELS system monitoring. Facility Safety committee will review monthly for 3 months. Additional education will be provided as necessary. Results of audit will be reviewed in PI to ensure systems being followed. Plan to be updated as indicated.</b></p> <p><b>Date of Compliance: 9/24/19</b></p>	

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K 353	Continued From page 3 located outside the riser room on the south end of the facility, revealed a keyed padlock was installed on the hasp to secure the PIV operating handle. Further inspection and operational testing of this lock found it did not latch and would not stay locked. Interview of the Maintenance Director at approximately 3:40 PM established he was not aware the PIV was not secured.  Actual NFPA standard:  13.3 Control Valves in Water-Based Fire Protection Systems. 13.3.1.3 Each normally open valve shall be secured by means of a seal or a lock or shall be electrically supervised in accordance with the applicable NFPA standards.	K 353		
K 372 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101  Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure smoke barriers were maintained to resist the passage of smoke. Failure to seal through-penetrations and membrane penetrations	K 372	<b>K 372</b>  <b>Specific Issue: Facility failed to ensure smoke barriers were maintained to resist the passage of smoke.</b>  <b>Other Residents: 14 residents, staff and visitors had the potential to be affected.</b>  <b>Systemic Changes:</b> <b>Smoke barrier wall adjacent to room 500 has been repaired.</b> <b>Assembly separating the attic to the ancillary space above the ceiling at room 305 has been repaired.</b> <b>Smoke barrier wall adjacent to room 411 with cabling has been repaired.</b> <b>Membrane at the rear exit door on the southwest side of facility has been repaired.</b> <b>Maintenance director will inspect monthly specific areas for penetration of smoke barriers.</b>	

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K 372	<p>Continued From page 4</p> <p>in smoke barrier walls, has the potential to allow smoke, fire and dangerous gases to pass between smoke compartments and hinder evacuation and/or the ability to defend in place. This deficient practice affected 18 residents and staff on the dates of survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 9/4/19 from 9:30 - 10:30 AM, above the ceiling inspections revealed the following:</p> <ul style="list-style-type: none"> <li>- The smoke barrier wall adjacent to room 500 had an approximately four inch diameter fire suppression pipe passing through an unsealed penetration of the 1-hour rated assembly.</li> <li>- The 1-hour rated assembly separating the attic to the ancillary space above the ceiling at room 305, revealed an approximately 1" PVC pipe that was cut and open, passing in to the space above.</li> <li>- The smoke barrier wall adjacent to room 411 revealed an approximately 1/2" conduit with data cabling that had not been sealed on either side of the barrier.</li> <li>- An approximately four inch by four inch square hole cut into the 1-hour membrane at the rear exit door on the southwest side of the facility.</li> </ul> <p>Actual NFPA standard:</p> <p>8.5.6 Penetrations. 8.5.6.3 Where a smoke barrier is also constructed as a fire barrier, the penetrations shall be protected in accordance with the requirements of 8.3.5 to limit the spread of fire for a time period equal to the fire resistance rating of the assembly and 8.5.6 to restrict the transfer of smoke, unless</p>	K 372	<p><b>Monitor: Executive director or designee will validate monthly inspections. Facility Safety Committee will review monthly for 3 months. Results of audit will be reviewed in PI to ensure systems are being followed. Plan to be updated as indicated.</b></p> <p><b>Date of Compliance: 9/24/19</b></p>	

