



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

BRAD LITTLE – Governor  
DAVE JEPPESEN – 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

June 17, 2019

Josh Smith, Administrator  
Avamere Transitional Care & Rehab - Boise  
1001 South Hilton Street  
Boise, ID 83705-1925

Provider #: 135077

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

Dear Mr. Smith:

On **May 31, 2019**, a Facility Fire Safety and Construction survey was conducted at Avamere Transitional Care & Rehab - Boise 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  
Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135077</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - ENTIRE BUILDING</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/31/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>AVAMERE TRANSITIONAL CARE &amp; REHAB - BOISE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1001 SOUTH HILTON STREET BOISE, ID 83705</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	<p><b>INITIAL COMMENTS</b></p> <p>The facility is a single story, Type V(111) structure originally built in 1978. It is fully sprinklered with an interconnected fire alarm/smoke detection system, which includes smoke detection in sleeping rooms. There is an on-site spark-ignited natural gas generator for the backup emergency power supply system (EPSS). Currently the facility is licensed for 111 SNF/NF beds and had a census of 63 on the date of the survey.</p> <p>The facility was found to be in substantial compliance during the annual fire/life safety survey conducted on May 31, 2019. 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 &amp; Construction</p>	K 000		

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

TITLE

(X6) DATE

06/27/2019

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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3232 Elder Street  
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Boise, ID 83720-0009  
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June 17, 2019

Josh Smith, Administrator  
Avamere Transitional Care & Rehab - Boise  
1001 South Hilton Street  
Boise, ID 83705-1925

Provider #: 135077

**RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER**

Dear Mr. Smith:

On **May 31, 2019**, an Emergency Preparedness survey was conducted at **Avamere Transitional Care & Rehab - Boise** 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 **July 1, 2019**. Failure to submit an acceptable PoC by **July 1, 2019**, may result in the imposition of civil monetary penalties by **July 22, 2019**.

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 **July 5, 2019**, (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 . A change in the seriousness of the deficiencies on **August 1, 2019**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **July 5, 2019**, includes the following:

Denial of payment for new admissions effective **August 31, 2019**.  
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 **December 1, 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 **May 31, 2019**, 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

Josh Smith, Administrator

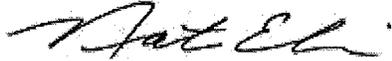
June 17, 2019

Page 4 of 4

This request must be received by **July 1, 2019**. If your request for informal dispute resolution is received after **July, 2019**, 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,

A handwritten signature in black ink, appearing to read "Nate Elkins".

Nate Elkins, Supervisor  
Facility Fire Safety and Construction

NE/lj

Enclosures

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

PRINTED: 06/14/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135077</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/31/2019</b>
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NAME OF PROVIDER OR SUPPLIER  <b>AVAMERE TRANSITIONAL CARE &amp; REHAB - BOISE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1001 SOUTH HILTON STREET BOISE, ID 83705</b>
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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
E 000	Initial Comments  The facility is a single story, Type V(111) structure originally built in 1978 and is located within a municipal fire district, with both county and state EMS services available. It is fully sprinklered with an interconnected fire alarm/smoke detection system, which includes smoke detection in sleeping rooms. There is an on-site spark-ignited natural gas generator for the backup emergency power supply system (EPSS). Currently the facility is licensed for 111 SNF/NF beds and had a census of 63 on the date of the survey.  The following deficiency was cited during the emergency preparedness survey conducted on May 31, 2019. 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	1. Emergency Preparedness Plan Policy and Procedure binder reviewed and updated to reflect findings from full scale disaster drill. All other policy's reviewed and updated as appropriate. Policy and Procedure binder adopted by facility for the next year and signed off by Administrator, Director of Nurses and Medical Director.  2. All residents had the potential to be affected by the deficient practice. Emergency Preparedness Plan Policy and Procedure binder reviewed and updated to reflect findings from full scale disaster drill. All other policy's reviewed and updated as appropriate. Policy and Procedure binder adopted by facility for the next year and signed off by Administrator, Director of Nurses and Medical Director.	
E 004 SS=D	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a)  [The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.]  * [For hospitals at §482.15 and CAHs at §485.625(a):] The [hospital or CAH] must comply with all applicable Federal, State, and local	E 004	3. Emergency Preparedness Plan audit developed to ensure that Policy and Procedures accurately reflect the needs of the facility as outlined by the Hazards and Vulnerability Assessment (HVA) as well as incorporate updates to Policy and Procedures needed as identified during facility Table Top and Full-Scale disaster drills.	

