



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. 'BUTCH' OTTER – Governor
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TAMARA PRISOCK—ADMINISTRATOR
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DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
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September 22, 2015

Daniel Mata, Administrator
Saint Alphonsus Transitional Rehabilitation Unit
1055 North Curtis Road
Boise, ID 83706-1309

Provider #: 135119

Dear Mr. Mata:

On **September 11, 2015**, a survey was conducted at Saint Alphonsus Transitional Rehabilitation Unit by the Idaho Department of Health and Welfare, Division of Licensing and Certification, 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/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated 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. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct." **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.**

Daniel Mata, Administrator
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After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **October 6, 2015**. Failure to submit an acceptable PoC by **October 6, 2015**, may result in the imposition of civil monetary penalties by **October 25, 2015**.

The components of a Plan of Correction as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained; and
- Include dates when corrective action will be completed in column (X5).

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **October 19, 2015 (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 **October 19, 2015**. A change in the seriousness of the deficiencies on **October 19, 2015**, may result in a

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change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **October 19, 2015** includes the following:

Denial of payment for new admissions effective **December 11, 2015**. [42 CFR §488.417(a)]

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **March 11, 2016**, 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, CMS will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **September 11, 2015** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

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

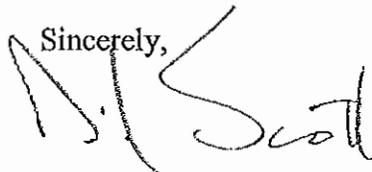
- **BFS Letters (06/30/11)**

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

This request must be received by **October 6, 2015**. If your request for informal dispute resolution is received after **October 6, 2015**, 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, comments or concerns, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2.

Sincerely,



DAVID SCOTT, R.N., Supervisor
Long Term Care

DS/lj
Enclosures

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

PRINTED: 09/21/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135119	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/11/2015
NAME OF PROVIDER OR SUPPLIER SAINT ALPHONSUS TRANSITIONAL REHABILITATION UNIT			STREET ADDRESS, CITY, STATE, ZIP CODE 1055 NORTH CURTIS ROAD BOISE, ID 83706		
(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	
F 000	INITIAL COMMENTS The following deficiencies were cited during the federal recertification survey conducted at the facility September 8-11, 2015. The surveyors conducting the survey were: Amy Barkley, RN, BSN, Team Coordinator Linda Kelly, RN Angela Morgan, RN, BSN Presie Billington, RN Abbreviations included: ADL=Activities of Daily Living BIMS=Brief Interview for Mental Status CAA=Care Area Assessment CNA=Certified Nursing Assistant IADL=Independent Activities of Daily Living IP=Infection Preventionist LN=Licensed Nurse LUE=Left Upper Extremity MDS=Minimum Data Set MSDS=Material Safety Data Sheet OT=Occupational Therapy PSA=Patient Safety Attendant RUE=Right Upper Extremity TCU=Transitional Care Unit UC=Unit Clerk	F 000			
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was	F 241	1.) What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #1 no longer resides at the facility. Resident #5 no longer resides at the facility. Resident #6 no longer resides at the facility.		

RECEIVED
OCT 15 2015
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Harold L. Johnson* TITLE: *NHA* (X6) DATE: *10/6/15*

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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F 241	<p>Continued From page 1</p> <p>determined the facility failed to ensure residents' privacy and dignity was protected. This was true for 3 of 7 sample residents (#s 1, 5 and 6). The deficient practice created the potential for residents to be embarrassed and/or experience an adverse effect on their self-esteem when staff entered their rooms without knocking and talked about them in their presence as if they weren't there. Findings included:</p> <p>1. On 9/9/15, 3 staff were observed entering resident rooms without first knocking as follows: * 8:00 a.m., CNA #5 entered Resident #5's room without knocking; * 8:05 a.m. - CNA #5 entered Resident #1's room without knocking; * 12:10 p.m. and 12:12 p.m. - LN #3 entered Resident #1's room without knocking; * 12:15 p.m. - LN #3 was informed of the observations and asked about the resident's privacy. The LN stated, "Yeah, okay." * 2:20 p.m. - LN #3 entered Resident #6's room without knocking; and * 2:36 p.m., LN #4 entered Resident 6's room without knocking.</p> <p>2. Resident #1 was admitted to the facility on 8/7/15 with multiple diagnoses, including sepsis.</p> <p>Resident #1's most recent MDS, dated 8/19/15, documented the resident was cognitively intact.</p> <p>On 9/8/15, Resident #1 was observed sitting in a chair next to her bed with a table on wheels placed in front of her. Resident #1 said she liked being at the facility, but she wanted to go home. Resident #1 became tearful and said she liked</p>	F 241	<p>2.) How you will identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken.</p> <p>All current residents have the potential to be affected by the same deficient practice.</p> <p>Education will be provided to Nursing (including Registered Nurses and Certified Nurses Assistants), Physical Therapy, Occupational Therapy, Speech Therapy, and Social Work colleagues working in the facility regarding Dignity and Respect of Individuality.</p> <p>3.) What measures will be put in place or what systematic change you will make to ensure that the deficient practice does not recur.</p> <p>Multidisciplinary (Nursing, PT,OT,SP) Team will develop education material on Dignity and Respect of Individuality. Mandatory education will be presented to all Nursing (including Registered Nurses</p>		

