



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

March 17, 2016

David Green, 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. Green:

On **March 7, 2016**, 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. 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

David Green, Administrator
March 17, 2016
Page 2 of 4

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 **March 30, 2016**. Failure to submit an acceptable PoC by **March 30, 2016**, may result in the imposition of civil monetary penalties by **April 19, 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 **April 11, 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 **April 11, 2016**. A change in the seriousness of the deficiencies on **April 11, 2016**, may result in a change in the remedy.

David Green, Administrator
March 17, 2016
Page 3 of 4

The remedy, which will be recommended if substantial compliance has not been achieved by **April 11, 2016**, includes the following:

Denial of payment for new admissions effective **June 7, 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 **September 7, 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 **March 7, 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:

David Green, Administrator
March 17, 2016
Page 4 of 4

<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 **March 30, 2016**. If your request for informal dispute resolution is received after **March 30, 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: 03/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 03/07/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BOISE	STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706
--	---

(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 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. The following deficiencies were cited during the annual life safety code survey conducted on March 7, 2016. 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: Nate Elkins Health Facility Surveyor Facility Fire 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 agreement by the facility that the surveyors findings constitute a deficiency and/or that the scope and severity of the deficiencies cited are correct applied.</i> RECEIVED MAR 31 2016 FACILITY STANDARDS	
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by	K 018	1. SPECIFIC ISSUE: The corridor door in the Therapeutic Dining Room (TDR) failed to close and latch properly. The door was repaired and adjusted to close and latch properly by the Maintenance Director on or before 04/15/2016. 2. OTHER RESIDENTS: All the other doors were checked for proper closing and latching to prevent and escaping of smoke in the event of a fire. The doors were checked by the Maintenance Director on or before 04/15/2016.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <i>Administrative</i>	(X6) DATE 3-30-16
--	--------------------------------	-----------------------------

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 03/07/2016	
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BOISE		STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706		
(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 018	<p>Continued From page 1</p> <p>CMS regulations in all health care facilities. 19.3.6.3</p> <p>This Standard is not met as evidenced by: Based on observation, operational testing, and interview the facility failed to maintain doors that protect corridor openings. Failure to maintain corridor doors could allow smoke and dangerous gases to pass freely into corridors affecting egress during a fire event. This deficient practice affected one of three smoke compartments, 47 residents, staff, and visitors on the date of survey. The facility is licensed for 153 SNF/NF beds with a census of 75 on the day of survey.</p> <p>Findings Include:</p> <p>During the facility tour on March 7, 2016 at approximately 11:45 AM, observation and operational testing of the corridor door to the Therapeutic Dining Room revealed the door would not close and latch properly when released from magnetic hold-open device. When asked, the Maintenance Supervisor stated the facility was unaware of the door not closing and latching properly.</p> <p>Actual NFPA standard:</p> <p>19.3.6.3 Corridor Doors. 19.3.6.3.1*</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and</p>	K 018	<p>3. SYSTEMIC CHANGES:</p> <p>The Maintenance Director, or his designee, will check doors weekly on rounds for one month then monthly thereafter.</p> <p>4. MONITOR:</p> <p>Maintenance Director, or his designee, will present his report to the PI committee for 3 months.</p> <p>5. Date of Compliance: April 15, 2016</p> <p>K 022</p> <p>1. SPECIFIC ISSUE:</p> <p>Appropriate exit signage was missing on the exit door in the 300 hallway by the sitting room.</p> <p>2. OTHER RESIDENTS:</p> <p>Appropriate exit signage on all exit doors was checked for compliance throughout the facility by the Maintenance Director on or before 04/15/2016.</p>	

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

Printed: 03/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 03/07/2016
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BOISE		STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706		
(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 018	Continued From page 2 the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.2. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: Existing roller latches demonstrated to keep the door closed against a force of 5 lbf (22 N) shall be permitted to be kept in service.	K 018	3. SYSTEMIC CHANGES: The Maintenance Director, or his designee, will check monthly x3 for appropriate signage and marking on exit doors. Any deficient signage will be noted and repaired. 4. MONITOR: The Maintenance Director, or his designee, will present reports to the PI Committee for 3 months. 5. Date of Compliance: April 30, 2016	
K 022 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. Doors, passages or stairways that are not a way of exit that are likely to be mistaken for an exit have a sign designating "No Exit".	K 022		

