



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P. O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
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September 20, 2019

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

Provider #: 135130

Dear Mr. Frasure:

On **September 6, 2019**, a survey was conducted at Aspen Transitional Rehabilitation by the Idaho Department of Health and Welfare, Division of Licensing and Certification, 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/or 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. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3.) **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

Joseph Frasure, Administrator
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After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **September 30, 2019**. Failure to submit an acceptable PoC by **September 30, 2019**, may result in the imposition of additional civil monetary penalties by **September 30, 2019** .

The components of a Plan of Correction, as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained.
- Include dates when corrective action will be completed in column (X5).

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

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

This agency is required to notify Centers for Medicare & Medicaid Services (CMS) Regional Office of the results of this survey. We are recommending to the CMS Regional Office that the following remedy(ies) be imposed:

- Civil money penalty,
- Denial of Payment effective December 6, 2019

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **March 6, 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 and Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

Your facility's noncompliance with the following:

- **F0883 -- S/S: F -- 483.80(d)(1)(2) -- Influenza And Pneumococcal Immunizations**

has been determined to constitute substandard quality of care (SQC) as defined at 42 CFR §488.301. Sections 1819 (g)(5)(c) and 1919 (g)(5)(c) of the Social Security Act and 42 CFR §488.325 (h) requires the attending physician of each resident who was found to have received substandard quality of care, as well as the state board responsible for licensing the facility's administrator be notified of the substandard quality of care. In order for us to satisfy these notification requirements, and in accordance with 42 CFR §488.325(g), you are required to provide the following information to this agency within ten (10) working days of your receipt of this letter:

The name and address of the attending physician of each resident found to have received substandard quality of care, as identified below:

Residents **#1, #15, #79, #132, #133** as identified on the enclosed Resident Identifier List.

Please note that in accordance with 42 CFR §488.325(g), your failure to provide this information timely will result in termination of participation or imposition of additional remedies.

If you believe the deficiencies have been corrected, you may contact Belinda Day, RN or Laura Thompson, RN, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. 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
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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 30, 2019**. If your request for informal dispute resolution is received after **September 30, 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, comments or concerns, please contact Belinda Day, RN or Laura Thompson, RN at (208) 334-6626, option 2.

Sincerely,



Laura Thompson, RN, Chief
Bureau of Facility Standards

lt/lj
Enclosures

c: Chairman, Board of Examiners - Nursing Home Administrators

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

PRINTED: 10/11/2019
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 09/06/2019
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	
F 000	INITIAL COMMENTS The following deficiencies were cited during the federal recertification and complaint survey conducted on September 3, 2019 to September 6, 2019. The surveyors conducting the survey were: Presie Billington, RN, Team Coordinator Brad Perry, LSW Michael Brunson, RN CDC = Centers for Disease Control and Prevention DON = Director of Nursing DNR = Do Not Resuscitate LPN = Licensed Practical Nurse MDS = Minimum Data Set mg = milligrams POST = Physician Orders for Scope of Treatment PRN = As Needed	F 000			
F 578 SS=F	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).	F 578		10/4/19	

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

TITLE

(X6) DATE

Electronically Signed

09/30/2019

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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F 578	Continued From page 1 (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and resident and staff interview, it was determined the facility failed to ensure residents' records included a copy of the Advance Directives, or documentation of their decision not to formulate an Advance Directive and residents were provided accurate information regarding Advance Directives upon admission. This was true for 12 of 12 residents (#1, #14, #15, #76, #78, #79, #80, #128, #129, #130, #131, & #133) reviewed for Advance Directives. These failures created the	F 578	F578 "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,		

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F 578	<p>Continued From page 2</p> <p>potential for harm should residents not have their decisions documented, honored, and respected when they were unable to make or communicate their health care preferences. Findings include:</p> <p>The State Operations Manual, Appendix PP, defines an Advanced Directive as "...a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated." The State Operations Manual also states a Physician Orders for Life-Sustaining Treatment (POLST) is a form designed to improve patient care by creating a portable medical order form that records patients' treatment wishes so that emergency personnel know what treatments the patient wants in the event of a medical emergency, taking the patient's current medical condition into consideration. A POLST paradigm form is not an Advance Directive.</p> <p>The facility's Advance Directives policy, dated 2/21/18, documented the following:</p> <p>* Prior to or upon admission, the Admission Coordinator or designee will provide information to the patient their right to make decisions concerning medical care and the right to formulate Advance Directives.</p> <p>* Prior to or upon admission, the Admission Coordinator or designee will inquire of the patient and/or their family members, about the existence of any written Advance Directives previously executed.</p>	F 578	<p>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> <ol style="list-style-type: none"> Residents #1, #15, #76, #78, #80, #128, #129, #130, #131, and #133 were discharged. Residents #14 and #79 were provided accurate information regarding Advanced Directives. Residents' #14 and #79 medical records contain documentation that this information was provided. Residents' #14 and #79 medical records also contain copies of their Advanced Directives or documentation of their decision not to formulate an Advanced Directive. All other residents have been provided accurate information regarding Advanced Directives. All residents' medical records contain documentation that this information was provided. All residents' medical records also contain copies of their Advanced Directives or documentation of their decision not to formulate an Advanced Directive. The following have been added to the admission packet for each new resident: <ol style="list-style-type: none"> Accurate information regarding Advanced Directives Documentation form for the provision to new residents of accurate information regarding Advanced Directives. 		

