



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

November 1, 2019

Brent Schneider, Administrator
The Terraces of Boise
5301 E. Warm Springs Ave.
Boise, ID 83716

Provider #: 135141

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

Dear Mr. Schneider:

On **October 17, 2019**, a Facility Fire Safety and Construction survey was conducted at **Terraces Of Boise, The** 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.

Brent Schneider, Administrator
November 1, 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 **November 14, 2019**. Failure to submit an acceptable PoC by **November 14, 2019**, may result in the imposition of civil monetary penalties by **December 6, 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 21, 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 15, 2020**.

Brent Schneider, Administrator
November 1, 2019
Page 3 of 4

A change in the seriousness of the deficiencies on **December 1, 2019**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **November 21, 2019**, includes the following:

Denial of payment for new admissions effective **January 17, 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 17, 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 17, 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.

Brent Schneider, Administrator
November 1, 2019
Page 4 of 4

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 **November 14, 2019**. If your request for informal dispute resolution is received after **November 14, 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: 135141	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - TERRACES OF BOISE-MAPLE COTTAGE B. WING _____	(X3) DATE SURVEY COMPLETED 10/17/2019
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NAME OF PROVIDER OR SUPPLIER TERRACES OF BOISE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 5301 E WARM SPRINGS AVE BOISE, ID 83716
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K 000	<p>INITIAL COMMENTS</p> <p>The facility is comprised of three (3), single-story Type V (111) structures. The buildings are approximately 12,465 square feet in size, each with 16 single-occupancy resident rooms. Each building is divided into two smoke compartments and is equipped with fire dampers. All three (3) units are fully sprinklered, with interconnected fire alarm/smoke detection systems. Each unit is provided with an on-site, diesel-fired Emergency Power Supply System (EPSS) generator. Currently the facility is licensed for 48 SNF/NF beds, and had a census of 28 on the dates of the survey.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on October 16 - 17, 2019. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Chapter 19, Existing Healthcare Occupancies, in accordance with 42 CFR 483.70.</p> <p>The Survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction</p>	K 000	<p>Preparation and execution of this Response and Plan of Correction does not constitute an admission or agreement by Greystone Terraces of Boise – Health Center of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies and Plan of Correction. The Plan of Correction is being prepared and/or executed solely because it is required by State and Federal Law. For the purposes of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this Response and Plan of Correction constitutes the facility's allegation of compliance.</p> <p>This written plan of correction serves as our allegation of compliance.</p>	
K 324 SS=D	<p>Cooking Facilities 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</p>	K 324	<p>CORRECTIVE ACTION</p> <p>The UL 300 hood system in "Linden" was cleaned and inspected by a properly trained, qualified person on 10/22/19</p>	10-22-19

RECEIVED
NOV 14 2019
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *B. N. A.* TITLE: Administrator (X6) DATE: 11-14-19

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 324	<p>Continued From page 1</p> <p>compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or</p> <p>* cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.</p> <p>Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor.</p> <p>18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and observation, the facility failed to ensure that UL 300 hood systems were inspected and/or cleaned in accordance with NFPA 96. Failure to inspect and if found to be grease-laden, cleaned on a semi-annual basis, has the potential to increase the risk associated with fires due to grease build-up. This deficient practice affected staff on the date of the survey.</p> <p>Findings include:</p> <p>During review of provided facility maintenance and inspection records conducted on 10/16/19 from 8:45 - 11:00 AM, records were not available demonstrating the "Linden" building commercial kitchen hood had been inspected for grease build-up.</p> <p>During the facility tour conducted on 10/16/19 from 11:00 AM - 4:00 PM, observation of the "Linden" building confirmed it was equipped with</p>	K 324	<p>OTHERS POTENTIALLY AFFECTED:</p> <p>No residents were affected by this deficiency because Linden is not occupied by residents only two staff members were affected.</p> <p>SYSTEMIC CHANGES:</p> <p>A properly trained, qualified person had inspected and cleaned the UL 300 hood systems in the other two occupied buildings. The contractor who performs this function will now clean and inspect the hood in "Linden"</p> <p>ON GOING COMPLIANCE:</p> <p>This hood will be cleaned and inspected every six months going forward. The Maintenance Supervisor will monitor compliance of this requirement. Completion date. 10-22-19</p>	