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F 241	Continued From page 2 Patient Safety Attendant #1. PSA #1, who was sitting in a chair outside of the resident's direct view, stated, "Don't talk to him, talk to me." On 9/9/15, Resident #1 was standing at her doorway and asked the two surveyors to enter her room. CNA #5 was inside Resident #1's room asking the resident to use her walker. UC #6 walked into Resident #1's room without knocking, approached the surveyors, and stated, "Do not interview [Resident #1] without an interpreter present."	F 241	and Certified Nurses Assistants), Physical Therapy, Occupational Therapy, Speech Therapy, and Social Work colleagues working in the facility. 4.) How the corrective action will be monitored to ensure the deficient practice will not recur. -Weekly Audits will be completed X4 weeks starting the week of October 19, 2015. -Audits will be completed by Supervisors (PT, OT, SP, and Nursing.) Each will complete the audit one week. -The audit will consist of observations of staff to validate that staff are knocking prior to entering resident's rooms.	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure a telephone and call light was accessible for 1 of 7 sampled residents (#6). The failure created the potential for the resident's needs to be unmet and for a negative effect on the resident's psychological well-being when assistance could not be summoned and telephone calls could not be answered or made. Findings included: Resident #6 was admitted to the facility in	F 246	F 246 1.) What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #6 no longer resides in the facility.	

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F 246	<p>Continued From page 3</p> <p>September 2015 following a motor vehicle accident with multiple fractures along the cervical, thoracic and lumbar spinal column, a comminuted (broken into small fragments) fracture of the right scapula, left humerus fracture status post surgery, left hip and pelvis fractures status post surgeries, and a right rib fracture.</p> <p>The resident's care plan documented impaired physical mobility and impaired ADL and IADL with total assistance needed for bed transfers and mobility.</p> <p>A 9/5/15 Occupational Therapy (OT) Initial Evaluation/Recommendation documented no weight bearing on the left arm and a neck brace to be worn at all times. It also documented, "UE [upper extremity] function; was unable to lift RUE at the shoulder against gravity. LUE demonstrated difficulty with horizontal adduction..."</p> <p>On 9/8/15 at 10:53 a.m., the resident was observed in bed with the neck brace in place when the telephone rang. The telephone was on the bedside table 3 feet away from the resident. The resident said she could not reach the phone. When asked how she would answer the phone, the resident stated, "I usually use my call light but I don't know where my call light is."</p> <p>On 9/8/15 at 3:35 p.m., the resident was again observed in bed with the neck brace in place. The telephone was on the left side of the bed and a call light with a cord was on the resident's lap. The resident said the call light had been on the floor earlier and, "If my call light is not here, I sometimes yell, 'Nurse, nurse.'"</p>	F 246	<p>2.) How you will identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken.</p> <p>On 10/5/2015 at 1330, the charge nurse checked each resident to ensure that his/her phone was in reach to meet reasonable accommodation of needs & preferences. Education will be provided to Nursing (including Registered Nurses and Certified Nurses Assistants), Physical Therapy, Occupational Therapy, Speech Therapy, and Social Work colleagues working in the facility regarding Reasonable Accommodation of Needs/Preferences.</p> <p>3.) What measures will be put in place or what systematic change you will make to ensure that the deficient practice does not recur.</p> <p>Multidisciplinary (Nursing, PT,OT,SP) Team will develop education material on</p>	

