



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 19, 2019

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 15, 2019**, 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

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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 **September 2, 2019**. Failure to submit an acceptable PoC by **September 2, 2019**, may result in the imposition of civil monetary penalties by **September 23, 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 **September 19, 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 **November 13, 2019**. A change in the seriousness of the deficiencies on **September 29, 2019**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **September 19, 2019**, includes the following:

Denial of payment for new admissions effective **November 15, 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 **February 15, 2020**, 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 15, 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:

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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:

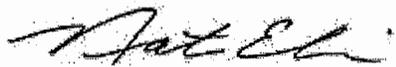
BFS Letters (06/30/11)

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

This request must be received by **September 2, 2019**. If your request for informal dispute resolution is received after **September 2, 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,



Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj

Enclosure

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 08/15/2019
NAME OF PROVIDER OR SUPPLIER ASPEN TRANSITIONAL REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 2867 EAST COPPER POINT DRIVE MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The building is a single story, 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 29 on the date of the survey. The following deficiencies were cited during the annual Fire/Life Safety survey conducted on August 14, 2019. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70. The Survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction	K 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.	
K 100 SS=D	General Requirements - Other CFR(s): NFPA 101 General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure compartmentation was maintained. Failure to maintain compartmentation	K 100		

RECEIVED
SEP 03 2019
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE *Administrator* (X6) DATE *9-2-19*

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 100	<p>Continued From page 1</p> <p>has the potential to limit the facility ability to safeguard against the transfer of fires, smoke and dangerous gases beyond the compartment and hinders installed fire suppression system response, by allowing heat to bypass these features. This deficient practice affected staff using the nourishment room on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 8/14/19 from 1:00 - 3:30 PM, observation of the Nourishment room revealed two (2) missing ceiling tiles from the suspended ceiling grid system and an approximately 2-1/2" diameter pipe passing into the wall through an unsealed membrane penetration.</p> <p>Interview of the accompanying Assistant Administrator at approximately 1:30 PM on 8/14/19, established that the ceiling tiles had been removed due to an above the ceiling leak and he was unaware of the unsealed penetration.</p> <p>Actual NFPA standard:</p> <p>19.1.1.3 Total Concept 19.1.1.3.1 All health care facilities shall be designed, constructed, maintained, and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants.</p> <p>19.1.1.3.2 Because the safety of health care occupants cannot be ensured adequately by dependence on evacuation of the building, their protection from fire shall be provided by appropriate arrangement of facilities; adequate, trained staff; and development of operating and maintenance procedures composed of the</p>	K 100	<p>K 100</p> <ol style="list-style-type: none"> 1. The membrane penetration by the 2-1/2" diameter pipe was sealed with fire barrier tested in accordance with ASTM E 814. The ceiling tiles were replaced. 2. See # 1 above. 3. The building's fire-compartment barriers will be checked by maintenance after any maintenance or repair work within that compartment. 4. Checking of fire-compartment barriers will be added to the routine maintenance monthly items. Any compartment that underwent maintenance or repair work will be checked for compliance to #3 above. If no repair or maintenance has occurred in that month then a random inspection of a fire-compartment's barrier will be completed. Inspections will include the suspended ceiling area. 5. Completion Date: September 19, 2019 	

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K 100	Continued From page 2 following: (1) Design, construction, and compartmentation (2) Provision for detection, alarm, and extinguishment (3) Fire prevention procedures and planning, training, and drilling programs for the isolation of fire, transfer of occupants to areas of refuge, or evacuation of the building 8.2.2 General. 8.2.2.1 Where required by other chapters of this Code, every building shall be divided into compartments to limit the spread of fire and restrict the movement of smoke. 8.3.5.1* Firestop Systems and Devices Required. Penetrations for cables, cable trays, conduits, pipes, tubes, combustion vents and exhaust vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a fire barrier shall be protected by a firestop system or device. The firestop system or device shall be tested in accordance with ASTM E 814, Standard Test Method for Fire Tests of Through Penetration Fire Stops, or ANSI/UL 1479, Standard for Fire Tests of Through- Penetration Firestops, at a minimum positive pressure differential of 0.01 in. water column (2.5 N/m ²) between the exposed and the unexposed surface of the test assembly.	K 100		
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9.	K 321		

