



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

October 15, 2019

Royal Jensen, Administrator  
Cascadia of Boise  
6000 W. Denton St.  
Boise, ID 83704

Provider #: 135146

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

Dear Mr. Jensen:

On **October 9, 2019**, a Facility Fire Safety and Construction survey was conducted at **Cascadia of Boise** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. Please provide **ONLY ONE** completion date for each federal and state tag in column (X5) Completion Date to signify when

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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 **October 28, 2019**. Failure to submit an acceptable PoC by **October 28, 2019**, may result in the imposition of civil monetary penalties by **November 19, 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 **November 13, 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 **January 7, 2020**. A change in the seriousness of the deficiencies on **November 23, 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 **November 13, 2019**, includes the following:

Denial of payment for new admissions effective **January 9, 2020**.  
42 CFR §488.417(a)

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **April 9, 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 **October 9, 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:

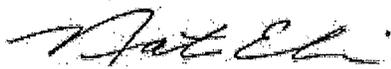
BFS Letters (06/30/11)

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

This request must be received by **October 28, 2019**. If your request for informal dispute resolution is received after **October 28, 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: 10/11/2019  
FORM APPROVED  
OMB NO. 0938-0091

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION:	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135146	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 - CASCADIA OF BOISE  B. WING:	(X3) DATE SURVEY COMPLETED  10/09/2019
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NAME OF PROVIDER OR SUPPLIER  CASCADIA OF BOISE	STREET ADDRESS, CITY, STATE, ZIP CODE 6000 W DENTON ST BOISE, ID 83704
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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 with a special feature of two Wwn-Doors located in areas A and B. The building is fully sprinklered and has a complete addressable fire alarm/smoke detection system including open areas and audible/visual notification throughout. Piped in Type 2 Medical Gas System and Vacuum System is plumbed into the facility from a rated manifold room. Emergency Power is provided by a Type 1 EPSS with an annunciator and emergency stop. Currently the facility is licensed for 99 SNF/NF beds and had a census of 70 on the date of the survey.  The following deficiencies were cited during the annual fire life safety survey conducted on October 9, 2019. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.  The Survey was conducted by:  Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction Sprinkler System - Maintenance and Testing CFR(s): NFPA 101	K 000		
K 353 SS#F	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	K 353		

RECEIVED  
OCT 29 2019  
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: Executive Director DATE: 10-25-19

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.

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

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OMB NO. 0938-0391

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K 353	<p>Continued From page 1 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 and interview, the facility failed to ensure fire suppression systems were maintained in accordance with NFPA 25. Failure to inspect system components as required, has the potential to hinder system performance during a fire event and/or render the facility not fully sprinklered after an activation or repair. This deficient practice affected 70 residents and staff on the date of the survey.</p> <p>Findings include:</p> <p>During review of provided facility inspection and testing records conducted on October 9, 2019, from approximately 8:30 AM - 11:30 AM, documentation for a first quarter, 2019 waterflow alarm flow test could not be produced. When asked, the Environmental Services Manager stated the facility had already identified this quarterly sprinkler inspection as missing and had already implemented a Plan of Correction (POC) to include training and scheduling to prevent this from happening again.</p> <p>Actual NFPA standard:</p>	K 353	<p><b>K 353</b></p> <p><b>1. Specific Issue:</b> The facility did not ensure that maintenance and testing of the fire sprinkler system was being completed as per NFPA 25 standards.</p> <p><b>2. Other Residents:</b> All residents are potentially impacted.</p> <p><b>3. Systemic changes:</b> Maintenance Director or designee will coordinate with inspection contractor to ensure all testing and inspection requirements are met.</p> <p><b>4. Monitor:</b> Executive Director or designee will audit the Maintenance Director's Quarterly fire sprinkler inspections monthly for 3 months. Results will be presented at QAPI meeting monthly to ensure systems are being followed.</p> <p><b>5. Date of Compliance:</b> 10/28/19</p>	

