January 27, 2017

Rick Holloway, 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. Holloway:

On January 19, 2017, 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 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 **February 9, 2017.** Failure to submit an acceptable PoC by **February 9, 2017,** may result in the imposition of civil monetary penalties by **March 1, 2017.**

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. If a State Form was issued as well, it should also be signed, dated and returned.

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 23, 2017,** (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 23, 2017.** A change in the seriousness of the deficiencies on **February 23, 2017,** may result in a change in the remedy.
The remedy, which will be recommended if substantial compliance has not been achieved by February 23, 2017, includes the following:

Denial of payment for new admissions effective April 19, 2017.
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 19, 2017, 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 Nate Elkins, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, option 3; 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 19, 2017, 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:

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 **February 9, 2017**. If your request for informal dispute resolution is received after **February 9, 2017**, 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, option 3.

Sincerely,

[Signature]

Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/jj
Enclosures
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 east wing of the second floor is a domiciliary care unit and not part of the skilled nursing facility. The facility is currently licensed for 131 SNF/NF beds.

The following deficiencies were cited during annual fire/life safety survey conducted on January 18 - 19, 2017. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.

The Survey was conducted by:

Linda Chaney
Health Facility Surveyor
Facility Fire Safety & Construction

Means of Egress - General
Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1

This STANDARD is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure fire rated assemblies were inspected in accordance with NFPA 101 Means of Egress - General.

A. All fire rated doors and assemblies were inspected by February 9, 2017.
B. All fire rated doors and assemblies have the potential to be affected.
C. Inspection forms which include proper functioning of the door mechanisms have been developed and an inspection will be done quarterly during preventive maintenance (PM) rounds.

K211 Means of Egress
2/9/2017
**K 211 Continued From page 1**

NFPA 80. Failure to inspect and test fire rated doors could result in a lack of system performance as designed. 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 112 on the day of the survey.

Findings include:

During record review on January 18, 2017, from approximately 9:00 AM to 1:00 PM, the facility was unable to produce documentation demonstrating an initial inspection and testing of the fire rated assemblies had been conducted. When asked about the missing documentation, the Maintenance Supervisor stated the facility was not aware of this requirement.

Actual NFPA standard:

NFPA 101

19.2.1 General. Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7, unless otherwise modified by 19.2.2 through 19.2.11.

7.2.1 Door Openings, 7.2.1.15 Inspection of Door Openings, 7.2.1.15.1 Where required by Chapters 11 through 43, the following door assemblies shall be inspected and tested not less than annually in accordance with 7.2.1.15.2 through 7.2.1.15.8:

1. Door leaves equipped with panic hardware or fire exit hardware in accordance with 7.2.1.7
2. Door assemblies in exit enclosures
3. Electrically controlled egress doors

**K 211**

D. The results of the monitoring will be reviewed by the Administrator when completed and presented at the monthly Quality Assurance (QA) meeting the month after the inspections were completed.
## Statement of Deficiencies

**Provider/Supplier/Clinical Identification Number:** 135131

**State of Deficiency:**

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>Summary Statement of Deficiencies (Each deficiency must be preceded by full regulatory or LSC identifying information)</th>
<th>ID PREFIX TAG</th>
<th>Provider's Plan of Correction (Each corrective action should be cross-referenced to the appropriate deficiency)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>K 211</strong></td>
<td>Continued From page 2. (4) Door assemblies with special locking arrangements subject to 7.2.1.6</td>
<td><strong>K 211</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>7.2.1.15.2 Fire-rated door assemblies shall be inspected and tested in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Smoke door assemblies shall be inspected and tested in accordance with NFPA 105, Standard for Smoke Door Assemblies and Other Opening Protectives.</td>
<td></td>
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</tr>
<tr>
<td><strong>K 222</strong></td>
<td>NFPA 101 Egress Doors</td>
<td><strong>K 222</strong></td>
<td><strong>K 222</strong> Egress Doors</td>
</tr>
<tr>
<td>SS=E</td>
<td>Egress Doors. Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING. Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times.</td>
<td>2/28/2017</td>
<td>A. The egress doors on the east and west side of the 2W wing have new hardware ordered. The vendor states it will take approximately 2 weeks for the replacement mechanisms to arrive and installation will occur once they arrive.</td>
</tr>
<tr>
<td></td>
<td>18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the</td>
<td></td>
<td>B. All doors requiring a delayed exit have the potential to be affected.</td>
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<td></td>
<td>C. All egress doors requiring a 15 second delay will be checked for proper operation and the results included on the monthly PM monitoring schedule.</td>
</tr>
</tbody>
</table>
**K 222 Continued From page 3**

Safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation.

