



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

December 10, 2019

Gary "Paul" Arnell, Administrator  
The Orchards of Cascadia  
404 North Horton Street  
Nampa, ID 83651-6541

Provider #: 135019

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

Dear Mr. Arnell:

On **December 3, 2019**, a Facility Fire Safety and Construction survey was conducted at **The Orchards of Cascadia** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

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

Gary "Paul" Arnell, Administrator  
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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 **December 23, 2019**. Failure to submit an acceptable PoC by **December 23, 2019**, may result in the imposition of civil monetary penalties by **January 14, 2020**.

Your PoC must contain the following:

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

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

Remedies may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **January 7, 2020**, (Opportunity to Correct). Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **March 2, 2020**. A change in the seriousness of the deficiencies on **January 17, 2020**, 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 **January 7, 2020**, includes the following:

Denial of payment for new admissions effective **March 3, 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 **June 3, 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 **December 3, 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:

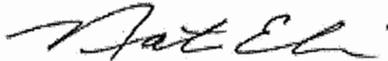
BFS Letters (06/30/11)

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

This request must be received by **December 23, 2019**. If your request for informal dispute resolution is received after **December 23, 2019**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



Nate Elkins, Supervisor  
Facility Fire Safety and Construction

NE/lj  
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135019</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - ENTIRE BUILDING</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/03/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>ORCHARDS OF CASCADIA, THE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>404 NORTH HORTON STREET NAMPA, ID 83651</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	<p><b>INITIAL COMMENTS</b></p> <p>The facility is a single-story Type V (111) occupancy, originally constructed in 1959. There is an automatic fire sprinkler system and interconnected fire alarm/smoke detection system. There have been multiple renovations to the building, the last of which was completed in 2017. There is an on-site, spark-fired (propane) Emergency Electrical System (EES) generator which provides backup emergency power. The facility is currently licensed for 100 beds and had a census of 80 on the dates of the survey.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on December 2 - 3, 2019. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70</p> <p>The survey was conducted by:</p> <p>Linda Chaney Health Facility Surveyor Facility Fire Safety &amp; Construction</p>	K 000	<p><i>This plan of correction is submitted as required under Federal and State regulations and statutes applicable to long-term care providers. The plan of Correction does not constitute agreement by the facility that the surveyors findings constitute a deficiency and/or that the scope and severity of the deficiencies cited are correct applied.</i></p>	
K 222 SS=F	<p><b>Egress Doors</b> CFR(s): NFPA 101</p> <p><b>Egress Doors</b> Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: <b>CLINICAL NEEDS OR SECURITY THREAT LOCKING</b> Where special locking arrangements for the clinical security needs of the patient are used,</p>	K 222	<p><b>K 222</b></p> <p>1. <b>SPECIFIC ISSUE:</b> The exit door leading out of the 500 hall and the dining room door have all been repaired, tested, and found functional by the maintenance director on or before 12/20/2019.</p> <p>2. <b>OTHER RESIDENTS:</b> Facility wide audit performed by Maintenance Director on or before 12/20/2019 to ensure facility maintained safe and appropriate delayed egress doors.</p> <p>3. <b>SYSTEMIC CHANGES:</b> Staff educated on or before 12/20/2019 by Executive Director or</p>	

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DEC 19 2019

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE **CEO** (X6) DATE **12/18/19**

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 222	<p>Continued From page 1</p> <p>only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times.</p> <p>18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6</p> <p><b>SPECIAL NEEDS LOCKING ARRANGEMENTS</b></p> <p>Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation.</p> <p>18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4</p> <p><b>DELAYED-EGRESS LOCKING ARRANGEMENTS</b></p> <p>Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system.</p> <p>18.2.2.2.4, 19.2.2.2.4</p> <p><b>ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS</b></p> <p>Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted.</p> <p>18.2.2.2.4, 19.2.2.2.4</p>	K 222	<p>designee regarding preventative maintenance policy and applicable NFPA standards.</p> <p>4. <b>MONITOR:</b> Executive Director or designee will validate that all doors are functioning per NFPA guidelines for egress. Facility to audits all doors to ensure compliance, then weekly x 3, then monthly x 3. Additional education will be provided as necessary. Results of audit will be reviewed in PI to ensure systems being followed. Plan to be updated as indicated.</p> <p>5. <b>Date of Compliance:</b></p>	12/20/2019