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K 324	Continued From page 2 a UL 300 hood system installed over the cooktop. 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. 11.5 Inspection, Testing, and Maintenance of Listed Hoods Containing Mechanical, Water Spray, or Ultraviolet Devices. Listed hoods containing mechanical or fire-actuated dampers, internal washing components, or other mechanically operated devices shall be inspected and tested by properly trained, qualified, and certified persons every 6 months or at frequencies recommended by the manufacturer in accordance with their listings. 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 Protection Systems. Records of system design,	K 353	K 353 CORRECTIVE ACTION The dry system gauges were inspected on 11/11/19 . The control valve on secured control valves, including outside Post Indicator Valves were inspected on 11/13/19.	11-13-19	

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K 353	<p>Continued From page 3</p> <p>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 and interview, the facility failed to ensure fire suppression systems were maintained in accordance with NFPA 25. Failure to ensure fire suppression systems were maintained free of obstructions and inspected as required, has the potential to hinder system performance during a fire event. This deficient practice affected 28 residents and staff on the date of the survey.</p> <p>Findings include:</p> <p>During review of provided maintenance and inspection records conducted on 10/16/19 from 8:45 - 11:00 AM, records revealed the following missing documentation:</p> <ul style="list-style-type: none"> - No record of a quarterly waterflow alarm testing completed during the second quarter of 2019 - No record for weekly dry system gauge inspection(s). - No record for monthly control valve inspection(s) on secured control valves, including outside Post Indicator Valves (PIV). 	K 353	<p>OTHERS POTENTIALLY AFFECTED</p> <p>All staff and residents residing in the facility have the potential to be affected.</p> <p>SYSTEMIC CHANGES</p> <p>The dry system gauges will be inspected weekly and the inspection will be documented.</p> <p>The control valve on secured control valves, including the outside Post Indicator Valves will be inspected monthly and the inspection will be documented.</p> <p>ONGOING COMPLIANCE:</p> <p>The administrator will monitor the weekly inspection documentation of the dry system gauge weekly for one month starting on 11-11-19 for compliance. The administrator will review the documentation of the monthly inspections of the control valves, including the outside Post Indicator Valve once a month for four months beginning on 11-13-19 for compliance. Completion date 11-13-19.</p>	

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K 353	Continued From page 4 Interview of the Maintenance Director conducted on 10/16/19 at approximately 11:15 AM revealed he was not aware of the missing documentation prior to the date of the survey. Actual NFPA standard: NFPA 25 5.2.4 Gauges. 5.2.4.2 Gauges on dry, preaction, and deluge systems shall be inspected weekly to ensure that normal air and water pressures are being maintained. 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. 13.3 Control Valves in Water-Based Fire Protection Systems. 13.3.2 Inspection. 13.3.2.1 All valves shall be inspected weekly. 13.3.2.1.1 Valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly.	K 353		
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line	K 914	K 914 CORRECTIVE ACTION The tool to test the hospital grade outlets was ordered on 11/8/19. All hospital grade outlets in the facility will be tested by 11/21/19. The following testing parameters will be tested: Physical integrity by visual	11-21-19