18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS

Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system.

18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS

Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted.

18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS

Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system.

18.2.2.2.4, 19.2.2.2.4 This STANDARD is not met as evidenced by:

D. The results of the monitoring will be presented at the monthly QA meeting.
Based on observation, operational testing and interview, the facility failed to ensure special locking arrangements were in accordance with NFPA 101. Failure to provide delayed egress locking arrangements for magnetically controlled means of egress could hinder the safe evacuation of residents during a fire or other emergency. This deficient practice affected 41 residents, staff and visitors on the date of the survey. The facility is licensed for 131 SNF/NF beds and had a census of 112 on the day of the survey.

Findings include:

During the facility tour on January 18 - 19, 2017, observation and operational testing of the two (2) exit doors to the stairwells on Two West revealed the doors were magnetically controlled and required a code to activate the locks.

When asked about the locking arrangement, the Maintenance Supervisor stated he was not aware of the delayed egress requirement. Actual NFPA standard:

19.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side, unless otherwise permitted by one of the following:
- (1) Locks complying with 19.2.2.2.5 shall be permitted.
- (2)*Delayed-egress locks complying with 7.2.1.6.1 shall be permitted.
- (3)*Access-controlled egress doors complying with 7.2.1.6.2 shall be permitted.
- (4) Elevator lobby exit access door locking in...
<table>
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<tr>
<th>K 222</th>
<th>Continued From page 5</th>
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<td>with 7.2.1.6.3 shall be permitted.</td>
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<tr>
<td>(5)</td>
<td>Approved existing door-locking installations shall be permitted.</td>
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<tr>
<td></td>
<td>7.2.1.6* Special Locking Arrangements.</td>
</tr>
<tr>
<td></td>
<td>7.2.1.6.1 Delayed-Egress Locking Systems.</td>
</tr>
<tr>
<td></td>
<td>7.2.1.6.1.1 Approved, listed, delayed-egress locking systems shall be permitted to be installed on door assemblies 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 11 through 43, provided that all of the following criteria are met:</td>
</tr>
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<td>(1) The door leaves shall unlock in the direction of egress upon actuation of one of the following:</td>
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<tr>
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<td>(a) Approved, supervised automatic sprinkler system in accordance with Section 9.7</td>
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<td>(b) Not more than one heat detector of an approved, supervised automatic fire detection system in accordance with Section 9.6</td>
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<td>(c) Not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6</td>
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<td>(2) The door leaves shall unlock in the direction of egress upon loss of power controlling the lock or locking mechanism.</td>
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<td>(3)* An irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions:</td>
</tr>
</tbody>
</table>
### Statement of Deficiencies and Plan of Correction

<table>
<thead>
<tr>
<th>Name of Provider or Supplier</th>
<th>Provider Identification Number</th>
<th>Street Address, City, State, Zip Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Idaho State Veterans Home - Boise</td>
<td>135131</td>
<td>320 Collins Road, 83702-4519 Boise, ID 83707</td>
</tr>
</tbody>
</table>

#### Summary Statement of Deficiencies

**K 222 Continued From page 6**

- The force shall not be required to exceed 15 lbf (67 N).
- The force shall not be required to be continuously applied for more than 3 seconds.
- The initiation of the release process shall activate an audible signal in the vicinity of the door opening.
- Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only.
- A readily visible, durable sign in letters not less than 1 in. (25 mm) high and not less than 1/8 in. (3.2 mm) in stroke width on a contrasting background that reads as follows shall be located on the door leaf adjacent to the release device in the direction of egress:
  
  **PUSH UNTIL ALARM SOUNDS**
  
  **DOOR CAN BE OPENED IN 15 SECONDS**

**K 291 Emergency Lighting**

- Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9, 18.2.9.1, 19.2.9.1
- This STANDARD is not met as evidenced by:
- Based on record review and interview the facility failed to provide monthly and annual emergency lighting test documentation. Failure to test the emergency lighting could inhibit egress of residents during an emergency. This deficient practice affected all residents, staff and visitors on the day of survey. The facility is licensed for 131 SNF/NF beds with a census of 112 on the date of survey.

