



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

TAMARA PRISOCK – ADMINISTRATOR  
DIVISION OF LICENSING & CERTIFICATION  
DEBRA RANSOM, R.N., R.H.I.T., Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0009  
PHONE 208-334-6626  
FAX 208-364-1888

November 25, 2015

Craig Johnson, Administrator  
Boundary County Nursing Home  
6640 Kaniksu Street  
Bonners Ferry, ID 83805-7532

Provider #: 135004

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

Dear Mr. Johnson:

On **November 19, 2015**, a Facility Fire Safety and Construction survey was conducted at **Boundary County Nursing Home** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. Please provide **ONLY ONE** completion date for each federal and state tag in column (X5) Completion Date to signify when

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you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office. If a State Form with deficiencies was issued, it should be signed, dated and returned along with the CMS-2567 Form.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **December 8, 2015**. Failure to submit an acceptable PoC by **December 8, 2015**, may result in the imposition of civil monetary penalties by **December 27, 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 **December 24, 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 **December 24, 2015**. A change in the seriousness of the deficiencies on **December 24, 2015**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **December 24, 2015**, includes the following:

Denial of payment for new admissions effective **February 19, 2016**.  
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 **May 19, 2016**, 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 **November 19, 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:

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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 **December 8, 2015**. If your request for informal dispute resolution is received after **December 8, 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

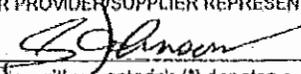
Printed: 11/23/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135004	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE BLDG  B. WING _____	(X3) DATE SURVEY COMPLETED  11/19/2015
NAME OF PROVIDER OR SUPPLIER <b>BOUNDARY COUNTY NURSING HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>6640 KANIKSU STREET BONNERS FERRY, ID 83805</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	INITIAL COMMENTS  The nursing facility is a Type V(111) structure, located on the upper level of a two story building, that is attached to the east end of the adjoining hospital. It is protected throughout by a complete automatic fire extinguishing system and a complete fire alarm system with smoke detection in corridors and open spaces. The nursing facility underwent a complete remodel and addition in 1994. The nursing facility is currently licensed for 28 SNF/NF beds, the census on the day of the survey was 26.  The following deficiencies were cited during the annual fire/life safety survey conducted on November 19, 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:  Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction	K 000	All dates indicated are for the year 2015. Disclaimer: Plan of correction is being submitted in accordance with specific regulatory requirements. It shall not be construed as an admission of any deficiency cited.  	
K 021 SS=D	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	K 021	Laundry door magnets will be removed. Doors will remain closed at all times unless passing through. All other hazardous area doors will be reviewed for similar compliance. Should hold open devices be requested in the future, the devices will release upon fire alarm activation.	

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

TITLE

(X6) DATE



CEO

12/8/2015

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting provided 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 021	<p>Continued From page 1</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that hazardous area doors were held open with approved releasing devices. Failure to ensure hazardous area doors were provided with an approved hold open device would allow smoke and dangerous gases to pass freely between compartments. This deficient practice affected staff and visitors occupying the basement service corridor on the date of the survey. The facility is licensed for 28 SNF/NF beds and had a census of 26 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on November 19, 2015 from 10:00 AM to 2:45 PM, observation of the laundry room doors entering the basement corridor found the devices used to hold each door open was a magnetic door stop which was not interconnected with the fire alarm and would prevent these doors from automatically self-closing in the event of a fire. Interview of the Maintenance Manager revealed the facility had been exploring the option to have these doors set up on magnetic hold-open devices interconnected with the fire alarm system.</p> <p>Actual NFPA standard: 19.2.2.2.6*</p>	K 021	<p>K021</p> <p>Laundry will be monitored daily by maintenance for one month, then weekly for the remainder of one year. The magnets will be removed by 12.18.15</p>	