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K 914	<p>Continued From page 5</p> <p>isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results.</p> <p>6.3.4 (NFPA 99)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review observation and interview, the facility failed to ensure facility hospital-grade electrical receptacles were maintained in accordance with NFPA 99. Failure to test hospital grade electrical receptacles annually has the potential to hinder system response during an emergency that encompasses a loss of power. This deficient practice affected 28 residents and staff on the date of the survey.</p> <p>Findings include:</p> <p>During review of provided maintenance documents conducted on 10/16/19 from 8:45 - 11:00 AM, documentation indicated outlet testing had been performed on "red" outlets, but no indication as to what testing procedures or performance testing had been conducted.</p> <p>During the facility tour conducted on 10/16/19 from 11:00 AM - 4:00 PM, observation of the outlets installed throughout the facility established all were hospital-grade outlets. Further observation of resident rooms identified both red</p>	K 914	<p>inspection, grounding circuit continuity, correct polarity of the hot and neutral connections, and retention force of the grounding blade.</p> <p>OTHERS POTENTIALLY AFFECTED</p> <p>All residents and staff residing in the facility have the potential to be affected.</p> <p>SYSTEMIC CHANGES</p> <p>Maintenance staff will test all electrical receptacles on an annual basis not just the "red" ones. The before mentioned parameters will be tested and documented.</p> <p>ONGOING COMPLIANCE</p> <p>The Maintenance Supervisor will monitor the testing and documentation of testing parameters to ensure each hospital grade outlet has been tested annually.</p> <p>Completion date: 11/21/19</p>	

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K 914	<p>Continued From page 6</p> <p>colored outlets as well as ivory colored outlets.</p> <p>When interviewed on 10/16/19 at approximately 10:30 AM, the Maintenance Director stated he had not been aware of the testing parameters required and that testing was required on outlets, other than those identified as "red".</p> <p>Actual NFPA standard:</p> <p>NFPA 99 Chapter 6 Electrical Systems</p> <p>6.3.3.2 Receptacle Testing in Patient Care Rooms.</p> <p>6.3.3.2.1 The physical integrity of each receptacle shall be confirmed by visual inspection.</p> <p>6.3.3.2.2 The continuity of the grounding circuit in each electrical receptacle shall be verified.</p> <p>6.3.3.2.3 Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed.</p> <p>6.3.3.2.4 The retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 g (4 oz).</p> <p>6.3.4.1 Maintenance and Testing of Electrical System.</p> <p>6.3.4.1.1 Where hospital-grade receptacles are required at patient bed locations and in locations where deep sedation or general anesthesia is administered, testing shall be performed after initial installation, replacement, or servicing of the device.</p> <p>6.3.4.1.2 Additional testing of receptacles in patient care rooms shall be performed at intervals defined by documented performance data.</p>	K 914		

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

Printed: 10/23/2019
FORM APPROVED
OMB NO. 0938-0391

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K 914	Continued From page 7 6.3.4.1.3 Receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months.	K 914		



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November 1, 2019

Brent Schneider, Administrator
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5301 E. Warm Springs Ave.
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RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER

Dear Mr. Schneider:

On **October 17, 2019**, an Emergency Preparedness survey was conducted at **The Terraces 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.

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- 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 21, 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 **December 16, 2019**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **November 21, 2019**, includes the following:

Denial of payment for new admissions effective **January 17, 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 17, 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 17, 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

Brent Schneider, Administrator

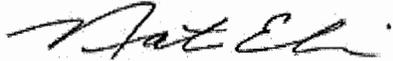
November 1, 2019

Page 4 of 4

This request must be received by **November 14, 2019**. If your request for informal dispute resolution is received after **November 14, 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