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F 578	<p>Continued From page 3</p> <p>* Information will be displayed in the medical record about whether or not the patient has executed an Advance Directive.</p> <p>The facility's policy was not followed.</p> <p>Examples include:</p> <p>a. Resident #76 was admitted to the facility on 8/31/19, with multiple diagnoses including right femur fracture.</p> <p>Resident #76's record did not include an Advance Directive or documentation the facility's policy for Advance Directives was provided to or discussed with her.</p> <p>On 9/5/19 at 9:45 AM, Resident #76 said she had a living will and said she did not remember facility staff asking for a copy of her living will.</p> <p>b. Resident #80 was admitted to the facility on 8/17/19, with multiple diagnoses including left femur fracture.</p> <p>Resident #80's record did not include an Advance Directive or documentation the facility's policy for Advance Directives was provided to or discussed with him or his representative.</p> <p>On 9/5/19 at 9:45 AM, Resident #80 said he had a living will and said facility staff did not ask him for a copy of his living will.</p> <p>c. Resident #78 was admitted to the facility on 8/30/19, with multiple diagnoses including left femur fracture.</p>	F 578	<p>c. Documentation form for residents to provide copies of Advanced Directives or to decline to formulate an Advanced Directive.</p> <p>All admission nurses have received an in-service about the need to provide information regarding Advance Directives and the need to document this provision or the resident's decision not to formulate Advanced Directives.</p> <p>4. All new residents' medical records will be audited by the Director of Nursing (DON) or her designee to ensure they contain the following:</p> <p>a. Documentation that accurate information was provided to the resident regarding Advanced Directives.</p> <p>b. Copies of Advanced Directives or the declination by the resident to formulate an Advanced Directive.</p> <p>These audits will be conducted weekly, for four weeks, for all residents admitted the previous week. After four weeks audit results will be shared with the QAPI Committee to ensure compliance and to decide on the need of any further audits.</p> <p>5. Completion date: October 4, 2019</p>		

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F 578	<p>Continued From page 4</p> <p>Resident #78's record did not include an Advance Directive or documentation the facility's policy for Advance Directives was provided to or discussed with him or his representative.</p> <p>On 9/4/19 at 3:05 PM, Resident #78 said facility staff did not ask if he had a living will.</p> <p>d. Resident #79 was admitted to the facility on 8/21/19, with multiple diagnoses including discitis of the lumbar region (an infection of the discs between the vertebra of the spine).</p> <p>Resident #79's record did not include documentation the facility's policy for Advance Directives was provided to or discussed with her or her representative.</p> <p>e. Resident #14 was admitted to the facility on 7/26/19, with multiple diagnoses including spinal fusion of the back.</p> <p>Resident #14's record did not include documentation the facility's policy for Advance Directives was provided to or discussed with her or her representative.</p> <p>f. Resident #1 was admitted to the facility on 8/14/19, with multiple diagnoses including periprosthetic right hip fracture (a broken bone that occurs around the implants of a total hip replacement).</p> <p>Resident #1's record did not include documentation the facility's policy for Advance Directives was provided to or discussed with him or his representative.</p>	F 578			

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F 578	Continued From page 5 g. Resident #15 was admitted to the facility on 7/25/19, with multiple diagnoses including aftercare following a surgical procedure of a left ankle fracture. Resident #15's record did not include documentation the facility's policy for Advance Directives was provided to or discussed with her or her representative. On 9/5/19 at 10:37 AM, Resident #15 said she did not remember if she was asked about an Advance Directive. h. Resident #128 was admitted to the facility on 8/31/19, with multiple diagnoses including aftercare following lumbar fusion surgical procedure. Resident #128's record record did not include an Advance Directive or documentation the facility's policy for Advance Directives was provided to or discussed with her or her representative. i. Resident #129 was admitted to the facility on 8/30/19, with multiple diagnoses including aftercare following a right knee joint replacement surgical procedure. Resident #129's record did not include an Advance Directive or documentation the facility's policy for Advance Directives was provided to or discussed with her or her representative. j. Resident #130 was admitted to the facility on 8/15/19, with multiple diagnoses including acute respiratory failure.	F 578			

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F 578	Continued From page 6 Resident #130's record did not include an Advance Directive or documentation the facility's policy for Advance Directives was provided to or discussed with her or her representative. On 9/5/19 at 10:20 AM, Resident #130's representative said Resident #130 had a living will, but she did not remember if the facility staff asked her for a copy of Resident #130's living will. k. Resident #131 was admitted to the facility on 8/27/19, with multiple diagnoses including acute respiratory failure. Resident #131's record did not include an Advance Directive or documentation the facility's policy for Advance Directives was provided to or discussed with him or his representative. l. Resident #133 was admitted to the facility on 8/27/19, with multiple diagnoses including congestive heart failure. Resident #133's record did not include and Advance Directive or documentation the facility's policy for Advance Directives was provided to or discussed with him or his representative. On 9/5/19 at 9:57 AM, Resident #133 said he had a living will, but did not remember if the facility staff asked for a copy his Living Will. On 9/6/19 at 8:34 AM, LPN #1 said if residents had a living will or Advance Directives, they were kept in the residents' charts under the Advance Directives tab. LPN #1 said the facility's	F 578			

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F 578	Continued From page 7 admissions staff did not always obtain a copy of residents' Advance Directives or living wills. On 9/6/19 at 9:13 AM, LPN #2 said when residents were admitted she offered them Advance Directive information and said she was not documenting the information was offered to them. LPN #2 said if residents had a living will or Advance Directives, she asked them or their representatives to bring those to the facility to be placed in the chart. On 9/6/19 at 8:36 AM and 9:16 AM, the DON said the POST form was used for code status and was considered the Advance Directive. The DON said if residents had a living will they placed it in the chart under the Advance Directive's tab. The DON said the admitting nurse asked the residents upon admission if they had an Advance Directive and if they did not have one, she expected staff to offer them assistance to formulate an Advance Directive.	F 578			
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section;	F 623		10/4/19	

