



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

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

DEBRA RANSOM, R.N., R.H.I.T., Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0009  
PHONE 208-334-6626  
FAX 208-364-1888

**CERTIFIED MAIL: 7012 1010 0002 0836 3967**

May 16, 2014

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

Provider #: 135119

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

Dear Mr. Mata:

On **May 12, 2014**, a Facility Fire Safety and Construction survey was conducted at **Saint Alphonsus Transitional Rehabilitation Unit** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies and a similar State 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 and state tag in column (X5) Completion Date to signify when you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date

Daniel Mata, Administrator  
May 16, 2014  
Page 2 of 4

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 Statement of Deficiencies and Plan of Correction, Form CMS-2567 and State Form, in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **May 29, 2014**. Failure to submit an acceptable PoC by **May 29, 2014**, may result in the imposition of civil monetary penalties by **June 17, 2014**.

Your PoC must contain the following:

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

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 **June 16, 2014**, (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 **June 16, 2014**. A change in the seriousness of the deficiencies on **June 16, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **June 16, 2014**, includes the following:

Daniel Mata, Administrator  
May 16, 2014  
Page 3 of 4

Denial of payment for new admissions effective **August 12, 2014**.  
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 **November 12, 2014**, if substantial compliance is not achieved by that time.

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

If you believe these deficiencies have been corrected, you may contact Mark P. Grimes, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, 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 **May 12, 2014**, 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/NursingFacilities/tabid/434/Default.aspx>

Daniel Mata, Administrator

May 16, 2014

Page 4 of 4

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 **May 29, 2014**. If your request for informal dispute resolution is received after **May 29, 2014**, 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,

A handwritten signature in black ink, appearing to read 'MPG', with a long horizontal flourish extending to the right.

Mark P. Grimes, Supervisor  
Facility Fire Safety and Construction

MPG/lj  
Enclosures

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

Printed: 05/28/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135119</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/12/2014</b>
NAME OF PROVIDER OR SUPPLIER <b>SAINT ALPHONSUS TRANSITIONAL REHABIL</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1055 NORTH CURTIS ROAD BOISE, ID 83706</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS  The Transitional Rehabilitation Unit, licensed for 15 SNF/NF beds, is temporarily located on the fourth floor/west wing of the South Tower building of St. Alphonsus Regional Medical Center. The South Tower is type I (443) fire resistive construction and is protected throughout by a complete automatic fire extinguishment system and smoke detection system. The fourth floor is provided with three enclosed stairways that discharge to grade via stairway extensions at the first floor.  The following deficiencies were identified during the annual CMS fire/life safety survey conducted on May 12, 2014. The facility was surveyed under the Life Safety Code 2000 Edition, Existing Health Care Occupancy, and in accordance with 42 CFR 483.70.  The surveyor conducting the survey was:  Dan Holbrook Health Facility Surveyor	K 000		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1½ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3  Roller latches are prohibited by CMS regulations in all health care facilities.	K 018	<b>K 018 --</b> 1.The facility repaired the door in patient room #4444. The door is latching correctly. 2. The facility will create a door monitoring system to identify deficient doors. 3. The facility will monitor the patient's doors monthly. Deficient doors will be repaired. 4.a)Administrator will monitor all the patient's doors b)Monitoring will be conducted monthly	<b>K 018</b>  Corrective action was completed 05/13/14

**RECEIVED**  
MAY 30 2014  
**FACILITY STANDARDS**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Daniel J. Metz* TITLE: *Rehab Director/SNF Administrator* (X6) DATE: *5.30.14*

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

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K 018	Continued From page 1  This Standard is not met as evidenced by: Based on observation and operational testing it was determined that the facility did not ensure that patient room doors were provided with a means suitable for keeping the doors closed. Patient room doors that do not positively latch when closed can allow smoke and fire gases to enter from the corridor in the event of a fire. The facility is licensed for 15 beds had a census of 9 residents on the day of survey. This deficiency affected one resident and all staff members in one of four smoke compartments.  Findings include:  During the tour of the facility on May 12, 2014 between the hours of 2:10 PM & 4:10 PM, operational testing revealed patient room #4444 corridor door would not latch when closed. This was observed and noted by the Safety Officer and the Surveyor.  This finding was acknowledged by the Administrator, Safety Officer, and the Engineering Manager during the exit interview on May 12, 2014.	K 018	<b>Continued from K 018</b>  For 4 months c) Monitoring will start 06/13/14 d) Monitoring will be completed 09/13/14		
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance	K 054	<b>K 054 –</b> 1.Facility located the Annual Fire alarm testing documents by vendor Simplex/Grinnell 2.Facility will test each smoke detector as required annually in the 3 <sup>rd</sup> quarter.	<b>K 054</b>  Corrective action was completed 05/13/14	