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

Printed: 10/23/2019
FORM APPROVED
OMB NO. 0938-0391

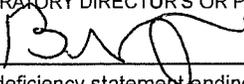
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135141	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/17/2019
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NAME OF PROVIDER OR SUPPLIER TERRACES OF BOISE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 5301 E WARM SPRINGS AVE BOISE, ID 83716
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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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E 000	Initial Comments The facility is comprised of three (3), single-story Type V (111) structures, located within a municipal fire district, with both county and state EMS services available. The buildings are approximately 12,465 square feet in size, each with 16 single-occupancy resident rooms. Each building is divided into two smoke compartments and is equipped with fire dampers. All three (3) units are fully sprinklered, with interconnected fire alarm/smoke detection systems. Each unit is provided with an on-site, diesel-fired Emergency Power Supply System (EPSS) generator. Currently the facility is licensed for 48 SNF/NF beds, and had a census of 28 on the dates of the survey. The following deficiencies were cited during the Emergency Preparedness Survey conducted on October 16 - 17, 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	Preparation and execution of this Response and Plan of Correction does not constitute an admission or agreement by Greystone Terraces of Boise – Health Center of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies and Plan of Correction. The Plan of Correction is being prepared and/or executed solely because it is required by State and Federal Law. For the purposes of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this Response and Plan of Correction constitutes the facility's allegation of compliance.	
E 006 SS=E	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.*	E 006	E006 CORRECTIVE ACTION: The facility HVA and the county all-hazard mitigation plans were reviewed and both are in alignment with each other.	11-12-19

RECEIVED
NOV 14 2019
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 11-14-19
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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 006	<p>Continued From page 1</p> <p>*[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents.</p> <p>*[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients.</p> <p>(2) Include strategies for addressing emergency events identified by the risk assessment.</p> <p>* [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to develop an EP plan that included a facility based and community based risk assessment. Failure to include the county identified risks when developing the facility EP Hazard Vulnerability Analysis (HVA) and relevant policies and procedures, has the potential to hinder the EP relevant training of staff ,by not fully identifying known hazards of the area. This deficient practice affected 28 residents, staff and visitors on the dates of the survey.</p> <p>Findings include:</p> <p>On 10/16/19 from 8:45 - 11:00 AM, review of the provided emergency plan, policies and</p>	E 006	<p>OTHERS POTENTIALLY AFFECTED:</p> <p>All residents, visitors and staff of the facility have the potential to be affected.</p> <p>SYSTEMIC CHANGES:</p> <p>The HVA will continue to include information as defined under the county all-hazard mitigation plan. All updates to the HVA will contain the latest information from the county all-hazard mitigation plan.</p> <p>ON GOING COMPLIANCE:</p> <p>During the annual review and update of the HVA the Maintenance Director will consult with the county to obtain the most current all-hazard mitigation plan and include it in the facility HVA. The administrator will review the plan for compliance.</p> <p>DATE COMPLETED: 11/12/19</p>	

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E 006	Continued From page 2 procedures, revealed the facility HVA did not include information as defined under the county all-hazard mitigation plan. At approximately 11:15 AM, the Maintenance Director was asked if the facility had a copy of the county plan, or if it was used when developing the HVA. The Maintenance Director stated he was unaware if it was consulted and that the assessment was completed internally through facility management. Reference: 42 CFR 483.73 (a) (1) - (2)	E 006		
E 007 SS=F	EP Program Patient Population CFR(s): 483.73(a)(3) [(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 an emergency; and continuity of operations, including delegations of authority and succession plans.** *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, it was determined the facility failed to provide an emergency plan, policies and procedures which addressed the types of services the facility has the ability to provide during an emergency. Failure to address the types of services the facility has the ability to provide, has the potential to hinder continuity of care and emergency management response	E 007	E007 CORRECTIVE ACTION: The facility Emergency Operation Plan now contains what types of services the facility has the ability to provide during an emergency. OTHERS POTENTIALL AFFECTED: All residents, staff, and visitors of the facility have the potential to be affected. SYSTEMIC CHANGES: The EOP will continue to include what types of services the facility has the ability to provide during an emergency. This information will be obtained from the facility assessment which will be reviewed and updated on an annual basis then included in the EOP.	11-14-19

