



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

April 2, 2015

Michael Crowley, Administrator  
Life Care Center of Boise  
808 North Curtis Road  
Boise, ID 83706-1306

Provider #: 135038

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

Dear Mr. Crowley:

On **March 24, 2015**, a Facility Fire Safety and Construction survey was conducted at **Life Care Center of Boise** 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

Michael Crowley, Administrator  
April 2, 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 15, 2015**. Failure to submit an acceptable PoC by **April 15, 2015**, may result in the imposition of civil monetary penalties by **May 5, 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 28, 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 28, 2015**. A change in the seriousness of the deficiencies on **April 28, 2015**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **April 28, 2015**, includes the following:

Michael Crowley, Administrator  
April 2, 2015  
Page 3 of 4

Denial of payment for new admissions effective **June 24, 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 24, 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 24, 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>

Michael Crowley, Administrator  
April 2, 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 15, 2015**. If your request for informal dispute resolution is received after **April 15, 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,



Mark P. Grimes, Supervisor  
Facility Fire Safety and Construction

MPG/lj  
Enclosures

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

Printed: 04/01/2015  
FORM APPROVED,  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135038</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/24/2015</b>	
NAME OF PROVIDER OR SUPPLIER <b>LIFE CARE CENTER OF BOISE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>808 NORTH CURTIS ROAD BOISE, ID 83706</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	<p><b>INITIAL COMMENTS</b></p> <p>The facility is a single story structure Type V (111) building that was built in 1967. It is fully sprinklered with smoke detection throughout, including sleeping rooms. In 1998 there was a major upgrade to the building including remodeling and a rehab addition. The facility is currently licensed for 153 SNF/NF beds.</p> <p>The following deficiencies were cited during the annual life safety code survey conducted on March 23, 2015. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.</p> <p>The Survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	K 000	<p>Preparation and/or execution of the plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies</p> <p style="text-align: right;"><b>RECEIVED</b> <b>APR 10 2015</b> <b>FACILITY STANDARDS</b></p>	
K 029 SS=F	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This Standard is not met as evidenced by: Based on observation, operational testing and</p>	K 029	<p><b>K029</b></p> <p><b>What Corrective actions will be accomplished for those residents/issues found to have been affected by the deficient practice.</b></p> <p>The kitchen door leading into the dining room from the cart storage area will be equipped with a self-closing device. The doors to rooms 304 and 305 will be equipped with self-closing devices.</p>	4/29/15

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

*m. s.*

TITLE

NHA

(X6) DATE

4/10/15

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.

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K 029	<p>Continued From page 1</p> <p>interview, the facility failed to ensure that hazardous areas were protected with self-closing doors. Failure to provide self-closing devices on doors to hazardous areas would allow smoke and dangerous gases to pass into corridors affecting egress during a fire event. This deficient practice affected 65 residents, staff and visitors on the date of the survey. The facility is licensed for 153 SNF/NF residents and had a census of 65 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on March 24, 2015 from 10:00 AM to 3:30 PM, observation and operational testing of the following doors found they were not equipped to self-close:</p> <p>Kitchen door leading into the dining room from the cart storage area. Rooms 304 and 305 converted to general storage measuring approximately ten feet by twelve feet (120 square feet).</p> <p>When asked, the Maintenance Director stated he was not aware of the requirement of self-closing devices on these doors.</p> <p>Actual NFPA standard:</p> <p>3.3.13.2 Area, Hazardous. An area of a structure or building that poses a degree of hazard greater than that normal to the general occupancy of the building or structure, such as areas used for the storage or use of combustibles or flammables; toxic, noxious, or corrosive materials; or heat-producing appliances.</p> <p>19.3.2 Protection from Hazards.</p>	K 029	<p><b>How you will identify other residents/issues having the potential to be affected by the same deficient practice.</b></p> <p>All other doors in the facility that lead to hazardous areas will be inspected to ensure that they are equipped with self-closing devices.</p> <p>If any issues are identified during that inspection they will be remedied in a timely manner.</p> <p><b>What measures will be put in place or what systematic changes you will make to ensure that the deficient practice does not recur;</b></p> <p>The Maintenance Supervisor will be inserviced on ensuring that all doors that lead into hazardous areas have self-closing devices.</p> <p><b>How the corrective actions will be monitored to ensure the deficient practice will not recur.</b></p> <p>The Administrator will conducted monthly audits to ensure that all doors that lead into hazardous areas have self closing devices and that they are functioning properly. The results of these audits will be reported to the Performance Improvement Committee. The Performance Improvement Committee will make recommendations as to when to discontinue the audits.</p> <p>The Administrator will ensure compliance.</p>	<p>4/24/15</p> <p>4/24/15</p> <p>4/24/15</p>