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

Printed: 03/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 03/07/2016
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BOISE		STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706		
(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 022	Continued From page 3 7.10, 18.2.10.1, 19.2.10.1 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to provide exit signage on exit doors. Failure to provide exit signage on exit doors could confuse evacuation in a dark smoke filled room or corridor. This deficient practice affected one of three smoke compartments, 6 residents, staff, and visitors on the date of survey. The facility is licensed for 153 SNF/NF beds with a census of 75 on the day of survey. Findings Include: During the facility tour on March 7, 2016 at approximately 1:10 PM, observation of the exit door in the sitting room of the 300 hallway revealed no exit signage above or near the exit door identifying the exit. When asked, the Maintenance Supervisor stated the door is utilized as an exit but was unsure why there was no exit sign above the door. Actual NFPA standard: 7.10.1.2* Exits. Exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign readily visible from any direction of exit access.	K 022	K 025 1. SPECIFIC ISSUE: There was a wall penetration on the smoke barrier wall above the cross corridor doors in the 100 hallway near rooms 111 and 116. 2. OTHER RESIDENTS: The hole in the smoke barrier wall above the cross corridor doors in the 100 hallway near rooms 111 and 116 was repaired by the Maintenance Director on or before 04/15/2016. 3. SYSTEMIC CHANGES: The Maintenance Director, or his designee, will check for compliance on monthly rounds. 4. MONITOR: The Maintenance Director, or his designee, will present report to PI Committee monthly for 3 months x3.	
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5	K 025	5. Date of Compliance: March 31, 2016	

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

Printed: 03/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 03/07/2016	
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BOISE		STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706		
(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 025	<p>Continued From page 4</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that smoke barriers were maintained. Failure to maintain smoke barriers could allow smoke and dangerous gases to pass freely between smoke compartments affecting egress and defending in place during a fire event. This deficient practice affected two of three smoke compartments, 70 residents staff and visitors on the date of the survey. The facility is licensed for 153 SNF/NF beds with a census of 75 on the day of the survey.</p> <p>Findings Include:</p> <p>During the facility tour on March 7, 2016 at approximately 10:00 AM, observation of the smoke barrier wall above the cross corridor doors in the 100 hallway near rooms 111 and 116 revealed an approximate 1 inch circular hole penetrating through the smoke barrier wall. When asked, the Maintenance Supervisor stated the facility was unaware of the penetration through the smoke barrier wall.</p> <p>Actual NFPA standard: 19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour. Exception No. 1: Where an atrium is used, smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with Exception No. 2 to 8.2.5.6(1). Not less than two separate smoke compartments shall be provided on each floor. Exception No. 2*: Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems where an approved, supervised</p>	K 025		

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

Printed: 03/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 03/07/2016
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BOISE		STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706		
(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 025	Continued From page 5 automatic sprinkler system in accordance with 19.3.5.3 has been provided for smoke compartments adjacent to the smoke barrier. 8.3.2* Continuity. Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces. Exception: A smoke barrier required for an occupied space below an interstitial space shall not be required to extend through the interstitial space, provided that the construction assembly forming the bottom of the interstitial space provides resistance to the passage of smoke equal to that provided by the smoke barrier.	K 025		
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure delayed egress doors were properly marked with correct signage. Failure to provide proper signage on delayed egress doors could cause confusion and hinder evacuation of occupants in the facility. This deficient practice affected one of three smoke compartments, 6 residents, staff, and visitors on the date of survey. The facility is licensed for 153 SNF/NF beds with a census of 75 on the day of survey. Findings Include: During the facility tour on March 7, 2016 at	K 038	K 038 1. SPECIFIC ISSUE: Proper signage on egress doors in the 300 hallway was missing. 2. OTHER RESIDENTS: Proper signage on all egress doors in all areas of the facility were checked for compliance by the Maintenance Director on or before 04/15/2016. 3. SYSTEMIC CHANGES: The Maintenance Director, or his designee, will check on monthly rounds to ensure all egress doors have proper signage. 4. MONITOR: The Maintenance Director, or his designee, will report monthly x3 to the PI Committee. 5. Date of Compliance: 04/15/2016	

