



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
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July 20, 2016

Joseph Frasure, Administrator
Aspen Transitional Rehabilitation
2867 East Copper Point Drive
Meridian, ID 83642-1716

Provider #: 135130

Dear Mr. Frasure:

On **July 5, 2016**, a survey was conducted at Aspen Transitional Rehabilitation 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.

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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 **August 1, 2016**. Failure to submit an acceptable PoC by **August 1, 2016**, may result in the imposition of penalties by **August 31, 2016**.

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 **August 9, 2016**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **October 3, 2016**. A change in the seriousness of the deficiencies on **August 19, 2016**, 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 **October 3, 2016** includes the following:

Denial of payment for new admissions effective **October 3, 2016**. [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 **January 1, 2017**, 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 **October 3, 2016** 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/NursingFa>

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[ilities/tabid/434/Default.aspx](#)

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

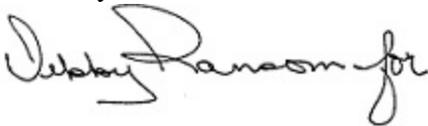
- BFS Letters (06/30/11)

[2001-10 Long Term Care Informal Dispute Resolution Process](#)
[2001-10 IDR Request Form](#)

This request must be received by **August 1, 2016**. If your request for informal dispute resolution is received after **August 1, 2016**, 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,

A handwritten signature in black ink, appearing to read "David Scott for". The signature is written in a cursive style.

David Scott, RN, Supervisor
Long Term Care

ds/
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135130	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/05/2016
NAME OF PROVIDER OR SUPPLIER ASPEN TRANSITIONAL REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 2867 EAST COPPER POINT DRIVE MERIDIAN, ID 83642		
(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 deficiency was cited during the complaint survey of your facility conducted on July 5, 2016. The surveyors conducting the survey were: Presie Billington, RN, Team Coordinator Jenny Walker, RN Survey Abbreviations: ADLs = Activities of Daily Living DON = Director of Nursing OT = Occupational Therapy PT = Physical Therapy ROM = Range of Motion	F 000			
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. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and review of records, it was determined the facility failed to ensure residents were safely supervised during the provision of staff-assisted cares. This was true for 1 of 5 (#2) sampled residents reviewed for falls and had the potential to cause harm when Resident #2 fell from bed while receiving pericare. Findings include:	F 323	"This plan of Correction is submitted as required under Federal and State regulations and statutes applicable to skilled nursing facilities. This plan of correction does not constitute an admission of liability, and such liability is hereby specifically denied. The submission of this plan does not constitute agreement by the facility that	8/8/16	

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

TITLE

(X6) DATE

Electronically Signed

07/29/2016

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 323	<p>Continued From page 1</p> <p>Resident #2 was admitted to the facility on 1/29/16 with multiple diagnoses, including rehabilitation post surgical repair of a knee joint and status post cerebrovascular accident (stroke) with left-sided weakness.</p> <p>Resident #2's 5-day MDS assessment, dated 2/5/16, and 14-day MDS assessment, dated 2/14/16, both documented extensive assistance of two staff were required for bed mobility, transfers, and toilet use, and unilateral ROM limitations of the upper and lower extremities.</p> <p>A 1/29/16 Fall Risk Evaluation documented Resident #2 was at high risk for falls; interventions in place included fall mats and an OT/PT consult.</p> <p>Resident #2's Activities of Daily Living (ADL) Care Plan, dated 2/5/16, documented she needed extensive assistance with bathing, dressing, toilet use, and extensive assistance of two persons with bed mobility.</p> <p>Resident #2's Fall Care Plan, documented the following:</p> <p>*2/5/16: Staff were to assist with transfers and ambulation; educate the resident and her family regarding fall risk and safety needs; encourage Resident #2 to keep the door to her room open when not engaged in personal cares, and ensure fall mats were in place.</p> <p>*2/15/16: Resident #2 experienced a non-injury fall on 2/15/16. No new approaches to help prevent falls were initiated.</p>	F 323	<p>the surveyor's conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied."</p> <p>Please accept this plan of correction as our credible allegation of compliance.</p> <p>F 323</p> <p>Patient Specific:</p> <p>Patient number 2 has been discharged.</p> <p>Other Patients:</p> <p>See systemic changes.</p> <p>Systemic Changes:</p> <p>The Incontinent Care policy and procedure has been revised to include safety precautions for protecting patients from rolling out of bed during cares.</p> <p>All direct care staff have been educated in provision of incontinent care including how to protect patients from rolling out of bed while performing cares in bed.</p> <p>Monitors:</p> <p>DON or designee will perform 5 weekly observations of staff performing Incontinent Care while in bed weekly x4 then monthly x5.</p>		