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K 353	Continued From page 2 NFPA 25  5.3.3 Waterflow Alarm Devices. 5.3.3.1 Mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly.	K 353		
K 907 SS=F	Gas and Vacuum Piped Systems - Maintenance Pr CFR(s): NFPA 101  Gas and Vacuum Piped Systems - Maintenance Program Medical gas, vacuum, WAGD, or support gas systems have documented maintenance programs. The program includes an inventory of all source systems, control valves, alarms, manufactured assemblies, and outlets. Inspection and maintenance schedules are established through risk assessment considering manufacturer recommendations. Inspection procedures and testing methods are established through risk assessment. Persons maintaining systems are qualified as demonstrated by training and certification or credentialing to the requirements of AASE 6030 or 6040. 5.1.14.2.1, 5.1.14.2.2, 5.1.15, 5.2.14, 5.3.13.4.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure positive pressure gas central piping systems and medical-surgical vacuum systems have a documented maintenance program. Failure to inventory, inspect, and maintain these systems, by a qualified person, could result in fire, explosion, or a lack of system performance as designed. This deficient practice affected all residents and staff on the date of the	K 907		

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K 907	<p>Continued From page 3 survey.</p> <p>Findings include:</p> <p>During record review on October 9, 2019, from approximately 8:30 AM to 11:30 AM, no documentation of a written maintenance program for the positive pressure gas central piping systems and medical-surgical vacuum system could be produced. When asked about the missing documentation, the Environmental Services Manager stated the facility was unaware of this requirement.</p> <p>Actual NFPA standard:</p> <p>NFPA 99 5.1.14.2.1* General. Health care facilities with installed medical gas, vacuum, WAGD, or medical support gas systems, or combinations thereof, shall develop and document periodic maintenance programs for these systems and their subcomponents as appropriate to the equipment installed. 5.1.14.2.2 Maintenance Programs. 5.1.14.2.2.1 Inventories. Inventories of medical gas, vacuum, WAGD, and medical support gas systems shall include at least all source subsystems, control valves, alarms, manufactured assemblies containing patient gases, and outlets. 5.1.14.2.2.2* Inspection Schedules. Scheduled inspections for equipment and procedures shall be established through the risk assessment of the facility and developed with consideration of the original equipment manufacturer recommendations and other recommendations as required by the authority having jurisdiction. 5.1.14.2.2.3 Inspection Procedures. The facility</p>	K 907	<p><b>K 907</b></p> <ol style="list-style-type: none"> <li><b>1. Specific Issue:</b> Facility did not ensure that a written maintenance program was in place for Medical Gas Systems.</li> <li><b>2. Other Residents:</b> All residents are potentially impacted.</li> <li><b>3. Systemic Changes:</b> Facility will create a written maintenance and testing program for Medical Gas systems that complies with NFPA standards. Maintenance and testing will be added to TELS system to ensure policy compliance.</li> <li><b>4. Monitor:</b> Executive Director or designee will review the plan before implementation and at QAPI for 3 months.</li> <li><b>5. Date of Compliance:</b> 10/28/19</li> </ol>	

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K 907	Continued From page 4 shall be permitted to use any inspection procedure(s) or testing methods established through its own risk assessment. 5.1.14.2.2.4 Maintenance Schedules. Scheduled maintenance for equipment and procedures shall be established through the risk assessment of the facility and developed with consideration of the original equipment manufacturer recommendations and other recommendations as required by the authority having jurisdiction. 5.1.14.2.2.5 Qualifications. Persons maintaining these systems shall be qualified to perform these operations. Appropriate qualification shall be demonstrated by any of the following: (1) Training and certification through the health care facility by which such persons are employed to work with specific equipment as installed in that facility (2) Credentialing to the requirements of ASSE 6040, Professional Qualification Standard for Medical Gas Maintenance Personnel (3) Credentialing to the requirements of ASSE 6030, Professional Qualification Standard for Medical Gas Systems Verifiers 5.1.14.2.3 Inspection and Testing Operations. 5.1.14.2.3.1 General. The elements in 5.1.14.2.2.2 through 5.1.15 shall be inspected or tested as part of the maintenance program as follows: (1)*Medical air source, as follows: (a) Room temperature (b) Shaft seal condition (c) Filter condition (d) Presence of hydrocarbons (e) Room ventilation (f) Water quality, if so equipped (g) Intake location (h) Carbon monoxide monitor calibration (i) Air purity	K 907		