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F 246	Continued From page 4 On 9/9/15 at 8:00 a.m., the resident's telephone was observed on a towel draped over the raised left side rail. The towel covered the controls on the side rail. On 9/9/15 at 2:08 p.m., the resident was observed in bed with the neck brace in place. The telephone and call light were both on the bedside table 3 feet away from the resident. On 9/9/15 at 2:10 p.m., OT #8 entered the resident's room. The resident told the OT she wanted her surgical staples removed. The OT picked up the call light off the bedside table and handed it to the resident to call the nurse. On 9/9/15 at 2:36 p.m., when OT #8 stepped out of the resident's room briefly, she was asked about the placement of the resident's telephone and call light. The OT said the resident could not reach the telephone or the call light when they were on the bedside table because she "can't turn on her side on her own." Moments later, the resident's telephone rang and the resident yelled, "Nurse, nurse please get my phone." The OT dashed back into the resident's room but the telephone had stopped ringing. The resident said she had not been able to reach her telephone "all day."	F 246	Reasonable Accommodation of Needs/Preferences. Mandatory education will be presented to all Nursing (including Registered Nurses and Certified Nurses Assistants), Physical Therapy, Occupational Therapy, Speech Therapy, and Social Work colleagues working in the facility. 4.) How the corrective action will be monitored to ensure the deficient practice will not recur. -Weekly Audits will be completed X4 weeks starting the week of October 19, 2015. -Audits will be completed by Supervisors (PT, OT, SP, and Nursing). Each will complete the audit one week. -The audit will consist of checking with residents to ensure that they have their phone and call light within reach.		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323			

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F 323	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure hazardous chemicals were securely stored and inaccessible to residents. Failure to safely store hazardous chemicals created the potential for skin, eye and respiratory tract irritation and stomach distress for all cognitively impaired, independently mobile residents. Findings include: 1. On 9/8/15, two containers of sani-cloth germicidal and bacteriocidal disposable wipes were observed on the window sill of Resident Room 3417. Unsecured sani-cloth wipes were also observed in other patient care areas, including: *One container in the shower room adjacent to Room 3425. *Two containers in the vicinity of the coffee maker in the common nutrition room. *One container in the room identified as the "Huddle Room." *Seven containers in the unmarked utility room across from Room 3424. On 9/8/15, the Unit Manager stated the utility room was not normally locked; the Administrator stated the sani-wipes should not have been stored in patient care areas and removed the sani-cloth containers from the common kitchen. On 9/9/15 at (8:20 PM), one Sani-cloth container was observed in the staff "huddle room," which was open and accessible to residents. When asked about the presence of the sani-cloth wipes, LN #7 stated the wipes should not have been available in the opened room.	F 323	F 323 <ul style="list-style-type: none"> • What corrective action will be accomplished for those residents found to have been affected by the deficient practice? • All Sani-Cloth containers were removed from patient rooms. • All Sani-Cloth containers were removed from the shower room adjacent to room 3425. • All Sani-Cloth containers were removed from room #3417 (3 East Gym). • All Sani-Cloth containers were removed from the nutrition room. • All Sani-Cloth containers were removed from the Huddle Room. • All Sani-Cloth containers were removed from the utility room across from room 3424. • A lock was placed on the utility room across from 3424 by the end of the day. • How you will identify other residents having potential to be affected by the same deficient 		

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F 323	Continued From page 6 Material Safety Data Sheets (MSDS) for the sani-cloth germicidal disposable wipes documented, "Caution: causes moderate eye irritation, avoid contact with eyes, ingestion may cause stomach distress, nausea or vomiting and inhalation may cause respiratory tract irritation. Do not eat or drink." MSDS for the bactericidal/germicidal disposable wipes documented, "Causes moderate eye irritation, the product may be harmful if it is absorbed through the skin. Prolonged or repeated dermal exposure can cause drying, defatting and dermatitis."	F 323	<i>practice and what corrective action will be taken.</i> <ul style="list-style-type: none"> • All Sani-Cloth containers were removed from patient rooms. • All Sani-Cloth containers were removed from the shower room adjacent to room 3425. • All Sani-Cloth containers were removed from room #3417 (3 East Gym). • All Sani-Cloth containers were removed from the nutrition room. • All Sani-Cloth containers were removed from the Huddle Room • All Sani-Cloth containers were removed from the utility room across from room 3424 • A lock was placed on the utility room across from 3424 by the end of the day. • <i>What measures will be put in place or what systematic change you will make to ensure that the deficient practice does not recur.</i> • Sani-Cloth containers will be stored in the Nurse Servers for staff access only. 		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.				