**K 291**

- Emergency Lighting
- NFPA 101 Emergency Lighting
- SS=F

A. There are less than 10 battery operated emergency lighting units in this facility, and all are located in non-patient care areas. These were tested for correct operation on February 7, 2017.

B. All other emergency exit lights are operated by the generator, which will be tested per the plan of correction for K918.
Findings include:

1.) During review of the emergency lighting test logs on January 18, 2017, from approximately 9:00 AM to 1:00 PM, records revealed that the last monthly thirty (30) second test of the emergency lighting was conducted in March 2016.

2.) During review of the emergency lighting test logs on January 18, 2017, from approximately 9:00 AM to 1:00 PM, records revealed that the last annual ninety (90) minute test of the emergency lighting was conducted in September 2015.

When asked, the Maintenance Supervisor stated the facility was unaware the tests were not completed or documentation maintained.

Actual NFPA reference:

NFPA 101
19.2.9 Emergency Lighting.
19.2.9.1 Emergency lighting shall be provided in accordance with Section 7.9.
7.9.3 Periodic Testing of Emergency Lighting Equipment.
7.9.3.1 Required emergency lighting systems shall be tested in accordance with one of the three options offered by 7.9.3.1.1, 7.9.3.1.2, or 7.9.3.1.3.
7.9.3.1.1 Testing of required emergency lighting systems shall be permitted to be conducted as follows:
(1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, except as otherwise permitted by
**K 291 Continued From page 8**

7.9.3.1.1(2).

(2)*The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction.

(3) Functional testing shall be conducted annually for a minimum of 11/2 hours if the emergency lighting system is battery powered.

(4) The emergency lighting equipment shall be fully operational for the duration of the tests required by 7.9.3.1.1(1) and (3).

(5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction.

7.9.3.1.2 Testing of required emergency lighting systems shall be permitted to be conducted as follows:

(1) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall be provided.

(2) Not less than once every 30 days, self-testing/self-diagnostic battery-operated emergency lighting equipment shall automatically perform a test with a duration of a minimum of 30 seconds and a diagnostic routine.

(3) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall indicate failures by a status indicator.

(4) A visual inspection shall be performed at intervals not exceeding 30 days.

(5) Functional testing shall be conducted annually for a minimum of 11/2 hours.

(6) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall be fully operational for the duration of the 11/2-hour test.

(7) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction.

7.9.3.1.3 Testing of required emergency lighting systems shall be permitted to be conducted as
K 291 Continued From page 9

follows:
(1) Computer-based, self-testing/self-diagnostic battery-operated
emergency lighting equipment shall be provided.
(2) Not less than once every 30 days, emergency
lighting equipment
shall automatically perform a test with a duration
of a minimum of 30 seconds and a diagnostic
routine.
(3) The emergency lighting equipment shall
automatically perform annually a test for a
minimum of 1/2 hours.
(4) The emergency lighting equipment shall be
fully operational for the duration of the tests
required by 7.9.3.1.3(2) and (3).
(5) The computer-based system shall be capable
of providing a report of the history of tests and
failures at all times.

K 324

K 324 Cooking Facilities

A. The range hood fire suppression
system was inspected on January 26,
2017.

B. There are no other range hoods in the
facility with a fire suppression
system.

C. The fire suppression system is now
on a six month inspection program.

D. The results of the fire suppression
system check will be reported to the
QA committee on a monthly basis
which includes the date of the prior
inspection and the date of the next
inspection.
**K.324 Continued From page 10**

hazardous areas, but shall not be open to the corridor.

18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2

This STANDARD is not met as evidenced by:

Based on record review and interview, the facility failed to maintain the fire suppression system for the kitchen hood in accordance with NFPA 96. Failure to maintain kitchen hood suppression systems could result in a lack of system performance, allowing fires to grow beyond incipient stages. This deficient practice affected staff and vendors in the kitchen on the date of the survey. The facility is licensed for 131 SNF/NF beds and had a census of 112 on the day of the survey.