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K 029	Continued From page 2 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft <sup>2</sup> (9.3 m <sup>2</sup> ) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft <sup>2</sup> (4.6 m <sup>2</sup> ), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  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	K 062	K062  What Corrective actions will be accomplished for those residents/issues found to have been affected by the deficient practice.  The sprinkler heads in the Housekeeping and Outdoor Storage rooms will be replaced with new sprinkler heads.	4/24/15

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K 062	<p>Continued From page 3</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that sprinklers were kept free of corrosion. Failure to maintain sprinklers could hinder the performance of the system during a fire event. This deficient practice affected 21 residents, staff and visitors on the day of the survey. The facility is licensed for 153 SNF/NF beds and had a census of 65 on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on March 24, 2015 from 1:00 PM to 3:30 PM, observation of the sprinkler head in the Housekeeping and Outdoor storage rooms found both heads to be corroded. When asked, the Maintenance Director stated he had never noticed the heads being corroded.</p> <p>Actual NFPA standard:</p> <p>NFPA 25</p> <p>2-2 Inspection. 2-2.1 Sprinklers. 2-2.1.1*</p> <p>Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. Exception No. 1*: Sprinklers installed in concealed spaces such as above suspended</p>	K 062	<p><b>How you will identify other residents/issues having the potential to be affected by the same deficient practice.</b></p> <p>All other sprinkler heads in the facility will be inspected to ensure that they are not corroded.</p> <p>If any issues are identified during that inspection they will be remedied in a timely manner.</p> <p><b>What measures will be put in place or what systematic changes you will make to ensure that the deficient practice does not recur;</b></p> <p>The Maintenance Supervisor will be in-serviced on ensuring that all sprinkler heads are free of corrosion and that if at anytime a sprinkler head is found to have corrosion it will be replaced in a timely manner.</p> <p><b>How the corrective actions will be monitored to ensure the deficient practice will not recur.</b></p> <p>The Administrator will conducted monthly audits to ensure that the sprinkler heads throughout the facility are free of corrosion. The results of these audits will be reported to the Performance Improvement Committee. The Performance Improvement Committee will make recommendations as to when to discontinue the audits.</p> <p>The Administrator will ensure compliance.</p>	<p>4/24/15</p> <p>4/24/15</p> <p>4/24/15</p>

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K 062  K 064 SS=F	<p>Continued From page 4 ceilings shall not require inspection. Exception No. 2: Sprinklers installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that fire extinguishers were installed at the proper height per NFPA 10. Failure to install extinguishers at the correct height could hinder access during a fire event. This deficient practice affected 65 residents, staff and visitors on the date of the survey. The facility is licensed for 153 SNF/NF beds and had a census of 65 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on March 24, 2015 from 10:00 AM to 3:30 PM, observation of the 10 lb fire extinguishers installed in the resident room corridors found that 10 were installed at a height ranging from 64 inches to 71 inches to the top of the extinguisher. Interview of the Maintenance Director found he was not aware of the height restriction of fire extinguisher installations.</p> <p>Actual NFPA standard:</p>	K 062  K 064	<p>K064</p> <p><b>What Corrective actions will be accomplished for those residents/issues found to have been affected by the deficient practice.</b></p> <p>The 10 lb fire extinguishers that are installed in the resident room corridors have been lowered to a height that is approved in the Life Safety Code Standards.</p> <p><b>How you will identify other residents/issues having the potential to be affected by the same deficient practice.</b></p> <p>All other fire extinguishers in the facility will be inspected to ensure that they are not installed at a height that does not meet the Life Safety Code Standards.</p> <p>If any issues are identified during that inspection they will be remedied in a timely manner.</p> <p><b>What measures will be put in place or what systematic changes you will make to ensure that the deficient practice does not recur;</b></p> <p>The Maintenance Supervisor will be inserviced on the Life Safety Code Standards as they relate to the height of installed fire extinguishers.</p>	4/24/15  4/24/15  4/24/15