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F 623	Continued From page 8 and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how	F 623			

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F 623	<p>Continued From page 9</p> <p>to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;</p> <p>(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;</p> <p>(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and</p> <p>(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.</p> <p>§483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.</p> <p>§483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate</p>	F 623			

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F 623	<p>Continued From page 10 relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the facility failed to ensure transfer notices were provided in writing to residents and residents' representatives. This was true for 1 of 1 resident (Resident #25) reviewed for transfers. This created the potential for harm if residents were not made aware of or able to exercise their rights related to transfers. Findings include:</p> <p>The facility's admission, transfer, and discharge policy, dated 2/21/18, documented when transferred emergently, residents or their legal representatives received a written reason for transfer as soon as practical.</p> <p>This policy was not followed.</p> <p>Resident #25 was admitted to the facility on 8/2/19, with multiple diagnoses, including acute osteomyelitis (infection of the bone) of the right foot and ankle.</p> <p>Resident #25's Nurse's Progress Notes documented he was transferred to the hospital for evaluation on 8/9/19, when he experienced a decrease in cognitive function. Resident #25's record did not include a written notice of transfer to him or his representative.</p> <p>On 9/6/19 at 11:40 AM, the DON said the facility did not provide written transfer notices to residents or their representatives, including Resident #25, when they were transferred</p>	F 623	<p>F623 "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> <ol style="list-style-type: none"> 1. Resident #25 was discharged. 2. A notification form that includes notification of the resident's transfer to the hospital, the reason for the transfer, the date of the transfer, the name of the hospital to which the resident is being transferred, the residents appeal rights, as well as the name, address, email address, and telephone number of the Office of the State Long-Term Care Ombudsman was added to the packet of information to be given to the resident at the time of the transfer. A copy of this information will be given to the resident's 		

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F 623	Continued From page 11 emergently to the hospital.	F 623	representative if possible or it will be mailed. 3. All licensed nurses were given an in-service on the need to provide the resident and the resident's representative with the "Aspen Transitional Rehab DISCHARGE NOTICE" at the time of transfer to the hospital. 4. All residents who are transferred to the hospital will have their records audited by the DON or her designee to ensure the information in #2 was provided to the resident and to the resident's representative. These audits will be conducted weekly, for four weeks, for all residents transferred to the hospital the previous week. After four weeks audit results will be shared with the QAPI Committee to ensure compliance and to decide on the need of any further audits. 5. Completion date: October 4, 2019		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;	F 625		10/4/19	

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F 625	<p>Continued From page 12</p> <p>(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and</p> <p>(iv) The information specified in paragraph (e)(1) of this section.</p> <p>§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, policy review, and staff interview, it was determined the facility failed to ensure a notice of their bed hold policy was provided to residents or their representatives upon transfer to the hospital. This was true for 1 of 1 resident (Resident #25) reviewed for transfers. This deficient practice created the potential for harm if residents were not informed of their right to return to their former bed/room at the facility within a specified time and may cause psychosocial distress if not informed they may be charged to reserve their bed/room. Findings include:</p> <p>The facility's Bed Hold policy, dated 2/21/18, documented the residents or their legal representatives received a written copy of thier bed hold procedures prior to transferring to a hospital.</p> <p>This policy was not followed.</p>	F 625	<p>F625</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> <ol style="list-style-type: none"> 1. Resident #25 was discharged. 2. The facility's bed-hold policy was 		

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F 625	Continued From page 13 Resident #25 was admitted to the facility on 8/2/19, with multiple diagnoses including acute osteomyelitis (infection of the bone) of the right foot and ankle. Resident #25's Nurse's Progress Notes documented he was transferred to the hospital for evaluation on 8/9/19, when he experienced a decrease in cognitive function. Resident #25's record did not include documentation a written notice of the facility's bed hold policy was provided to him or his representative. On 9/6/19 at 12:37 PM, the DON said the facility did not provide a copy of the bed hold notice to Resident #25 or his representative because the facility would have readmitted him upon discharge from the hospital. She said the bed hold policy was not given to residents or their representatives when they transferred emergently to the hospital. On 9/6/19 at 1:58 PM, the Administrator said the facility was not providing bed hold notices when residents were transferred to the hospital.	F 625	added to the packet of information to be given to the resident at the time of transfer to the hospital. A copy of this information will be given to the resident's representative if possible or it will be mailed. 3. All licensed nurses were given an in-service on the need to provide the resident with the "BED HOLD POLICY" at the time of transfer to the hospital. 4. All residents who are transferred to the hospital will have their records audited by the DON or her designee to ensure the information in #2 was provided to the resident and to the resident's representative. These audits will be conducted weekly, for four weeks, for all residents transferred to the hospital the previous week. After four weeks audit results will be shared with the QAPI Committee to ensure compliance and to decide on the need of any further audits. 5. Completion date: October 4, 2019		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's	F 655		10/4/19	

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F 655	<p>Continued From page 14 admission.</p> <p>(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-</p> <p>(A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable.</p> <p>§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-</p> <p>(i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).</p> <p>§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:</p> <p>(i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and resident and staff interview, it was determined the facility failed to ensure residents' code status was documented on their baseline care plan. This</p>	F 655	<p>F655 "This plan of Correction is submitted as required under Federal and State regulations and statutes applicable to</p>		