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K 372	Continued From page 5 the requirements of 8.5.6.4 are met.	K 372		
K 511 SS=F	<p>8.3.5.1* Firestop Systems and Devices Required. Penetrations for cables, cable trays, conduits, pipes, tubes, combustion vents and exhaust vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a fire barrier shall be protected by a firestop system or device. The firestop system or device shall be tested in accordance with ASTM E 814, Standard Test Method for Fire Tests of Through Penetration Fire Stops, or ANSI/UL 1479, Standard for Fire Tests of Through-Penetration Firestops, at a minimum positive pressure differential of 0.01 in. water column (2.5 N/m<sup>2</sup>) between the exposed and the unexposed surface of the test assembly.</p> <p>Utilities - Gas and Electric CFR(s): NFPA 101</p> <p>Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure safe electrical installations were maintained in accordance with NFPA 70. Failure</p>	K 511	<p><b>K 511</b></p> <p><b>Specific Issue: The facility failed to ensure safe electrical installations were maintained.</b></p> <p><b>Other Residents:</b></p> <p>.</p> <p><b>Systemic Changes:</b> <b>Microwave removed from office.</b> <b>Outlet replaced 9/5/19</b> <b>Interior court yard interconnected conduit –mounted electrical connections disconnected at circuit box and lights and wiring removed.</b> <b>Items blocking the electrical panels have been removed.</b> <b>Electrical boxes above the ceiling at the smoke barrier doors by room 512 and 502 have been replaced.</b> <b>Facility Maintenance Director or designee will monitor for safe electrical installations on a monthly basis.</b> <b>Findings will be reported to Executive Director.</b></p>	

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K 511	<p>Continued From page 6</p> <p>to ensure electrical installations are in accordance with approved listing(s), maintained to prevent accidental contact with live parts and ensure electrical shutoffs are free of obstructions, has the potential to expose residents to electrical shock, the increased risk of arc fires and limits staff capabilities during a power loss. This deficient practice affected 35 residents, staff and visitors on the dates of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on 9/3/19 from 2:00 - 4:40 PM, above the ceiling inspections revealed the following observations of installed electrical installations:</p> <ul style="list-style-type: none"> <li>- The office abutting the 500 Nurse's station and Royal Fork Dining room was observed to have a microwave using a relocatable power tap (RPT) to supply power from the outlet.</li> <li>- The fire suppression system riser room was observed to have an electrical outlet disconnected from the outlet box, with exposed wiring and without a protective cover.</li> <li>- Observation of the interior resident courtyard landscaping revealed a total of five (5) interconnected conduit-mounted electrical connections with broken conduits on both the feed and return side, resulting in exposed wiring. Further observation established 1 of the 5 installations was a Ground Fault Interrupter (GFI) outlet and was observed to be missing its protective cover.</li> </ul> <p>At approximately 4:30 PM, when asked about the condition of these installations, the Maintenance Director stated the landscaper had broken these conduit(s) during prior performance of landscaping maintenance.</p> <ul style="list-style-type: none"> <li>- Observation of the 200 hall nurse's station</li> </ul>	K 511	<p><b>Monitor: Executive Director or designee will review electrical installations report for compliance. Facility safety committee will review for 3 months. Results of audit will be reviewed in PI to ensure systems being followed.</b></p> <p><b>Date of Compliance: 9/24/19</b></p>	

