



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSSELL S. BARRON – Director

TAMARA PRISOCK – ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
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

September 18, 2018

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

Provider #: 135130

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Mr. Frasure:

On **September 5, 2018**, 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 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. 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

Joseph Frasure, Administrator
September 18, 2018
Page 2 of 4

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 the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office. If a State Form with deficiencies was issued, it should be signed, dated and returned along with the CMS-2567 Form.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **October 1, 2018**. Failure to submit an acceptable PoC by **October 1, 2018**, may result in the imposition of civil monetary penalties by **October 23, 2018**.

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. If a State Form was issued as well, it should also be signed, dated and returned.

All references to federal regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Remedies may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **October 10, 2018**, (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 **October 10, 2018**. A change in the seriousness of the deficiencies on **October 10, 2018**, may result in a change in the remedy.

Joseph Frasure, Administrator
September 18, 2018
Page 3 of 4

The remedy, which will be recommended if substantial compliance has not been achieved by **October 10, 2018**, includes the following:

Denial of payment for new admissions effective **December 5, 2018**.
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 **March 5, 2019**, 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 Nate Elkins, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, option 3; 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 **September 5, 2018**, 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:

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<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

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

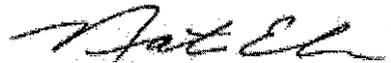
BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process
2001-10 IDR Request Form

This request must be received by **October 1, 2018**. If your request for informal dispute resolution is received after **October 1, 2018**, 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, option 3.

Sincerely,



Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosures

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

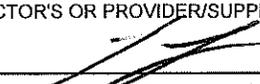
Printed: 09/18/2018
FORM APPROVED
OMB NO. 0938-0391

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 09/05/2018
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NAME OF PROVIDER OR SUPPLIER ASPEN TRANSITIONAL REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 2867 EAST COPPER POINT DRIVE MERIDIAN, ID 83642
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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	<p>INITIAL COMMENTS</p> <p>The building is a single story, type V (111) structure, comprised of three (3) smoke compartments, originally constructed in 2005. The building is protected throughout by an automatic fire extinguishing system and is equipped with an interconnected, addressable fire alarm system with smoke detection throughout. There is a diesel-fired, emergency generator on site. The facility is currently licensed for 30 SNF/NF beds with a census of 22 on the date of the survey.</p> <p>The following deficiencies were cited during the annual Fire/Life Safety survey conducted on September 5, 2018. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.</p> <p>The Survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction</p>	K 000	<p style="text-align: center;">RECEIVED</p> <p style="text-align: center;">OCT 02 2018</p> <p style="text-align: center;">FACILITY SERVICES DEPT</p> <p>“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 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>	
K 353 SS=F	<p>Sprinkler System - Maintenance and Testing CFR(s): NFPA 101</p> <p>Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p>	K 353		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 10-1-18
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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

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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 353	Continued From page 1 c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to ensure that fire suppression systems were maintained in accordance with NFPA 25. Failure to inspect system components has the potential to hinder system performance during a fire event and/or render the facility not fully sprinklered after an activation or repair. This deficient practice affected 22 residents, staff and visitors on the date of the survey. Findings include: During review of provided facility inspection and testing records conducted on 9/5/18 from 8:30 - 10:30 AM, no records were available indicating the dry system gauges were inspected on a weekly basis. Actual NFPA standard: NFPA 25 5.2.4 Gauges. 5.2.4.2 Gauges on dry, preaction, and deluge systems shall be inspected weekly to ensure that normal air and water pressures are being maintained.	K 353	K 353 1. Dry-system gauges for the fire sprinkler system were inspected to ensure normal air and water pressures are being maintained. 2. The dry-system gauges will be inspected weekly to ensure normal air and water pressures are being maintained. 3. The dry-system gauges weekly inspection form was added to the weekly maintenance log-book and will be completed by maintenance personnel each week after the inspection. 4. The administrator will review the maintenance log-book monthly to ensure the weekly inspections of the dry-system gauges occur and that normal air and water pressures are being maintained. 5. Completion Date: October 9, 2018	
K 916 SS=F	Electrical Systems - Essential Electric System CFR(s): NFPA 101 Electrical Systems - Essential Electric System	K 916		