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F 655	<p>Continued From page 15</p> <p>was true for 2 of 12 residents (#80 and #129) reviewed for baseline care plans. This failure created the potential for harm should a residents' wishes not be followed regarding their code status due to lack of information on the baseline care plan. Findings include:</p> <p>The facility's Baseline Care Plan policy, dated 2/27/18, documented the baseline care plan was developed to address the resident's goals and needs.</p> <p>The facility's policy was not followed.</p> <p>a. Resident #80 was admitted to the facility on 8/17/19, with multiple diagnoses including left femur fracture.</p> <p>A POST, dated 8/17/19, documented his code status was a DNR.</p> <p>Resident #80's Baseline Care Plan, dated 8/17/19, did not include documentation regarding his code status.</p> <p>On 9/5/19 at 9:45 AM, Resident #80 said his code status was a DNR.</p> <p>b. Resident #129 was admitted to the facility on 8/30/19, with multiple diagnoses including post-operative care following a joint replacement surgery of the right knee.</p> <p>Resident #129's physician's orders, dated 8/30/19, documented her code status was "Full Code."</p> <p>Resident #129's POST form, dated 9/3/19,</p>	F 655	<p>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> <ol style="list-style-type: none"> 1. Residents #80and #129 were discharged. 2. All residents had their medical records reviewed to ensure the Baseline Care Plan included the resident's code status. The admitting nurse will note the resident's code status on the Baseline Care Plan. All admission nurses have received an in-service about the need to note each new resident's code status on the Baseline Care Plan. 3. All new residents' medical records will be audited by the DON or her designee to ensure the Baseline Care Plans contain the resident's code status. These audits will be conducted weekly, for four weeks, for all residents admitted the previous week. After four weeks audit results will be shared with the QAPI Committee to ensure compliance and to decide on the need of any further audits. 		

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F 655	Continued From page 16 documented she was a "Full Code." Resident #129's baseline care plan, dated 8/30/19, did not include documentation regarding her code status. On 9/6/19 at 9:21 AM, the DON said Resident #80's and Resident #129's code status were not documented on the baseline care plan. The DON said she expected to see the code status on the baseline care plan	F 655	4. Completion date: October 4, 2019		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these	F 758		10/4/19	

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F 758	<p>Continued From page 17 drugs;</p> <p>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and</p> <p>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.</p> <p>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the facility failed to ensure residents receiving PRN lorazepam (anti-anxiety medication) had a clinical rationale documented supporting the continued use of the medication beyond 14 days. This was true for 2 of 5 residents (#9 and #15) reviewed for unnecessary medications. This deficient practice had the potential for harm should residents receive psychotropic medications that were unnecessary or ineffective. Findings include:</p> <p>The facility's Psychopharmacological Medication Management policy, dated 11/27/17, documented</p>	F 758	<p>F758 "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</p>		

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F 758	<p>Continued From page 18</p> <p>PRN psychotropic medications would not exceed 14 days unless medically necessary and a rationale was documented by the patient's physician.</p> <p>This policy was not followed.</p> <p>1. Resident #9 was admitted to the facility on 8/12/19, with multiple diagnoses including transient ischemic attack (a temporary blockage of blood flow to the brain) and atrial fibrillation (irregular heart beat).</p> <p>A physician's order, dated 8/12/19, documented Resident #9 was to receive lorazepam 0.5 mg, orally three times a day as needed for anxiety. The order did not include a stop date for the PRN lorazepam.</p> <p>An MDS assessment, dated 8/25/19, documented Resident #9 was cognitively intact and received anti-anxiety medication on three out of the past seven days.</p> <p>A physician's progress note dated 8/21/19, documented Resident #9 had anxiety and she used lorazepam 0.5 mg three times a day as needed, and had been on that medication "chronically."</p> <p>There was no documentation in Resident #9's record to support the continuation of lorazepam beyond 14 days.</p> <p>On 9/5/19 at 11:45 AM, the DON said she did not find the stop date for Resident #9's lorazepam.</p> <p>2. Resident #15 was admitted to the facility on 7/25/19, with multiple diagnoses including anxiety</p>	F 758	<p>applied."</p> <p>Please accept this plan of correction as our credible allegation of compliance.</p> <ol style="list-style-type: none"> 1. Residents #9 and #15 were discharged. 2. All residents with PRN anti-anxiety medications had their medical records reviewed to ensure each PRN anti-anxiety medication had a stop date not exceeding 14 days. If the prescribing practitioner believes a PRN anti-anxiety medication should be extended beyond 14 days then her/his rationale is documented along with a new stop date. 3. The Nurse Manager or her designee will review all new PRN medication orders to ensure all PRN psychotropic medication have a stop date not exceeding 14 days. If the prescribing practitioner believes a psychotropic medication should be extended beyond 14 days then the Nurse Manager or her designee will ensure the practitioner's rationale is documented along with a new stop date. All licensed nurses were given an in-service on the need to ensure all PRN psychotropic medication have a stop date not exceeding 14 days. If the prescribing practitioner believes a psychotropic medication should be extended beyond 14 days then the practitioner's rationale must be documented along with a new stop date. 4. All residents with PRN psychotropic medication orders will have their medical 		

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F 758	Continued From page 19 disorder. A physician's order, dated 7/25/19, documented Resident #15 was to receive lorazepam 0.5 mg, orally three times a day as needed for anxiety. The order did not include a stop date for the PRN lorazepam. An MDS assessment, dated 8/25/19, documented Resident #15 was cognitively intact and received anti-anxiety medication on seven out of the previous seven days. A physician's progress note, dated 8/23/19, documented Resident #15 had generalized anxiety disorder and she was to receive lorazepam 0.5 mg three times a day as needed. There was no documentation in Resident #15's record to support the continuation of lorazepam beyond 14 days. On 9/5/19 at 11:45 AM, the DON said she did not find the stop date for Resident #15's lorazepam.	F 758	records audited by the DON or her designee to ensure all PRN psychotropic medication have a stop date not exceeding 14 days or, if the prescribing practitioner believes a psychotropic medication should be extended beyond 14 days, then the practitioner's rationale is documented along with a new stop date. These audits will be conducted weekly, for four weeks, for all residents admitted the previous week. After four weeks audit results will be shared with the QAPI Committee to ensure compliance and to decide on the need of any further audits. 5. Completion date: October 4, 2019		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable	F 812		10/4/19	

