



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

C.L. "BUTCH" OTTER – Governor  
RICHARD M. ARMSTRONG – Director

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

March 30, 2015

Philip Herink, Administrator  
Life Care Center of Treasure Valley  
502 North Kimball Place  
Boise, ID 83704-0608

Provider #: 135123

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

Dear Mr. Herink:

On **March 16, 2015**, a Facility Fire Safety and Construction survey was conducted at **Life Care Center of Treasure Valley** 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 and a similar State Form 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 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

Philip Herink, Administrator  
March 30, 2015  
Page 2 of 4

page 2). After each deficiency has been answered and dated, the administrator should sign both Statement of Deficiencies and Plan of Correction, Form CMS-2567 and State Form, in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **April 13, 2015**. Failure to submit an acceptable PoC by **April 13, 2015**, may result in the imposition of civil monetary penalties by **April 29, 2015**.

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 and the state licensure survey report, State Form.

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **April 20, 2015**, (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 **April 20, 2015**. A change in the seriousness of the deficiencies on **April 20, 2015**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **April 20, 2015**, includes the following:

Philip Herink, Administrator  
March 30, 2015  
Page 3 of 4

Denial of payment for new admissions effective **June 16, 2015**.  
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 **September 16, 2015**, 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 Mark P. Grimes, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, 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 **March 16, 2015**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

Philip Herink, Administrator  
March 30, 2015  
Page 4 of 4

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 **April 13, 2015**. If your request for informal dispute resolution is received after **April 13, 2015**, 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.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. P. Grimes', with a long horizontal flourish extending to the right.

Mark P. Grimes, Supervisor  
Facility Fire Safety and Construction

MPG/lj  
Enclosures

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

PRINTED: 03/23/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135123	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____		(X3) DATE SURVEY COMPLETED  03/16/2015
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF TREASURE VALLEY			STREET ADDRESS, CITY, STATE, ZIP CODE 502 NORTH KIMBALL PLACE BOISE, ID 83704		
(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 facility is a single story structure of Type V(111) construction that was built in 1996. The building is protected throughout by an automatic fire extinguishing system and has a complete fire alarm system. Currently the facility is licensed for 120 SNF beds.  The following deficiencies were cited during the annual life safety code survey conducted on March 16, 2015. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.  The Survey was conducted by:  Nathan Elkins Health Facility Surveyor Fire Life Safety & Construction	K 000	<i>This plan of correction is submitted as required under Federal and State regulations and statutes applicable to long-term care providers. The Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is specifically denied. The submission of this Plan of Correction does not constitute agreement by the facility that the surveyors findings and/or constitute a deficiency, or that the scope and severity of the deficiencies cited are correct applied.</i>		
K 021 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:  a) the required manual fire alarm system;  b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and  c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2	K 021	K021  SPECIFIC ISSUE  Door wedge was removed from 300 hall unit Managers office.  OTHER RESIDENTS  All doors without magnetic door holders were assessed to assure that no door wedges were in use.		

RECEIVED  
APR 19 2015  
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_  
*Executive Director 4/16/15*

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135123	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____		(X3) DATE SURVEY COMPLETED  03/16/2015
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF TREASURE VALLEY			STREET ADDRESS, CITY, STATE, ZIP CODE 502 NORTH KIMBALL PLACE BOISE, ID 83704		
(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 021	Continued From page 1  This STANDARD is not met as evidenced by: Based on observation and interview it was determined that the facility failed to ensure that doors in an exit passageway did not have any impediments to closing. This deficient practice can allow smoke and fire gases to spread rapidly into the corridors delaying evacuation in the event of a fire. This deficiency affected one of four smoke compartments, nineteen residents, and staff on the day of survey.  Findings include:  During the facility tour on March 16, 2015 at approximately 2:30 PM, observation revealed a rubber door wedge was being utilized to hold open the Unit Manager's Office door. When questioned about the door wedge, the Maintenance Supervisor stated that he was unaware of the door being held open with a door wedge. The facility is licensed for 120 beds with a census of 97 on the day of survey.  Actual NFPA reference:  19.2.2.2.6* Any-door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier, or hazardous area enclosure shall be permitted to be held open only by an automatic release device that complies with 7.2.1.8.2. The automatic sprinkler system, if provided, and the fire alarm system, and the systems required by 7.2.1.8.2 shall be arranged to initiate the closing action of	K 021	<b>SYSTEMIC CHANGES</b>  Executive Director and/or Director of Maintenance in-serviced all facility staff on NFPA 19.2.2.2.6 that prohibits any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure can only be held open by a device(s) arranged to automatically close by activation by fire alarm system.  <b>MONITOR</b>  Executive Director and/or Director of Maintenance will audit the 300 Unit Mangers door and any other doors that do not have magnetic door holders to assure door wedges are not being used, during grand rounds weekly x 4, monthly x3 and quarterly x 3 to assure it is not be held open by a device not connected to the fire alarm system. Results will be presented to the facility performance improvement committee.  <b>AUDITS BEGIN: 04/10/15</b>  <b>DATE OF COMPLIANCE: 04/13/15</b>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135123	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  03/16/2015
--	--	---	--

NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF TREASURE VALLEY	STREET ADDRESS, CITY, STATE, ZIP CODE 502 NORTH KIMBALL PLACE BOISE, ID 83704
---	---