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

Printed: 03/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 03/07/2016
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BOISE		STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706		
(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 038	<p>Continued From page 6</p> <p>approximately 1:10 PM, observation of the delayed egress door located in the 300 hallway Sitting Room revealed the door did not have a readily visible sign warning occupants that the door was equipped with delayed egress. When asked, the Maintenance Supervisor stated the facility was unaware the delayed egress sign was missing from the door.</p> <p>Actual NFPA standard: 19.2.2.2.1 Doors complying with 7.2.1 shall be permitted.</p> <p>7.2.1.6 Special Locking Arrangements. 7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed-egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met.</p> <p>(a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6.</p> <p>(b) The doors shall unlock upon loss of power controlling the lock or locking mechanism.</p> <p>(c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process</p>	K 038		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 03/07/2016
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BOISE		STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706		
(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 038	Continued From page 7 shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) * On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS	K 038		
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 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that fire suppression systems were inspected and maintained in accordance with NFPA 25. Failure to provide inspection and maintenance of sprinkler systems could result in these systems not performing as designed during a fire event. This deficient practice affected one of three smoke compartments, 6 residents, staff and visitors on the date of the survey. The facility is licensed for 153 SNF/NF beds and had a census of 75 on the day of the survey. Findings Include: 1.) During the facility tour on March 7, 2016 at approximately 1:20 PM, observation of the storage closet located in the Station 3 Dining Room revealed a painted sprinkler head. When	K 062	K 062 1. SPECIFIC ISSUE: The sprinkler head in the storage closet located in the Station 3 Dining Room was painted and missing an escutcheon. 2. OTHER RESIDENTS: The painted sprinkler head in the storage closet located in the Station 3 Dining Room was replaced by the Maintenance Director on or before 04/15/2016. The missing escutcheon from the sprinkler assembly in the storage closet of the Station 3 Dining Room was replaced by the Maintenance Director on or before 04/15/2016. 3. SYSTEMIC CHANGES: The Maintenance Director, or his designee, will check sprinkler heads and escutcheon throughout the facility on rounds monthly x3. 4. MONITOR:	

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

Printed: 03/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 03/07/2016
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BOISE		STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706		
(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	Continued From page 8 asked, the Maintenance Supervisor stated the facility was unaware of the painted sprinkler head. 2.) During the facility tour on March 7, 2016 at approximately 1:20 PM, observation of the storage closet located in the Station 3 Dining Room revealed the escutcheon missing from the sprinkler assembly exposing a 2" circular hole through the ceiling. When asked, the Maintenance Supervisor stated the facility was unaware of the missing escutcheon. NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems 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 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. NFPA 13 Standard for the Installation of Sprinkler Systems 3-2.7.2* Escutcheon plates used with a recessed or flush-type sprinkler shall be part of a listed sprinkler assembly.	K 062	The Maintenance Director, or his designee, will report to PI Committee monthly x3 any observed infractions. 5. Date of Compliance: 04/15/2016 K 072 1. SPECIFIC ISSUE: The Hoyer Lift and electronic weight scale were being stored in the hallway impeding egress. 2. OTHER RESIDENTS: The Hoyer Lift and electronic weight scale were immediately removed from the hallway to a proper storage area by the Maintenance Director. 3. SYSTEMIC CHANGES: The nursing staff was in serviced and reminded of the necessity of keeping hallways and means of egress free of equipment and items at all times. 4. MONITOR: The Maintenance Director, or his designee, will report compliance to the PI Committee monthly x3.	
K 072 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress shall be continuously	K 072	5. Date of Compliance: April 15, 2016	

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

Printed: 03/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 03/07/2016	
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BOISE		STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706		
(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 072	<p>Continued From page 9</p> <p>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 shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1 This Standard is not met as evidenced by: Based on observation and interview, the facility did not ensure that means of egress was maintained free from obstructions. Failure to provide exit access free of obstructions could prevent the safe evacuation of residents during an emergency. This deficient practice affected one of three smoke compartments, 12 residents, staff members, and visitors on the date of survey. The facility is licensed for 153 SNF/NF beds with a census of 75 on the day of survey.</p> <p>Findings Include:</p> <p>During the facility tour on March 7, 2016, between 9:00 AM and 2:00 PM, observation revealed the facility was storing a Hoyer Lift and an Electronic Weight Scale in the exit access corridor outside of room 105 and the Director of Nursing office. When asked, the Maintenance Supervisor stated the facility was unaware the equipment was obstructing exit access.</p> <p>Actual NFPA Standard:</p> <p>NFPA 101, 7.1.10 Means of Egress Reliability. 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. 7.1.10.2.1 No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress therefrom,</p>	K 072		