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F 431	<p>Continued From page 7</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure medications were securely stored and not accessible to residents. This was true for 1 of 7 sampled residents (#1) when an unsecured medication in the resident's room created a potential hazard if the cognitively impaired resident ingested the medication or applied it incorrectly. Findings include:</p> <p>Resident #1 was admitted to the facility on 8/7/15 with multiple diagnosis including Sepsis. On 9/8/15 at 2:15 PM, a tube of Santyl (an enzymatic debriding ointment used for dermal ulcers) was observed inside of the resident's room on the window sill. On 9/8/15 at 3:00 PM, LN #2 said the medication should not be stored inside the resident's room, but rather in a secure location.</p>		<ul style="list-style-type: none"> The shower room adjacent to room 3425 is a high-observation room and patients are only in the shower room with a staff member. A Sani-Cloth holder will be mounted on the wall with a sign stating "Not for Use on Skin". The Nutrition Room is a high-observation area for staff and visitor use rather than patient use. A door sign will be placed stating "Please check with staff before entering". A Sani-Cloth holder will be mounted on the wall with a sign stating "Not for Use on Skin". A door sign will be placed on the Huddle Room door stating "Staff Only." A keypad lock will replace the lock on the utility room across from room 3424. Room 3417 is the 3 East Gym. This is a high-observation area. A San-Cloth holder will be mounted on the wall with a sign stating "Not for Use on Skin." 		
F 441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a</p>				

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F 441	<p>Continued From page 8 safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, and resident and staff interview, it was determined the facility failed to</p>		<ul style="list-style-type: none"> To be compliant with the infection control policies of the hospital and facility, staff must have access to Sani-Cloths to clean equipment between patient use. How the corrective action will be monitored to ensure the deficient practice will not recur. Education will be completed 10/19/2015. Weekly Audits will be completed X4 weeks starting the week of October 19, 2015 to ensure Sani-Cloths are not in patient areas. Audits will be completed by Supervisors (PT, OT, SP, and Nursing). Each will complete the audit one week. Audits will consist of ensuring that Sani-Cloths are only located in approved holders in specified locations (shower room adjacent to 3424, Nutrition Room, room 3417/3E Gym) and in the nurse servers. 		

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F 441	Continued From page 9 properly store a contaminated urinal where it would not pose the potential for contamination. This was true for 1 of 7 sampled residents (#5). Failure to implement infection control measures placed the residents at risk to develop infections. Findings include: 1. Resident #5 was admitted to the facility on 8/10/15, and readmitted on 9/5/15, with multiple diagnoses, including recent laparoscopic cholecystectomy. Resident #5's most recent MDS assessment, dated 8/22/15, documented the resident was cognitively intact. On 9/8/15 at 2:18 PM, Resident #5's empty urinal was observed on the his over bed table next to a drinking glass. At 2:40 PM, Resident #5's empty urinal was observed on the over bed table without the drinking glass present. On 9/9/15 at 8:00 AM and at 12:25 PM, Resident #5's urinal was observed on the resident's over bed table next to his morning and lunch meals. On 9/9/15 at 4:00 PM, Resident #5 said it was not sanitary to have urine on his over the bed table with his meal and that he preferred not to have urinal on the over bed table. On 9/10/15 at 8:17 AM and 8:40 AM, Resident #5's urinal, with urine in it, was observed next to his breakfast meal on the over bed table. On 9/10/15 at 8:50 AM, CNA #1 stated Resident #5's urinal should not be next to his meal.	F431	1.) What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Santyl was placed in Resident #1's locked medication box on 9/8/2015. Resident #1 no longer resides at the facility. 2.) How you will identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken. -9/18/2015 Education was provided to all Registered Nurses and Support Associates in the facility regarding the requirement to keep all medications locked in the patient's medication box including ointments for wound care. -10/5/2015 the charge nurse checked each Resident's Room to ensure that all medications were locked in the medication box.		
F 468	483.70(h)(3) CORRIDORS HAVE FIRMLY				