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E 007	Continued From page 3 during an emergency. This deficient practice affected 28 residents, staff and visitors on the dates of the survey. Findings include: On 10/16/19 from 8:45 - 11:00 AM, review of provided emergency plan, policies and procedures, revealed the plan failed to define what types of services the facility had the ability to provide during an emergency. Reference: 42 CFR 483.73 (a) (3)	E 007	ON GOING COMPLIANCE: The Administrator will make sure the updated information of services the facility has the ability to provide during an emergency will be included in the EOP. DATE COMPLETED: 11/14/19	
E 013 SS=E	Development of EP Policies and Procedures CFR(s): 483.73(b) (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including,	E 013	E013 CORRECTIVE ACTION: The facility HVA now includes information from the county all-hazard mitigation plan and was used to identify risks. OTHERS POTENTIALLY AFFECTED All residents, staff, and visitors have the potential to be affected. SYSTEMIC CHANGES: The facility HVA will consider and utilize the most current county all-hazard mitigation plan when developing the identified risks.	11-14-19

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E 013	<p>Continued From page 4</p> <p>but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least annually.</p> <p>*[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, the facility failed to ensure policies and procedures were aligned with a community-based and facility-based HVA. Failure to develop policies based on relevant facility and community based risks, has the potential to confuse staff and result in irrelevant training on hazards that are not consistent with the facility location. This deficient practice affected 28 residents, staff and visitors on the dates of the survey.</p> <p>Findings include:</p> <p>On 10/16/19 from 8:45 - 11:00 AM, review of the provided emergency plan, policies and procedures, revealed the facility HVA did not utilize and consider the county all-hazard</p>	E 013	<p>ON GOING COMPLIANCE:</p> <p>The Maintenance Director will obtain the most current county all-hazard mitigation plan and include this information when developing identified risks. This information will be used during the annual assessment and used to update the HVA.</p> <p>DATE COMPLETED: 11/14/19</p>	

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E 013	Continued From page 5 mitigation plan when developing the identified risks, only using information generated from internal staff management discussions. Reference: 42 CFR 483.73 (b) Additional Reference: E - 0006	E 013			
E 025 SS=F	Arrangement with Other Facilities CFR(s): 483.73(b)(7) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] *[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services	E 025	E025 CORRECTIVE ACTION: Arrangements with three other nursing homes have been made. OTHERS POTENTIALLY AFFECTED: All residents, staff, and visitors have the potential to be affected. SYSTEMIC CHACES: An annual review of the arrangements with other nursing homes will take place to make sure the contact information is current and the nursing homes continue to agree to cooperate with each other. ON GOING COMPLIANCE: The administrator will conduct the annual review of arrangements with other nursing homes and update the arrangements as needed. DATE COMPLETED: 11/12/19	11-12-19	

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

Printed: 10/23/2019
FORM APPROVED
OMB NO. 0938-0391

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E 025	Continued From page 6 to facility patients. *[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients. This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the facility failed to document a current plan for arrangements between the facility and other skilled nursing facilities. Failure to develop arrangements with other nursing home providers has the potential to limit support services to continue care during an emergency. This deficient practice affected 28 residents, staff and visitors on the dates of the survey. Findings include: On 10/16/19 from 8:45 - 11:00 AM, review of provided EP policies and procedures, failed to demonstrate arrangements with other nursing homes, but indicated that evacuation procedures were to be from the skilled nursing facility to the adjacent assisted living facility. Reference: 42 CFR 483.73 (b) (7)	E 025		
E 029 SS=F	Development of Communication Plan CFR(s): 483.73(c) (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.	E 029	E029 CORRECTIVE ACTION: The EP now contains a communication plan that documents contact information for emergency	11-14-19

