November 21, 2016

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

Provider #: 135119

Dear Mr. Gibbons:

On November 9, 2016, 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 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. **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.
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 December 1, 2016. Failure to submit an acceptable PoC by December 1, 2016, may result in the imposition of penalties by December 26, 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 December 14, 2016 (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 February 7, 2017. A change in the seriousness of the deficiencies on December 24, 2016, may result in a change in the remedy.
The remedy, which will be recommended if substantial compliance has not been achieved by **February 7, 2017** includes the following:

Denial of payment for new admissions effective **February 7, 2017**. [42 CFR §488.41(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 **May 8, 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 **February 7, 2017** 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:

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 1, 2016. If your request for informal dispute resolution is received after December 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,

David Scott, RN, Supervisor
Long Term Care

DS/lj
Enclosures
The following deficiencies were cited during the federal recertification survey conducted at the facility from November 7, 2016 to November 9, 2016.

The surveyors conducting the survey were:

Brad Perry, BSW, LSW, Team Coordinator
Nina Sanderson, BSW, LSW
Edith Cecil, RN
Susan Costa, RN

Survey Definitions:
CNA = Certified Nursing Assistant
CVA = Cerebral Vascular Accident (stroke)
DON = Director of Nursing
LN = Licensed Nurse
TRU = Transitional Rehabilitation Unit

F 226 1. Employee A completed Abuse and Neglect training following the Survey and prior to unsupervised patient care. No residents were affected. The facility will protect all residents, current and future during orientation and preceptorship by changing the orientation time line. Attached orientation plan was changed to provide Abuse and Neglect training prior to any patient contact. This will preclude any possibility that newly hired employees will have unsupervised resident contact prior to receiving Abuse and Neglect training. Orientation time line will be monitored, signed and dated by the preceptor and employee to ensure compliance. Preceptor training regarding changes will be completed and all new preceptors will be trained regarding the new Orientation time line. A training attendance sheet will be maintained in the Nurse supervisor office.

An Audit of all new employees' orientation sheets and staff assignments will be completed by the Nurse Manager or designee weekly ensuring compliance. After 3 months, if there are no issues, the audit may be reduced to monthly. The audit report will be provided to the Administrator or designee. A report out of the audits will be added to the agenda at the Quality/Infection Control Quarterly meetings.

Laboratory Director's or Provider/Supplier Representative's Signature: [Signature]

Title: Nursing Home Administrator

Date: 12-15-16

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.
Continued From page 1

contact with residents until after they completed abuse and neglect training, and b) the facility's abuse and neglect policies and procedure protected all residents while an abuse investigation was completed. These deficient practices created the potential for resident abuse to go unrecognized and reported, unsafe or inappropriate responses to abuse situations, and all residents in the facility at risk of abuse while incidents of verbal abuse were investigated. Findings include:

1. Employees A was hired on 10/31/16. She was on orientation status and working with a preceptor on 11/08/16. On 11/8/16 at 10:45 am, Employee A stated the classroom training for Abuse and Neglect was scheduled for 11/10/16. She stated she had not received training for Abuse and Neglect. Employee A stated she was working with her preceptor, but felt competent, and that day it was decided that the assignments would be split and she would take "half the hallway."

Staff were assigned to unsupervised resident care before receiving Abuse and Neglect training.

2. A facility policy titled "Abuse of Patient-Allegations Involving Staff," dated February 2003 and revised April 2006, documented under the section entitled "Protection of the Patient During the Investigation," that "if the accusation is verbal in nature and does not have elements of physical, sexual abuse or violence, the clinical coordinator [in consultation with the nurse manager or charge nurse] will have the discretion to suspend or reassign the staff member to other patients." Additionally, the policy documented, "in a large unit, the staff member may be reassigned to other patients. In a small

Corrective action will be completed by 12/13/16.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER: 135119

(SX) DATE SURVEY COMPLETED: 11/09/2016

NAME OF PROVIDER OR SUPPLIER

SAINT ALPHONSUS TRANSITIONAL REHABILITATION UNIT

STREET ADDRESS, CITY, STATE, ZIP CODE

1055 NORTH CURTIS ROAD

BOISE, ID 83706

(X2) MULTIPLE CONSTRUCTION

A. BUILDING—

R. WING—

(X3) COMPLETION DATE

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 226 Continued From page 2

unit, the staff member may need to be reassigned to another area. In no circumstances should the staff member continue to care for or participate in the care of the patient following the accusation.

