



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

Gary "Paul" Arnell, Administrator
Life Care Center of Treasure Valley
502 North Kimball Place
Boise, ID 83704-0608

Provider #: 135123

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

Dear Mr. Arnell:

On **March 8, 2016**, a Facility Fire Safety and Construction survey was conducted at **Life Care Center of Treasure Valley** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be one that comprises a pattern 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 **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 12, 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 12, 2016**. A change in the seriousness of the deficiencies on **April 12, 2016**, 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 **April 12, 2016**, includes the following:

Denial of payment for new admissions effective **June 8, 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 8, 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 8, 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:

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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 **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,

A handwritten signature in black ink, appearing to read 'M. Grimes', followed by a horizontal line extending to the right.

Mark P. Grimes, Supervisor
Facility Fire Safety and Construction

MPG/lj
Enclosures

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135123 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____ | (X3) DATE SURVEY COMPLETED 03/08/2016 |
|--|---|--|---|

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|--|---------------|---|----------------------|
|--------------------|--|---------------|---|----------------------|

| | | | | |
|---------------|--|-------|--|--|
| K 000 | <p>INITIAL COMMENTS</p> <p>The facility is a single story structure of Type V(111) construction that was built in 1996. The building is protected throughout by an automatic fire extinguishing system and has a complete fire alarm system with fire dampers. Currently the facility is licensed for 120 SNF beds.</p> <p>The following deficiencies were cited during the annual life safety code survey conducted on March 8, 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>Nate Elkins Health Facility Surveyor Fire Life Safety & Construction</p> <p>Mark Grimes Supervisor Fire Life Safety & Construction</p> | K 000 | <p><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></p> | |
| K 072 SS=E | <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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. 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, operational testing, and interview, the facility failed to ensure exit doors would easily operate from the egress side. Failure to ensure exit doors would easily operate properly could delay egress of occupants during an emergency event. This deficient practice affected</p> | K 072 | <p>K 072</p> <p>1. SPECIFIC ISSUE: Rug located outside of southeast side dayroom courtyard door causing difficult opening of door removed and door readjusted to clear the height of the rug on or before 3/30/2016 by Director of Maintenance. Exit gate in courtyard off of the northeast hall was readjusted to allow ease of operation on or before 3/30/2016 by Director of Maintenance.</p> | |

| | | |
|---|------------------------------------|-----------------------------|
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  | TITLE Executive Director | (X6) DATE 3/29/16 |
|---|------------------------------------|-----------------------------|

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.

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|--|--|---|--|---|
| NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF TREASURE VALLEY | | STREET ADDRESS, CITY, STATE, ZIP CODE 502 NORTH KIMBALL PLACE BOISE, ID 83704 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
| K 072 | <p>Continued From page 1</p> <p>one of six smoke compartments, 20 residents, staff, and visitors on the date of survey. The facility is licensed for 120 SNF/NF beds with a census of 99 on the day of survey.</p> <p>Findings Include:</p> <p>1.) During the facility tour on March 8, 2016 at approximately 1:00 PM, observation and operational testing of the Day Room exit door leading from the courtyard into the facility revealed the door required excessive force to open to the minimum required width due to a rug impeding the swinging motion of the door. When asked, the maintenance Supervisor stated the facility was unaware the door was hard to open.</p> <p>2.) During the facility tour on March 8, 2016 at approximately 1:15 PM, observation and operational testing of the wooden gate leading to the exit discharge from the 300 hallway Dining Room revealed the gate door required excessive force to open. When asked, the maintenance Supervisor stated the facility was unaware the door was hard to open.</p> <p>Actual NFPA standard:</p> <p>19.2 MEANS OF EGRESS REQUIREMENTS 19.2.1 General. Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7. Exception: As modified by 19.2.2 through 19.2.11.</p> <p>7.2.1.4.5 The forces required to fully open any door manually in a means of egress shall not exceed 15 lbf (67 N) to release the latch, 30 lbf (133 N) to</p> | K 072 | <p>2. OTHER RESIDENTS: All exit doors were assessed for ease of exit/entry on or before 3/30/2016 by Director of Maintenance. All courtyard exit gates were assessed for ease of exit/entry and adjusted as indicated on or before 3/30/2016 by Director of Maintenance.</p> <p>3. SYSTEMIC CHANGES: Staff educated on or before 3/30/2016 by Executive Director or designee regarding preventative maintenance policy and tools available to communicate maintenance issues.</p> <p>4. MONITOR: Executive Director or designee will audit 100% of exit doors and exit gates to ensure ease of egress weekly x 4, monthly x 3 then quarterly x 3. Additional education will be provided as necessary.</p> | |

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

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| K 072 | Continued From page 2 set the door in motion, and 15 lbf (67 N) to open the door to the minimum required width. Opening forces for interior side-hinged or pivoted-swinging doors without closers shall not exceed 5 lbf (22 N). These forces shall be applied at the latch stile. Exception No. 1: The opening force for existing doors in existing buildings shall not exceed 50 lbf (222 N) applied to the latch stile. Exception No. 2: The opening forces for horizontal sliding doors shall be as provided in Chapters 22 and 23. Exception No. 3: The opening forces for power-operated doors shall be as provided in 7.2.1.9. | K 072 | Results of audit will be reviewed in PI to ensure systems being followed. Plan to be updated as indicated. 5. Date of Compliance: | 3/30/2016 |