RECEIVED  
JUN 27 2019  
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Joshua Smith</i>	TITLE Administrator	(X6) DATE 6/27/2019
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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.

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NAME OF PROVIDER OR SUPPLIER  <b>AVAMERE TRANSITIONAL CARE &amp; REHAB - BOISE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1001 SOUTH HILTON STREET BOISE, ID 83705</b>
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E 004	<p>Continued From page 1</p> <p>emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.</p> <p>The emergency preparedness program must include, but not be limited to, the following elements:]</p> <p>(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least annually.</p> <p>* [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least annually.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, the facility failed to demonstrate the Emergency Plan (EP) had been updated annually. Failure to update the EP annually has the potential to provide information not relevant to the facility procedures and hinder emergency response during a disaster. This deficient practice affected 63 residents and staff on the date of the survey.</p> <p>Findings include:</p> <p>During review of the provided EP conducted on 5/31/19 from 9:00 - 11:00 AM, records indicated areas of the plan were identified as needing updates to procedures based on evaluation of the outcome of one of the two required full-scale events.</p>	E 004	<p>4. Audit will be conducted no less than 2x yearly and results will be brought to the QAPI committee for review.</p> <p>5. 5 July 2019</p>	

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E 004	Continued From page 2 Further review established the full scale event which was conducted in October of 2018, specifically identified areas of improvement needed in the EP evacuation procedure such as the marking of doors, but no updated revisions demonstrating this improvement were documented in the EP as of the date of survey.  Reference: 42 CFR 483.73 (a) Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6)  [(b) Policies and procedures. The [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:]  (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.  *[For RNHCs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency.  *[For Hospice at §418.113(b):] Policies and	E 004	<ol style="list-style-type: none"> <li>1. Use of Volunteers Policy reviewed and adopted by for next year by Administrator, Director of Nurses and Medical Director.</li> <li>2. All residents had the potential to be affected by the deficient practice. Use of Volunteers Policy reviewed and adopted by for next year by Administrator, Director of Nurses and Medical Director.</li> <li>3. Emergency Preparedness Plan audit developed to ensure that Policy and Procedures accurately reflect the needs of the facility as outlined by the Hazards and Vulnerability Assessment (HVA) as well as incorporate updates to Policy and Procedures needed as identified during facility Table Top and Full-Scale disaster drills.</li> <li>4. Audit will be conducted no less than 2x yearly and results will be brought to the QAPI committee for review.</li> <li>5. 5 July 2019</li> </ol>	
E 024 SS=F		E 024		

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E 024	<p>Continued From page 3</p> <p>procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, it was determined the facility failed to develop Operational Plans which addressed the use of volunteers during an emergency. Lack of a plan, policy and procedure specific to the use of volunteers, potentially hinders the facility's ability to provide continuity of care during a disaster. This deficient practice had the potential to affect the 63 residents and staff in the facility on the date of the survey.</p> <p>Findings include:</p> <p>Review of provided emergency plan, policies and procedures conducted on 05/31/19 from 9:30 - 11:00 AM, failed to demonstrate a plan, policy or procedure for the use of volunteers during an emergency.</p> <p>Reference: 42 CFR 483.73 (b) (6)</p>	E 024		
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