



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

August 12, 2020

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 **August 4, 2020**, 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.

Joseph Frasure, Administrator
August 12, 2020
Page 2 of

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. 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 **August 25, 2020**. Failure to submit an acceptable PoC by **August 25, 2020**, may result in the imposition of civil monetary penalties by **September 16, 2020**.

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 **September 8, 2020**, (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 **November 2, 2020**. A change in the seriousness of the deficiencies on **September 18, 2020**, may result in a change in the remedy.

Joseph Frasure, Administrator
August 12, 2020
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The remedy, which will be recommended if substantial compliance has not been achieved by **September 8, 2020**, includes the following:

Denial of payment for new admissions effective **November 4, 2020**.
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 **February 4, 2021**, 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 **August 4, 2020**, 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:

Joseph Frasure, Administrator
August 12, 2020
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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:

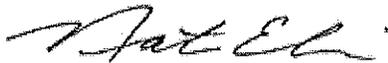
BFS Letters (06/30/11)

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

This request must be received by **August 25, 2020**. If your request for informal dispute resolution is received after **August 25, 2020**, 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

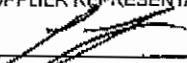
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 08/04/2020
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	<p>INITIAL COMMENTS</p> <p>The building is a single story, Type V (111) structure originally constructed in 2005. The building is protected throughout by an automatic fire extinguishing system with an interconnected, addressable fire alarm/smoke detection system. Emergency power is provided through an on-site, diesel-fired, Emergency Power Supply System (EPSS) generator set. The facility is currently licensed for 30 SNF beds with a census of 20 on the date of the survey.</p> <p>The following deficiencies were cited during the annual Fire/Life Safety survey conducted on August 4, 2020. 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 AUG 25 2020 FACILITY STANDARDS</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 511 SS=D	<p>Utilities - Gas and Electric CFR(s): NFPA 101</p> <p>Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2</p> <p>This REQUIREMENT is not met as evidenced</p>	K 511		

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

TITLE

(X6) DATE



Administrator

8-25-20

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 SERVICESPrinted: 08/11/2020
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 08/04/2020
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 511	<p>Continued From page 1</p> <p>by: Based on observation, the facility failed to ensure electrical installations were maintained in accordance with NFPA 70. Failure to ensure electrical panel access is maintained free of obstructions, has the potential to hinder staff response during a power loss or other emergency. This deficient practice affected staff on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 8/4/20 from 1:00 - 3:00 PM, observation of the main electrical disconnect panels, revealed the area on both sides was obstructed from access by a haphazard storage assortment of maintenance tools and supplies.</p> <p>Actual NFPA standard:</p> <p>NFPA 70 II. 600 Volts, Nominal, or Less 110.26 Spaces About Electrical Equipment. Access and working space shall be provided and maintained about all electrical equipment to permit ready and safe operation and maintenance of such equipment.</p> <p>(A) Working Space. Working space for equipment operating at 600 volts, nominal, or less to ground and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A)(1), (A)(2), and (A)(3) or as required or permitted elsewhere in this Code.</p>	K 511	<ol style="list-style-type: none"> 1. The area around the main electrical disconnect panels has been cleared of maintenance tools and supplies to allow easy access to said panels. 2. See # 1 above. 3. An "Electrical Room" tab was added to the Maintenance binder. Directions are to ensure the area is kept clear of tools and supplies. 4. The electrical room was added to the "Maintenance Monthly Reviews" to ensure monthly verification of completion. 5. Completion Date: August 31, 2020 		



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August 12, 2020

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 **August 4, 2020**, 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"

Joseph Frasure, Administrator
August 12, 2020
Page 2 of 4

(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 **August 25, 2020**. Failure to submit an acceptable PoC by **August 25, 2020**, may result in the imposition of civil monetary penalties by **September 16, 2020**.