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F 812	<p>Continued From page 20</p> <p>safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.</p> <p>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy review, it was determined the facility failed to ensure kitchen equipment was maintained in a sanitary manner. This was true for 12 of 12 residents (#1, #14, #15, #76, #78, #79, #80, #128, #129, #130, #131, and #133) and the other 17 residents who dined and resided in the facility. This placed residents at risk for potential contamination of food and adverse health outcomes. Findings include:</p> <p>The facility's kitchen cleaning policy, dated 5/2013, documented staff cleaned the range after each use and spills were cleaned as they occurred on the range and in the ovens.</p> <p>This policy was not followed.</p> <p>On 9/3/19 at 9:15 AM, the following observations were made in the kitchen with Cook #1:</p> <ul style="list-style-type: none"> * There was a build-up of blackened food debris which covered 4 of 4 gas top grill burners. * There was a build-up of grease and blackened food debris in the bottom of 1 of 2 ovens. <p>On 9/3/19 at 9:17 AM, Cook #1 said the build-up</p>	F 812	<p>F812 "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> <ol style="list-style-type: none"> 1. The 4 gas top grill burners and both ovens were cleaned. 2. See #1 3. A daily cleaning schedule was created to track the cleaning of the stovetop grill burners and the ovens. Each will be cleaned on days they are each used and after spills. All kitchen staff 		

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F 812	Continued From page 21 on the gas burners was "at least a week's worth" and he said the oven was not cleaned because staff did not have the time to clean it. On 9/3/19 at 1:32 PM, the Certified Dietary Manager said the gas burners were not cleaned as expected. She said the oven debris was from a cake spill a few days prior and it was not cleaned after the spill.	F 812	were given an in-service on the need to clean the stovetop grill burners and ovens on days they are used and after spills. 4. The Food Services Director or her designee will audit the cleaning schedule to ensure compliance with cleaning each day of use as well as after spills. These audits will be completed weekly for four weeks. After four weeks the audits will be completed monthly if deemed appropriate by the QAPI Committee. 5. Completion date: October 4, 2019		
F 883 SS=F	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza	F 883		10/4/19	

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F 883	<p>Continued From page 22</p> <p>immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-</p> <p>(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview, record review, and policy review, it was determined the facility failed to implement an immunization program that tracked the type of pneumococcal vaccine received and to ensure immunizations were offered and/or provided as indicated. This was true for 5 of 5 residents (#1, #15, #79, #132 and</p>	F 883	<p>F883</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</p>		

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F 883	<p>Continued From page 23</p> <p>#133) reviewed for pneumococcal immunizations and had the potential to affect all residents residing in the facility. This deficient practice placed residents at risk of developing pneumococcal pneumonia and developing serious, potentially life threatening complications. Findings include:</p> <p>The Centers for Disease Control and Prevention (CDC) website, dated 12/6/17, and accessed on 9/13/19 included recommendations for Pneumococcal vaccination (PCV13 or Prevnar 13®, and PPSV23 or Pneumovax23®) for all adults 65 years or older as follows:</p> <ul style="list-style-type: none"> * Give 1 dose of PCV13 to all adults 65 years or older who have not previously received a dose. * Give 1 dose of PPSV23 to all adults 65 years or older at least 1 year after any prior PCV13 dose and at least 5 years after any prior PPSV23 dose. * Adults who received one or two doses of PPSV23 before age 65 should receive one final dose of the vaccine at age 65 or older. <p>The facility's pneumococcal vaccination policy and procedure, dated 6/6/18, documented the facility followed the CDC guidelines for Pneumococcal Vaccination in adults. The policy documented the following:</p> <ul style="list-style-type: none"> * All patients were educated on the risks versus benefits of the pneumococcal vaccination. * If the patient consented to the vaccination, the type of vaccine administered was documented 	F 883	<p>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> <ol style="list-style-type: none"> 1. Residents #1, #15, #132, and #133 were discharged. Resident #79's medical record was updated to include the dates of administration of both the PPSV23 and the PCV13 in accordance with CDC guidelines. 2. All residents have had their medical records updated to show: they have received the pneumococcal immunizations including dates and types of immunization, or they have contraindications to immunization, or they have refused. If the resident refuses, the reason will be documented. If the refusal is due to prior immunization(s) then the date(s) and type(s) of previous immunization(s) will be documented. 3. The Pneumococcal Informed Consent form was updated to include the resident's previous pneumococcal immunizations including dates and types of immunization, immunization contraindications, or resident refusals. It also includes reasons for any refusals. If refusals are for previous immunizations 		