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E 029	<p>Continued From page 7</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to document a facility communications plan to ensure continuity of care across agencies during a disaster. Failure to provide a communication plan that includes how the facility interacts with emergency management agencies, other long-term care providers and provides both primary and alternate forms of communication, has the potential to hinder both internal and external emergency response by personnel. This deficient practice affected 28 residents, staff and visitors on the dates of the survey.</p> <p>Findings include:</p> <p>On 10/16/19 from 8:45 - 11:00 AM, review of the provided EP policies and procedures, failed to reveal the facility had developed a communication plan that documented contact information for emergency agencies, physicians, and volunteer organizations. Further review of the EP failed to establish what methods of transferring information to emergency management agencies, or what primary and alternate forms of communication would be implemented during disasters.</p> <p>Reference: 42 CFR 483.73 (c)</p> <p>Additional reference(s)</p> <p>E-0030 E-0031 E-0032 E-0034</p>	E 029	<p>agencies, physicians, and volunteer organizations. The EP also contains the methods of transferring information to emergency management agencies and what primary and secondary alternative forms of communication will be implemented during disasters.</p> <p>OTHERS POTENTIALLY AFFECTED: All residents, staff, and visitors in the facility have the potential to be affected.</p> <p>SYSTEMIC CHANGES: During the annual review of the EP the contact information for emergency agencies, physicians, and volunteer agencies will be reviewed and updated. The primary and secondary forms of communication will be reviewed and updated as well.</p> <p>ON GOING COMPLIANCE: The administrator will review the EP emergency contact information and communication methods at the annual review to determine it is correct and current.</p> <p>DATE COMPLETED: 11/14/19</p>		
E 030 SS=F	Names and Contact Information CFR(s): 483.73(c)(1)	E 030			

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

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E 030	<p>Continued From page 8</p> <p>[(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 all of the following:]</p> <p>(1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers.</p> <p>*[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers.</p> <p>*[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers.</p> <p>*[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the</p>	E 030	<p>E030</p> <p>CORRECTIVE ACTIONS:</p> <p>The EP now contains a communication plan that includes contact information for staff, resident physicians, other long-term care agencies, and volunteers.</p> <p>OTHERS POTENTIALLY AFFECTED:</p> <p>All residents, staff, and visitors in the facility have the potential to be affected.</p> <p>SYSTEMIC CHANGES:</p> <p>During the annual review of the EP the communication plan will be reviewed to ensure the contact information for staff, resident physicians, other long term care agencies, and volunteers is current.</p> <p>ON GOING COMPLIANCE:</p> <p>The administrator will review the EP communication plan to ensure the contact information is current.</p> <p>DATE COMPLETED: 11/14/19</p>	11-14-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135141	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/17/2019
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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
E 030	<p>Continued From page 9 following:</p> <ul style="list-style-type: none"> (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. <p>*[For HHAs at §484.102(c):] The communication plan must include all of the following:</p> <ul style="list-style-type: none"> (1) Names and contact information for the following: <ul style="list-style-type: none"> (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. <p>*[For OPOs at §486.360(c):] The communication plan must include all of the following:</p> <ul style="list-style-type: none"> (1) Names and contact information for the following: <ul style="list-style-type: none"> (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, the facility failed to document a communication plan which included contact information for staff, resident physicians, other long-term care facilities and applicable volunteer agencies. Failure to have a communication plan which includes contact information for those parties assisting in the facility's response and recovery during a disaster, has the potential to hinder both internal and external emergency response efforts. This deficient practice affected 28 residents, staff and visitors on the dates of the survey.</p>	E 030		

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OMB NO. 0938-0391

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E 030	Continued From page 10 Findings include: On 10/16/19 from 8:45 - 11:00 AM, review of the provided EP policies and procedures, failed to demonstrate a communication plan that included contact information for staff, resident physicians, other long-term care agencies and volunteers. Reference: 42 CFR 483.73 (c) (1)	E 030		
E 031 SS=F	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 all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[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. *[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.	E 031	E031 CORRECTIVE ACTION: The EP now contains contact information for federal and local emergency preparedness staff, the state licensing and certification agency, state ombudsman and other sources of assistance. OTHERS POTENTIALL AFFECTED: All residents, staff, and visitors in the facility have the potential to be affected. SYSTEMIC CHANGES: During the annual review of the EP the contact information for federal and local emergency preparedness staff, the state licensing and certification agency, state ombudsman and other sources contact information will be reviewed and updated as necessary.	11-14-19