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 **September 8, 2020**, (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 **September 26, 2020**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **September 8, 2020**, includes the following:

Joseph Frasure, Administrator
August 12, 2020
Page 3 of 4

Denial of payment for new admissions effective **November 4, 2020**.
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 **February 4, 2021**, 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 **August 4, 2020**, 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>

Joseph Frasure, Administrator
August 12, 2020
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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 **August 25, 2020**. If your request for informal dispute resolution is received after **August 25, 2020**, 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

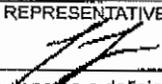
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 08/04/2020
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
E 000	Initial Comments The building is a single story, Type V (111) structure originally constructed in 2005, located within a municipal fire district, with both county and state EMS services available. The building is protected throughout by an automatic fire extinguishing system with an interconnected, addressable fire alarm/smoke detection system. Emergency power is provided through an on-site, diesel-fired, Emergency Power Supply System (EPSS) generator set. The facility is currently licensed for 30 SNF beds with a census of 20 on the date of the survey. The following deficiencies were cited during the annual Emergency Preparedness survey conducted on August 4, 2020. The facility was surveyed under the Emergency Preparedness Rule in accordance with 42 CFR 483.73. The Survey was conducted by: Cam Durbank Health Facility Surveyor Facility Fire Safety & Construction	E 000	 <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>	
E 004 SS=F	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. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop	E 004		

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

TITLE

(X6) DATE



Administrative

8-25-20

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

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 08/04/2020
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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E 004	<p>Continued From page 1</p> <p>and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following:</p> <p>* [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local 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>* [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC 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 every 2 years. This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to ensure the Emergency Operations Plan (EOP) was reviewed and updated annually. Failure to ensure an annual review and update of the EOP has the potential to hinder the facility response by using outdated information in preparing policies and procedures for emergencies. This deficient practice affected all residents, staff and visitors on the date of the survey.</p> <p>Findings include: During review of provided EOP documentation for</p>	E 004	<ol style="list-style-type: none"> 1. The annual review of the Emergency Operations Plan (EOP) was completed. The annual review Hazard Vulnerability Analysis (HVA) was completed. The HVA included the update for the current National Health Crisis. 2. See # 1 above. 3. The annual reviews of the EOP and HVA were added to the monthly "Routine Maintenance Contracts". The items on the "Routine Maintenance Contracts" are reviewed monthly to ensure completion before due dates. 4. The EOP and HVA reviews were placed on the agenda for the Quality Assurance and Performance Improvement (QAPI) Committee to ensure compliance. 5. Completion Date: August 31, 2020. 		

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

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 08/04/2020
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E 004	Continued From page 2 policies and procedures conducted on 8/4/2020 from 9:00 - 10:00 AM, the date for the annual review was documented as June of 2019. Further review of the Hazard Vulnerability Analysis (HVA) established the date of the last review was 2018 and no update for the current National Health Crisis had been documented. Reference: 42 CFR 483.73 (a)	E 004		
E 006 SS=F	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. *[For LTC facilities at §483.73(a)(1):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a)(1):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be	E 006	E 006 1. The annual review Hazard Vulnerability Analysis (HVA) was completed. The HVA included the update for the current National Health Crisis indicating a score of 3 or high probability. 2. See # 1 above. 3. The annual review HVA was added to the monthly "Routine Maintenance Contracts". The items on the "Routine Maintenance Contracts" are reviewed monthly to ensure completion before due dates. 4. The HVA review was placed on the agenda for the Quality Assurance and Performance Improvement (QAPI) Committee to ensure compliance. 5. Completion Date: August 31, 2020.	

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

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 08/04/2020
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
E 006	Continued From page 3 reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a Hazard Vulnerability Analysis (HVA) that utilized current data on community and facility-specific risks. Failure to identify and plan for risks identified by local, state authorities as specific not only to the facility location, but the healthcare industry, has the potential to expose residents, staff and visitors to those increased risks associated. This deficient practice affected all residents, staff and visitors on the date of the survey. Findings include: During review of provided EOP documentation for	E 006		