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

PRINTED: 09/21/2015
FORM APPROVED
OMB NO. 0938-0391

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F 468 SS=D	<p>Continued From page 10 SECURED HANDRAILS</p> <p>The facility must equip corridors with firmly secured handrails on each side.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure that handrails were securely fastened to walls. This had the potential to affect 7 of 7 (#'s 1, 2, 3, 4, 5, 6, & 7) sampled residents, one random resident (#8), and any ambulatory resident in the facility. Findings included: On 9/8/15 at 11:57 PM, during the initial tour of the facility, unattached and/or loose handrails were observed in corridors at the following locations: *Outside of Room 3418 *Outside of the shower room *Along the corridor between Rooms 3422 and 3425. On 9/8/15 at 3:55, the Administrator was shown each of the three areas of unattached and loose handrails. The Administrator stated he could see that the handrails were loose and unattached from the handrail brackets.</p>		<p>3.) <i>What measures will be put in place or what systematic change you will make to ensure that the deficient practice does not recur.</i></p> <p>-Education will be provided to all Registered Nurses working in the facility on the requirement to keep all medications locked in the patient medication box. - Related policies will be sent for a required read through the Policy and Procedure Manual Electronic System.</p> <p>4.) <i>How the corrective action will be monitored to ensure the deficient practice will not recur.</i></p> <p>-Weekly Audits will be completed X4 weeks starting the week of October 19, 2015. -Audits will be completed by Supervisors (PT, OT, SP, and Nursing). Audits will consist of ensuring all medications are lock in approved, permanently affixed storage compartments.</p>		

F 441

- 1.) *What corrective action will be accomplished for those residents found to have been affected by the deficient practice?*

Resident #5 no longer resides at the facility.

- 2.) *How you will identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken.*

Colleagues for all disciplines (Nursing, PT, OT, SP) have been educated to not store urinals on bed side tables and to help residents locate urinals in a place accessible to them but that does not put residents at risk for the development or transmission of disease or infection.

- 3.) *What measures will be put in place or what systematic change you will make to ensure that the deficient practice does not recur.*

The TRU is working with Supply Chain to purchase urinal holders that will affix to the side rail allowing ease of access to the urinal for residents but without compromising infection control measures and putting the resident at risk.

- 4.) *How the corrective action will be monitored to ensure the deficient practice will not recur.*

-Once Urinal Holders are purchased, weekly audits X4 weeks will be conducted to ensure usage and proper placement for patient

access and compliance with infection prevention measures.

-Audits will be completed by Supervisors (OT, PT, SP, and Nursing). Each will complete the audit one week.

-Audits will consist of ensuring that all residents that are using a urinal for bladder management have a urinal holder placed in a location accessible to them and not placed in a location where contamination could occur.

F 468

1.) *What corrective action will be accomplished for those residents found to have been affected by the deficient practice?*

Resident #1 no longer resides at the facility.

Resident #2 no longer resides at the facility.

Resident #3 no longer resides at the facility.

Resident #4 no longer resides at the facility.

Resident #5 no longer resides at the facility.

Resident #6 no longer resides at the facility.

Resident #7 no longer resides at the facility.

Resident # 8 no longer resides at facility.

2.) *How you will identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken.*

After the initial tour of the facility at 11:57 am on 9/8/2015, not in the pm, the Engineering Department was contacted by the Administrator to address the loose handrails outside of room 3418, outside the shower room, and along the corridor between rooms 3422 and 3425. On 9/9/2015, the loose handrails were tightened by the Engineering Department. All other handrails at the facility were checked by the Engineering Department.

- 3.) *What measures will be put in place or what systematic change you will make to ensure that the deficient practice does not recur.*

The Engineering Department will inspect handrails in the facility more frequently than previously.

- 4.) *How the corrective action will be monitored to ensure the deficient practice will not recur.*

-Corrective action will be completed by October 19, 2015

-The Engineering Department will inspect the handrails in the facility bi-monthly X1 month, then monthly X2, and then quarterly.

Should the Engineering Department determine a different inspection frequency is more appropriate to insure the safety of our residents then they have the authority to revise the inspection frequency.

All education and corrective action for all F-Tags will be completed by October 19, 2015.

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER SAINT ALPHONSUS TRANSITIONAL REHABIL	STREET ADDRESS, CITY, STATE, ZIP CODE 1055 NORTH CURTIS ROAD BOISE, ID 83706
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C 000 16.03.02 INITIAL COMMENTS

The following deficiencies were cited during the state licensure survey conducted at the facility September 8-11, 2015. The surveyors conducting the survey were:
Amy Barkley, RN, BSN, Team Coordinator
Linda Kelly, RN
Angela Morgan, RN, BSN
Presie Billington, RN

C 000

RECEIVED
09/15/2015
FACILITY STANDARDS

C 409 02.120.05.i Required Room Closet Space

i. Closet space in each sleeping room shall be twenty inches by twenty-two inches (20" x 22") per patient/resident. Common closets utilized by two (2) or more patients/residents shall be provided with substantial dividers for separation of each patient's/resident's clothing for prevention of cross contamination. All closets shall be equipped with doors. Freestanding closets shall be deducted from the square footage in the sleeping room.