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K 321	<p>Continued From page 3</p> <p>When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9</p> <table border="0"> <tr> <td>Area</td> <td>Automatic Sprinkler</td> </tr> <tr> <td colspan="2">Separation N/A</td> </tr> <tr> <td colspan="2">a. Boiler and Fuel-Fired Heater Rooms</td> </tr> <tr> <td colspan="2">b. Laundries (larger than 100 square feet)</td> </tr> <tr> <td colspan="2">c. Repair, Maintenance, and Paint Shops</td> </tr> <tr> <td colspan="2">d. Soiled Linen Rooms (exceeding 64 gallons)</td> </tr> <tr> <td colspan="2">e. Trash Collection Rooms (exceeding 64 gallons)</td> </tr> <tr> <td colspan="2">f. Combustible Storage Rooms/Spaces (over 50 square feet)</td> </tr> <tr> <td colspan="2">g. Laboratories (if classified as Severe Hazard - see K322)</td> </tr> </table> <p>This REQUIREMENT is not met as evidenced by: Based on observation and operational testing, the facility failed to ensure doors from the corridor and entering hazardous areas would self-close as designed. Failure to ensure doors from the corridor entering hazardous areas such as laundries self-close, has the potential to allow fire, smoke and dangerous gases to pass into corridors and affect safe evacuation of residents during a fire. This deficient practice affected staff and those residents using the corridor to enter physical therapy or the main dining area on the date of the survey.</p> <p>Findings include:</p>	Area	Automatic Sprinkler	Separation N/A		a. Boiler and Fuel-Fired Heater Rooms		b. Laundries (larger than 100 square feet)		c. Repair, Maintenance, and Paint Shops		d. Soiled Linen Rooms (exceeding 64 gallons)		e. Trash Collection Rooms (exceeding 64 gallons)		f. Combustible Storage Rooms/Spaces (over 50 square feet)		g. Laboratories (if classified as Severe Hazard - see K322)		K 321	<p>K 321</p> <ol style="list-style-type: none"> 1. The self-closing door entering the clean side of laundry was repaired to ensure it does not drag on the floor and can easily self-close as designed. 2. See # 1 above. 3. Self-closing doors will be inspected monthly to ensure they operate as designed including free movement during closing. This inspection will be recorded on the monthly "Fire Door Inspection" log. 4. The administrator or his designee will review the monthly "Fire Door Inspection" logs to ensure compliance with #3 above. 5. Completion Date: September 19, 2019 	
Area	Automatic Sprinkler																					
Separation N/A																						
a. Boiler and Fuel-Fired Heater Rooms																						
b. Laundries (larger than 100 square feet)																						
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K 321	Continued From page 4 During the facility tour conducted on 8/14/19 from 1:00 -3:30 PM, observation and operational testing of the door from the corridor entering the clean side of the main laundry, revealed the door was obstructed from fully self-closing as designed by dragging and becoming stuck on the floor when activated. Actual NFPA standard: 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.7.1. 19.3.2.1.3 The doors shall be self-closing or automatic-closing. 19.3.2.1.5 Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Rooms with soiled linen in volume exceeding 64 gal (242 L) (6) Rooms with collected trash in volume exceeding 64 gal (242 L) (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than	K 321		

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K 321 K 353 SS=E	<p>Continued From page 5 those that would be considered a severe hazard</p> <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> <p>c) Water system supply source _____</p> <p>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 observation, the facility failed to ensure fire suppression systems were maintained in accordance with NFPA 25. Failure to conduct testing of systems and ensure fire suppression system sprinkler pendants were maintained free of obstructions such as paint or corrosion, has the potential to hinder suppression system response during a fire event. This deficient practice affected staff and residents using the main dining hall on the date of the survey.</p> <p>Findings include:</p> <p>1) During review of the provided facility maintenance and inspection records conducted</p>	K 321 K 353	<p>K 353</p> <ol style="list-style-type: none"> 1. The 10-year testing of dry sprinkler system pendants was completed by All Valley Fire Inspections and Services. The sprinkler pendant over the dishwashing area was replaced by All Valley Fire Inspections and Services. 2. See #1 above. 3. The 10-year testing of the dry sprinkler system pendants was added to the "Routine Maintenance Contracts". The items on the "Routine Maintenance Contracts" are reviewed monthly by maintenance staff to ensure completion before due dates. 4. The administrator or his designee will review the monthly "Routine Maintenance Contracts" log to ensure compliance with #3 above. 5. Completion Date: September 19, 2019 	

