June 8, 2018

Joe Rudd, Jr., 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. Rudd, Jr.:

On May 31, 2018, 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
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 **June 21, 2018.** Failure to submit an acceptable PoC by **June 21, 2018,** may result in the imposition of civil monetary penalties by **July 13, 2018.**

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 may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **July 5, 2018,** (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 **July 5, 2018.** A change in the seriousness of the deficiencies on **July 5, 2018,** may result in a change in the remedy.
The remedy, which will be recommended if substantial compliance has not been achieved by **July 5, 2018**, includes the following:

Denial of payment for new admissions effective **August 31, 2018**.

*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 **December 1, 2018**, 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 visit, 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 **May 31, 2018**, 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 June 21, 2018. If your request for informal dispute resolution is received after June 21, 2018, 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,

Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/jj
Enclosures
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CIA

IDENTIFICATION NUMBER:

135038

(X2) MULTIPLE CONSTRUCTION

A. BUILDING

B. WING

(X3) DATE SURVEY COMPLETED

05/31/2018

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

E 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 equipped with a diesel fired, emergency EPSS generator with automatic transfer and is supported by a municipal fire authority, including county emergency response services. Currently the facility is licensed for 153 SNF/NF beds with a census of 74 on the date of the survey.

The following deficiencies were cited during the emergency preparedness survey conducted on May 30 and 31, 2018. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.

The Survey was conducted by:

Sam Burbank
Health Facility Surveyor
Facility Fire Safety & Construction

E 004 Develop EP Plan, Review and Update Annually

SS=D CFR(s): 483.73(a)

[The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.]

* [For hospitals at §482.15 and CAHs at §485.625(a): The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

JUN 21 2018

FACILITY STANDARDS

This Plan of Correction is required under Federal and State Regulations and statutes applicable to long-term care providers. This Plan of Correction does not constitute an admission of liability on part of the facility, and such liability is specifically denied. The submission of this Plan of Correction does not constitute agreement by the facility that the surveyor's findings and/or conclusions constitute a deficiency, or that the scope and severity of the deficiencies cited are correctly applied.

Additional Abbreviations:

EP = Emergency Plan
SDC = Staff Development Coordinator
QA = Quality Assurance
IDT = Interdisciplinary Team

Corrective Action:


Identification:

All residents, staff, and visitors are identified as potentially being affected by this deficiency.

Continued on p. 2

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**

**Provider/Supplier/CLA Identification Number:** 135038

**Multiple Construction**

- **Building:**
- **Wing:**

**Date Survey Completed:** 05/31/2018

**Name of Provider or Supplier:** LIFE CARE CENTER OF BOISE

**Street Address, City, State, Zip Code:** 808 NORTH CURTIS ROAD

**State:** BOISE, **ID:** 83706

**Summary Statement of Deficiencies**

*(Each deficiency must be preceded by full regulatory or LSC identifying information)*

**E 004** Continued From page 1

<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>PREFIX</th>
<th>TAG</th>
</tr>
</thead>
</table>

[hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.

The emergency preparedness program must include, but not be limited to, the following elements:

(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least annually.

* [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least annually.

This **REQUIREMENT** is not met as evidenced by:

Based on record review, it was determined the facility failed to develop an Emergency Preparedness program in accordance with 42 CFR 483.73 which is reviewed and updated annually. Failure to review and update emergency preparedness plan, policies and procedures annually has the potential to hinder resident continuity of care during a disaster. This deficient practice affected 74 residents, staff and visitors on the date of the survey.

**Findings include:**

On 5/30/18 from 10:00 AM - 3:00 PM, review of the provided emergency plan, policies and procedures, revealed the facility had not conducted and documented an annual review of the emergency plan in accordance with the standard. Documentation of the annual review located on page 7 of the Manual Signature sheet,

---

**Systemic Changes:**

1. Facility Interdisciplinary Team (IDT) to review and update EP and related policies and procedures annually.

2. Facility IDT received inservice regarding the requirement for the annual review of the EP and related policies and procedures.

**Monitor:**

Facility Administrator to ensure completion of the annual review of EP and related policies and procedures.