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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	
E 006	Continued From page 4 policies and procedures conducted on 8/4/2020 from 9:00 - 10:00 AM, it was established the last update of the HVA was in 2018. Further review of the scoring of the HVA on Pandemic, revealed a scoring of "1", or low probability, contradicting the declared national healthcare emergency in effect as directed from both the departments of Health and Human Services (HHS) and the Centers for Medicaid and Medicare Services (CMS). Interview of the Administrator at approximately 9:30 AM established he was aware of the current national crisis, but had not yet updated the HVA to reflect the severity of the community risk. Reference: 42 CFR 483.73 (a) (1) - (2)	E 006			
E 013 SS=D	Development of CP 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 every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility 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.	E 013	E 013 1. The annual review Hazard Vulnerability Analysis (HVA) was completed. The HVA included the update for the current National Health Crisis indicating a score of 3 or high probability. The HVA was completed using the available county, state, and federal information concerning COVID-19. The HVA was aligned with the current COVID-19 facility policy. 2. See # 1 above. 3. The annual review HVA was added to the monthly "Routine Maintenance Contracts". The items on the "Routine Maintenance Contracts" are reviewed monthly to ensure completion before due dates. 4. The HVA review was placed on the agenda for the Quality Assurance and Performance Improvement (QAPI) Committee to ensure compliance. 5. Completion Date: August 31, 2020.		

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E 013	<p>Continued From page 5</p> <p>For ESRD Facilities at §494.62(d): Policies and procedures. The dialysis facility 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 every 2 years. 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: Based on record review, the facility failed to utilize current community information and risk assessment when developing the facility HVA. Failure to consider both community and regional information on significant risks that would affect the facility, has the potential to hinder and divert focus in the development of policies and procedures that would be relevant to the facility plan. This deficient practice affected all residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During review of the EOP policies and procedures conducted on 8/4/20 from 9:00 - 10:00 AM, review of the provided facility HVA established the risk of the current national pandemic as a low probability and did not represent considerations of the available county, state and federal identified high risk of a COVID-19 outbreak. This finding was further contradicted by failure to align the HVA with the policy the facility developed specific to the risk of COVID-19, potentially creating misinformation</p>	E 013			

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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) JD 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 013	Continued From page 6 and confusion in the training of staff for their response to this national emergency.	E 013		
E 015 SS=D	<p>Reference: 42 CFR 483.73 (b)</p> <p>Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1)</p> <p>[(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 every 2 years (annually for LTC). At a minimum, the policies and procedures must address the following:</p> <p>(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:</p> <ul style="list-style-type: none"> (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: <ul style="list-style-type: none"> (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. <p>*[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures.</p> <p>(6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the</p>	E 015	<p>E 015</p> <ol style="list-style-type: none"> 1. The facility water management plan was reviewed. Risks associated with waterborne pathogens were identified and control measures were implemented to mitigate identified risks. 2. See #1 above. 3. Monitors for each control measure were implemented. 4. Each monitor from #3 above were added to the "Maintenance Monthly Reviews" to ensure monthly verification of completion. 5. Completion Date: August 31, 2020. 	

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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 83842		
(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 015	<p>Continued From page 7</p> <p>following:</p> <p>(iii) The provision of subsistence needs for hospice employees and patients, whether they 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 review of the facility EOP and provided information for the facility water management plan, the facility failed to ensure a reliable potable water source for residents, staff and visitors was provided during any emergency need. Failure to perform control measures on those identified risks associated with waterborne pathogens in the facility water management plan, potentially increased the risk of exposure to residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During review of the provided water management plan conducted on 8/4/20 from 9:00 - 10:00 AM, documentation established twenty-nine associated risk areas for waterborne pathogens, both from source areas and at point-of-use (POU). Further review of this document identified only one (1) control measure, monitoring of hot water temperatures, but nothing further for mitigation and monitoring of the remaining</p>	E 015			

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E 015	<p>Continued From page 8 identified risks as defined under CDC guidelines and ASHRAE 188 standard.</p> <p>Additionally, the review summary of the document identified a city organization that was not related to, or geographically relevant to the facility or its water source.</p> <p>Reference: 42 CFR 483.73 (b) (1)</p>	E 015		