



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 13, 2019

John Schulkins, Administrator
Canyon West of Cascadia
2814 S. Indiana Ave.
Caldwell, ID 83605-5925

Provider #: 135051

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Mr. Schulkins:

On **September 5, 2019**, a Facility Fire Safety and Construction survey was conducted at **Canyon West 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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September 13, 2019
Page 2 of 4

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 26, 2019**. Failure to submit an acceptable PoC by **September 26, 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 10, 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 4, 2019**.

John Schulkins, Administrator
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A change in the seriousness of the deficiencies on **October 20, 2019**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **October 10, 2019**, includes the following:

Denial of payment for new admissions effective **December 5, 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 5, 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 5, 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.

John Schulkins, Administrator
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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:

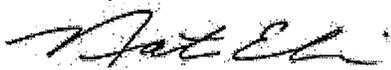
BFS Letters (06/30/11)

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

This request must be received by **September 26, 2019**. If your request for informal dispute resolution is received after **September 26, 2019**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosures

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

Printed: 09/10/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135051	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 09/05/2019
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NAME OF PROVIDER OR SUPPLIER CANYON WEST OF CASCADIA	STREET ADDRESS, CITY, STATE, ZIP CODE 2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	INITIAL COMMENTS The facility is a single story, Type V(111) structure originally constructed in 1969. The facility is protected throughout by an automatic fire sprinkler system in accordance with NFPA 13, with an interconnected fire alarm/smoke detection system. The facility is equipped with an on-site, diesel-fired, Emergency Power Supply System (EPSS) generator. The facility is divided into four (4) smoke compartments and is currently licensed for 103 SNF/NF beds with a census of 63 on the date of the survey. The following deficiencies were cited during the annual life safety code survey conducted on July 23, 2018. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70. The Survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction	K 000		
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure means of egress were	K 211	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Canyon West of Cascadia does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The center reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.	

RECEIVED
SEP 26 2019
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE CEO	(X6) DATE 26 Sep 2019
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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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NAME OF PROVIDER OR SUPPLIER CANYON WEST OF CASCADIA		STREET ADDRESS, CITY, STATE, ZIP CODE 2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605		
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K 211	<p>Continued From page 1</p> <p>maintained in accordance with NFPA 101. Failure to ensure doors equipped with delayed egress were functional as designed, has the potential to hinder evacuation of residents during an emergency. This deficient practice affected 28 residents and staff on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 9/5/19 from 10:00 - 11:00 AM, observation of the north and northwest exit doors, revealed both were equipped with magnetic locking arrangements. Further observation of these doors established the northwest door and the north leaf on the west exit door would not release under applied pressure.</p> <p>Interview of the Plant Operations Manager at approximately 10:30 AM established he was not aware of these doors not being operational as designed.</p> <p>Actual NFPA Standard:</p> <p>7.2.1.6* Special Locking Arrangements. 7.2.1.6.1 Delayed-Egress Locking Systems. 7.2.1.6.1.1 Approved, listed, delayed-egress locking systems shall be permitted to be installed on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6 or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 11 through 43, provided that all of the following criteria are met: (1) The door leaves shall unlock in the direction of egress upon actuation of one of the following:</p>	K 211	<p>K211</p> <p>Corrective Action The door mechanisms on the doors identified were repaired. The doors now function properly.</p> <p>Other Areas The remainder of the building's exterior doors were inspected to identify any problems with the release mechanisms. No issues were found.</p> <p>Facility Systems Doors with self-releasing mechanisms on the magnetic lock will be reviewed monthly to identify any problems, with repairs being made as indicated.</p> <p>Monitor The Administrator or designee will randomly round within the center to ensure that no door issues related to the magnetic locking arrangements are found.</p> <p>Date of Compliance September 26, 2019</p>	

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K 211	Continued From page 2 (a) Approved, supervised automatic sprinkler system in accordance with Section 9.7 (b) Not more than one heat detector of an approved, supervised automatic fire detection system in accordance with Section 9.6 (c) Not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6 (2) The door leaves shall unlock in the direction of egress upon loss of power controlling the lock or locking mechanism. (3)*An irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions: (a) The force shall not be required to exceed 15 lbf (67 N). (b) The force shall not be required to be continuously applied for more than 3 seconds. (c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening. (d) Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only. (4)*A readily visible, durable sign in letters not less than 1 in. (25 mm) high and not less than 1.8 in. (3.2 mm) in stroke width on a contrasting background that reads as follows shall be located on the door leaf adjacent to the release device in the direction of egress: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS (5) The egress side of doors equipped with delayed-egress locks shall be provided with emergency lighting in accordance with Section 7.9.	K 211		
K 324	Cooking Facilities	K 324		