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K 054	<p>Continued From page 2 with the manufacturer's specifications. 9.6.1.3</p> <p>This Standard is not met as evidenced by: Based on record review, the facility failed to provide sensitivity testing of 4th floor, west, smoke detectors. Not maintaining smoke detectors may result in failure to detect smoke in the event of fire. The deficient practice affected 4 of 4 smoke compartments, all patients, staff, and visitors. The facility is licensed for 15 SNF/NF beds and had a census of 9 the day of the survey.</p> <p>Findings include:</p> <p>A review of the facility fire alarm system records on May 12, 2014 at 11:30 AM, revealed the facility was unable to provide documentation of current smoke detector sensitivity testing for the fourth floor, west wing. The fourth floor west wing was reactivated and is temporarily being used for TRU while the 3rd floor is under construction. Interview with the Safety Officer and the Engineering Manager revealed the facility was aware of the requirement for biannual sensitivity testing but failed to produce documentation of testing.</p> <p>This finding was acknowledged by the Administrator, Safety Officer, and the Engineering Manager during the exit interview on May 12, 2014.</p> <p>Actual NFPA Standard: NFPA 72, 7-3.2.1. Smoke detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and</p>	K 054	<p><b>Continued from K 054</b></p> <p>3. Facility will test each smoke detector throughout the facility and replace the non-working ones.</p> <p>4. a) Engineering department in the facility will performed annual testing on smoke detectors. Documentation is located in the engineering manager's office. b) Monitoring will be conducted annually. c) Monitoring was started 5/13/14 d) Monitoring will be on-going</p>	

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K 054	Continued From page 3 marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked); the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector-caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed.	K 054		
K 070 SS=E	<b>NFPA 101 LIFE SAFETY CODE STANDARD</b> Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8  This Standard is not met as evidenced by: Based on observation and interview it was determined that the facility did not ensure the use of un-authorized portable space heaters did not occur. Use of portable heating devices has the potential to cause a fire. The facility is licensed for 15 SNF/NF beds and had a census of 9 patients on the day of survey. This deficiency affected four patients and all staff members and visitors in two of four smoke compartments.  Findings include:  1. During the tour of the facility on May 12, 2014 between the hours of 2:10 PM and 4:10 PM, observation of four Hospitalists offices revealed the use of un-authorized portable space heaters in two of them. This was observed and noted by the Safety Officer and surveyor. Safety Officer	K 070	<b>K 070 -</b>  1. The facility removed all the un-authorized portable space heaters in the hospitalist's office. 2. The facility will create a monitoring system to identify possible usage of un-authorized portable space heaters in the facility. 3. The facility will provide in-service training to all staff for the proper usage of space heaters. Sign-in sheets will be kept. Monitoring of usage of un-authorized portable space heaters will be conducted. 4. a)Administrator will monitor the use of un-authorized portable space heaters b)Monitoring will be conducted monthly For 4 months c) Monitoring will start 06/13/14 d) Monitoring will be completed 09/13/14	<b>K 070</b>  Corrective action was completed 05/13/14

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K 070	<p>Continued From page 4</p> <p>stated he was not aware of the presence of the heaters.</p> <p>2. During the tour of the facility on May 12, 2014 between the hours of 2:10 PM and 4:10 PM, observation of office #4409 revealed the use of an un-authorized portable space heater. This was observed and noted by the Safety Officer and surveyor. Safety Officer stated he was not aware of the presence of the heater.</p> <p>These findings were acknowledged by the Administrator, Safety Officer, and the Engineering Manager during the exit interview on May 12, 2014.</p> <p>Actual NFPA Standard: 19.7.8 Portable Space-Heating Devices. Portable space-heating devices shall be prohibited in all health care occupancies. Exception: Portable space-heating devices shall be permitted to be used in nonsleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C).</p>	K 070		

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C 000	<p><b>16.03.02 INITIAL COMMENTS</b></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 Transitional Rehabilitation Unit, licensed for 15 SNF/NF beds, is temporarily located on the fourth floor/west wing of the South Tower building of St. Alphonsus Regional Medical Center. The South Tower is type I (443) fire resistive construction and is protected throughout by a complete automatic fire extinguishment system and smoke detection system. The fourth floor is provided with three enclosed stairways that discharge to grade via stairway extensions at the first floor.</p> <p>The following deficiencies were identified during the annual CMS fire/life safety survey conducted on May 12, 2014. The facility was surveyed under the Life Safety Code 2000 Edition, Existing Health Care Occupancy, and 42 CFR 483.70 and in accordance with IDAPA 16.03.02.</p> <p>The surveyor conducting the survey was:</p> <p>Dan Holbrook Health Facility Surveyor</p> <p>Refer to CMS form 2567</p> <p>K018 Door Latch K054 Sensitivity Testing K070 Portable Space Heaters</p>	C 000	<p style="text-align: center;"><b>RECEIVED</b> MAY 30 2014 <b>FACILITY STANDARDS</b></p> <p>CMS form 2567 – See attached plan of corrections for the following deficiencies:</p> <p>K018</p> <p>K054</p> <p>K070</p>	

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Daniel M. Mata* TITLE: *Rehab Director / SNF Administrator* (X6) DATE: *5-30-14*