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F 883	<p>Continued From page 24 and recorded in the patient's record.</p> <p>* The next dose was scheduled according to the [CDC] guidelines.</p> <p>The facility's Pneumococcal Vaccination informed consent included a section for the resident to decline immunizations. The section did not include which pneumococcal vaccine the resident declined.</p> <p>The facility also provided a blank copy of their Immunization Tracking form which included four columns titled: Patient, Influenza, Pneumovac, and Hepatitis. The form did not differentiate the two Pneumovac vaccines PPV13 and PPSV23.</p> <p>The pneumococcal vaccine status of the following residents, each aged 65 or older, was not effectively tracked, as follows:</p> <p>1. Resident #1 was admitted to the facility on 7/25/19 and was readmitted on 8/14/19, with multiple diagnoses including aftercare following a surgical correction of a right hip joint fracture.</p> <p>An MDS assessment, dated 8/31/19, documented Resident #1 was cognitively intact and was up to date with his pneumococcal vaccination.</p> <p>A Pneumococcal Immunization Informed Consent form, dated 7/25/19, documented Resident #1 declined to receive the vaccine as he already received the pneumococcal vaccine in "19." The consent form did not include documentation of what type of pneumococcal vaccine(s) Resident #1 previously received.</p>	F 883	<p>then dates and types of those immunizations will be included. All residents will have previous immunizations, contraindications, or refusals tracked in an "Preventative Health Care" section of their Medication Administration Record (MAR). All admission nurses have received an in-service about the need to document the following on each new resident: She/He has received the pneumococcal immunizations including dates and types of immunization, or they have contraindications to immunization, or they have refused. If the resident refuses, the reason will be documented. If the refusal is due to prior immunization(s) then the date(s) and type(s) of previous immunization(s) will be documented. The admission nurses have also been in-service on the changes to the Pneumococcal Informed Consent form as well as the need to also document the resident's immunization status in the "Preventative Health Care" section of the MAR.</p> <p>4. All new residents' medical records will be audited by the DON or her designee to ensure the Pneumococcal Informed Consent has been completed as stated in #3, and that a corresponding entry has been made in the resident's "Preventative Health Care" section of the MAR. These audits will be conducted weekly, for four weeks, for all residents admitted the previous week. After four weeks audit results will be shared with the QAPI Committee to ensure compliance and to</p>		

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F 883	<p>Continued From page 25</p> <p>On 9/5/19 at 8:31 AM, the DON said she did not know what type of pneumococcal vaccine Resident #1 received. The DON then printed Resident #1's physician progress/clinic note, dated 6/27/19, which documented Resident #1 was due for the PCV13. The progress note did not document if Resident #1 received the PCV13 on that visit. The progress note did not include documentation whether Resident #1 had previously received the PPSV23 vaccine.</p> <p>2. Resident #15 was admitted to the facility on 7/25/19, with multiple diagnoses including aftercare following a surgical procedure of a left ankle fracture.</p> <p>An MDS assessment, dated 8/25/19, documented Resident #15 was cognitively intact and was up to date with her pneumococcal vaccination.</p> <p>A Pneumococcal Immunization Informed Consent, dated 7/25/19, documented Resident #15 declined to receive the pneumococcal vaccine as she already received the vaccine in "19." The consent form did not include documentation of what type of pneumococcal vaccine(s) Resident #15 previously received.</p> <p>On 9/5/19 at 8:43 AM, the DON said she did not find documentation of Resident #15's pneumococcal immunization.</p> <p>3. Resident #79 was admitted to the facility on 8/21/19, with multiple diagnoses including discitis (inflammation of the intervertebral disc) of lumbar region and acute respiratory failure.</p>	F 883	<p>decide on the need of any further audits.</p> <p>5. Completion date: October 4, 2019</p>		

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F 883	<p>Continued From page 26</p> <p>An MDS assessment, dated 8/14/19, documented Resident #79 was cognitively intact and she was up to date with her pneumococcal vaccination.</p> <p>A Pneumococcal Immunization Informed Consent, dated 8/21/19, documented Resident #79 declined to receive the pneumococcal vaccine as she already received the vaccine in "18." The consent form did not include documentation of what type of pneumococcal vaccine(s) Resident #79 previously received.</p> <p>On 9/5/19 at 8:49 AM, the DON was asked what type of pneumococcal vaccine Resident #79 received. The DON provided Resident #79's a Summary of Hospitalization report from her record, which documented she received PPSV23 in 9/1/10 and PCV13 in 9/1/15.</p> <p>4. Resident #132 was admitted to the facility on 8/14/19, with multiple diagnoses including infection of the right hip joint.</p> <p>An MDS assessment, dated 8/14/19, documented Resident #132 was cognitively intact and he was up to date with his pneumococcal vaccination.</p> <p>A Pneumococcal Immunization Informed Consent, dated 8/14/19, documented Resident #132 declined to receive the pneumococcal vaccine as he already received the vaccine in "17." The consent form did not include documentation of what type of pneumococcal vaccine(s) Resident #132 previously received.</p>	F 883			

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F 883	<p>Continued From page 27</p> <p>On 9/5/19 at 8:12 AM, the DON was asked what type of pneumococcal vaccine Resident #132 received. The DON printed Resident #132's hospital record, dated 11/20/17, which documented Resident #132 received PPSV23 in 10/1/03 and PCV13 in 11/13/17.</p> <p>5. Resident #133 was admitted to the facility on 8/27/19, with multiple diagnoses including congestive heart failure (a chronic progressive condition affecting the pumping power of the heart muscles).</p> <p>An MDS assessment, dated 9/3/19, documented Resident #133 was cognitively intact and was up to date with his pneumococcal vaccination.</p> <p>A Pneumococcal Immunization Informed Consent, dated 8/27/19, documented Resident #133 declined to receive the pneumococcal vaccine as he already received the vaccine in "19." The consent form did not include documentation of what type of pneumococcal vaccine(s) Resident #133 previously received.</p> <p>On 9/5/19 at 8:22 AM, the DON said she did not know what type of pneumococcal vaccine Resident #133 received.</p> <p>On 9/5/19 at 11:33 AM, the DON said the MDS Nurse was responsible for tracking the residents' immunizations. The DON said the facility tracked residents' immunizations, but it was resident specific. The DON said they have to print residents' immunization record individually. The DON said they had a tracking form, but they did not transcribe the residents' immunization history to the tracking form. The DON then provided a</p>	F 883			