**Completion Date:** July 5, 2018
Summary Statement of Deficiencies

<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>E 004</td>
<td>E 004</td>
<td>Corrective Action:</td>
</tr>
<tr>
<td>Continued From page 2</td>
<td></td>
<td>1. Hurricanes have been removed from Hazard Vulnerability Assessment (HVA) as hazard for the facility.</td>
</tr>
<tr>
<td>did not contain any signatures of those persons listed as required for review.</td>
<td></td>
<td>2. HVA has been reviewed and updated to reflect pertinent hazards for the facility geographic location and that the facility may encounter or be vulnerable to.</td>
</tr>
<tr>
<td>Further review of the provided plan, policies and procedures revealed the facility HVA (Hazard Vulnerability Analysis) provided information of the impact of Hurricanes, which are not geographically relevant to the facility location.</td>
<td></td>
<td>3. The hazard presented by the fossil fuel depot, located to the south of the facility has been included in the HVA.</td>
</tr>
<tr>
<td>Reference: 42 CFR 483.73 (a)</td>
<td></td>
<td>Identification:</td>
</tr>
<tr>
<td>E 006</td>
<td>E 006</td>
<td>All residents, staff, and visitors are identified as possibly being affected by this deficiency.</td>
</tr>
<tr>
<td>Plan Based on All Hazards Risk Assessment</td>
<td>Plan Based on All Hazards Risk Assessment</td>
<td>Systemic Changes:</td>
</tr>
<tr>
<td>SS=F CFR(s): 483.73(a)(1)-(2)</td>
<td>SS=F CFR(s): 483.73(a)(1)-(2)</td>
<td>1. Facility IDT to receive inservice regarding the HVA and the requirement to review and update it annually.</td>
</tr>
<tr>
<td>[(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:]</td>
<td></td>
<td>2. Facility IDT to review and update the HVA annually.</td>
</tr>
<tr>
<td>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.*</td>
<td></td>
<td>Monitor: Administrator / Designee to ensure EP and HVA are reviewed and updated annually, July 5, 2018.</td>
</tr>
<tr>
<td>*For LTC facilities at §483.73(a)(1):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*For ICF/IIDs at §483.475(a)(1):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2) Include strategies for addressing emergency events identified by the risk assessment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>* For Hospices at §418.113(a)(2):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2) Include strategies for addressing emergency events identified by the risk assessment, including the</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Identification: All residents, staff, and visitors are identified as possibly being affected by this deficiency.

Systemic Changes:

1. Facility IDT to receive inservice regarding the HVA and the requirement to review and update it annually.
2. Facility IDT to review and update the HVA annually.

Monitor: Administrator / Designee to ensure EP and HVA are reviewed and updated annually, July 5, 2018.
**NAME OF PROVIDER OR SUPPLIER**
LIFE CARE CENTER OF BOISE

**STREET ADDRESS, CITY, STATE, ZIP CODE**
808 NORTH CURTIS ROAD
BOISE, ID 83706

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>PRECISION</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX</th>
<th>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>
</thead>
<tbody>
<tr>
<td>E 006</td>
<td>Continued From page 3</td>
<td></td>
<td>management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to develop an Emergency Preparedness program that included a relevant facility based and community based risk assessment. Failure to provide a relevant facility and community based risk assessment, has the potential to focus staff training and resources on hazards that are not site specific. This deficient practice affected 74 residents, staff and visitors on the date of the survey. Findings include: 1) On 5/30/18 from 2:00 - 2:30 PM, review of the provided emergency plan, policies and procedures, revealed the facility HVA (Hazard Vulnerability Analysis) provided information of the impact of Hurricanes, which are not geographically relevant to the facility. Review of the county all-hazard mitigation plan for the area found no indication Hurricanes were a likely occurrence. 2) On 5/30/18 from 2:00 - 2:30 PM, comparison of the county hazard mitigation plan found hazmat was regarded as a substantial risk to the community, yet the facility found the risk of external hazmat exposure as low. Further observation of the facility location revealed two (2) fully operational fossil fuel depots, one across the street and one less than one-half mile from the facility. Interview of 3 of 3 staff members identified this risk as substantial to the facility's potential for disasters.</td>
<td>E 006</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Statement of Deficiencies and Plan of Correction

**X1** Provider/Supplier/Clinic Identification Number: 135038

**X2** Multiple Construction
A. Building
B. Wing

**X3** Date Survey Completed: 05/31/2018

**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)

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Summary Statement of Deficiencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>E 006</td>
<td>Continued From page 4</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3) On 5/30/18 from 2:00 - 2:30 PM, comparison of the provided HVA to one provided from the EP plan dated 2004, revealed the information contained on external hazmat risk was the same and had not been reviewed or recently updated.