*[Signature]* CEO 12/8/2015

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K 021	Continued From page 2 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 all such doors throughout the smoke compartment or throughout the entire facility.  7.2.1.8.2 In any building of low or ordinary hazard contents, as defined in 6.2.2.2 and 6.2.2.3, or where approved by the authority having jurisdiction, doors shall be permitted to be automatic-closing, provided that the following criteria are met: (1) Upon release of the hold-open mechanism, the door becomes self-closing. (2) The release device is designed so that the door instantly releases manually and upon release becomes self-closing, or the door can be readily closed. (3) The automatic releasing mechanism or medium is activated by the operation of approved smoke detectors installed in accordance with the requirements for smoke detectors for door release service in NFPA 72, National Fire Alarm Code®. (4) Upon loss of power to the hold-open device, the hold-open mechanism is released and the door becomes self-closing. (5) The release by means of smoke detection of one door in a stair enclosure results in closing all doors serving that stair.	K 021			
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested	K 062			

*E. Johnson* CEO 12/8/2015

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K 062	<p>Continued From page 3</p> <p>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 record review, observation and interview, the facility failed to ensure that fire suppression systems were maintained in accordance with NFPA 25. Failure to maintain fire suppression systems could hinder their ability to contain fires and allow them to grow beyond incipient stages. This deficient practice affected all residents, staff and visitors on the date of the survey. The facility is licensed for 28 SNF/NF residents and had a census of 26 on the day of the survey.</p> <p>Findings include:</p> <p>1) During record review conducted on November 19, 2015 from 8:30 AM to 10:00 AM, review of facility fire suppression inspection reports provided, indicated the installed anti-freeze solution was propylene glycol, with a concentration in excess of the allowable 38 percent. Review of records and inspection of the tags on the anti-freeze loop revealed the concentration. Interview of the Maintenance Manager revealed she was not aware the percentage requirements for anti-freeze solution installations.</p> <p>2) During the facility tour conducted on November 19, 2015 from 10:00 AM to 2:45 PM, observation of the installed fire suppression system revealed painted heads in the following locations:</p> <p>(a) Social Services had one painted sprinkler head.</p>	K 062	<p>K062</p> <p>1) The anti-freeze solution will be changed, not to exceed 38 percent. This is the only antifreeze system in the facility, therefore no other areas and/or systems are affected by the same deficient practice. Upon correction, the vendor will be required to provide documented proof of compliance of the correct antifreeze saturation percentage. The system is and will continue to be checked annually for antifreeze compliance levels. The antifreeze system will meet compliance by 12.24.15.</p> <p>2) Painted sprinkler heads will be replaced. All sprinkler heads in the facility will be checked for cleanliness compliance. During and after each painting project, all area sprinkler heads will be protected during the project and checked at the</p>	

*[Handwritten Signature]* CEO 12/8/2015

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K 062	<p>Continued From page 4</p> <p>(b) The primary entrance had three painted sprinkler heads.</p> <p>(c) The employee breakroom had two painted sprinkler heads.</p> <p>3) During the facility tour conducted on November 19, 2015 from 10:00 AM to 2:45 PM, observation of the Kitchen revealed two (2) sprinkler heads above the main cooking line loaded with grease and lint.</p> <p>Actual NFPA standard:</p> <p>Finding 1</p> <p>NFPA 25 2-3.4* Antifreeze Systems. The freezing point of solutions in antifreeze shall be tested annually by measuring the specific gravity with a hydrometer or refractometer and adjusting the solutions if necessary. Solutions shall be in accordance with Tables 2-3.4(a) and (b).</p> <p>The use of antifreeze solutions shall be in accordance with any state or local health regulations. [See Table 2-3.4(b).]</p> <p>Finding 2 and 3</p> <p>NFPA 25 2-2.1 Sprinklers. 2-2.1.1* 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</p>	K 062	<p>K062 conclusion of the project. Heads will also be checked after each painting project and monthly for the duration of one year. The painted sprinkler heads will be replaced by 12.24.15.</p> <p>3) Excessively dirty sprinkler heads in the kitchen will be replaced. All sprinkler heads in the kitchen will be checked for cleanliness. All sprinkler heads in the kitchen will be placed on a monthly visual check and semi-annual cleaning cycle. The dirty sprinkler heads will be replaced by 12.24.15.</p>	

*SC Director CEO 12/8/2015*

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K 062	Continued From page 5 concealed spaces such as above suspended 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  See also: NFPA 25 TIA 11-1	K 062		

*S. Jones* CEO 12/8/2015