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F 883	<p>Continued From page 28</p> <p>record of pneumococcal immunization for Resident #1, Resident #132 and Resident #133, which she printed out from Idaho's Immunization Reminder Information system (IRIS) website.</p> <p>On 9/5/19 at 1:15 PM, LPN #3 said she was the MDS Nurse. LPN #3 said she was not aware she was to track residents' immunizations. LPN #3 said she found out she was to track residents' immunizations when she was asked by the DON earlier that morning.</p> <p>On 9/5/19 at 1:30 PM, LPN #2 said she asked the residents upon admission if they were current with their pneumococcal immunization. LPN #2 said if the resident said yes, she wrote "already received" in the reason for declination and the year it was received. LPN #2 said she did not ask the resident whether it was PPSV23 vaccine or PCV13 vaccine or both.</p> <p>The facility did not ensure residents were informed about both the PPSV23 vaccine and the PCV13 vaccine according to CDC guidelines, or differentiate the vaccines before they declined the vaccination. The facility also did not have a system to track vaccinations to ensure residents were offered or received the appropriate pneumococcal vaccine.</p>	F 883			



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
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September 30, 2019

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

Provider #: 135130

Dear Mr. Frasure:

On **September 2, 2019** through **September 6, 2019**, an unannounced on-site complaint survey was conducted at Aspen Transitional Rehabilitation. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007959

ALLEGATION: #1

The facility failed to provide adequate supervision to a resident to prevent falls.

FINDINGS:

During the investigation, the records of 12 current residents and three discharged residents were reviewed for quality of care and quality of life concerns. The facility's Grievance file and Incidents and Accidents report were also reviewed.

There were no grievances in the facility's Grievance file or concerns documented in the Incidents and Accidents reports related to residents not receiving appropriate assistance when needed.

During the initial tour of the facility, observations were conducted. Staff were observed to interact with residents appropriately and provide assistance to the residents as needed.

Eleven residents were interviewed individually, 8 of whom were admitted to the facility for aftercare following a surgical procedure. None of the 11 residents voiced concerns regarding staff not providing assistance to their needs. The residents said the staff assisted them in a timely manner and as needed.

One resident's representative was interviewed. She denied having any concerns with the care her family member received in the facility.

One resident's closed record was reviewed and documented she was admitted to the facility in July 2019 for aftercare following resident needed a front wheel walker (FWW) for ambulation and transfer with stand by assistance. A PT progress note documented the resident demonstrated she was able to independently transfer throughout her therapy using her FWW without the use of her wheelchair.

The resident's record documented she fell when being assisted by a Certified Nursing Assistant (CNA) to choose her clothes for the day. They were both standing in front of her closet. When the resident got the clothes she had chosen, she turned right without using her walker and lost her balance and fell on the floor. The resident was in pain and unable to move her left leg, the leg she had surgically repaired. The resident was then sent to the hospital.

An Emergency Room report documented the resident said she was not fully awake when she started to get dressed. She went to turn and forgot her walker and fell onto her left side. An x-ray report documented she had a left hip fracture. She subsequently underwent surgery to repair her broken hip. The resident was readmitted back to the facility.

An Occupational Therapist was interviewed and said the resident wanted to become independent with her daily routine and sometimes forgot to use her walker during their therapy sessions.

Based on investigative findings, the allegation the facility failed to provide adequate supervision to prevent a fall could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Joseph Frasure, Administrator
September 30, 2019
Page 3 of 3

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,

A handwritten signature in cursive script, appearing to read "Belinda Day".

Belinda Day, RN, Supervisor
Long Term Care Program

BD/lj



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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E-mail: fsb@dhw.idaho.gov

September 30, 2019

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

Provider #: 135130

Dear Mr. Frasure:

On **September 2, 2019** through **September 6, 2019**, an unannounced on-site complaint survey was conducted at Aspen Transitional Rehabilitation. The complaint allegations or entity-reported incidents, findings and conclusions are as follows:

Complaint #ID00008068

ALLEGATION #1:

The facility failed to ensure a resident was free from sexual abuse.

FINDINGS #1:

During the investigation the records of 12 current residents and the records of three discharged residents were reviewed for quality of care and quality of life concerns. The facility's Grievance file and Incidents and Accidents reports from October 2017 through November 2017 were also reviewed.

There were no grievances in the Grievance file or documented concerns in the Incidents and Accidents reports related to residents feeling uncomfortable when they were being provided with their showers/baths by the staff.

Joseph Frasure, Administrator
September 30, 2019
Page 2 of 2

During the initial tour of the facility, observations were conducted. Staff were observed to interact with residents in an appropriate and dignified manner.

Eleven residents were interviewed individually. No concerns were voiced regarding discomfort with staff while being assisted with baths or showers. The residents said they were provided with privacy and respect by the staff during their personal care.

One resident's representative was interviewed. She said she had no concerns with the care her family member received in the facility.

Six staff members were interviewed and said they received training regarding different types of abuse upon hire and a refresher course twice a year. None of the staff members heard of a resident being uncomfortable during their bathing or showers.

The Administrator was interviewed and said he provided training to the staff regarding abuse upon their hire and then twice a year. The Administrator said he gave an in-service training on specific issues when needed. The abuse training record was reviewed and there were no concerns noted.