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K 324 SS=D	<p>Continued From page 3 CFR(s): NFPA 101</p> <p>Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * 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 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. 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. 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 record review and interview, the facility failed to ensure a semi-annual inspection of the Kitchen hood was conducted in accordance with NFPA 96. Failure to conduct semi-annual inspections of cooking ventilation systems could increase the risk of fires due to excessive build-up of grease laden vapors. This deficient practice affected staff and visitors in the kitchen on the date of the survey.</p>	K 324	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Canyon West of Cascadia does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The center reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.</p> <p>K324 Corrective Action An inspection was made for the most recent period.</p> <p>Facility Systems The inspection has been placed on a web-based maintenance calendar to ensure that it is compliant with the requirement of minimum every six months having an inspection. Cleaning will take place as indicated.</p> <p>Monitor The Administrator or designee will review with the maintenance technician to ensure that hood inspection occurs every 6 months.</p> <p>Date of Compliance September 26, 2019</p>	

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K 324	Continued From page 4 Findings include: During record review of provided maintenance and inspection records conducted on 9/5/19 from 8:30 - 10:30 AM, no record was available for a hood inspection within the past six months prior to May 6, 2019. At approximately 10:00 AM, when asked about the missing semi-annual inspection, the Plant Operations Manager stated he had been under the impression the inspection was only required annually. Actual NFPA standard: NFPA 96 11.4* Inspection for Grease Buildup The entire exhaust system shall be inspected for grease buildup by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction and in accordance with Table 11.4. 11.6 Cleaning of Exhaust Systems 11.6.1 Upon inspection, if the exhaust system is found to be contaminated with deposits from grease-laden vapors, the contaminated portions of the exhaust system shall be cleaned by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction.	K 324		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 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	K 353	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Canyon West of Cascadia does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The center reserves the right	

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K 353	<p>Continued From page 5 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 record review, observation and interview, the facility failed to ensure that installed fire suppression systems were maintained in accordance with NFPA 25. Failure to ensure fire suppression systems are maintained as designed, has the potential to hinder system response during a fire. This deficient practice affected 63 residents and staff on the date of the survey.</p> <p>Findings include:</p> <p>1) During review of the provided maintenance and inspection records of the installed fire suppression system conducted on 9/5/19 from 8:30 - 10:30 AM, records indicated the dry sprinklers were dated 2006, but no records were provided for demonstrating the last dry system testing or replacement. Interview of the Plant Operations Manager at approximately 11:30 AM, established he was not aware of the last performed UL testing or replacement of the dry sprinklers.</p>	K 353	<p>to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.</p> <p>K353 Corrective Action Sprinklers will be replaced as indicated. In addition, quarterly waterflow testing will be performed going forward each quarter. Last, the sprinkler head was replaced in the shower room abutting room 205.</p> <p>Facility Systems Sprinklers will be sent out for UL testing or replaced according to regulatory requirements. Quarterly waterflow testing will be placed on a monitoring system to ensure that inspections take place as appropriate. Last all other sprinkler heads were inspected for rust and none were found.</p> <p>Monitor The Administrator or designee will randomly audit monitoring systems for sprinkler testing, waterflow testing, and will round within the center to ensure that there are no rusty sprinkler heads.</p> <p>Date of Compliance September 26, 2019</p>	