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K 916	<p>Continued From page 2</p> <p>Alarm Annunciator</p> <p>A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, the facility failed to ensure the Essential Electrical System (EES) was equipped with a remote annunciator that was readily observable in a regular work station in accordance with NFPA 99. Failure to provide an annunciator that is readily observed has the potential to hinder facility staff awareness to system failures during a power outage or other emergency. This deficient practice affected 22 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 9/5/18 from approximately 1:00 - 3:00 PM, a remote annunciator for the EES was observed installed in the rear of the electrical service room, behind the installed electrical service panels and transfer switch.</p> <p>Actual NFPA standard:</p> <p>NFPA 99 6.4.1.1 On-Site Generator Set. 6.4.1.1.17 Alarm Annunciator. A remote annunciator that is storage battery powered shall be provided to operate outside of the generating</p>	K 916	<p>K 916</p> <ol style="list-style-type: none"> 1. Nursing-staff members have been in-serviced on the need to monitor the Essential Electrical System (EES) remote annunciator in the electrical service room while the new annunciator panel is manufactured and installed. This manufacturing and installation process is expected to take 6-8 weeks depending on the manufacturing time of the annunciator panel. 2. A contract has been signed to install an EES remote annunciator in the copy room (a regular workstation that is used 24 hours per day). This location allows staff to monitor the annunciator from the copy room, nurse's station, and nurse managers' offices. 3. The new annunciator will be permanently installed in the wall and will be hard wired. 4. The administrator will verify the remote annunciator is installed in the copy room and will report the completion of this project to the QAPI committee. 5. Completion Date: October 9, 2018 	

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K 916	Continued From page 3 room in a location readily observed by operating personnel at a regular work station (see 700.12 of NFPA 70, National Electrical Code). The annunciator shall be hard-wired to indicate alarm conditions of the emergency or auxiliary power source as follows: (1) Individual visual signals shall indicate the following: (a) When the emergency or auxiliary power source is operating to supply power to load (b) When the battery charger is malfunctioning (2) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate the following: (a) Low lubricating oil pressure (b) Low water temperature (below that required in 6.4.1.1.11) (c) Excessive water temperature (d) Low fuel when the main fuel storage tank contains less than a 4-hour operating supply (e) Overcrank (failed to start) (f) Overspeed	K 916		
K 926 SS=E	Gas Equipment - Qualifications and Training CFR(s): NFPA 101 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on record review, and interview, the facility failed to ensure continuing education and staff training was provided on the risks associated with	K 926		

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 09/05/2018
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K 926	<p>Continued From page 4</p> <p>the storage, handling and use of medical gases and their cylinders. Failure to provide training of safety and the risks associated with medical gases, potentially increases risks associated, hindering staff response on the use and handling of oxygen. This deficient practice potentially affected oxygen dependent residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During review of provided training records on 9/5/18 from 8:30 - 10:30 AM, records provided did not demonstrate continuing training was performed on an annual basis for the risks associated with oxygen and its use.</p> <p>Interview of 3 of 3 staff members revealed none had participated in a facility provided, continuing education program, on the risks associated with the storage, handling or use of medical gases such as oxygen.</p> <p>Actual NFPA standard:</p> <p>NFPA 99 11.5.2 Gases in Cylinders and Liquefied Gases in Containers. 11.5.2.1 Qualification and Training of Personnel. 11.5.2.1.1* Personnel concerned with the application and maintenance of medical gases and others who handle medical gases and the cylinders that contain the medical gases shall be trained on the risks associated with their handling and use. 11.5.2.1.2 Health care facilities shall provide programs of continuing education for their personnel. 11.5.2.1.3 Continuing education programs shall include periodic review of safety guidelines and</p>	K 926	<p>K 926</p> <ol style="list-style-type: none"> Staff members have been provided training on the risks associated with the storage, handling and use of medical oxygen and its use. The oxygen training mentioned in 1. above has been added to the new-hire orientation and training materials to be given to all new employees. The oxygen training mentioned in 1. Above was added to the annual in-service schedule for the facility. All staff members will receive this training annually in September. The administrator will review all new hire information monthly to ensure all new hires receive the above mentioned oxygen training. The administrator will also verify the annual in-service schedule is followed. The administrator will report his findings to the QAPI Committee. Completion Date: October 9, 2018 	

