



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

January 14, 2016

Randal Barnes, Administrator
Idaho State Veterans Home-- Boise
PO Box 7765
Boise, ID 83707-1765

Provider #: 135131

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

Dear Mr. Barnes:

On **January 6, 2016**, a Facility Fire Safety and Construction survey was conducted at **Idaho State Veterans Home-- 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. 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 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

Randal Barnes, Administrator
January 14, 2016
Page 2 of 4

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 **January 27, 2016**. Failure to submit an acceptable PoC by **January 27, 2016**, may result in the imposition of civil monetary penalties by **February 15, 2016**.

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 **February 10, 2016**, (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 **February 10, 2016**. A change in the seriousness of the deficiencies on **February 10, 2016**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **February 10, 2016**, includes the following:

Randal Barnes, Administrator
January 14, 2016
Page 3 of 4

Denial of payment for new admissions effective **April 6, 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 **July 6, 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 **January 6, 2016**, 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>

Randal Barnes, Administrator
January 14, 2016
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 **January 27, 2016**. If your request for informal dispute resolution is received after **January 27, 2016**, 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: 01/13/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135131	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 01/06/2016
--	--	---	--

NAME OF PROVIDER OR SUPPLIER IDAHO STATE VETERANS HOME - BOISE	STREET ADDRESS, CITY, STATE, ZIP CODE 320 COLLINS ROAD, 83702-4519 BOISE, ID 83707
--	--

(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>INITIAL COMMENTS</p> <p>The two story facility is Type II (111) fire resistive construction built in 1978, with an addition completed in February, 2004. The building is fully sprinklered with a complete fire alarm/smoke detection system which was updated in 2003. The facility has multiple exits to grade and is equipped with two hour corridor walls. The facility is currently licensed for 131 SNF/NF beds.</p> <p>The following deficiencies were cited during annual fire/life safety survey conducted on January 6, 2016. 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 & Construction</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems have an adequate and reliable water supply which provides continuous and automatic pressure. 9.7.1.1, NFPA 13</p> <p>This Standard is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure the fire suppression system was maintained in accordance with NFPA 25. Failure to maintain the fire suppression system could result in a lack of</p>	K 000	<p style="text-align: center;">REGISTERED NURSING ASSISTANT JAN 27 2016 FACILITY COMPLAINT</p> <p>K063 Residents: No specific residents were identified as being affected by this deficient practice.</p> <p>Other residents: All residents at the Idaho State Veterans Home - Boise (ISVH-B) have the potential to be affected by having the three (3) corroded and four (4) painted sprinkler heads.</p>	2/01/16
K 063 SS=F		K 063		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Administrator* (X6) DATE *1-27-16*

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.

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

Printed: 01/13/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135131	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 01/06/2016
NAME OF PROVIDER OR SUPPLIER IDAHO STATE VETERANS HOME - BOISE		STREET ADDRESS, CITY, STATE, ZIP CODE 320 COLLINS ROAD. 83702-4519 BOISE, ID 83707		
(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 063	Continued From page 1 system performance during a fire event. This deficient practice affected all residents, staff and visitors on the date of the survey. The facility is licensed for 131 SNF/NF beds and had a census of 97 on the day of the survey. Findings include: A) During review of the facility fire suppression system inspection reports conducted on January 6, 2015 from approximately 8:30 AM to 10:00 AM, no documentation was provided for the following inspections as required under NFPA 25: 1) No quarterly inspection for the third quarter of 2015 2) No 3-year full trip testing for the installed dry system since 2010 3) No 5-year internal obstruction investigation report Interview of the Maintenance Supervisor revealed he was not aware the required inspections had not been completed. B) During the facility tour conducted on January 6, 2015 from approximately 10:00 AM to 4:00 PM, observation of the installed fire suppression system revealed the following: 1) Three (3) corroded sprinkler heads. One each in Janitorial supply/storage areas located at One West; Two West and the main service corridor. 2) Four (4) painted sprinkler heads located in the basement Central Supply. Actual NFPA standard: Finding A	K 063	Immediate measure: Contacted facility fire alarm company to replace above noted sprinkler heads. Fire alarm company contacted to complete the required 3 year full trip testing and the 5 year internal obstruction investigation report. Systemic correction: Replacement of noted sprinkler heads to be complete by February 1, 2016. Completion of above listed 5 year inspection was completed by January 7, 2016. Completion of above listed 3 year inspection will be completed by March 2016. Monitoring: Maintenance department to check sprinkler heads during monthly preventative rounds. The three inspections noted were added to a Routine Preventative Maintenance spreadsheet to track future completion dates. Maintenance Supervisor to report to monthly facility Quality Assurance Meeting.	