Based on investigative findings, the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,



Belinda Day, RN, Supervisor
Long Term Care Program

BD/lj



IDAHO DEPARTMENT OF
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BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
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October 25, 2019

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

Provider #: 135130

Dear Mr. Frasure:

On **September 3, 2019** through **September 6, 2019**, an unannounced on-site complaint survey was conducted at Aspen Transitional Rehabilitation. The complaint was investigated in conjunction with the annual recertification survey. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00008216

ALLEGATION #1:

Documentation in resident records was inaccurate.

FINDINGS #1:

During the survey, 12 resident records were reviewed, observations were conducted, and staff were interviewed.

The progress notes were reviewed for 12 resident records. The progress notes were not identical to one another in either a single record or between different records.

Four resident records documented they had an indwelling catheter. The records included documentation of fluid input and output. Three nurses said they documented assessments and progress notes in residents' records at the time, or as close to, of the assessment or event.

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On 9/3/19, a resident's catheter output was observed to be measured by a Certified Nursing Assistant (CNA), who reported it to the nurse so it could be documented in their record.

Two CNAs said they reported input and output of residents' fluids to nurses for them to document in the resident's record.

Based on the investigative findings, the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

Residents' leg catheter bags were not empty as needed.

FINDINGS #2:

During the survey, resident records were reviewed, facility grievances were reviewed, observations were conducted, residents were interviewed, and staff were interviewed.

The facility grievances were reviewed from June 2019 to September 2019 with no reports of catheter concerns from staff or residents. The records of four residents with catheters were reviewed with no concerns regarding catheter care.

Multiple observations were made of four residents' catheter drainage bags, including one resident with a leg bag, and they were not overly full. One CNA was observed draining a resident's catheter drainage bag, without incident.

Four residents with catheter bags said staff emptied them on a regular basis, and they had no concerns regarding their catheter care. Two CNAs, one nurse, and the Director of Nursing (DON) said residents' catheter bags were emptied each shift and more frequently, if needed.

Based on the investigative findings, the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

Dirty linens were left unwashed in the washing machine overnight and dirty linens were placed on residents' beds.

FINDINGS #3:

During the survey, observations were conducted, facility grievances were reviewed, residents were interviewed, and staff were interviewed.

The facility's grievance file did not document concerns with dirty linens.

Two early morning observations of the facility's washing machines were conducted and no dirty linens were found in the washing machines. Bed linens in 28 residents' rooms were observed to be clean and free of stains. A linen closet was observed to have clean linens available for residents' beds. A stained bed sheet was observed in the laundry room trash.

Eleven residents said there were no concerns with dirty bed linens. Two CNAs said soiled linens were changed as needed and when residents were bathed. They said dirty linens were washed out before they went into the washing machine and were bagged appropriately. The Housekeeping Supervisor said dirty linens were not kept in the washing machine. She said if a stain could not be washed out then the linen was thrown away, like the one observed in the facility's trash.

Based on the investigative findings, the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

Residents were not transferred correctly.

FINDINGS #4:

During the survey, observations were conducted, personnel records were reviewed, residents were interviewed, and staff were interviewed.

Five CNAs' and three nurses' training records documented they received training on transferring residents.

Two residents were observed being transferred with facility staff assistance, to and from their wheelchairs and their beds, with no concerns identified.

Eleven residents said they had no concerns with staff assistance regarding transfers. A nurse and two CNAs said they received training for transferring residents. The DON and an Occupational Therapist (OT) said staff were trained in transferring residents. The OT said since the facility specialized in therapy and transitioning residents back to their homes, staff received extra training individualized to each resident's needs.

Based on the investigative findings, the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

Residents' bathrooms were not cleaned.

FINDINGS #5:

During the survey, observations were conducted, residents were interviewed, and staff were interviewed.

The facility's grievance file did not document a concern with dirty bathrooms.

Bathrooms in 28 residents' rooms were observed on the initial tour and were not dirty. Bathrooms in 12 residents' rooms were observed from September 3, 2019 to September 6, 2019 and were not left dirty. Housekeeping staff were observed cleaning residents' bathrooms every day from September 3, 2019 to September 6, 2019.

Eleven residents said staff kept their bathrooms clean. One CNA and one housekeeper said residents' bathrooms were cleaned every day and as needed. The Housekeeping Supervisor said housekeeping staff cleaned residents' bathrooms every day and when needed.

It could not be established the facility failed to clean residents' bathrooms. Therefore, the allegation was unsubstantiated and no deficient practice was identified.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

The facility did not investigate an incident when a controlled substance for a resident was missing.

FINDINGS #6:

During the survey, observations were conducted, facility medication errors were reviewed, and staff were interviewed.

Medication error investigations from July 2019 to September 2019 were reviewed. A medication error investigation, dated 8/8/19, documented 2.5 milliliters of a controlled substance was missing. The investigation documented the nurse in question had notified their supervisor about the discrepancy and they could not explain where the missing medication had gone. The investigation documented the facility had contacted the Board of Nursing regarding the nurse in question. The facility employee records were reviewed and the nurse in question no longer worked at the facility.

Two nurses and 25 medications administrations were observed during Medication Pass from September 4, 2019 to September 6, 2019, and no concerns were identified.

Two nurses said if medications, including controlled substances were missing, they immediately notified the charge nurse or the DON. They said two nurses counted residents' controlled medication at shift change to make sure medications were not missing. The DON said each medication error and any missing medication incidents were investigated, including the incident on 8/8/19. The DON said the nurse in question no longer worked at the facility.

Based on the investigative findings, the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

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If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,

A handwritten signature in black ink, appearing to read "Laura Thompson". The signature is cursive and somewhat stylized.

Laura Thompson, RN, Supervisor
Long Term Care Program

LT/lj