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

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K 926	Continued From page 5 usage requirements for medical gases and their cylinders.	K 926		



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September 18, 2018

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

Provider #: 135130

RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER

Dear Mr. Frasure:

On **September 5, 2018**, an Emergency Preparedness 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 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. 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 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 the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **October 1, 2018**. Failure to submit an acceptable PoC by **October 1, 2018**, may result in the imposition of civil monetary penalties by **October 23, 2018**.

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. If a State Form was issued as well, it should also be signed, dated and returned.

All references to federal regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Remedies may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **October 10, 2018**, (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 **October 10, 2018**. A change in the seriousness of the deficiencies on **October 10, 2018**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **October 10, 2018**, includes the following:

Denial of payment for new admissions effective **December 5, 2018**.
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 **March 5, 2019**, 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 Nate Elkins, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, option 3; 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 **September 5, 2018**, 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>

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

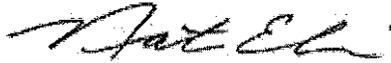
This request must be received by **October 1, 2018**. If your request for informal dispute resolution is received after **October 1, 2018**, the request will not be granted.

Joseph Frasure, Administrator
September 18, 2018
Page 4 of 4

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, option 3.

Sincerely,

A handwritten signature in black ink, appearing to read "Nate Elkins". The signature is fluid and cursive, with a prominent initial "N" and a trailing flourish.

Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosures

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

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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 _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/05/2018
NAME OF PROVIDER OR SUPPLIER ASPEN TRANSITIONAL REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 2887 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	
E 000	Initial Comments The building is a single story, type V (111) structure, comprised of three (3) smoke compartments, originally constructed in 2005. The building is protected throughout by an automatic fire extinguishing system and is equipped with an interconnected, addressable fire alarm system with smoke detection throughout. There is a diesel-fired, emergency generator on site and the facility has local, county and state EMS services available. The facility is currently licensed for 30 SNF/NF beds with a census of 22 on the date of the survey. The following deficiencies were cited during the annual Emergency Preparedness survey conducted on September 5, 2018. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73. The Survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction	E 000	"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 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." Please accept this plan of correction as our credible allegation of compliance.		
E 009 SS=F	Local, State, Tribal Collaboration Process CFR(s): 483.73(a)(4) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a	E 009		10/9/18	

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

TITLE

(X6) DATE

10/01/2018

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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E 009	<p>Continued From page 1</p> <p>disaster or emergency situation, including documentation of the facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts.</p> <p>* [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the dialysis facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency. This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the facility failed to document collaboration with local, tribal, regional, State and Federal EP officials and integrated emergency response efforts. Failure to develop a collaborative planning effort with multi-jurisdictional entities, has the potential to limit the facilities options during a disaster. This deficient practice affected 22 residents, staff and visitors on the date of the survey.</p> <p>Findings include: On 9/5/18 from 8:30 AM - 1:30 PM, review of provided policies, procedures and the emergency plan, failed to establish documentation indicating collaborative involvement with local, tribal, regional State and Federal EP officials, including</p>	E 009	<p>E009</p> <ol style="list-style-type: none"> 1. The facility has contacted local, regional, State and Federal emergency preparedness officials to begin participation in integrated responses to disaster and emergency situations, planning, and staff training. 2. The facility has contacted local, regional, State and Federal emergency preparedness officials to begin participation in integrated responses to disaster and emergency situations, planning, and staff training. 3. The facility's participation with local, regional, State and Federal officials in disaster responses, planning, and training will be monitored monthly by the maintenance staff. This monitoring will be documented on maintenance monthly checklists. 4. The administrator will review the maintenance checklists monthly ensure there is a continued relationship with the local, regional, State and Federal emergency preparedness officials. 5. Completion Date: October 9, 2018 		