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K 064	Continued From page 5 NFPA 10 1-6.10 Fire extinguishers having a gross weight not exceeding 40 lb (18.14 kg) shall be installed so that the top of the fire extinguisher is not more than 5 ft (1.53 m) above the floor. Fire extinguishers having a gross weight greater than 40 lb (18.14 kg) (except wheeled types) shall be so installed that the top of the fire extinguisher is not more than 3 1/2 ft (1.07 m) above the floor. In no case shall the clearance between the bottom of the fire extinguisher and the floor be less than 4 in. (10.2 cm).	K 064	<b>How the corrective actions will be monitored to ensure the deficient practice will not recur.</b>  The Administrator will conducted monthly audits to ensure that all fire extinguishers are installed at a height that is appropriate per the Life Safety Code Standards. The results of these audits will be reported to the Performance Improvement Committee. The Performance Improvement Committee will make recommendations as to when to discontinue the audits.	4/24/15
K 072 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10  This Standard is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure that means of egress were maintained free of impediments to their instant use in an emergency. Failure to provide a rapid means of egress could hinder the safe evacuation of occupants during an emergency. This deficient practice affected 23 residents, staff and visitors in 2 of 4 smoke compartments on the date of the survey. The facility is licensed for 153 SNF/NF beds and had a census of 65 on the day of the survey.  Findings include:	K 072	<b>The Administrator will ensure compliance.</b>  K072  <b>What Corrective actions will be accomplished for those residents/issues found to have been affected by the deficient practice.</b>  The Two doors exiting the Kitchen; one (1) leading into the dining room and (1) exiting the main corridor have been adjusted so that they require a single operation to release from the egress side.  The doors to rooms 304 and 306 have been adjusted so that they require a single operation to release from the egress side.	4/24/15  4/24/15





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NAME OF PROVIDER OR SUPPLIER <b>LIFE CARE CENTER OF BOISE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>808 NORTH CURTIS ROAD BOISE, ID 83706</b>		
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K 143	<p>Continued From page 8</p> <p>liquid oxygen on asphalt could result in explosive reactions from cylinder leaks combining with the asphalt, a known hydrocarbon. This deficient practice exposed all residents, staff and visitors to high hazard, explosive conditions from improper transferring of liquid oxygen between cylinders.</p> <p>Findings include:</p> <p>During the facility tour conducted on March 24, 2015 at 12:00 PM, observation of the vendor supplying liquid oxygen to the facility revealed the vendor moving four (4) liquid oxygen cylinders to the rear of his service van parked on the back asphalt parking area at the rear of the facility. This location was not equipped, signed or designated as a transfill location.</p> <p>The vendor was further observed by both the surveyor and the Maintenance Director to transfill two of the cylinders directly over the asphalt, without any separation or protection between the transfilling of liquid oxygen and the hydrocarbon.</p> <p>When asked if he understood the risks the vendor was exposing the facility to, the Maintenance Director stated he did.</p> <p>Actual NFPA standard:</p> <p>NFPA 99</p> <p>8-6.2.5.2 Transferring Liquid Oxygen. Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows: (a) Separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour</p>	K 143	<p><b>How you will identify other residents/issues having the potential to be affected by the same deficient practice.</b></p> <p>The Facility will create a tracking sheet that is designed to identify potentially hazardous situations that may come up as a result of outside Vendors not acting in a safe and professional manner.</p> <p><b>What measures will be put in place or what systematic changes you will make to ensure that the deficient practice does not recur;</b></p> <p>All Staff will be in-serviced on ensuring that all outside Vendors that come to the facility behave in a safe and professional manner that is consistent with the Life Safety Code Standards.</p> <p><b>How the corrective actions will be monitored to ensure the deficient practice will not recur.</b></p> <p>The Administrator will conducted monthly audits to ensure that all outside Vendors that come to the facility behave in a safe and professional manner that is consistent with the Life Safety Code Standards. The results of these audits will be reported to the Performance Improvement Committee. The Performance Improvement Committee will make recommendations as to when to discontinue the audits.</p> <p>The Administrator will ensure compliance.</p>	<p>4/24/15</p> <p>4/24/15</p> <p>4/24/15</p>