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K 511	<p>Continued From page 7</p> <p>revealed two (2) electrical panels blocked by storage of two (2) blood pressure monitors, boxes and a Nurse's cart.</p> <p>2) During the facility tour conducted on 9/4/19 from 9:30 - 10:30 AM, above the ceiling inspection(s) of installed electrical systems revealed the following:</p> <ul style="list-style-type: none"> <li>- Above the ceiling at the smoke barrier doors by room 512 revealed two (2) approximately four inch by four inch electrical junction boxes with exposed wiring.</li> <li>- Above the ceiling at the smoke barrier doors by room 502 revealed an approximately four inch by four inch electrical junction box with exposed wiring and an approximately two inch by four inch outlet box in the one-hour wall assembly, without the protective cover plate.</li> </ul> <p>Interview of the Maintenance Director at approximately 10:00 AM on 9/4/19 established he was not aware of these open electrical installations prior to the date of the survey.</p> <p>Actual NFPA standard:</p> <p>NFPA 70</p> <p>110.27 Guarding of Live Parts. (A) Live Parts Guarded Against Accidental Contact. Except as elsewhere required or permitted by this Code, live parts of electrical equipment operating at 50 volts or more shall be guarded against accidental contact by approved enclosures or by any of the following means: (1) By location in a room, vault, or similar enclosure that is accessible only to qualified persons. (2) By suitable permanent, substantial partitions</p>	K 511		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135094</b>	(X2)-MULTIPLE-CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/04/2019</b>
NAME OF PROVIDER OR SUPPLIER <b>WELLSPRING HEALTH &amp; REHABILITATION OF</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2105 12TH AVENUE ROAD NAMPA, ID 83686</b>		
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K 511	<p>Continued From page 8</p> <p>or screens arranged so that only qualified persons have access to the space within reach of the live parts. Any openings in such partitions or screens shall be sized and located so that persons are not likely to come into accidental contact with the live parts or to bring conducting objects into contact with them.</p> <p>(3) By location on a suitable balcony, gallery, or platform elevated and arranged so as to exclude unqualified persons.</p> <p>(4) By elevation of 2.5 m (8 ft) or more above the floor or other working surface.</p> <p>110.3 Examination, Identification, Installation, and Use of Equipment.</p> <p>(A) Examination. In judging equipment, considerations such as the following shall be evaluated:</p> <p>(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.</p> <p>(2) Mechanical strength and durability, including, for parts designed to enclose and protect other equipment, the adequacy of the protection thus provided</p> <p>(3) Wire-bending and connection space</p> <p>(4) Electrical insulation</p> <p>(5) Heating effects under normal conditions of use and also under abnormal conditions likely to arise in service</p>	K 511			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135094</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/04/2019</b>
NAME OF PROVIDER OR SUPPLIER <b>WELLSPRING HEALTH &amp; REHABILITATION OI</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2105 12TH AVENUE ROAD NAMPA, ID 83686</b>		
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K 511	Continued From page 9 (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 listing or labeling  400.8 Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces Exception to (4): Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of 368.56(B) (5) Where concealed by walls, floors, or ceilings or located above suspended or dropped ceilings (6) Where installed in raceways, except as otherwise permitted in this Code (7) Where subject to physical damage  Additional reference: UL 1363 XBYS	K 511		
K 923 SS=E	Gas Equipment - Cylinder and Container Storage CFR(s): NFPA 101  Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3.	K 923	<b>K923</b>  <b>Specific Issue: Facility failed to ensure oxygen cylinders were maintained in accordance with NFPA99.</b>  <b>Other Residents: All residents utilizing oxygen have the potential to be affected by the storage of cylinders.</b>	

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K 923	<p>Continued From page 10 &gt;300 but &lt;3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure oxygen cylinders were maintained in accordance with NFPA 99. Failure to segregate oxygen cylinders in storage has the potential to inadvertently use the incorrect cylinder during an emergency requiring supplemental oxygen. This deficient practice</p>	K 923	<p><b>Systemic Changes: Facility staff were in-service on the proper storage of cylinders. Hospice agency was notified and empty cylinders were removed from facility. Maintenance Director or designee will monitor compliance on rounds, documenting findings.</b></p> <p><b>Monitor: Executive Director or designee will validate documentation is completed. Findings will be presented to safety committee for 3 months. Additional education will be provided as necessary. Results will then be presented to PI committee to ensure compliance.</b></p> <p><b>Date of Compliance: 9/24/19</b></p>		

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K 923	<p>Continued From page 11</p> <p>affected those residents requiring supplemental oxygen treatment and staff on the dates of the survey.</p> <p>During the facility tour conducted on 9/3/19 from 2:00 - 4:00 PM, observation of the oxygen storage and transfill room in the west end of the facility, revealed a single rack with a resident identifier on the side of the storage area, that housed two (2) additional racks; one (1) marked as "Full" and another marked as "Empty". Further observation of the resident-assigned rack revealed it housed six (6) cylinders, one (1) of which was missing the plastic protective cap cover for the valve.</p> <p>Additionally, at approximately 2:30 PM, a direct care staff member was asked at this storage location to identify if the cylinder missing the plastic protective cover was "Empty" or "Full". He stated the tank would be considered "Empty" and was stored with five (5) "Full" cylinders.</p> <p>Actual NFPA standard:</p> <p>NFPA 99</p> <p>11.6.5 Special Precautions - Storage of Cylinders and Containers.</p> <p>11.6.5.1 Storage shall be planned so that cylinders can be used in the order in which they are received from the supplier.</p> <p>11.6.5.2 If empty and full cylinders are stored within the same enclosure, empty cylinders shall be segregated from full cylinders.</p> <p>11.6.5.3 Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed in a rapid manner.</p>	K 923		
K 924 SS=D	Gas Equipment - Testing and Maintenance Requi CFR(s): NFPA 101	K 924		