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

Printed: 08/16/2019
FORM APPROVED
OMB NO. 0938-0391

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K 353	<p>Continued From page 6 on 8/14/19 from 10:45 AM - 12:00 PM, no records were available demonstrating the last ten-year testing or replacement of dry sprinkler system pendants.</p> <p>2) During the facility tour conducted on 8/14/19 from 1:00 - 3:30 PM, observation of the installed sprinkler pendant over the dishwashing area, revealed the pendant was corroded.</p> <p>Actual NFPA standard:</p> <p>NFPA 25 5.2* Inspection. 5.2.1 Sprinklers. 5.2.1.1* Sprinklers shall be inspected from the floor level annually.</p> <p>5.2.1.1.1* Sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., upright, pendent, or sidewall). 5.2.1.1.2 Any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical damage (4) Loss of fluid in the glass bulb heat responsive element (5)*Loading (6) Painting unless painted by the sprinkler manufacturer</p> <p>5.3.1.1.1.6* Dry sprinklers that have been in service for 10 years shall be replaced or representative samples shall be tested and then retested at 10-year intervals.</p>	K 353		
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101	K 914		

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K 914	Continued From page 7 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to ensure resident room electrical receptacles were maintained in accordance with NFPA 99. Failure to test resident room electrical receptacles annually has the potential to hinder system response during an emergency that encompasses a loss of power. This deficient practice affected 29 residents and staff on the date of the survey. Findings include: During review of provided maintenance documents conducted on 8/14/19 from 8:30 - 10:30 AM, no documentation was available	K 914	K 914 1. The annual testing of the resident room outlets was completed. Any outlet found to have a problem with physical integrity, continuity of the grounding circuit, polarity of the hot and neutral connections, or the retention force was replaced. 2. See #1 above. 3. Annual testing of the resident room outlets was added to the "Routine Maintenance Contracts". The items on the "Routine Maintenance Contracts" are reviewed monthly to ensure completion before due dates. 4. The administrator or his designee will review the monthly "Routine Maintenance Contracts" log to ensure compliance with #3 above. 5. Completion Date: September 19, 2019	

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 08/15/2019
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 914	<p>Continued From page 8 demonstrating an annual test conducted on resident room outlets.</p> <p>Actual NFPA standard:</p> <p>NFPA 99 Chapter 6 Electrical Systems</p> <p>6.3.3.2 Receptacle Testing in Patient Care Rooms. 6.3.3.2.1 The physical integrity of each receptacle shall be confirmed by visual inspection. 6.3.3.2.2 The continuity of the grounding circuit in each electrical receptacle shall be verified. 6.3.3.2.3 Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed. 6.3.3.2.4 The retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 g (4 oz).</p> <p>6.3.4.1 Maintenance and Testing of Electrical System. 6.3.4.1.1 Where hospital-grade receptacles are required at patient bed locations and in locations where deep sedation or general anesthesia is administered, testing shall be performed after initial installation, replacement, or servicing of the device. 6.3.4.1.2 Additional testing of receptacles in patient care rooms shall be performed at intervals defined by documented performance data. 6.3.4.1.3 Receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months.</p>	K 914		



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 19, 2019

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 15, 2019**, an Emergency Preparedness survey was conducted at Aspen Transitional Rehabilitation 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

Enclosure

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

Printed: 08/16/2019
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 08/15/2019
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	<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 and located within a municipal fire district. 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 Power Supply System (EPSS) generator on-site and the facility has county and state EMS services available. The facility is currently licensed for 30 SNF/NF beds with a census of 29 on the date of the survey.</p> <p>The facility was found to be in substantial compliance during the Emergency Preparedness survey conducted on August 14, 2019. 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>Sam Burbank 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.