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F 323	<p>Continued From page 2</p> <p>A Fall Incident Report, dated 2/15/16, documented Resident #2 fell in her room while staff performed peri-care. The Report documented, "CNA called this RN to room, patient was found lying on her left side over the crash mat. When asked what happened? CNA responded the patient rolled out of bed while she was changing her. Apparently, patient was being turned to her left side. CNA was positioned behind the patient and placing a new attends when patient rolled out of bed..." The Report documented a "chair/wheelchair alarm" was initiated, but did not include interventions to prevent future falls when receiving staff-assisted pericare.</p> <p>On 7/5/16 at 1:55 pm, the DON stated Resident #2 was care planned to receive assistance from 1-2 staff for ADLs and that an OT assessment concluded she required one staff member's assistance for bed mobility.</p> <p>On 7/5/16 at 3:55 pm, CNA #1, when asked how she performed care on a resident in bed, stated she rolls the resident to her side and tucks the soiled attends underneath the resident before then rolling the resident away from her to clean the resident's peri-area.</p> <p>Review of the policy and procedure for Incontinent Care did not document how to protect the resident from rolling out of bed when performing cares.</p> <p>The facility failed to ensure the safety of Resident #2 was safe from rolling out-of-bed when staff performed cares.</p>	F 323	<p>Date Audits will start: 08/01/2016</p> <p>Date of Compliance: 08/08/2016</p>		



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July 25, 2016

Joseph Frasure, Administrator
Aspen Transitional Rehabilitation
2867 East Copper Point Drive
Meridian, ID 83642-1716

Provider #: 135130

Dear Mr. Frasure:

On **July 5, 2016**, an unannounced on-site complaint survey was conducted at Aspen Transitional Rehabilitation.

The following documents were reviewed:

- The identified resident's closed record and along with the records of four other sampled residents;
- Incident/Accident Reports from December 2015 to June 2016;
- Grievances from December 2015 to June 2016; and.
- Policy and Procedure for Incontinent Care.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007250

ALLEGATION #1:

Resident rolled out of bed while her adult brief was being changed by staff.

Joseph Frasure, Administrator
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FINDINGS:

The Fall Incident Report, dated February 5, 2016, documented the resident rolled out of her bed while a CNA was changing her soiled adult brief. The CNA was positioned behind the resident while placing a new adult brief.

This allegation was substantiated, and the facility was cited at F323 for failure to prevent the fall.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #2:

An identified resident requested assistance to finish her meal and was told by aides that Occupational Therapy would like her to feed herself. No assistance was provided.

FINDINGS:

During the complaint investigation, residents were observed in the dining room during meals. Staff were observed to be asking residents if they needed any assistance or items. Staff were attentive with all residents.

One resident who eats independently in her room was interviewed and said the CNAs are very helpful. She said she did not need any help with eating but she was able to get help when she needed it.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The resident's discharge instructions included two narcotic pain medications. It was not made clear why she needed two different pain medications, or which was to be used in order.

FINDINGS:

During the complaint investigation, an LN responsible for preparing the discharge instructions for the resident said the detailed instructions for the pain medications was written on the prescription prepared by a physician, and was explained in to the resident and family. She stated

Joseph Frasure, Administrator
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she ensured the family understood the instructions by questions and gave a contact number should the resident or family have any questions.

The Discharge Instructions and Summary of the identified resident documented, "Norco 10 mg every 4 hours as needed, Oxycodone 2.5 -5 mg every 3 hours as needed,..."

Based on interview and record review, this allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The Reporting Party was informed that the identified resident had only one shower during the two weeks she was in the facility.

FINDINGS:

The shower record of the identified resident documented the resident received four showers and refused one shower while in the facility.

Interviews with three residents revealed no concern with their showers. All three residents said they were receiving a shower every other day. One resident said she had her shower almost everyday and stated, "You just have to ask for it, if you want it to be done everyday."

Based on interviews and review of clinical record, the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

The Physical Therapy staff got "real smart" with the resident when the resident was on the "power bar" trying to walk. The resident said she could not do it and the Physical Therapy staff said, "You're not trying."

FINDINGS:

Observations of interactions between Physical Therapy staff and residents were completed during

Joseph Frasure, Administrator
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the complaint investigation. Physical Therapy staff were observed to be attentive to the residents. Physical Therapy staff were also heard explaining to resident how to perform the particular exercise and how to use a four wheeled walker in a regular tone of voice. One resident was interviewed regarding her therapy and stated she was very happy with her progress and the Physical Therapy staff were encouraging her to do exercises.

Based on observations and interview, the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

If you have questions, comments or concerns regarding our investigation, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

David Scott, RN, Supervisor
Long Term Care

DS/lj