On 11/9/16 at 11:00 am, the Director of Risk Management reviewed the facility policy and stated "My expectation would be the employee be placed on administrative suspension until the investigation was completed."

The facility policy to relocate a staff member accused of verbal abuse to another resident or unit did not ensure all residents would be protected from abuse while the investigation was in process.

F 371 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY

The facility must:

(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and

(2) Store, prepare, distribute and serve food under sanitary conditions

This REQUIREMENT is not met as evidenced by:

Based on observation, policy review, and staff interview, it was determined the facility failed to ensure food was prepared and served under sanitary conditions when multiple staff were observed in the kitchen without head and facial hair restraints and when a bowl of pureed

F 371 1. Hair/Beard restraints - Resident #4 is still on the sub acute unit and is potentially affected by the non-compliant issue. All other residents listed have been discharged. Residents present prior to implementation of corrective action had the potential to be affected. There is no evidence that there were any detrimental effects to patients. All production staff will be in-serviced regarding effective restraining of hair as per internal policy, which includes head coverings that contain bangs and wispy fly-away hair. The Policy will be revised to include covering of Beard and Moustache hair of any length. A daily, stringent enforcement of this policy will be the practice moving forward. All male production staff will be trained regarding the previous CDHD approved policy as it pertains to beards. Daily enforcement of the policy will be on-going. In-service to occur December 8, 2016. Attendance will be documented. Individual coaching of out-of-compliance employees began the next day(s) following the Survey citation and will be documented as to the education of each individual employee by 12-13-16. Daily checks will be documented and maintained by the Nutritional services department. A weekly audit report will be provided to the Administrator or designee regarding compliance. After 1 month with no issues, the audit frequency will be moved to monthly. A rollup report will be provided at the quarterly quality & infection control meeting.
**F 371** Continued From page 3

peaches was delivered to Resident #1 without a cover. This affected 7 of 7 sampled residents (#s 1-7) and had the potential to affect all residents who dined in the facility. This failure created the potential for contamination of food and exposed residents to potential disease causing pathogens. Findings included:

1. The facility's Dress Code-Food and Nutrition policy, dated May 2014, documented: "Hair Restrains-Plain black ball caps or professional culinary hair restraints are mandatory and must be worn while in food preparation areas at all times. Hairnets, paper caps and black ball caps are provided ... Facial Hair-Any facial hair including but not limited to beards, goatees, mustaches, side burns must be no longer than 1/4 of an inch in length and maintained in a neatly trimmed and professional manner at all times."

The 2013 FDA Food Code, Chapter 2, Part 2-4, Hygiene Practices, Hair Restraints, subpart 402.11, Effectiveness, documented, "(A) Except as provided in (B) of this section, food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food..."

On 11/7/16 from 8:15 am to 8:40 am, during the initial observation of the kitchen with the Patient Care Supervisor and the Executive Chef present, three male cooks were observed in the kitchen without a facial restraint to cover their beard and mustache hair. The Patient Care Supervisor and Executive Chef also had beard and mustache hair which was not covered. The three cooks were either observed preparing or cooking food.

**F 371**

2. Uncovered food - Resident #4 is still on the sub acute unit and is potentially affected by the non-compliant issue. All other residents listed have been discharged. Residents present prior to implementation of corrective action had the potential to be effected. There is no evidence that were any detrimental effects to patients. All food being delivered to the TRU unit that will not be delivered directly to a resident’s room via enclosed cart will be covered. This includes food designated “Nurse to Deliver” as well as any other patient food items. Delivery staff will be in-serviced as to the new procedure; participation in the education will be documented. This Plan of Care was implemented the next day following the Survey citation. Education documentation will be completed by December 13, 2016. Spot checks for compliance will be completed at least weekly during the first month and monthly thereafter. The spot checks will be documented and maintained by Nutritional services. A weekly audit report will be provided to the Administrator or designee regarding compliance. After 1 month with no issues, the audit frequency will be moved to monthly. A rollup report will be provided at the quarterly infection control meeting.
Three female cooks were observed to have their hair pulled back and secured with hair clips or pony tail holders, without head hair restraints. Two of the women had long bangs which were not secured. All three female cooks were either observed preparing or cooking food.

On 11/7/16 at 8:25 am, the Patient Care Supervisor said those employees within the kitchen should have had their hair pulled back and facial hair should be neat and trimmed.