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E 031	Continued From page 11 (iv) The State Protection and Advocacy Agency. This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to ensure the EP had a communication plan that provided contact information for emergency management officials and other resources of assistance. Failure to provide contact information for federal agencies, local emergency preparedness staff, state licensing and certification agency, state ombudsman and other sources of assistance, has the potential to hinder facility response and continuity of care for the 28 residents, staff and visitors in the facility on the dates of the survey. Findings include: On 10/16/19 from 8:45 - 11:00 AM, review of the provided EP, failed to establish a communication plan was included that provided contact information for federal and local emergency preparedness staff, the state licensing and certification agency, state ombudsman and other sources of assistance. Reference: 42 CFR 483.73 (c) (2)	E 031	ON GOING COMPLIANCE: The administrator will review the EP plan to provide current contact information for federal and local emergency preparedness staff, the state licensing and certification agency, state ombudsman and other sources of assistance. DATE COMPLETED: 11/14/19	
E 034 SS=F	Information on Occupancy/Needs CFR(s): 483.73(c)(7) [(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 all of the following: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its	E 034	E034 CORRECTIVE ACTION: The EP now contains a communication plan that documents what methods the facility will use to share information on its capabilities and abilities to provide assistance when communicating with emergency management officials.	11-14-19

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E 034	<p>Continued From page 12</p> <p>ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.</p> <p>*[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.</p> <p>*[For Inpatient Hospice at §418.113:]: (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to provide a communication plan for sharing information on its ability to provide assistance with emergency management officials. Failure to provide a plan to share information with emergency personnel on the facility's abilities to provide assistance during a disaster, has the potential to hinder response assistance and continuation of care for the 28 residents, staff and visitors on the dates of the survey.</p> <p>Findings include:</p> <p>On 10/16/19 from 8:45 - 11:00 AM, review of the provided EP failed to demonstrate a communication plan that documented what method the facility would use to share information on its capabilities and abilities to provide assistance when communicating with emergency management officials.</p> <p>Reference:</p>	E 034	<p>OTHER POTENTIALLY AFFECTED:</p> <p>All residents, staff, and visitors have the potential to be affected.</p> <p>SYSTEMIC CHANGES:</p> <p>During the annual review of the EP the communication plan will be reviewed and the methods of communication to emergency officials will be evaluated and made current as needed.</p> <p>ON GOING COMPLIANCE:</p> <p>The administrator will review the EP to make sure the communication methods to emergency officials concerning the facilities' capabilities and abilities to provide assistance is current and still valid.</p> <p>DATE COMPLETED: 11/14/19</p>		

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E 034	Continued From page 13 42 CFR 483.73 (c) (7)	E 034			
E 036 SS=F	<p>EP Training and Testing CFR(s): 483.73(d)</p> <p>(d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.</p> <p>*[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h).</p> <p>*[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and</p>	E 036	<p>E036</p> <p>CORRECTIVE ACTION:</p> <p>Facility staff were trained and tested on their knowledge of the EP on 11/13 and 11/14 .</p> <p>OTHERS POTENTIALLY AFFECTED:</p> <p>All residents, visitors, and staff have the potential to be affected:</p> <p>SYSTEMIC CHANGES:</p> <p>Annual training and testing of staff's knowledge of the EP will be conducted.</p> <p>ON GOING COMPLIANCE:</p> <p>The administrator will review the staff training of the EP to make sure it includes testing of their knowledge of the contents of the plan.</p> <p>DATE COMPLETED: 11/14/19</p>	11-14-19	

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E 036	Continued From page 14 updated at least annually. This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the facility failed to provide an emergency prep training and testing program for the EP contents. Lack of a facility staff testing program on the contents of the EP, has the potential to hinder staff performance by limiting retained knowledge of response procedures for disasters. This deficient practice affected 28 residents, staff and visitors on the dates of the survey. Findings include: On 10/16/19 from 8:45 - 11:00 AM, review of the provided EP, along with associated inservices, revealed the facility training program was primarily an online format, however the program content only directed staff to "know" the contents of the EP and did not provide relevant testing on the contents of that document. Reference: 42 CFR 483.73 (d)	E 036			
E 037 SS=F	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.	E 037	E037 CORRECTIVE ACTION: Facility staff were trained on the policies and procedures as outlined in the EP on 11/13 and 11/14. OTHERS POTENTIALLY AFFECTED: All staff, visitors, and residents have the potential to be affected.	11-14-19	