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

Printed: 03/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 03/07/2016
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706	
(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 072 K 147 SS=E	Continued From page 10 or visibility thereof. NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure safe use of electrical appliances and medical devices in accordance with the National Electrical Code. This deficient practice affected one of three smoke compartments, 47 residents, staff and visitors on the date of survey. The facility is licensed for 153 SNF/NF beds with a census of 75 the day of survey. Findings Include: 1.) During the facility tour on March 7, 2016 at approximately 11:00 AM, observation of Room 209 revealed a zip (light weight extension) cord plugged into a small plastic Christmas tree as a substitute for fixed wiring. When asked, the Maintenance Supervisor stated the facility was unaware the zip cord was being used in the resident room. 2.) During the facility tour on March 7, 2016 at approximately 1:30 PM, observation of Room 220 revealed an oxygen concentrator plugged into an inappropriately listed multi-plug adapter. When asked, the Maintenance Supervisor stated the facility was unaware the oxygen concentrator was plugged into a multi-plug adapter. 3.) During the facility tour on March 7, 2016 at approximately 2:00 PM, observation of the outside wall on the south side of the facility revealed an uncovered electrical outlet faceplate broken exposing live wires. When asked, the	K 072 K 147	K 147 1. SPECIFIC ISSUE: 1) A light weight extension cord was plugged into a small plastic Christmas tree that was immediately disconnected and removed by the maintenance director. 2) An oxygen concentrator was plugged into the multi-plug adapter and was removed and plugged into a safe and appropriate plug. 3) The electrical outlet faceplate on the outside south side wall of the facility was cracked. The outlet faceplate was replaced by the Maintenance Director. 2. OTHER RESIDENTS: The electronic appliances and medical devices were checked for proper usage by the Maintenance Director on or before 04/15/2016. All faceplates in the facility were checked by the Maintenance Director to ensure that they were not cracked or damaged on or before 04/15/2016. 3. SYSTEMIC CHANGES: The Maintenance Director, or his designee, will ensure on monthly maintenance rounds that all electric appliances, medical devices and outlets are safe and in compliance.	

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

Printed: 03/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 03/07/2016
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BOISE		STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706		
(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 11</p> <p>Maintenance Supervisor stated the facility was unaware the electrical outlet faceplate was broken.</p> <p>Actual NFPA standard:</p> <p>(Items 1-2) NFPA 70 National Electrical Code 1999 Edition 400-8. Uses Not Permitted Unless specifically permitted in Section 400-7, flexible cords and cables shall not be used for the following:</p> <ol style="list-style-type: none"> 1. As a substitute for the fixed wiring of a 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 <p>Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of Section 364-8.</p> <ol style="list-style-type: none"> 5. Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors 6. Where installed in raceways, except as otherwise permitted in this Code <p>Also see UL listings: XBYS Guide information XBZN2 Guide information</p> <p>(Item 3) NFPA 70 National Electrical Code 1999 Edition</p> <p>ARTICLE 406 Receptacles, Cord Connectors, and Attachment Plugs (Caps) 406.5 Receptacle Faceplates (Cover Plates). Receptacle faceplates shall be installed so as to completely cover the opening and seat against</p>	K 147	<p>4. MONITOR: The Maintenance Director, or his designee, will make a report to the PI Committee monthly x3 for compliance.</p> <p>5. Date of Compliance: April 15, 2016</p>	

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

Printed: 03/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 03/07/2016
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BOISE		STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706		
(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 12 the mounting surface.</p> <p>406.8 Receptacles in Damp or Wet Locations. (A) Damp Locations. A receptacle installed outdoors in a location protected from the weather or in other damp locations shall have an enclosure for the receptacle that is weatherproof when the receptacle is covered (attachment plug cap not inserted and receptacle covers closed). An installation suitable for wet locations shall also be considered suitable for damp locations. A receptacle shall be considered to be in a location protected from the weather where located under roofed open porches, canopies, marquees, and the like, and will not be subjected to a beating rain or water runoff. (B) Wet Locations. (1) 15- and 20-Ampere Outdoor Receptacles. 15- and 20-ampere, 125- and 250-volt receptacles installed outdoors in a wet location shall have an enclosure that is weatherproof whether or not the attachment plug cap is inserted. (2) Other Receptacles. All other receptacles installed in a wet location shall comply with (a) or (b): (a) A receptacle installed in a wet location where the product intended to be plugged into it is not attended while in use (e.g., sprinkler system controller, landscape lighting, holiday lights, and so forth) shall have an enclosure that is weatherproof with the attachment plug cap inserted or removed. (b) A receptacle installed in a wet location where the product intended to be plugged into it will be attended while in use (e.g., portable tools, and so forth) shall have an enclosure that is weatherproof when the attachment plug is removed. (C) Bathtub and Shower Space. A receptacle shall not be installed within a bathtub or shower</p>	K 147		

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

Printed: 03/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 03/07/2016	
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BOISE		STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706		
(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 13 space. (D) Protection for Floor Receptacles. Standpipes of floor receptacles shall allow floor-cleaning equipment to be operated without damage to receptacles. (E) Flush Mounting with Faceplate. The enclosure for a receptacle installed in an outlet box flush-mounted on a wall surface shall be made weatherproof by means of a weatherproof faceplate assembly that provides a watertight connection between the plate and the wall surface.	K 147		