(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 021  K 062 SS=F	<p>Continued From page 2 all such doors throughout the smoke compartment or throughout the entire facility.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined that the facility failed to ensure that automatic sprinkler heads were continuously maintained in a reliable condition. This deficient practice can hinder the sprinkler heads to effectively operate during a fire event. This deficiency affected two of four smoke compartments, seventeen residents, and staff members on the day of survey.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. During the facility tour on March 16, 2015 between 1:00 PM and 4:00 PM, observation of the laundry room revealed excessive lint and dust covering all the sprinkler heads.</li> <li>2. During the facility tour on March 16, 2015 between 1:00 PM and 4:00 PM, observation of the tub room in "D" wing revealed excessive lint and dust covering the sprinkler head.</li> </ol> <p>Interview with the Maintenance Supervisor revealed the facility was unaware of the sprinkler heads having excessive build-up of lint and dust.</p>	K 021  K 062	<p>K062</p> <p><b>SPECIFIC ISSUE</b></p> <p>Laundry and D wing tub room sprinkler heads were cleaned of lint and dust.</p> <p><b>OTHER RESIDENTS</b></p> <p>All sprinkler heads in the facility were visually inspected for lint and dust.</p> <p><b>SYSTEMIC CHANGES</b></p> <p>The facility Executive Director has in-serviced the Maintenance Director and all staff on NFPA 19.7.6, 4.6.2., NFPA 13, NFPA 25, 9.7.5 that the automatic sprinkler heads are continuously maintained and in reliable condition and specifically, they are free of lint and dust.</p> <p><b>Monitor</b></p> <p>Executive Director and/or Director of Maintenance will monitor through grand rounds that sprinklers are free of lint in the laundry room and both a wing and d wing tub rooms, weekly x4, monthly x3 and quarterly x3. Results will be presented to the facility performance improvement committee.</p> <p>Audits to being: 04/10/15</p> <p><b>DATE OF COMPLIANCE: 04/13/15</b></p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135123	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  03/16/2015
--	--	---	--

NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF TREASURE VALLEY	STREET ADDRESS, CITY, STATE, ZIP CODE 502 NORTH KIMBALL PLACE BOISE, ID 83704
---	---

(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 062	<p>Continued From page 3</p> <p>The facility is licensed for 120 beds with a census of 97 on the day of survey.</p> <p>Actual NFPA Standard: 19.7.6 Maintenance and Testing. (See 4.6.12.) 4.6.12 Maintenance and Testing. 4.6.12.1 Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be continuously maintained in accordance with applicable NFPA requirements or as directed by the authority having jurisdiction.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure electrical wiring was in accordance with the National Electrical Code. The deficient practice affected one of four smoke compartments, seventeen residents, and staff on the day of survey.</p> <p>Findings include:</p> <p>During the facility tour on March 16, 2015 at approximately 2:00 PM, observation revealed a refrigerator was plugged into a relocatable power tap in the Social Worker's office located in "D"</p>	K 062	<p>K147</p> <p>SPECIFIC ISSUE</p> <p>The re-locatable power tap that had the refrigerator in D-wing Social service office was removed.</p> <p>OTHER RESIDENTS</p> <p>All resident and office areas were inspected to assure that appliances are not plugged into re-locatable power taps.</p>	
K 147 SS=D		K 147		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135123	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  03/16/2015	
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF TREASURE VALLEY		STREET ADDRESS, CITY, STATE, ZIP CODE 502 NORTH KIMBALL PLACE BOISE, ID 83704		
(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 147	<p>Continued From page 4 wing. Appliances are designed to be directly plugged into a receptacle. Interview with the Maintenance Supervisor revealed that the facility was unaware of this practice. The facility is licensed for 120 SNF beds with a census of 97 on the day of survey.</p> <p>Actual NFPA Standard: 110-3. Examination, Identification, Installation, and Use of Equipment (a) Examination. In judging equipment, considerations such as the following shall be evaluated:</p> <ol style="list-style-type: none"> <li>1. Suitability for installation and use in conformity with the provisions of this Code</li> <li>FPN: Suitability of equipment use may be identified by a description marked on or provided with a product to identify the suitability of the product for a specific purpose, environment, or application. Suitability of equipment may be evidenced by listing or labeling.</li> <li>2. Mechanical strength and durability, including, for parts designed to enclose and protect other equipment, the adequacy of the protection thus provided</li> <li>3. Wire-bending and connection space</li> <li>4. Electrical insulation</li> <li>5. Heating effects under normal conditions of use and also under abnormal conditions likely to arise in service</li> <li>6. Arcing effects</li> <li>7. Classification by type, size, voltage, current capacity, and specific use</li> <li>8. Other factors that contribute to the practical safeguarding of persons using or likely to come in contact with the equipment</li> </ol> <p>(b) Installation and Use. Listed or labeled equipment shall be installed and used in accordance with any instructions included in the</p>	K 147	<p><b>SYSTEMIC CHANGES</b></p> <p>The Executive Director and/or Director of Maintenance in-serviced all staff on NFPA 70, National Electrical code 9.1.2 that appliances are designed to be directly plugged into a receptacle and not a "surge protector".</p> <p><b>MONITOR</b></p> <p>Executive Director and/or Director of Maintenance will monitor through the facility grand rounds weekly x 4, monthly x 3 and quarterly x 3. Results will be presented to the facility performance improvement committee.</p> <p>Audits begin: 04/10/2015</p> <p><b>DATE OF COMPLIANCE: 04/13/2015</b></p>	

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

PRINTED: 03/23/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135123	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  03/16/2015
--	--	---	--

NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF TREASURE VALLEY	STREET ADDRESS, CITY, STATE, ZIP CODE 502 NORTH KIMBALL PLACE BOISE, ID 83704
---	---

(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 147	Continued From page 5 listing or labeling. See UL listings: XBYS Guide Information XBZN2 Guide Information	K 147		