Findings include:

During review of inspection records provided for the kitchen hood suppression system conducted on January 18, 2017, from approximately 9:00 AM to 1:00 PM, records revealed the last date of inspection of the system was conducted in December 2015. No records could be produced for the required semi-annual inspections for 2016. Interview of the Maintenance Supervisor revealed the facility was unaware the inspections had been overlooked for 2016.

Actual NFPA standard:

NFPA 96

11.2.1* Maintenance of the fire-extinguishing
<table>
<thead>
<tr>
<th>ID</th>
<th>PROVIDER/SUPPLIER/CLA ID IDENTIFICATION NUMBER:</th>
<th>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION</th>
<th>ID</th>
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<tbody>
<tr>
<td>K324</td>
<td>135131</td>
<td>(X1) PROVIDER/SUPPLIER/CLIA ID IDENTIFICATION NUMBER:</td>
<td>K324</td>
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<tr>
<td>K363</td>
<td></td>
<td>Statement of Deficiencies</td>
<td>K363 Corridor-Doors</td>
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<tr>
<td>K324, K363</td>
<td></td>
<td>Overview</td>
<td>2/23/2017</td>
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### K 324

- Continued From page 11
- Systems and listed exhaust hoods containing a constant or fire-activated water system that is listed to extinguish a fire in the grease removal devices, hood exhaust plenums, and exhaust ducts shall be made by properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction at least every 6 months.

### K 363

- NFPA 101 Corridor - Doors
- Corridor - Doors
- 2012 EXISTING
- 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 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. 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 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or...
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER</th>
<th>MULTIPLE CONSTRUCTION</th>
<th>DATE SURVEY COMPLETED</th>
</tr>
</thead>
<tbody>
<tr>
<td>135131</td>
<td>A. BUILDING 01 - ENTIRE BUILDING</td>
<td>01/19/2017</td>
</tr>
</tbody>
</table>

**NAME OF PROVIDER OR SUPPLIER**

**IDAHO STATE VETERANS HOME - BOISE**

**STREET ADDRESS, CITY, STATE, ZIP CODE**

320 COLLINS ROAD, 83702-4518  
BOISE, ID 83707

**ID PREFIX TAG**

<table>
<thead>
<tr>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
<td>(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
</tr>
</tbody>
</table>

**K 363**

Continued From page 12

frames in window assemblies.

19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485

Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.

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, preventing defend in place.

This deficient practice has the potential to affect 48 residents, staff, and visitors on the date of survey. The facility is licensed for 131 SNF/NF beds with a census of 112 on the day of survey.

Findings include:

1.) During the facility tour on January 18, 2017, from approximately 1:00 PM to 4:30 PM, observation and operational testing of the three (3) sets of double doors from the dining room to the corridor, revealed an approximately 1/2" gap between the doors when fully closed.

2.) During the facility tour on January 18 - 19, 2017, observation and operational testing of the corridor doors to the following resident rooms revealed gaps at the top of the doors ranging in size from 1/4" to 1/2" that would not resist the passage of smoke and fire when fully closed:

First floor:
- Resident Room 303
- Resident Room 322
- Resident Room 326
- Resident Room 332
**IDaho State Veterans Home - Boise**

<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
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</table>
| K 363 | Continued From page 13  
Second floor, Two West:  
- Resident Room 211  
- Resident Room 223  
- Resident Room 227  
- Resident Room 228  