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K 924	<p>Continued From page 12</p> <p>Gas Equipment - Testing and Maintenance Requirements Anesthesia apparatus are tested at the final path to patient after any adjustment, modification or repair. Before the apparatus is returned to service, each connection is checked to verify proper gas and an oxygen analyzer is used to verify oxygen concentration. Defective equipment is immediately removed from service. Areas designated for servicing of oxygen equipment are clean and free of oil, grease, or other flammables. Manufacturer service manuals are used to maintain equipment and a scheduled maintenance program is followed. 11.4.1.3, 11.5.1.3, 11.6.2.5, 11.6.2.6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and operational testing, the facility failed to ensure transfilling of medical gases such as oxygen, were performed in accordance with NFPA 99. Failure to ensure mechanical ventilation in transfilling locations was operational as designed, has the potential to create an oxygen-rich environment which increases the risk for fires and explosions. This deficient practice affected staff on the dates of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 9/3/19 from 2:00 - 4:00 PM, observation and operational testing by the Maintenance Director of the mechanical ventilation in the oxygen transfill location on the west end of the facility, established the fan motor was running, but the fan blades were not moving and lacking exhaust airflow when tested with a single sheet of note paper placed on the grille.</p>	K 924	<p><b>K 924</b></p> <p><b>Specific Issue: Facility failed to ensure mechanical ventilation in transfilling location was operational as designed.</b></p> <p><b>Other Residents: This has the potential to affect staff.</b></p> <p><b>Systemic Changes: Vent was replaced. Vent will be added to TELS system to monitor monthly. Maintenance Director or designee will report findings to Executive Director.</b></p> <p><b>Monitor: Executive Director or designee will validate findings. Safety Committee will review monthly for 3 months. Results of audit will be reviewed in PI to ensure systems are followed.</b></p> <p><b>Date of Compliance: 9/24/19</b></p>		

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K 924	Continued From page 13  Actual NFPA standard:  NFPA 99  9.3.7.5.3.2 Mechanical exhaust shall be at a rate of 1 L/sec of airflow for each 300 L (1 cfm per 5 ft3 of fluid) designed to be stored in the space and not less than 24 L/sec (50 cfm) nor more than 235 L/sec (500 cfm).	K 924		



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 12, 2019

Debbie Mills, Administrator  
Wellspring Health & Rehabilitation of Cascadia  
2105 12th Avenue Road  
Nampa, ID 83686-6312

Provider #: 135094

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

Dear Ms. Mills:

On **September 4, 2019**, an Emergency Preparedness survey was conducted at **Wellspring Health & Rehabilitation of Cascadia** 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 **September 25, 2019**. Failure to submit an acceptable PoC by **September 25, 2019**, may result in the imposition of civil monetary penalties by **October 17, 2019**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.
- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567. If a State Form was issued as well, it should also be signed, dated and returned.

All references to federal regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Remedies may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **October 9, 2019**, (Opportunity to Correct). Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on . A change in the seriousness of the deficiencies on **October 27, 2019**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **October 9, 2019**, includes the following:

Denial of payment for new admissions effective **December 4, 2019**.  
42 CFR §488.417(a)

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **March 4, 2020**, 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 **September 4, 2019**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

Go to the middle of the page to Information Letters section and click on State and select the following:

BFS Letters (06/30/11)

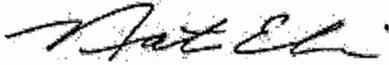
2001-10 Long Term Care Informal Dispute Resolution Process  
2001-10 IDR Request Form

Debbie Mills, Administrator  
September 12, 2019  
Page 4 of 4

This request must be received by **September 25, 2019**. If your request for informal dispute resolution is received after **September 25, 2019**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,

A handwritten signature in black ink, appearing to read "Nate Elkins".