This Rule is not met as evidenced by: Based on staff interview and observation it was determined the facility did not provide the required closet space of 20 inches x 22 inches for residents in the TRU (Transitional Rehabilitation Unit) in the facility. Findings Include:

On 9/11/15, the Administrator confirmed that the closets had not changed in size and all of the closets in the residents' rooms on the TRU were smaller than the required size.

C 409

1.) What corrective action will be accomplished for those residents found to have been affected by the deficient practice?
Resident #1 no longer resides at facility.
Resident #2 no longer resides at facility.
Resident #3 no longer resides at facility.
Resident #4 no longer resides at facility.
Resident #5 no longer resides at facility.
Resident #6 no longer resides at facility.
Resident #7 no longer resides at facility.
Resident #8 no longer resides at facility.

2.) How you will identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken.

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Donald A. Gibbons

TITLE

N/A

(X8) DATE

10/6/15

Bureau of Facility Standards

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C 664 C 664	<p>Continued From page 1</p> <p>02.150,02,a Required Members of Committee</p> <p>a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative. This Rule is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure its Infection Control Committee included all required members. This had the potential to affect 7 of 7 sampled residents (#'s 1, 2, 3, 4, 5, 6, and 7) and all residents in the facility who were vulnerable to nosocomial infections. Findings include:</p> <p>On 9/10/15, infection control quarterly meeting attendance was reviewed with the Infection Preventionist (IP). The facility's medical director, pharmacist, dietary services supervisor, a representative from the housekeeping unit, and a maintenance service representative were not listed as attendees at the 2/12/15, 5/14/15, and 8/13/15 quarterly Infection Control Committee meeting signature sheet.</p> <p>The 2/12/15 Infection Control Committee Quarterly sign-in sheet did not include the signatures of the medical director, pharmacist, housekeeping, or maintenance representative.</p> <p>The 5/14/15 Infection Control Committee Quarterly sign-in sheet did not include the signatures of the medical director, pharmacist, or housekeeping representative.</p> <p>The 8/13/15 Infection Control Committee Quarterly sign-in did not include the signatures of a pharmacist, housekeeping representative, or</p>	C664	<p>All patients have the potential to be affected by the same deficient practice.</p> <p>3.) What measures will be put in place or what systematic change you will make to ensure that the deficient practice does not recur.</p> <p>- The facility is requesting a renewal of the waiver currently in place for the size of the closets in the residents' rooms.</p> <p>4.) How the corrective action will be monitored to ensure the deficient practice will not recur.</p> <p>-Completion date: October 19, 2015.</p> <p>-No monitoring required.</p> <p>1.) What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident #1 no longer resides at the facility.</p> <p>Resident #2 no longer resides at the facility.</p> <p>Resident #3 no longer resides at the facility.</p> <p>Resident #4 no longer resides at the facility.</p>	

Bureau of Facility Standards

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C 664	Continued From page 2 maintenance representative. On 9/11/15, the Administrator provided a copy of an e-mailed document from the Medical Director stating the Medical Director attended, but forgot to sign-in to the quarterly meetings on 2/12/15 and 5/14/15.	C 664	Resident #5 no longer resides at the facility. Resident #6 no longer resides at the facility. Resident #7 no longer resides at the facility. 2.) How you will identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken. Education will be provided to the Committee Representatives on the expectations of attendance/participation in the quarterly Infection Prevention meetings. 3.) What measures will be put in place or what systematic change you will make to ensure that the deficient practice does not recur. Education will be provided to the Committee Representatives on the expectations of attendance/participation in the quarterly Infection Prevention meetings. Meetings will be set up for FY 16 and sent out to committee members.	

Committee members will be asked to identify a designee to attend the meeting in their absence. Designees will be notified of their appointment, the expectations, and the meeting dates and times.

4.) *How the corrective action will be monitored to ensure the deficient practice will not recur.*

-Quarterly Infection Prevention Meeting attendance will be reviewed by the Administrator. Corrective Action will be taken with any missing required committee members/ designees at that time.

All education and corrective action for all C-Tags will be completed by October 19, 2015.