



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 3936

December 11, 2013

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

Provider #: 135130

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Mr. Frasure:

On **December 3, 2013**, a Facility Fire Safety and Construction survey was conducted at **Aspen Transitional Rehabilitation** 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 one that comprises a pattern 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

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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 **December 24, 2013**. Failure to submit an acceptable PoC by **December 24, 2013**, may result in the imposition of civil monetary penalties by **January 13, 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 **January 7, 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 **January 7, 2014**. A change in the seriousness of the deficiencies on **January 7, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **January 7, 2014**, includes the following:

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Denial of payment for new admissions effective **March 3, 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 **June 3, 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 **December 3, 2013**, 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>

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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 24, 2013**. If your request for informal dispute resolution is received after **December 24, 2013**, 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
Enclosures

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

Printed: 12/09/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135130	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE STRUCTURE B. WING _____	(X3) DATE SURVEY COMPLETED 12/03/2013
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
K 000	INITIAL COMMENTS The building is a single story, 25,000+ square foot structure of type V (111) construction completed in August of 2005. The building is protected throughout by an automatic fire extinguishing system designed/installed per applicable requirements of NFPA Std 13 for a light hazard occupancy. The building is equipped with an addressable fire alarm system with smoke detection throughout and the system is off-site monitored. Portable ABC multipurpose fire extinguishers are provided throughout and the range hood/ductwork/cooking surfaces are protected by a fixed fire extinguishing system. Currently the facility is licensed for 30 beds. The following deficiency was cited during the annual life safety code survey conducted on December 3, 2013. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, New 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 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD There is an automatic sprinkler system, installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, with approved components, devices, and equipment, to provide complete coverage of all portions of the facility. The system is maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. There is a reliable, adequate water supply for the system. The system is equipped	K 056	"This plan of correction is submitted as required under Federal and State regulations and statutes applicable to long term care providers. 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 the surveyor's conclusion are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied."	

RECEIVED
DEC 20 2013
FACILITY STANDARDS

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

TITLE

(X6) DATE

 Administrator 12-19-13

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 056	<p>Continued From page 1 with waterflow and tamper switches which are connected to the fire alarm system. 18.3.5.</p> <p>This Standard is not met as evidenced by: Based on observation and interview the facility did not ensure that the sprinkler system was installed in accordance NFPA 13. Unprotected areas can allow a fire to grow, accelerate and spread. The facility had a census of thirty residents on the day of survey. These deficiencies affected two of six exits from the facility.</p> <p>Findings include:</p> <p>1. During the tour of the facility on December 3, 2013 at 1:00 PM, observation of the exit by the dining room revealed a combustible overhang above the exit discharge that is approximately five feet by seven feet in size that does not have any sprinkler protection. When questioned about the lack of sprinkler protection the Administrator stated that he was unaware that the overhang was not provided with sprinkler protection.</p> <p>2. During the tour of the facility on December 3, 2013 at 1:10 PM, observation of the west exit revealed a combustible overhang above the exit discharge that is approximately five feet by seven feet in size that does not have any sprinkler protection. When questioned about the lack of sprinkler protection the Administrator stated that he was unaware that the overhang was not provided with sprinkler protection.</p>	K 056	<p>K 056</p> <p>Patient Specific:</p> <p>No specific patients were found to have been affected.</p> <p>Other Patients:</p> <p>See "Systemic Changes"</p> <p>Systemic Changes:</p> <p>Treasure Valley Fire Protection, a Fire Sprinkler System installation company, has been contracted to install sprinklers in the exit overhang by the dining room and the west-exit overhang.</p> <p>Monitors:</p> <p>The administrator will monitor the City of Meridian permit process and installation of the sprinklers through Treasure Valley Fire Protection. Monitoring will be done weekly until the sprinklers are installed.</p> <p>Date of Compliance:</p> <p>12/30/13</p>	

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

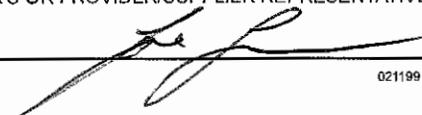
Printed: 12/09/2013
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K 056	Continued From page 2 Actual NFPA Standard: NFPA 13 Standard for the Installation of Sprinkler Systems 1999 Edition 5-13.8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 ft (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.	K 056		

Bureau of Facility Standards

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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 building is a single story, 25,000+ square foot structure of type V (111) construction completed in August of 2005. The building is protected throughout by an automatic fire extinguishing system designed/installed per applicable requirements of NFPA Std 13 for a light hazard occupancy. The building is equipped with an addressable fire alarm system with smoke detection throughout and the system is off-site monitored. Portable ABC multipurpose fire extinguishers are provided throughout and the range hood/ductwork/cooking surfaces are protected by a fixed fire extinguishing system. Currently the facility is licensed for 30 beds.</p> <p>The following deficiency was cited during the annual life safety code survey conducted on December 3, 2013. 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	<p>RECEIVED DEC 20 2013 FACILITY STANDARDS</p>	
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</p>	C 226	<p>C226</p> <p>Please refer to the Plan of Correction for K 056</p> <p>Date of Compliance: 12/30/13</p>	

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



TITLE
Administrator

(X6) DATE
12-19-13

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C 226	Continued From Page 1 applicable to health care facilities. This Rule is not met as evidenced by: Refer to the following Federal "K" tags on the CMS - 2567: 1. K056 Automatic fire sprinkler system installation.	C 226		