Nate Elkins, Supervisor  
Facility Fire Safety and Construction

NE/lj  
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135094</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/04/2019</b>
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E 000	Initial Comments  The facility is a single story Type V (III) structure originally constructed in 1998. It is located within a municipal fire district, with both county and state EMS services available. there was an addition of 60 beds in March 2001 and a vent unit expansion in 2014. The facility is equipped with two (2) diesel powered, Emergency Power Supply System (EPSS) generators, one (1) for the main existing portion of the facility and one (1) for the vent unit. The facility is fully sprinklered with an interconnected fire alarm/smoke detection system. The facility is currently licensed for 120 SNF/NF beds, and had a census of 54 on the dates of the survey.  The following deficiencies were cited during the emergency preparedness survey conducted on September 3 - 4, 2019. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.  The Survey was conducted by:  Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction	E 000		
E 004 SS=F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a)  [The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.]  * [For hospitals at §482.15 and CAHs at §485.625(a):] The [hospital or CAH] must comply	E 004	<b>E004</b>  <b>Specific Issue: Facility failed to demonstrate the Emergency Plan (EP) had been reviewed annually.</b>  <b>Other Residents: This has the potential to affect 54 residents, staff and visitors on the date of the survey.</b>	

**RECEIVED**  
SEP 25 2019  
**FACILITY STANDARDS**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE <i>Administrator</i>	(X6) DATE <i>9/24/19</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.

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E 004	<p>Continued From page 1</p> <p>with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.</p> <p>The emergency preparedness program must include, but not be limited to, the following elements:]</p> <p>(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least annually.</p> <p>* [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least annually.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, the facility failed to demonstrate the Emergency Plan (EP) had been reviewed annually. Failure to review the EP for discrepancies and update with corrected information, has the potential to provide non-relevant policies or procedures to facility staff, hindering emergency response and disaster training. This deficient practice affected 54 residents, staff and visitors on the dates of the survey.</p> <p>Findings include:</p> <p>1) During review of the provided EP conducted on 9/3/19 from 9:00 - 11:00 AM, documentation provided revealed a section on "Emergency Code Designation". In this section, the list of codes was formatted with color coordinations for specific</p>	E 004	<p><b>Systemic Changes: Safety committee met and reviewed Emergency Plan on 9/24/19. Color codes on employee badges updated to match EP section "Emergency Code Designation".</b></p> <p><b>Active Shooter or Angry Person policy and procedure and EP reviewed for compliance.</b></p> <p><b>Orientation in-services, EP and staff badges reviewed and updated for all codes.</b></p> <p><b>Emergency telephone list and emergency management committee contact list updated to include phone number for State Licensing and Certification.</b></p> <p><b>Monitor: Executive Director or designee will validate that annual Emergency Plan (EP) has been reviewed by Safety Committee.</b></p> <p><b>Date of Compliance: 9/24/19</b></p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135094</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/04/2019</b>
NAME OF PROVIDER OR SUPPLIER <b>WELLSPRING HEALTH &amp; REHABILITATION OF</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2105 12TH AVENUE ROAD NAMPA, ID 83686</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
E 004	Continued From page 2 events. Review of the code labeled "Green", established it was identified as the code to be used in the event of Evacuation and the code labeled "Silver" was assigned to an Active Shooter/Hostile Threat. This code designation was also provided in the list of codes on the back of each staff member's name badge.  Further review of the policy and procedure section for "Active Shooter or Angry Person" revealed code "Green" was to be called "3 times" during this disaster event, conflicting both previously identified areas. Review of the section on "Emergency Evacuation" did not establish a code to be used during this procedure at all.  Additionally, review of provided Orientation inservices documentation, indicated an additional code for flood, "Code Aqua", that was neither in the EP or included on the back of staff badges.  2) During review of the provided EP conducted on 9/3/19 from 9:00 - 11:00 AM, documentation provided revealed two sections with emergency phone contact information: "Emergency Telephone List" and "Emergency Management Committee Contact List". Neither of these two (2) lists contained the phone number for State Licensing and Certification.  Reference: 42 CFR 483.73 (a)	E 004			
E 031 SS=D	Emergency Officials Contact Information CFR(s): 483.73(c)(2)  [(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 annually.] The communication plan must include	E 031	<b>E 031</b>  <b>Specific Issue: Facility failed to ensure current contact information for emergency management officials and other resources of assistance was provided in the communication plan of the EOP</b>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135094</b>	(X2)-MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/04/2019</b>
NAME OF PROVIDER OR SUPPLIER <b>WELLSPRING HEALTH &amp; REHABILITATION OF</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2105 12TH AVENUE ROAD NAMPA, ID 83686</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
E 031	<p>Continued From page 3 all of the following:</p> <p>(2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance.</p> <p>*[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, or local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance.</p> <p>*[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to ensure current contact information for emergency management officials and other resources of assistance was provided in the communication plan of the EOP. Failure to provide contact information for the State Licensing and Certification Agency has the potential to hinder facility response and continuity of care for the 54 residents, staff and visitors in the facility on the dates of the survey.</p> <p>Findings include:</p> <p>On 9/3/19 from 9:00 - 11:00 AM, review of the provided EP, failed to demonstrate the phone</p>	E 031	<p><b>Other Residents: This could affect all residents</b></p> <p><b>Systemic Changes: Safety committee met and reviewed Emergency Plan to include emergency management officials and other resources of assistance contact information. EP will be reviewed on an annual basis by safety committee.</b></p> <p><b>Monitor: Executive Director or designee will validate that annual Emergency Plan (EP) has been reviewed by Safety Committee.</b></p> <p><b>Date of Compliance: 9/24/19</b></p>		