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K 907	Continued From page 5 (j) Dew point (2)*Medical vacuum source - exhaust location (3) WAGD source - exhaust location (4)*Instrument air source - filter condition (5)*Manifold sources (including systems complying with 5.1.3.5.10, 5.1.3.5.11, 5.1.3.5.12, and 5.1.3.5.13), as follows: (a) Ventilation (b) Enclosure labeling (6) Bulk cryogenic liquid source inspected in accordance with NFPA 55, Compressed Gases and Cryogenic Fluids Code (7) Final line regulation for all positive pressure systems - delivery pressure (8)*Valves - labeling (9)*Alarms and warning systems-lamp and audio operation (10) Alarms and warning systems, as follows: (a) Master alarm signal operation (b) Area alarm signal operation (c) Local alarm signal operation (11)*Station outlets/inlets, as follows: (a) Flow (b) Labeling (c) Latching/delatching (d) Leaks 5.1.14.2.3.2 Manufactured Assemblies Employing Flexible Connection(s) Between the User Terminal and the Piping System. (A) Non-stationary booms and articulating assemblies, other than head walls utilizing flexible connectors, shall be tested for leaks, per manufacturer's recommendations, every 18 months or at a duration as determined by a risk assessment. (B) The system pressure to non-stationary booms and articulating arms shall be maintained at operating pressure until each joint has been examined for leakage by effective means of leak	K 907			

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K 907	Continued From page 6 detection that is safe for use with oxygen. (C) Safe working condition of the flexible assemblies shall be confirmed. (D) D.I.S.S. connectors internal to the boom and assemblies shall be checked for leakage. (E) Leaks, if any, shall be repaired (if permitted), or the components replaced (if required), and the equipment retested prior to placing the equipment back into service. (F) Additional testing of non-stationary booms or articulating arms shall be performed at intervals defined by documented performance data. 5.1.14.3 Medical Gas and Vacuum Systems Information and Warning Signs. 5.1.14.3.1 The gas content of medical gas and vacuum piping systems shall be labeled in accordance with 5.1.11.1. 5.1.14.3.2 Labels for shutoff valves shall be in accordance with 5.1.11.2 and updated when modifications are made changing the areas served. 5.1.14.4 Medical Gas and Vacuum Systems Maintenance and Record Keeping. See B.5.2. 5.1.14.4.1 Permanent records of all tests required by 5.1.12.3.1 through 5.1.12.3.14 shall be maintained in the organization's files. 5.1.14.4.2 The supplier of the bulk cryogenic liquid system shall, upon request, provide documentation of vaporizer(s) sizing criteria to the facility. 5.1.14.4.3 An annual review of bulk system capacity shall be conducted to ensure the source system has sufficient capacity. 5.1.14.4.4 Central supply systems for nonflammable medical gases shall conform to the following: (1) They shall be inspected annually. (2) They shall be maintained by a qualified representative of the equipment owner.	K 907			

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K 907	<p>Continued From page 7</p> <p>(3) A record of the annual inspection shall be available for review by the authority having jurisdiction.</p> <p>5.1.14.4.5 A periodic testing procedure for nonflammable medical gas and vacuum and related alarm systems shall be implemented.</p> <p>5.1.14.4.6 Whenever modifications are made that breach the pipeline, any necessary installer and verification test specified in 5.1.12 shall be conducted on the downstream portions of the medical gas piping system.</p> <p>5.1.14.4.7 Procedures, as specified, shall be established for the following:</p> <p>(1) Maintenance program for the medical air compressor supply system in accordance with the manufacturer's recommendations</p> <p>(2) Facility testing and calibration procedure that ensures carbon monoxide monitors are calibrated at least annually or more often if recommended by the manufacturer</p> <p>(3) Maintenance program for both the medical-surgical vacuum piping system and the secondary equipment attached to medical-surgical vacuum station inlets to ensure the continued good performance of the entire medical-surgical vacuum system</p> <p>(4) Maintenance program for the WAGD system to ensure performance</p> <p>5.1.14.4.8 Audible and visual alarm indicators shall meet the following requirements:</p> <p>(1) They shall be periodically tested to determine that they are functioning properly.</p> <p>(2) Records of the test shall be maintained until the next test is performed.</p> <p>5.1.14.4.9 Medical-surgical vacuum station inlet terminal performance, as required in 5.1.12.3.10.4, shall be tested as follows:</p> <p>(1) On a regular preventive maintenance schedule as determined by the facility</p>	K 907		

