



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

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

CERTIFIED MAIL: 70073020000140446635

January 9, 2012

Joseph Caroselli, Administrator
Idaho Elks Rehabilitation Hospital & Subacute Rehabilitation Unit
PO Box 1100
Boise, Idaho 83701

Provider #: 135114

Dear Mr. Caroselli:

On **January 4, 2012**, a Facility Fire Safety and Construction survey was conducted at Idaho Elks Rehabilitation Hospital & Subacute Rehabilitation Unit by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. **This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies/Plan of Correction, CMS Form 2567L, listing Medicare/Medicaid deficiencies, and a similar form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **Please provide ONLY ONE completion date for each Federal/State Tag in column X5 (Complete Date), to signify when you allege that each tag will be back in compliance. NOTE: The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2).** After each deficiency has been answered and dated, the administrator should sign both the CMS Form 2567L and State Statement of Deficiencies, in the spaces provided, and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **January 23, 2012**. Failure to submit an acceptable PoC by **January 23, 2012**, may result in the imposition of civil monetary penalties by **February 11, 2012**.

Joseph Caroselli, Administrator
January 9, 2012
Page 2 of 3

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.

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 **February 8, 2012 (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 8, 2012**. A change in the seriousness of the deficiencies on **February 8, 2012**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **February 8, 2012** includes the following:

Denial of payment for new admissions effective **April 4, 2012**. [42 CFR §488.417(a)]

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **July 4, 2012**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

Joseph Caroselli, Administrator
January 9, 2012
Page 3 of 3

If you believe these deficiencies have been corrected, you may contact Mark P. Grimes, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0036, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **January 4, 2012** 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://www.healthandwelfare.idaho.gov/Rainbow/Documents/medical/2001_10.pdf
http://www.healthandwelfare.idaho.gov/Rainbow/Documents/medical/2001_10_attach1.pdf
http://www.healthandwelfare.idaho.gov/Rainbow/Documents/medical/2001_10_attach2.pdf

This request must be received by **January 23, 2012**. If your request for informal dispute resolution is received after **January 23, 2012**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



Mark P. Grimes
Supervisor
Facility Fire Safety and Construction

MPG/lj

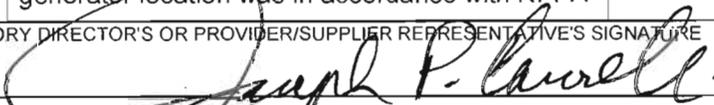
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135114	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE NF FLOOR B. WING _____	(X3) DATE SURVEY COMPLETED 01/04/2012
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NAME OF PROVIDER OR SUPPLIER ID ELKS REHAB HOSP & SA REHAB UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 1100 BOISE, ID 83701
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	INITIAL COMMENTS The facility is within a 4 story rehab hospital built in 1999-2000 that is fully sprinklered with Type I (443) construction. There is smoke detection in hallways, open spaces and patient rooms. Currently the SRU is located on the third floor and is licensed for 20 SNF beds. The following deficiencies were cited during the annual life safety code survey conducted on January 3, 2012 and January 4, 2012. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70. The Survey was conducted by: Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction	K 000		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This Standard is not met as evidenced by: Based on record review, interview and observation the facility did not ensure that the emergency generator battery was being inspected on a weekly basis and that the generator location was in accordance with NFPA	K 144		

RECEIVED
JAN 23 2012
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE CEO	(X6) DATE 1/20/12
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

 Printed: 01/05/2012
 FORM APPROVED
 OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135114	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE NF FLOOR B. WING _____	(X3) DATE SURVEY COMPLETED 01/04/2012
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K 144	<p>Continued From page 1</p> <p>110. Failure to inspect the generator battery on a weekly basis could result in the generator not starting or functioning properly and the lack of backup emergency lighting can impede corrective maintenance in the event of a power outage. The facility had a census of sixteen residents on the day of survey. These deficiencies affected all residents, staff and visitors present on the day of the survey.</p> <p>Findings include:</p> <p>1. During record review on January 3, 2012 at 11:01 AM, the facility was unable to provide documented weekly electrolyte battery inspections for the generator. Observation of the generator batteries revealed that they were not the maintenance free type. When questioned about the weekly battery inspections the Maintenance Supervisor stated that he was unaware of the requirement for weekly inspections.</p> <p>2. During a tour of the facility on January 3, 2012 at 11:03 AM, observation of the emergency generator building revealed that it was not equipped with backup emergency lighting. When questioned about the lack of emergency lighting the Maintenance Supervisor stated that he was unaware of the requirement for emergency lighting in the generator room.</p> <p>Actual NFPA Standard:</p> <p>NFPA 110 Standard for Emergency and Standby Power Systems 1999 Edition</p> <p>6-3.6* Storage batteries, including electrolyte levels, used in connection with Level 1 and Level 2</p>	K 144	<p>K144 - #1: A documentation form for testing battery electrolyte levels on 8 emergency generator batteries was produced Jan. 5, 2012. Testing is assigned to one Engineering technician. The testing will be completed every Friday morning. The first test was completed Jan. 6, 2012.</p> <p>K144 - #2: A back-up emergency lighting fixture was installed in the generator enclosure by Miller Electric Company on Jan. 5, 2012. It was tested on Jan. 5, 2012, and it operated correctly. We will test the light on a regular schedule, once every 2 months. <i>30 seconds per month and 90 minutes, 1X per year</i> See attached work orders.</p>	<p>1-6-12</p> <p>1-5-12</p>

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K 144	<p>Continued From page 2</p> <p>systems shall be inspected at intervals of not more than 7 days and shall be maintained in full compliance with manufacturer ' s specifications. Defective batteries shall be repaired or replaced immediately upon discovery of defects.</p> <p>5-3.1 The Level 1 or Level 2 EPS equipment location shall be provided with battery-powered emergency lighting. The emergency lighting charging system and the normal service room lighting shall be supplied from the load side of the transfer switch.</p>	K 144		
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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135114	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE NF FLOOR B. WING _____	(X3) DATE SURVEY COMPLETED 01/04/2012
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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2.</p> <p>The facility is within a 4 story rehab hospital built in 1999-2000 that is fully sprinklered with Type I (443) construction. There is smoke detection in hallways, open spaces and patient rooms. Currently the SRU is located on the third floor and is licensed for 20 SNF beds.</p> <p>The following deficiencies were cited during the annual life safety code survey conducted on January 3, 2012 and January 4, 2012. The facility was surveyed under IDAPA 16.03.02, Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities.</p> <p>The surveyor conducting the survey was:</p> <p>Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction</p>	C 000		
C 226	<p>02.106 FIRE AND LIFE SAFETY</p> <p>106. FIRE AND LIFE SAFETY. Buildings on the premises used as facilities shall meet all the requirements of local, state and national codes concerning fire and life safety standards that are applicable to health care facilities.</p> <p>This Rule is not met as evidenced by: Refer to the following Federal "K" tags on the CMS - 2567:</p>	C 226		

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

Joseph L. Amell

TITLE **CEO**

(X6) DATE **1/20/12**

STATE FORM 021199 9LVS21 If continuation sheet 1 of 2