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K 353	<p>Continued From page 6</p> <p>2) During review of the provided maintenance and inspection records of the installed fire suppression system conducted on 9/5/19 from 8:30 - 10:30 AM, no records were available indicating a quarterly waterflow alarm testing was completed during the first quarter of 2019.</p> <p>3) During the facility tour conducted on 9/5/19 from 10:30 AM - 1:00 PM, observation of installed sprinkler pendants revealed the sprinkler in the shower abutting room 205 was corroded.</p> <p>Actual NFPA standard:</p> <p>5.2* Inspection.</p> <p>5.2.1 Sprinklers.</p> <p>5.2.1.1* Sprinklers shall be inspected from the floor level annually.</p> <p>5.2.1.1.1* Sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., upright, pendent, or sidewall).</p> <p>5.2.1.1.2 Any sprinkler that shows signs of any of the following shall be replaced:</p> <p>(1) Leakage</p> <p>(2) Corrosion</p> <p>(3) Physical damage</p> <p>(4) Loss of fluid in the glass bulb heat responsive element</p> <p>(5)*Loading</p> <p>(6) Painting unless painted by the sprinkler manufacturer</p> <p>5.2.1.1.3* Any sprinkler that has been installed in the incorrect orientation shall be replaced.</p> <p>5.2.1.1.4 Any sprinkler shall be replaced that has signs of leakage; is painted, other than by the sprinkler manufacturer, corroded, damaged, or loaded; or is in the improper orientation.</p>	K 353		

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K 511	<p>Continued From page 8</p> <p>11:00 AM - 1:00 PM, observation of installed electrical systems revealed the Laundry room was using a 3 to 1 multiple plug adapter (MPA), plugged into an extension cord to supply power to three appliances, including a heat label maker.</p> <p>Actual NFPA standard:</p> <p>NFPA 70</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> <p>(6) Arcing effects</p> <p>(7) Classification by type, size, voltage, current capacity, and specific use</p>	K 511	<p>Date of Compliance September 26, 2019</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135051	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 09/05/2019
NAME OF PROVIDER OR SUPPLIER CANYON WEST OF CASCADIA		STREET ADDRESS, CITY, STATE, ZIP CODE 2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605		
(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 511	Continued From page 9 (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	K 511		
K 918 SS=F	Electrical Systems - Essential Electric System CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance	K 918	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Canyon West of Cascadia does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The center reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 918	<p>Continued From page 10 with NFPA 110. .</p> <p>Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.</p> <p>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure the EPSS generator set was maintained in accordance with NFPA 110. Failure to maintain the EPSS generator as defined under NFPA standards has the potential to render the facility without emergency power during extended power outages or other disasters. This deficient practice affected 63 residents and staff on the date of the survey.</p> <p>Findings include:</p> <p>During review of the facility maintenance and inspection records for the EPSS generator set</p>	K 918	<p>conclusions that form the basis for the deficiency.</p> <p>K918 Corrective Action The 4-hour load test had been completed.</p> <p>Facility Systems The facility will place the testing on its scheduling system to ensure compliance.</p> <p>Monitor The Administrator or designee will randomly audit outlets for multiple plug adapters within the facility to ensure that there are none.</p> <p>Date of Compliance September 26, 2019</p>	

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K 918	<p>Continued From page 11</p> <p>conducted on 9/5/19 from 8:30 - 10:00 AM, no record was available demonstrating a 4-hour load test had been conducted within the past three years. Interview conducted at approximately 10:45 AM established the Plant Operations Manager was not aware of the last time a four-hour load test had been conducted.</p> <p>Actual NFPA standard:</p> <p>8.4.9* Level 1 EPSS shall be tested at least once within every 36 months.</p> <p>8.4.9.1 Level 1 EPSS shall be tested continuously for the duration of its assigned class (see Section 4.2).</p> <p>8.4.9.2 Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 continuous hours.</p>	K 918		



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

John Schulkins, Administrator
Canyon West of Cascadia
2814 South Indiana Avenue
Caldwell, ID 83605-5925

Provider #: 135051

RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER

Dear Mr. Schulkins:

On **September 5, 2019**, an Emergency Preparedness survey was conducted at Canyon West 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
Enclosure

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E 000	<p>Initial Comments</p> <p>The facility is a single story, Type V(111) structure originally constructed in 1969, located within a municipal fire district with both county and state EMS support services available. The facility is protected throughout by an automatic fire sprinkler system in accordance with NFPA 13, with an interconnected fire alarm/smoke detection system. The facility is equipped with an on-site, diesel-fired, Emergency Power Supply System (EPSS) generator. The facility is divided into four (4) smoke compartments and is currently licensed for 103 SNF/NF beds with a census of 63 on the date of the survey.</p> <p>The facility was found to be in substantial compliance during the emergency preparedness survey conducted on September 5, 2019. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.</p> <p>The Survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction</p>	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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.