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E 009	Continued From page 2 such involvement as participation in county EMS or regional healthcare coalition meetings.	E 009			
E 013 SS=D	Reference: 42 CFR 483.73 (a) (4) Development of EP Policies and Procedures CFR(s): 483.73(b) (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least annually. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and	E 01 E 013	1. The facility policies and procedures were updated to exclude references to hurricanes leaving specifics on responding to high-wind situations that may occur in Meridian Idaho. 2. The facility policies and procedures were updated to exclude references to hurricanes leaving specifics on responding to high-wind situations that may occur in Meridian Idaho. 3. The facility's Emergency Operating Plan was updated with the new policies and procedures. 4. The administrator will report to the QAPI Committee so the updated policies and procedures can be reviewed. The QAPI Committee will continue to review and update the policies and procedures annually thereafter. 5. Completion Date: October 9, 2018	18	

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E 013	<p>Continued From page 3</p> <p>implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, it was determined the facility failed to develop policies and procedures based on the Emergency Plan, that aligned with a facility and community based risk assessment. Failure to align policies and procedures with a facility and community based risk assessment has the potential to develop training and practices that are not reflective of relevant hazards. This deficient practice affected 22 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>On 9/5/18 from 8:30 AM - 1:00 PM, review of provided policies and procedures revealed the risk of Hurricanes was not included in the HVA, but the facility procedures included policies for risks associated with Hurricanes/High Winds. Further evaluation of those policies and procedures established several references to Hurricanes as an event and both the effects of, warnings to and procedures for those occurrences.</p> <p>Reference:</p>	E 013		

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E 013	Continued From page 4 42 CFR 483.73 (b)	E 013		
E 015 SS=F	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they	E 015	1. The facility policies and procedures were updated to include provisions of food, water, medications, and medical supplies for evacuations as well as sheltering in place. The updates also include provisions for sewage and waste disposal during evacuation or shelter-in-place events. 2. The facility policies and procedures were updated to include provisions of food, water, medications, and medical supplies for evacuations as well as sheltering in place. The updates also include provisions for sewage and waste disposal during evacuation or shelter-in-place events. 3. The facility's Emergency Operating Plan was updated with the new policies and procedures. 4. The administrator will report to the QAPI Committee so the updated policies and procedures can be reviewed. The QAPI Committee will continue to review and update the policies and procedures annually thereafter. 5. Completion Date: October 9, 2018	8

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E 015	<p>Continued From page 5</p> <p>evacuate or shelter in place, include, but are not limited to the following:</p> <p>(A) Food, water, medical, and pharmaceutical supplies.</p> <p>(B) Alternate sources of energy to maintain the following:</p> <p>(1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.</p> <p>(2) Emergency lighting.</p> <p>(3) Fire detection, extinguishing, and alarm systems.</p> <p>(C) Sewage and waste disposal.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, observation and interview, the facility failed to provide an emergency plan which included the subsistence provisions of food and water for residents, staff and visitors in the event of a disaster. Failure to provide sufficient food and water in the event of a disaster has the potential to limit the facility's ability of providing continuity of care in an emergency. This deficient practice affected 22 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>1) On 9/5/18 from 8:30 AM - 3:00 PM, review of provided emergency plan, policies and procedures for the facility did not indicate the means the facility chose to employ to provide food and water for residents and staff in the event of a disaster which might require sheltering in place for extended periods.</p> <p>2) On 9/5/18 from 10:30 AM - 12:00 PM, interview of the Dietary Manager established she had not</p>	E 015		