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NAME OF PROVIDER OR SUPPLIER <b>WELLSPRING HEALTH &amp; REHABILITATION OF</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2105 12TH AVENUE ROAD NAMPA, ID 83686</b>		
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E 031	Continued From page 4 number for the State Licensing and Certification agency was included in the contact information.	E 031		
E 037 SS=F	Reference: 42 CFR 483.73 (c) (2)  EP Training Program CFR(s): 483.73(d)(1)  (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following:  (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures.  *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures.  *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing	E 037	<b>E 037</b>  <b>Specific Issue: Facility annual in-service of EP not conducted.</b>  <b>Other Residents: This has the potential to affect all residents.</b>  <b>Systemic Changes: Staff in-service and testing of EP conducted 9/20/19. Safety Committee will conduct in-service annually for all staff.</b>  <b>Monitor: Executive Director will monitor for compliance. Safety Committee will ensure staff are in-service and tested annually and upon hire on the EP. Safety Committee will report to PI annual training.</b>  <b>Date of Compliance: 9/24/19</b>	

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E 037	<p>Continued From page 5</p> <p>hospice employees, and individuals providing services under arrangement, consistent with their expected roles.</p> <p>(ii) Demonstrate staff knowledge of emergency procedures.</p> <p>(iii) Provide emergency preparedness training at least annually.</p> <p>(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.</p> <p>*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training.</p> <p>*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in</p>	E 037			

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NAME OF PROVIDER OR SUPPLIER <b>WELLSPRING HEALTH &amp; REHABILITATION OF</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2105 12TH AVENUE ROAD NAMPA, ID 83686</b>		
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E 037	<p>Continued From page 6 case of an emergency. (iv) Maintain documentation of all training.</p> <p>*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.</p> <p>*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures.</p>	E 037		

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E 037	<p>Continued From page 7</p> <p>*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure annual inservice training was conducted on the contents of the EP. Failure to train staff annually on the EP contents and any relevant changes or updates based on review, has the potential to hinder staff response to disasters from provided conflicts of information. This deficient practice affected 54 residents, staff and visitors on the dates of the survey.</p> <p>Findings include:</p> <p>During review of provided EP inservice training records conducted on 9/3/19 from 9:00 - 11:00 AM, records did not indicate an annual inservice on the EP was conducted. When asked at approximately 10:45 AM if any annual inservice was done, the Maintenance Director stated he was not aware of any EP annual inservice conducted for staff, only initial orientation training.</p> <p>Reference: 42 CFR 483.73 (d) (1)</p>	E 037			