On 11/8/16 from 9:35 am to 10:45 am, during observations of the kitchen with the Patient Care Supervisor present, six male cooks were observed without a facial restraint to cover their beard and mustache hair. The Patient Care Supervisor also had beard and mustache hair which was not covered. The six cooks were either observed preparing or cooking food. One male cook was observed to have a beard restraint. Three female cooks were observed to have their hair pulled back and secured with hair clips or pony tail holders, without head hair restraints. One of the women had unsecured long wispy hairs on her head near the back of her neck, which was not secured. All three female cooks were either observed preparing or cooking food. Four female cooks were observed to have hairnets which covered their hair.

On 11/8/16 at 10:00 am, the Patient Care Supervisor said following the concerns expressed the day before, he and his supervisor had determined a few of the employees were out of compliance with facility policy regarding hair nets and longer beard and mustache hair. He reviewed the Food Code and he said it did not specify a facial hair length.
F 371 Continued From page 5

On 11/8/16 at 10:50 am, the Food Service Director with the Patient Care Supervisor present said did not know why the facility's policy included an acceptable length for facial hair when the Food Code did not specify an acceptable length.

2. On 11/7/16 at 12:00 pm, a resident meal tray was observed in the hallway outside of Resident #1's room. The tray was resting on an elevated chair the staff used for computer charting in the hallway. The meal tray included 3 covered beverages, a covered bowl of food, and a covered plate. A small bowl of pureed peaches was uncovered. The tray remained on the chair until 12:10 pm, when the CNA took the tray into Resident #1's room. During the hallway observation, 1 RN and 2 CNA's walked past the tray.

On 11/7/16 at 2:35 pm, the meal tray was observed in Resident #1's room on the window shelf beside the air conditioner/heat vent. LN #1 stated Resident #1 was not hungry, and did not eat her lunch that day. She confirmed the bowl of pureed peaches was uncovered, and stated all foods should be covered.

The Dietary Department failed to ensure residents' meals were covered and delivered appropriately.

F 441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and
(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.

(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.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, it was determined the facility failed to ensure oral suctioning devices did not come into contact with

F 441: Resident #1 was discharged and is not affected by this issue. Residents present prior to implementation of corrective action had the potential to be effected. There is no evidence that there were any detrimental effects to patients. Suction tube Attachment device #9785 will be utilized to secure the suction within reach of the patient preventing the device from falling to the floor. Residents using suctioning devices independently will be educated to ask for replacement devices should the device accidently touch contaminated surfaces. In-servicing of all employees will be provided by the Nursing and Therapy supervisors, an in-service log will be maintained. Resident education will be documented in the medical record. A daily audit of patients who are independent with suction devices will be performed by the nurse manager or designee for compliance. The audit will assess the use of the suction attachment device and the documentation of resident education on the use of the device. Daily audits will be maintained in the nursing office. Report out of the daily audits for the identified patients will be provided to the administrator or designee at the quarterly quality/infection control meetings.
the floor. This deficient practice created the potential for pathogens to contaminate the devices, placing residents at risk of disease or infection. This affected 1 of 5 sampled residents (#1) who required suctioning, and had the potential to affect all residents who required oral suctioning. Findings include:

Resident #1 was admitted to the facility on 11/1/16 with diagnoses which included CVA and left-sided weakness. She was on aspiration precautions, and a oral suction device was available for her to use independently.

On 11/7/16 at 12:08 pm, Resident #1 was observed in bed. She stated she was tired, and did not want to eat lunch. When asked what the high pitched hissing sound was, Resident #1 stated it was the suction canister on the wall. Resident #1 then pointed to the tubing of the oral suction device used to suction her mouth; the device was resting on the floor. Resident #1 was cautioned not to use the device until it was changed.

On 11/7/16 at 12:12 pm, CNA #1 and LN #1 were notified of the suction tubing and oral suction device that was on the floor. Both staff went into Resident #1’s room and confirmed the suction canister was resting on the floor. RN #1 asked CNA #1 to replace the suction device as she disconnected and discarded the tip and tubing.