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E 037	Continued From page 15 (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 hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least annually. (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. *[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	E 037	SYSTEMIC CHANGES: Annual training will be provided to staff on the policies and procedures as outlined in the EP. ON GOING COMPLIANCE: The administrator will review the staff training of the EP to make sure it includes training on the policies and procedure as outlined in the EP. DATE COMPLETED: 11/14/19		

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E 037	<p>Continued From page 16</p> <p>their expected roles.</p> <p>(ii) After initial training, provide emergency preparedness training at least annually.</p> <p>(iii) Demonstrate staff knowledge of emergency procedures.</p> <p>(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:</p> <p>(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.</p> <p>(ii) Provide emergency preparedness training at least annually.</p> <p>(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.</p> <p>(iv) Maintain documentation of all training.</p> <p>*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:</p> <p>(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.</p> <p>(ii) Provide emergency preparedness training at least annually.</p> <p>(iii) Maintain documentation of the training.</p> <p>(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</p>	E 037		

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E 037	<p>Continued From page 17 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> <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. This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the facility failed to provide an emergency prep training program for the EP contents. Lack of a facility staff training program on the contents of the EP, has the potential to hinder staff performance by limiting knowledge of response policies and procedures for disasters as defined.</p>	E 037			

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E 037	Continued From page 18 This deficient practice affected 28 residents, staff and visitors on the dates of the survey. Findings include: On 10/16/19 from 8:45 - 11:00 AM, review of the provided EP, along with associated inservices, revealed the facility training program was primarily an online format, however the program content only directed staff to "know" the contents of the EP and did not provide relevant training that referenced the policies and procdures as outlined in that document. Reference: 42 CFR 483.73 (d) (1)	E 037			
E 039 SS=F	EP Testing Requirements CFR(s): 483.73(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based	E 039	E039 CORRECTIVE ACTION: The facility has scheduled an internal tabletop drill, with facility leaders before 11/21/19 12/1/19 SB The facility is working with St. Luke's Health Systems to participate in a multi-agency community drill. A time has not been determined yet. OTHERS POTENTIALLY AFFECTED: All residents, visitors, and staff have the potential to be affected.	<p>SB 12/1/19 11-21-19</p> <p>THE FACILITY WILL BE FUNCTIONAL BY EXERCISE 12/1/19</p>	

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E 039	<p>Continued From page 19</p> <p>full-scale exercise for 1 year following the onset of the actual event.</p> <p>(ii) Conduct an additional exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, facility-based.</p> <p>(B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.</p> <p>*[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following:</p> <p>(i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, the facility failed to complete two (2) full scale drills as required. Failure to complete two full-scale exercises for the activation of the EP, has the potential to</p>	E 039	<p>SYSTEMIC CHANGES:</p> <p>Training of staff for emergency preparedness will include two full scale events to test the effectiveness of the EP policies and procedures.</p> <p>ON GOING COMPLIANCE:</p> <p>The administrator will review the staff training of the EP to make sure it contains two full scale events or exercises that tests the effectiveness of the EP policies and procedures.</p> <p>DATE COMPLETED: 11/21/19 12/1/19</p>	

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E 039	<p>Continued From page 20</p> <p>hinder staff performance during an actual emergency. This deficient practice affected 28 residents and staff on the date of the survey.</p> <p>Findings include:</p> <p>During review of the provided facility EP conducted on 10/16/19 from 8:45 - 11:00 AM, records failed to establish the facility had documented participation in two (2) full-scale events or exercises, that tested the effectiveness of the EP policies and procedures.</p> <p>Reference: 42 CFR 483.73 (d) (1)</p>	E 039		