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

Printed: 04/01/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135038</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/24/2015</b>
NAME OF PROVIDER OR SUPPLIER <b>LIFE CARE CENTER OF BOISE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>808 NORTH CURTIS ROAD BOISE, ID 83706</b>		
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K 143	Continued From page 9 fire-resistive construction; and (b) The area is mechanically ventilated, is sprinklered, and has ceramic or concrete flooring; and (c) The area is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted. Transferring shall be accomplished utilizing equipment designed to comply with the performance requirements and producers of CGA Pamphlet P-2.6, Transfilling of Low-Pressure Liquid Oxygen to be Used for Respiration, and adhering to those procedures. The use and operation of small portable liquid oxygen systems shall comply with the requirements of CGA Pamphlet P-2.7, Guide for the Safe Storage, Handling and Use of Portable Liquid Oxygen Systems in Health Care Facilities.	K 143		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2  This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that electrical circuits were labeled and wiring installations were in accordance with NFPA 70. Failure to identify electrical circuits and maintain wiring installations could result in inability to identify circuits during an emergency and overload or shock due from the result of improper wiring installations. This deficient practice affected staff and vendors of the main Laundry on the date of the survey. The facility is licensed for 103 SNF/NF beds and had a census of 63 on the day of the survey.  Findings include:	K 147	K147  <b>What Corrective actions will be accomplished for those residents/issues found to have been affected by the deficient practice.</b>  The electrical panels labeled LA and LB in the main laundry room have been updated so that all circuits are completely labeled.  The two relocatable power taps that were being used in the main laundry area have been removed.	4/24/15  4/24/15

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K 147	Continued From page 10  1) During the facility tour conducted on March 24, 2015 from 1:30 PM to 3:30 PM, observation of the electrical panels labeled LA and LB in the main laundry found not all circuits were completely labeled. Further observation found that these panels were part of the emergency system.  Interview of the Maintenance Director found he had not been aware of the missing labeling on these two panels.  2) During the facility tour conducted on March 24, 2015 from 1:30 PM to 3:30 PM, observation of the main Laundry found two relocatable power taps being used to supply power to the equipment. One had a washer, soap dispenser and water softener plugged in. The second had a soap dispenser plugged in and used to extend the power cord to the outlet.  Actual NFPA standard:  NFPA 70  Finding 1 110.22 Identification of Disconnecting Means. Each disconnecting means shall be legibly marked to indicate its purpose unless located and arranged so the purpose is evident. The marking shall be of sufficient durability to withstand the environment involved.  Finding 2 400.8 Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a	K 147	<b>How you will identify other residents/issues having the potential to be affected by the same deficient practice.</b>  All other electrical panels will be inspected to ensure that all circuits are completely labeled.  A Facility audit will be conducted to ensure that there are no other relocatable power taps that are being used in violation of the Life Safety Code Standards.  If any issues are identified during that inspection they will be remedied in a timely manner.  <b>What measures will be put in place or what systematic changes you will make to ensure that the deficient practice does not recur;</b>  The Maintenance Supervisor will be in-serviced on ensuring that all electrical panels are labeled in accordance with the Life Safety Code Standards.  All Staff will be in-serviced on ensuring that the facility does not use relocatable power taps in violation of the Life Safety Code Standards.  <b>How the corrective actions will be monitored to ensure the deficient practice will not recur.</b>	4/24/15  4/24/15  4/24/15  4/24/15

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K 147	Continued From page 11 structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of 368.8. (5) Where concealed by walls, floors, or ceilings or located above suspended or dropped ceilings (6) Where installed in raceways, except as otherwise permitted in this Code  Also see UL XBY5. Guide Info	K 147	The Administrator will conducted monthly audits to ensure that the facility is in compliance with the Life Safety Code Standards as they relate to properly labeled electrical panels and the inappropriate use of relocatable power taps. The results of these audits will be reported to the Performance Improvement Committee. The Performance Improvement Committee will make recommendations as to when to discontinue the audits.  The Administrator will ensure compliance.	4/24/15