Resident #1’s suction tubing was not secured to ensure the oral suction device was readily available and clean for her use.
Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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<tr>
<th>ID</th>
<th>PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:</th>
<th>MULTIPLE CONSTRUCTION BUILDING:</th>
<th>DATE SURVEY COMPLETED</th>
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<td>MDS001680</td>
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NAME OF PROVIDER OR SUPPLIER

SAINT ALPHONSUS TRANSITIONAL REHABILITATION

STREET ADDRESS, CITY, STATE, ZIP CODE

1055 NORTH CURTIS ROAD

BOISE, ID 83706

SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
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<th>INITIAL COMMENTS</th>
<th>CORRECTIVE ACTIONS</th>
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<tr>
<td>C000</td>
<td>16.03.02</td>
<td>INITIAL COMMENTS</td>
<td>The following deficiencies were cited during the State licensure survey of your facility conducted 11/7/16 through 11/9/16.</td>
<td>The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Nina Sanderson, BSW, LSW Edith Cecil, RN Susan Costa, RN</td>
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<td>C000</td>
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<td>Abbreviations: DON = Director of Nursing</td>
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<tr>
<td>C099</td>
<td>02.009</td>
<td>CRIMINAL HISTORY AND BACKGROUND CHECK REQUIRE</td>
<td>1. Criminal History and Background Check. A skilled nursing and intermediate care facility must complete a criminal history and background check on employees and contractors hired or contracted with after October 1, 2007, who have direct patient access to residents in the skilled nursing and intermediate care facility. A Department check conducted under IDAPA 16.05.06, &quot;Criminal History and Background Checks,&quot; satisfies this requirement. Other criminal history and background checks may be accepted provided they meet the criteria in Subsection 009.02 of this rule and the entity conducting the check issues written findings. The entity must provide a copy of these written findings to both the facility and the employee. (3-26-08)</td>
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<td>2. Scope of a Criminal History and Background Check. The criminal history and background check must, at a minimum, be a fingerprint-based criminal history and background check that</td>
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PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

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STATE FORM 6899

STATE date below

DATE SIGNATURE

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

Nursing Home Administrator

12-15-16
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:**

MDS001680

**MULTIPLE CONSTRUCTION BUILDING:**

A.

B. WING

**DATE SURVEY COMPLETED:**

11/09/2016

**NAME OF PROVIDER OR SUPPLIER:**

SAINT ALPHONSOUS TRANSITIONAL REHABILI

**STREET ADDRESS, CITY, STATE, ZIP CODE:**

1055 NORTH CURTIS ROAD
BOISE, ID 83706

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<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETE DATE</th>
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<tr>
<td>C 099</td>
<td>Continued From page 1 includes a search of the following record sources: (3-26-08)</td>
<td>C 099</td>
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<td></td>
<td>a. Federal Bureau of Investigation (FBI); (3-26-08)</td>
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<td>b. Idaho State Police Bureau of Criminal Identification; (3-26-08)</td>
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<td>c. Sexual Offender Registry; (3-26-08)</td>
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<td>d. Office of Inspector General List of Excluded Individuals and Entities; and (3-26-08)</td>
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<td>e. Nurse Aide Registry. (3-26-08)</td>
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<td>3. Availability to Work. Any direct patient access individual hired or contracted with on or after October 1, 2007, must self-disclose all arrests and convictions before having access to residents. The individual is allowed to only work under supervision until the criminal history and background check is completed. If a disqualifying crime as described in IDAPA 16.05.06, &quot;Criminal History and Background Checks, &quot; is disclosed, the individual cannot have access to any resident. (3-26-08)</td>
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<td>4. Submission of Fingerprints. The individual's fingerprints must be submitted to the entity conducting the criminal history and background check within twenty-one (21) days of his date of hire. (3-26-08)</td>
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<td>5. New Criminal History and Background Check. An individual must have a criminal history and background check when: (3-26-08)</td>
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<td>a. Accepting employment with a new employer; and (3-26-08)</td>
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<td>b. His last criminal history and background check was completed more than three (3) years prior to his date of hire. (3-26-08)</td>
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<td>06. Use of Criminal History Check Within Three</td>
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<td>(X4) ID PREFIX TAG</td>
<td>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
<td>ID PREFIX TAG</td>
<td>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
<td>(X5) COMPLETE DATE</td>
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<td>C 099</td>
<td>Years of Completion. Any employer may use a previous criminal history and background check obtained under these rules if:</td>
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<td>a. The individual has received a criminal history and background check within three (3) years of his date of hire;</td>
<td>C 099</td>
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<td>b. The employer has documentation of the criminal history and background check findings;</td>
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<td>c. The employer completes a state-only background check of the individual through the Idaho State Police Bureau of Criminal Identification, and</td>
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<td>(3-26-08)</td>
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<td>d. No disqualifying crimes are found.</td>
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<td>(3-26-08)</td>
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<td>07. Employer Discretion. The new employer, at its discretion, may require an individual to complete a criminal history and background check at any time, even if the individual has received a criminal history and background check within the three (3) years of his date of hire.</td>
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<td>(3-26-08)</td>
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<td></td>
<td>This Rule is not met as evidenced by:</td>
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<td>Based on staff interview and review of personnel files, it was determined the facility failed to ensure 2 of 5 employees (C and D) had completed criminal history background checks that included fingerprinting. This had the potential to result in direct resident care provided by staff who may have histories of a undisclosed disqualifying crimes. Findings include:</td>
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<td></td>
<td>On 11/8/16 at 8:45 am, five personnel records were reviewed with the Human Resources Business Partner. The personnel records for Employees C and D did not have documentation that a complete criminal history background</td>
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</tbody>
</table>
Continued From page 3