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E 015	Continued From page 6 made provisions for emergency water supplies for extended durations, either by contracts for that provision, or stored water on site. Further interview failed to establish, what if any emergency food supply agreements were in place, or how long the food supply on hand would last. 3) On 9/5/18 from 10:30 AM to 12:00 PM, interview of 2 of 2 staff members established they were not aware if the facility had any provisions for emergency food and water on hand for extended shelter-in-place stays. Reference: 42 CFR 483.73 (b) (1) LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8)	E 035	<ol style="list-style-type: none"> The facility's policy has been updated to include provisions for sharing emergency plan information with every resident and their families or representatives. The emergency plan information has been shared with all current residents. The facility's policy has been updated to include provisions for sharing emergency plan information with every resident and their families or representatives. The emergency plan information has been added to the admission paperwork that is given to every new resident. Emergency plan information has been added to the admission paperwork that is given to every new resident. The administrator will report to the QAPI Committee so the updated policies and procedures can be reviewed. The QAPI Committee will continue to review and update the policies and procedures annually thereafter. Completion Date: October 9, 2018 	0/9/18	
E 035 SS=D	<p>[(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following:</p> <p>(8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the facility failed to provide policies, procedure or plan identifying the method of sharing information on the emergency plan with residents, families, or representatives. Failure to share the emergency plan and its contents with residents, families, or</p>				

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E 035	Continued From page 7 representatives, has the potential to create confusion and lack of understanding of the facility's response during a disaster. This deficient practice potentially affected 22 residents, staff and visitors on the date of the survey. Findings include: On 9/5/18 from 8:30 - 10:30 AM, during review of provided emergency plan, policies and procedures, no documentation was provided demonstrating the facility policy and method for sharing information with residents, their families or representatives on the contents of the emergency plan, or the facility's procedures during such events. Reference: 42 CFR 483.73 (c) (8) EP Testing Requirements CFR(s): 483.73(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual,	E 039	1. The facility has completed a full-scale facility based exercise to test the emergency plan. The exercise includes an analysis of the facility's response and any changes that were made to the emergency plan. 2. The facility has completed a full-scale facility based exercise to test the emergency plan. The exercise includes an analysis of the facility's response and any changes that were made to the emergency plan. 3. The required emergency-plan exercises were place on the annual in-service schedule to ensure completion annually. 4. The QAPI committee will review any completed emergency-plan exercises quarterly to ensure completion and to ensure necessary updates to the emergency plan are made. 5. Completion Date: October 9, 2018	/18	
E 039 SS=F		E C			

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E 039	<p>Continued From page 8</p> <p>facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event.</p> <p>(ii) Conduct an additional exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, facility-based.</p> <p>(B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.</p> <p>*[For RNHCs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following:</p> <p>(i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as</p>	E 039			

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E 039	<p>Continued From page 9 needed. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to participate in two exercises which tested the emergency preparedness readiness of the facility. Failure to participate in full-scale, actual, or tabletop events has the potential to reduce the facility's effectiveness to provide continuity of care to residents during an emergency. This deficient practice affected 22 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>On 9/5/18 from 8:30 - 10:30 AM, review of provided emergency plan documents revealed documentation demonstrating the facility had participated in one (1) of the required two (2) exercises of the emergency preparedness plan, policies and procedures.</p> <p>Interview of the Administrative Assistant on 9/5/18 from 2:30 - 3:00 PM substantiated the facility had only documented one (1) actual event which followed a procedure identified in the emergency plan.</p> <p>Reference:</p> <p>42 CFR 483.73 (d) (1)</p>	E 039		