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

PRINTED: 12/09/2019  
FORM APPROVED  
OMB NO. 0938-0391

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K 222	<p>Continued From page 2</p> <p><b>ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS</b></p> <p>Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, operational testing and interview, the facility failed to ensure special locking arrangements were in accordance with NFPA 101. Failure to provide operational delayed egress locking arrangements for magnetically controlled means of egress could hinder the safe evacuation of residents during a fire or other emergency. This deficient practice affected 50 residents and staff on the dates of the survey.</p> <p>Findings include:</p> <p>During the facility tour on December 3, 2019, at approximately 11:20 AM to 11:40 AM, operational testing of exit doors in the 500 hallway and dining room, revealed they were labeled as delayed egress doors, with signage stating the magnetic lock would drop after 15 seconds. However, operational testing of the door revealed the magnetic lock would not release, even after 15 seconds or more. The Maintenance Supervisor stated at approximately 11:45 AM, the facility was not aware the delayed egress component on the doors was not functioning properly.</p> <p>Actual NFPA standard:</p> <p>7.2.1.6* Special Locking Arrangements.</p>	K 222		

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K 222	<p>Continued From page 3</p> <p>7.2.1.6.1 Delayed-Egress Locking Systems.</p> <p>7.2.1.6.1.1 Approved, listed, delayed-egress locking systems shall be permitted to be installed on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6 or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 11 through 43, provided that all of the following criteria are met:</p> <p>(1) The door leaves shall unlock in the direction of egress upon actuation of one of the following:</p> <p>(a) Approved, supervised automatic sprinkler system in accordance with Section 9.7</p> <p>(b) Not more than one heat detector of an approved, supervised automatic fire detection system in accordance with Section 9.6</p> <p>(c) Not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6</p> <p>(2) The door leaves shall unlock in the direction of egress upon loss of power controlling the lock or locking mechanism.</p> <p>(3)*An irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions:</p> <p>(a) The force shall not be required to exceed 15 lbf (67 N).</p> <p>(b) The force shall not be required to be continuously applied for more than 3 seconds.</p> <p>(c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening.</p> <p>(d) Once the lock has been released by the</p>	K 222		



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K 353	<p>Continued From page 5</p> <p>Based on observation and interview, the facility failed to ensure fire suppression system pendants were maintained free of obstructions such as paint or corrosion. Failure to maintain fire sprinkler pendants free of obstructions could hinder system performance during a fire event. This deficient practice affected 66 residents and staff on the dates of the survey.</p> <p>Findings include:</p> <p>Observation during the facility tour on December 3, 2019, from approximately 10:15 AM to 11:40 AM, revealed the following sprinkler heads were obstructed with non-factory paint or corrosion:</p> <ul style="list-style-type: none"> <li>- Unit #1 shower room</li> <li>- Activities closet between room #401 &amp; #403</li> <li>- Storage room between room #511 &amp; #513</li> <li>- Right side of hallway exiting the dining room, heading towards the 200 hallway.</li> </ul> <p>When asked, at approximately 12:00 PM, the Maintenance Supervisor stated the facility recently replaced other sprinkler heads with paint/corrosion and were not aware these were missed.</p> <p>Actual NFPA standard:</p> <p>NFPA 25 5.2.1 Sprinklers. 5.2.1.1* Sprinklers shall be inspected from the floor level annually. 5.2.1.1.1* Sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., upright, pendent, or sidewall). 5.2.1.1.2 Any sprinkler that shows signs of any of the following shall be replaced:</p>	K 353	<p>Results of audit will be reviewed in PI to ensure systems being followed. Plan to be updated as indicated.</p> <p>5. <b>Date of Compliance:</b> 12/20/2019</p>	