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NAME OF PROVIDER OR SUPPLIER  CASCADIA OF BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE. 6000 W DENTON ST BOISE, ID 83704	
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K 907	Continued From page 8 maintenance staff (2) Based on flow of free air (NI/min or SCFM) into a station inlet while simultaneously checking the vacuum level 5.1.15* Category 1 Maintenance. Facilities shall have a routine maintenance program for their piped medical gas and vacuum systems. 5.2 Category 2 Piped Gas and Vacuum Systems. 5.2.1* Applicability. These requirements shall apply to health care facilities that qualify for Category 2 systems as referenced in Chapter 4. 5.2.1.1 Section 5.2 through 5.2.12 shall apply to new health care facilities or facilities making changes that alter the piping. 5.2.1.2 Subsection 5.2.13 5.2.14* Category 2 Maintenance. Facilities shall have a routine maintenance program for their piped medical gas and vacuum systems. 5.3.13.4.2 A periodic testing procedure for Category 3 gas and vacuum systems and related alarm systems shall be implemented.	K 907		



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

October 15, 2019

Royal Jensen, Administrator  
Cascadia of Boise  
6000 W. Denton St  
Boise, ID 83704

Provider #: 135146

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

Dear Mr. Jensen:

On **October 9, 2019**, an Emergency Preparedness survey was conducted at **Cascadia of Boise** 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 **October 28, 2019**. Failure to submit an acceptable PoC by **October 28, 2019**, may result in the imposition of civil monetary penalties by **November 19, 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 **November 13, 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 **November 29, 2019**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **November 13, 2019**, includes the following:

Denial of payment for new admissions effective **January 9, 2020**.  
42 CFR §488.417(a)

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **April 9, 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 **October 9, 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

Royal Jensen, Administrator

October 15, 2019

Page 4 of 4

This request must be received by **October 28, 2019**. If your request for informal dispute resolution is received after **October 28, 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". The signature is fluid and cursive, with a prominent initial "N" and a trailing flourish.

Nate Elkins, Supervisor  
Facility Fire Safety and Construction

NE/lj

Enclosures

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

PRINTED: 10/11/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135146	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  10/09/2019
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NAME OF PROVIDER OR SUPPLIER  CASCADIA OF BOISE	STREET ADDRESS, CITY, STATE, ZIP CODE 8000 W DENTON ST BOISE, ID 83704
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E 000	Initial Comments  The facility is a single story, Type V (111) structure with a special feature of two Won-Doors located in areas A and B. The building is fully sprinklered and has a complete addressable fire alarm/smoke detection system including open areas and audible/visual notification throughout. Piped in Type 2 Medical Gas System and Vacuum System is plumbed into the facility from a rated manifold room. Emergency Power is provided by a Type 1 EPSS with an annunciator and emergency stop. Currently the facility is licensed for 99 SNF/NF beds and had a census of 70 on the date of the survey.  The following deficiency was cited during the annual emergency preparedness survey conducted on October 9, 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:  Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction EP Program Patient Population OFR(s): 483.73(a)(3)	E 000		
E 007 SS=D	[(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:]  (3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in	E 007		

RECEIVED  
OCT 29 2019  
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Blessen* TITLE *Executive Director* (X8) DATE *10-25-19*

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.

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

PRINTED: 10/11/2019  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135146</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>10/09/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>CASCADIA OF BOISE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>6000 W DENTON ST BOISE, ID 83704</b>		
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E 007	<p>Continued From page 1 an emergency; and continuity of operations, including delegations of authority and succession plans.**</p> <p>*Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to provide an emergency plan that addressed the resident population, including persons at risk. Failure to provide information on the resident population served within the facility and their unique vulnerabilities in the event of a disaster, could potentially hinder evacuation and continuation of resident care during an emergency. This deficient practice affected all residents and staff on the date of the survey.</p> <p>Findings include:</p> <p>On October 9, 2019, from approximately 8:30 AM to 11:30 AM, review of the provided emergency preparedness plan revealed the resident population, including persons at risk was not addressed in the plan. Interview of the Environmental Services Manager at approximately 1:00 PM, revealed the facility was aware of this requirement, but had not yet addressed it in the emergency preparedness plan.</p> <p>Reference: 42 CFR 483.73 (a) (3)</p>	E 007	<p><b>E 007</b></p> <ol style="list-style-type: none"> <li><b>Specific Issue:</b> The facility did not ensure that the Emergency Management plan contained a resident risk assessment.</li> <li><b>Other Residents:</b> All residents are potentially affected.</li> <li><b>Systemic changes:</b> Maintenance Director, Executive Director or designee will attach the facility assessment to the emergency plan. A TELS schedule will be created to update the emergency plan annually.</li> <li><b>Monitor:</b> Executive Director or designee will audit the Emergency Management plan monthly for 3 months. Results will be presented at QAPI meeting monthly.</li> <li><b>Date of Compliance:</b> 10/28/19</li> </ol>		