When asked, the Maintenance Supervisor stated the facility was unaware of the door gaps.  
**Actual NFPA Standards:**  
19.3.6.3* Corridor Doors.  
19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be doors constructed to resist the passage of smoke and shall be constructed of materials such as the following:  
1. 13/4 in. (44 mm) thick, solid-bonded core wood  
2. Material that resists fire for a minimum of 20 minutes | K 363 | | |
| K 372 SS=E | **NFPA 101 Subdivision of Building Spaces - Smoke Barrier**  
Subdivision of Building Spaces - Smoke Barrier  
Construction 2012 EXISTING  
Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier.  
19.3.7.3, 8.6.7.1(1)  
Describe any mechanical smoke control system in REMARKS. | K 372 | **K372 Subdivision of Building Spaces-Smoke Barrier**  
A. The doors identified in the 2567 will be adjusted and fixed by February 10, 2017.  
B. All doors which form a smoke barrier have the potential to be affected.  
C. Maintenance will complete an inspection of all smoke barrier doors for proper sealing. These doors will be inspected monthly as part of the monthly PM audits. | 2/23/2017 |
K 372 Continued From page 14
This STANDARD is not met as evidenced by:
Based on observation and operational testing, the facility failed to ensure that smoke barrier doors would fully self-close and resist the passage of smoke as designed. Smoke compartment doors which do not resist the passage of smoke could allow smoke and byproducts of combustion to pass between compartments during a fire. This deficient practice affected 73 residents, staff and visitors on the day of the survey. The facility is licensed for 131 SNF/NF beds and had a census of 112 on the day of the survey.

Findings include:

During the facility tour on January 18-19, 2017, observation and operational testing of the following smoke compartment doors revealed gaps between the doors when fully closed that would not resist the passage of smoke:
1.) East Wing at Nurse's Station (approx. 1/4" gap)
2.) Corner of the Activity Room/Dining Room (approx. 1/4" gap)
3.) Secured Care Unit, by Conference Room (approx. 1/4" gap)
4.) Two West, doors between resident rooms 216 and 217 would not close completely when activated leaving a large gap. (approx. 8 inches)

Actual NFPA standard:

8.5.4 Opening Protectives.
8.5.4.1* Doors in smoke barriers shall close the opening, leaving only the minimum clearance necessary for proper operation, and shall be without louvers or grilles. The clearance under the bottom of a new door shall be a maximum of
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
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<tbody>
<tr>
<td>K 372</td>
<td>Continued From page 15</td>
<td>K 372</td>
<td>K 712 Fire Drills</td>
<td>2/9/2017</td>
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<tr>
<td>K 712</td>
<td>3/4 in. (19 mm).</td>
<td>K 712</td>
<td>A. A fire drill was conducted during the day shift on February 2, 2017. Fire drills will be conducted on the other shifts randomly over the next two months such that drills occur once per shift per quarter.</td>
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</table>
| SS=F             | Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to provide documentation of fire drills on all shifts quarterly. Failure to perform fire drills on each shift quarterly could result in confusion and hinder the safe evacuation of residents during a fire event. This deficient practice affected all residents, staff and visitors on the date of survey. The facility is licensed for 131 SNF/NF beds and had a census of 112 on the day of the survey. 

Findings Include: 

During record review conducted at the facility on January 18, 2017, from approximately 9:00 AM to 1:00 PM, review of the fire drill reports revealed that the facility was missing fire drill documentation on first and second shifts for second quarter 2016 and all shifts for fourth quarter 2016. When asked, the Maintenance |
| K 712 | Continued From page 16
Supervisor stated that he was new to his position and was unaware that fire drills had not been performed during those time frames.

Actual NFPA Standard:

**NFPA 101**

19.7.1.4* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions.

19.7.1.6 Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions.

| K 918 | NFPA 101 Electrical Systems - Essential Electric System

Electrical Systems - Essential Electric System Maintenance and Testing

The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.

Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual...
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

<table>
<thead>
<tr>
<th>PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:</th>
<th>MULTIPLE CONSTRUCTION</th>
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<tbody>
<tr>
<td>135131</td>
<td>A. BUILDING 01 - ENTIRE BUILDING</td>
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<tr>
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<td>BOISE, ID 83707</td>
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<tr>
<td>K 918 Continued From page 17 transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the generator for the EES (Essential Electrical System) was maintained in accordance with NFPA 110. Failure to inspect and test EES generators could result in a lack of system reliability during a power loss. 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 112 on the date of the survey. Findings include: 1.) During review of the facility generator inspection and testing records on January 18, 2017, from approximately 9:00 AM to 1:00 PM, the facility failed to provide weekly generator inspection logs between April 28, 2016 and November 23, 2016. 2.) During review of the facility generator inspection and testing records on January 18, 2017, from approximately 9:00 AM to 1:00 PM,</td>
<td>K 918</td>
<td>D. The Maintenance Director will report the findings of the generator inspections and tests at the monthly QA meeting.</td>
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