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K 353	Continued From page 6 (1) Leakage (2) Corrosion (3) Physical damage (4) Loss of fluid in the glass bulb heat responsive element (5) *Loading (6) Painting unless painted by the sprinkler manufacturer	K 353	K 511  1. <b>SPECIFIC ISSUE:</b> The following electrical areas were corrected on or before 12/20/2019 by Director of Maintenance and licensed electrician: Staff break room water dispenser Rm 511 refrigerator PT office refrigerator Activity office refrigerator Unit 4/5 nook DON office refrigerator MDS office air conditioner Case manager air conditioner Social services office Office adjacent to main entrance	
K 511 SS=F	Utilities - Gas and Electric CFR(s): NFPA 101  Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2  This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure safe electrical installations in accordance with their listed assemblies and those requirements under NFPA 70. Use of relocatable power taps (RPTs) outside of those defined in the UL listings, has the potential to expose residents to risks of electrocution and arc fires. This deficient practice affected 1 resident and staff on the dates of the survey.  Findings include:  During the facility tour conducted on December 3,	K 511	2. <b>OTHER RESIDENTS:</b> Facility wide audit performed by Maintenance Director on or before 12/20/2019 to ensure facility maintained safe electrical installations.  3. <b>SYSTEMIC CHANGES:</b> Facility staff educated by Executive Director or designee on or before 12/20/2019 to ensure understanding of safe electrical installations throughout the facility.	

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K 511	Continued From page 7 2019, from approximately 10:00 AM to 12:30 PM, observation of installed electrical systems revealed the following:  1.) The staff break room was using a Multi-Plug Adapter (MPA) at the purified water dispenser. 2.) Room number 511 was using a Relocatable Power Tap (RPT) to power a refrigerator. 3.) The Physical Therapy Office was using a RPT to power a refrigerator. 4.) The Activity Managers Office had an extension cord in use, providing power to a refrigerator. 5.) Unit 4/5 nook had two RPTs connected in series (daisy-chained). 6.) The Director of Nursing Office was using a RPT to power a refrigerator. 7.) The MDS office was using a RPT to power a window air conditioning unit. 8.) The Case Manager's Office was using a RPT to power a window air conditioning unit and refrigerator. 9.) The Social Services Office had two RPTs connected in series (daisy-chained). 10.) The office adjacent to the main entrance was using a RPT to power a refrigerator.  Actual NFPA standard:  NFPA 70  110.2 Approval. The conductors and equipment required or permitted by this Code shall be acceptable only if approved.  Informational Note: See 90.7, Examination of Equipment for Safety, and 110.3, Examination, Identification, Installation, and Use of Equipment. See definitions of Approved, Identified, Labeled, and Listed.	K 511	4. <del>MONITOR</del> Executive Director or designee will audit random electrical installations weekly x 3 then monthly x 3 to ensure ongoing compliance.  Additional education will be provided as necessary. Results of audit will be reviewed in PI to ensure systems being followed. Plan to be updated as indicated.  5. <b>Date of Compliance:</b>	12/20/2019