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

Printed: 01/13/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135131	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 01/06/2016
--	--	---	--

NAME OF PROVIDER OR SUPPLIER IDAHO STATE VETERANS HOME - BOISE	STREET ADDRESS, CITY, STATE, ZIP CODE 320 COLLINS ROAD. 83702-4519 BOISE, ID 83707
---	--

(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 063	<p>Continued From page 2</p> <p>2-3 Testing. 2-3.1 Sprinklers. 2-3.3* Alarm Devices. Waterflow alarm devices including, but not limited to, mechanical water motor gongs, vane-type waterflow devices, and pressure switches that provide audible or visual signals shall be tested quarterly.</p> <p>Chapter 9 Valves, Valve Components, and Trim 9-4.4 Dry Pipe Valves/Quick-Opening Devices. 9-4.4.2.2.1* Every 3 years and whenever the system is altered, the dry pipe valve shall be trip tested with the control valve fully open and the quick-opening device, if provided, in service.</p> <p>Chapter 10 Obstruction Investigation 10-2.2* Obstruction Prevention. Systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This investigation shall be accomplished by examining the interior of a dry valve or preaction valve and by removing two cross main flushing connections.</p> <p>Finding B</p> <p>NFPA 25 2-2 Inspection. 2-2.1 Sprinklers. 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion,</p>	K 063		
-------	---	-------	--	--

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

Printed: 01/13/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135131	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 01/06/2016
NAME OF PROVIDER OR SUPPLIER IDAHO STATE VETERANS HOME - BOISE		STREET ADDRESS, CITY, STATE, ZIP CODE 320 COLLINS ROAD, 83702-4519 BOISE, ID 83707		
(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 063	Continued From page 3 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 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.	K 063		
K 064 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19:3.5.6, NFPA 10 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that fire extinguishers were installed in accordance with NFPA 10. Failure to mount extinguishers at the correct height could result in injury or extinguisher damage. This deficient practice affected 86 residents, staff and visitors on the date of the survey. The facility is licensed for 131 SNF/NF beds and had a census of 97 on the day of the survey. Findings include: During the facility tour conducted on January 6, 2016 from approximately 10:00 AM to 4:00 PM, observation of the installed fire extinguishers revealed extinguishers installed in the following locations were installed over 60" in height,	K 064	K064 Residents: No specific residents were identified as being affected by this deficient practice. Other residents: All residents at the Idaho State Veterans Home - Boise (ISVH-B) have the potential to be affected by having the installed fire extinguishers installed over 60" in height. Immediate measure: Maintenance Department switched out the fire extinguishers to ensure the height does not exceed 60".	1/13/16

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

 Printed: 01/13/2016
 FORM APPROVED
 OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135131	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 01/06/2016
NAME OF PROVIDER OR SUPPLIER IDAHO STATE VETERANS HOME - BOISE		STREET ADDRESS, CITY, STATE, ZIP CODE 320 COLLINS ROAD. 83702-4519 BOISE, ID 83707		
(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 064	<p>Continued From page 4</p> <p>ranging from approximately sixty-two (62) inches to sixty-seven (67) inches when measured from the floor to the top of the extinguisher :</p> <p>A. Four extinguishers in One West B. Five extinguishers in Two West C. Laundry D. Main Entrance by elevator E. Canteen</p> <p>Actual NFPA standard:</p> <p>NFPA 10</p> <p>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).</p>	K 064	<p>Systemic corrections: Maintenance Department will conduct quarterly measurements to ensure the height requirement is in place.</p> <p>Monitoring: Maintenance department to - Conduct quarterly measurements of fire extinguisher heights. Maintenance Supervisor to report to the monthly facility Quality Assurance Meeting.</p>	