check, including fingerprints, had been completed for the 2 employees.

The Human Resources Business Partner stated it was his understanding that the criminal history background was only required for those individuals permanently hired into the Rehab (TRU) cost center. He stated that Employees C and D provided therapy services, and were hired into the therapy department cost center.

Required Room Closet Space

1. 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 failed to ensure residents were provided with the required closet space of 20 inches x 22 inches in the TRU (Transitional Rehabilitation Unit) in the facility. Findings include:

On 11/7/16 at 9:40 am, the Administrator Designee confirmed that the closets had not changed in size and all of the closets in the residents' rooms on the TRU were smaller than

Corrective action will be completed by 12-13-16
## Bureau of Facility Standards

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>C409</td>
<td>Continued From page 4 that which was required by state rules. She stated the average length of resident stay was 9 days, and would request a waiver for the requirement.</td>
<td>C409</td>
<td>C664- 1. Residents present prior to implementation of corrective action had the potential to be effected. There is no evidence that there were any detrimental effects to patients. The Infection Control Committee (ICC) quarterly meetings will be changed to the beginning of each quarter so that meetings can be rescheduled within the required timeframe if required members are not in attendance at the regularly scheduled meeting. The current practice of using the bolding format to indicate meeting attendees was improved to prevent errors leading to improper attendance documentation. A new sign in sheet will be created which requires attendees to sign and print their names in addition to the current practice of using bolding format to indicate meeting attendees. The required members of the Committee will be listed by title. A note at the top of the sign in sheet will state that the meeting must be rescheduled within 2 weeks if any required committee members are not present. The sign in sheet was implemented at the next meeting following the survey citation on November 10, 2016. Prior to meeting start the Administrator or designee will confirm that all required attendees are present as auditable safeguard.</td>
</tr>
</tbody>
</table>
| C664 | 02.150,02,a Required Members of Committee  
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 staff interview and review of the Infection Control Committee (ICC) meeting attendance records, it was determined the facility failed to ensure a representative from required departments attend quarterly meetings. The lack of participation of all departments created the potential for negative outcomes for residents, visitors, and staff in the facility. Findings include:  
On 11/9/16 at 10:10 am, the facility's Infection Control Program was reviewed with the Infection Preventionist (IP.) The IP provided ICC attendance records dated 2/11/16, 5/12/16, and 8/11/16. The records documented the following:  
On 2/11/16, a representative from housekeeping did not attend the ICC meeting.  
On 5/12/16, the Administrator, a Pharmacist, and a housekeeping representative did not attend the ICC meeting.  
On 8/11/16, the Administrator, a Pharmacist, and the DON did not attend the ICC meeting. The IP did not offer any explanation why the | C664 | |

**NAME OF PROVIDER OR SUPPLIER**

SAINT ALPHONSUS TRANSITIONAL REHABILI

**STREET ADDRESS, CITY, STATE, ZIP CODE**

1055 NORTH CURTIS ROAD  
BOISE, ID 83706

**DATE SURVEY COMPLETED**

11/09/2016

**PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER**

MDS001680
<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>C664</td>
<td>Continued From page 5 Administrator, Pharmacist, DON, and Housekeeping representative did not attend the meetings.</td>
<td>C664</td>
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Bureau of Facility Standards

STATE FORM 5899 Q7LD11 If continuation sheet 6 of 6