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K 511	Continued From page 8  110.3 Examination, Identification, Installation, and Use of Equipment. (A) Examination. In judging equipment, considerations such as the following shall be evaluated: (1) Suitability for installation and use in conformity with the provisions of this Code Informational Note: Suitability of equipment use may be identified by a description marked on or provided with a product to identify the suitability of the product for a specific purpose, environment, or application. Special conditions of use or other limitations and other pertinent information. Suitability of equipment may be evidenced by listing or labeling. (2) Mechanical strength and durability, including, for parts designed to enclose and protect other equipment, the adequacy of the protection thus provided (3) Wire-bending and connection space (4) Electrical insulation (5) Heating effects under normal conditions of use and also under abnormal conditions likely to arise in service (6) Arcing effects (7) Classification by type, size, voltage, current capacity, and specific use (8) Other factors that contribute to the practical safeguarding of persons using or likely to come in contact with the equipment (B) Installation and Use. Listed or labeled equipment shall be installed and used in accordance with any instructions included in the listing or labeling.	K 511			
K 712 SS=F	Fire Drills CFR(s): NFPA 101	K 712			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135019</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - ENTIRE BUILDING</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>12/03/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>ORCHARDS OF CASCADIA, THE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>404 NORTH HORTON STREET NAMPA, ID 83651</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 712	<p>Continued From page 9</p> <p><b>Fire Drills</b> Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide documentation of required fire drills, one per shift per quarter. Failure to perform fire drills on each shift quarterly could result in confusion and hinder the safe evacuation of residents during a fire event. This deficient practice affected all residents and staff on the dates of the survey.</p> <p>Findings include:</p> <p>During record review on December 2, 2019, from approximately 9:00 AM to 12:00 PM, fire drill documentation revealed the facility failed to perform fire drills on third shift (NOC) during the first, second and third quarters of 2019. When asked, at approximately 12:30 PM, the Maintenance Supervisor stated the facility was unaware of the missing fire drills.</p> <p>Actual NFPA standard:</p> <p>19.7.1.6 Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and</p>	K 712	<p>K 712</p> <ol style="list-style-type: none"> <li><b>SPECIFIC ISSUE:</b> Based on record review, the facility failed to conduct fire drills for every shift in every quarter in accordance with NFPA 101, 2012 edition, section 19.7.1.6 (specifically drills for NOC shift). NOC shift fire drill was conducted for fourth quarter 2019 on 12/17/2019 by Director of Maintenance.</li> <li><b>OTHER RESIDENTS:</b> All residents are potentially affected.</li> <li><b>SYSTEMIC CHANGES:</b> Facility staff educated by Executive Director or designee on or before 12/20/2019 to ensure understanding of NFPA standards for fire drills.</li> <li><b>MONITOR:</b> Executive Director or designee will audit fire drills conducted monthly x 3 to ensure ongoing compliance. Additional education will be provided as necessary. Results of audit will be reviewed in PI to ensure systems being followed. Plan to be updated as indicated.</li> <li><b>Date of Compliance:</b></li> </ol>	12/20/2019

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

PRINTED: 12/09/2019  
FORM APPROVED  
OMB NO. 0938-0391

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K 712	Continued From page 10 administrative staff) with the signals and emergency action required under varied conditions.	K 712		



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

December 10, 2019

Gary "Paul" Arnell, Administrator  
The Orchards of Cascadia  
404 North Horton Street  
Nampa, ID 83651-6541

Provider #: 135019

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

Dear Mr. Arnell:

On **December 3, 2019**, an Emergency Preparedness survey was conducted at The Orchards of Cascadia by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. Your facility was found to be in substantial compliance with Federal regulations during this survey.

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

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

Sincerely,

Nate Elkins, Supervisor  
Facility Fire Safety and Construction

NE/lj  
Enclosure

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

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E 000	<p>Initial Comments</p> <p>The facility is a single-story Type V (111) occupancy, originally constructed in 1959. There is an automatic fire sprinkler system and interconnected fire alarm/smoke detection system. There have been multiple renovations to the building, the last of which was completed in 2017. There is an on-site, spark-fired (propane) Emergency Electrical System (EES) generator which provides backup emergency power. The facility is currently licensed for 100 beds and had a census of 80 on the dates of the survey.</p> <p>The facility was found to be in substantial compliance during the annual Emergency Preparedness Survey conducted on December 2 - 3, 2019. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.</p> <p>The survey was conducted by:</p> <p>Linda Chaney Health Facility Surveyor Facility Fire Safety &amp; Construction</p>	E 000		

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

TITLE

(X6) DATE

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