



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 21, 2018

Nolan Hoffer, Administrator
St Luke's Rehab-- Elks Sub Acute Rehab Unit
600 North Robbins Road
Boise, ID 83702-4565

Provider #: 135114

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Mr. Hoffer:

On **September 18, 2018**, a Facility Fire Safety and Construction survey was conducted at St Luke's Rehab-- Elks Sub Acute Rehab 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. Your facility was found to be in substantial compliance with Federal regulations during this survey.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, which states that the facility complies with the requirements of CFR 42, 483.70(a) of the federal requirements. This form is for your records only and does not need to be returned.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact this office 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: 09/20/2018
FORM APPROVED
OMB NO. 0938-0391

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 09/18/2018
NAME OF PROVIDER OR SUPPLIER ST LUKE'S REHAB - ELKS SUB ACUTE REHAB UNIT			STREET ADDRESS, CITY, STATE, ZIP CODE 600 NORTH ROBBINS ROAD BOISE, ID 83702	
(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	<p>INITIAL COMMENTS</p> <p>The facility is located on the third floor of a four (4) story building, Type I (443) construction. Floors one and two contain a rehabilitation hospital, physical therapy gyms, building services and administrative offices. The fourth floor is an Ambulatory Surgery Center. The building was built in 1999-2000 and is fully sprinklered and equipped with a manual fire alarm system with smoke detection throughout. The Essential Electrical System is supplied by a diesel powered, on-site automatic generator. Currently the sub-acute rehabilitation unit is licensed for 20 SNF beds and had a census of 13 on the dates of the survey.</p> <p>The facility was found to be in substantial compliance during the annual fire/life safety survey conducted on September 17 - 18, 2018. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70, and 42 CFR 483.80.</p> <p>The Survey was conducted by:</p> <p>Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction</p>	K 000		

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

TITLE

(X6) DATE

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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September 21, 2018

Nolan Hoffer, Administrator
St Luke's Rehab-- Elks Sub Acute Rehab Unit
600 North Robbins Road
Boise, ID 83702-4565

Provider #: 135114

RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER

Dear Mr. Hoffer:

On **September 18, 2018**, an Emergency Preparedness survey was conducted at St Luke's Rehab-- Elks Sub Acute Rehab Unit by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. Your facility was found to be in substantial compliance with Federal regulations during this survey.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, which states that the facility complies with the requirements of CFR 42, 483.70(a) of the federal requirements. This form is for your records only and does not need to be returned.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact this office at (208) 334-6626, option 3.

Sincerely,

Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/20/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135114	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/18/2018
NAME OF PROVIDER OR SUPPLIER ST LUKE'S REHAB - ELKS SUB ACUTE REHAB UNIT			STREET ADDRESS, CITY, STATE, ZIP CODE 600 NORTH ROBBINS ROAD BOISE, ID 83702	
(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	<p>Initial Comments</p> <p>The facility is located on the third floor of a four (4) story building, Type I (443) construction. Floors one and two contain a rehabilitation hospital, physical therapy gyms, building services and administrative offices. The fourth floor is an Ambulatory Surgery Center. The building was built in 1999-2000 and is fully sprinklered and equipped with a manual fire alarm system with smoke detection throughout. The Essential Electrical System is supplied by a diesel powered, on-site automatic generator. Currently the sub-acute rehabilitation unit is licensed for 20 SNF beds and had a census of 13 on the dates of the survey.</p> <p>The facility was found to be in substantial compliance during the initial Emergency Preparedness Survey conducted on September 17 - 18, 2018. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.</p> <p>The Survey was conducted by:</p> <p>Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction</p>	E 000		

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

TITLE

(X6) DATE

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.