Reference:
42 CFR 483.73 (a) (1) - (2)

<table>
<thead>
<tr>
<th>E 026</th>
<th>Roles Under a Waiver Declared by Secretary</th>
</tr>
</thead>
<tbody>
<tr>
<td>SS=E</td>
<td>CFR(s): 483.73(b)(8)</td>
</tr>
</tbody>
</table>

[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:]

[(8)] [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.

*For RNHCl's at §403.748(b):* Policies and procedures. (b) The role of the RNHCl under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials.

This REQUIREMENT is not met as evidenced by:
Based on record review, it was determined the facility failed to document their role under an 1135

**Corrective Action:**
Document defining role of facility in the event of 1135 waiver, as declared by the Secretary, and provisions of care as required if identified by emergency management officials has been included in the facility EP.

**Identification:**
All residents, staff, and visitors are identified as possibly being affected by this deficiency.

**Systemic Changes:**
Review of this document to be included in the annual IDT review of the facility EP.

**Monitor:**
Administrator / Designee to ensure EP and HVA are reviewed and updated annually: July 5, 2018
STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CWA
IDENTIFICATION NUMBER:
135038

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(X3) DATE SURVEY
COMPLETED
05/31/2018

NAME OF PROVIDER OR SUPPLIER
LIFE CARE CENTER OF BOISE

STREET ADDRESS, CITY, STATE, ZIP CODE
808 NORTH CURTIS ROAD
BOISE, ID 83706

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY
OR LSC IDENTIFYING INFORMATION)

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>E 026</td>
<td>Continued From page 5</td>
<td></td>
</tr>
</tbody>
</table>

waiver as declared by the Secretary and the provisions of care as required under this action if identified by emergency management officials. Failure to plan for alternate means of care and the role under an 1135 waiver has the potential to limit facility options during an emergency. This deficient practice potentially affects reimbursement and continuity of care for the 74 residents, staff and visitors housed on the date of the survey along with the available surge needs of the community during a disaster.

Findings include:

On 5/30/18 from 10:30 AM - 3:00 PM, review of the provided emergency plan, policies and procedures, did not demonstrate the role of the facility under the declaration of an 1135 waiver, should that condition be enacted by the Secretary.

Reference:
42 CFR 483.73 (b) (8)

E 030 Names and Contact Information

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>E 030</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

[c] The [facility, except RNHCl, hospices, transplant centers, and HHAs] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:

(1) Names and contact information for the following:
(i) Staff,
(ii) Entities providing services under arrangement,
(iii) Patients' physicians
(iv) Other [facilities].

Corrective Action:
1. Communication Plan portion of EP reviewed and updated to include other LTC facilities and volunteers.
2. Communication Plan to be reviewed and updated annually.

Identification:
All residents, staff, and visitors are identified as possibly being affected by this deficiency.

Systemic Changes:
1. Communication Plan to be reviewed and updated annually.
2. Facility staff to receive inservice regarding Communication Plan and the availability of names and contact information of parties that may be of assistance in the facility's response to an emergency or disaster.

Continued on p. 7
<table>
<thead>
<tr>
<th>ID PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>E 030</td>
<td>Monitor: Facility Administrator / Designee to ensure Communication Plan is reviewed and updated annually.</td>
<td></td>
</tr>
</tbody>
</table>

---

**SUMMARY STATEMENT OF DEFICIENCIES**

**E 030 Continued From page 6**

(v) Volunteers.

*[For RNHCls at §403.748(c):] The communication plan must include all of the following:

(1) Names and contact information for the following:

(i) Staff.

(ii) Entities providing services under arrangement.

(iii) Next of kin, guardian, or custodian.

(iv) Other RNHCls.

(v) Volunteers.

*[For ASCs at §416.45(c):] The communication plan must include all of the following:

(1) Names and contact information for the following:

(i) Staff.

(ii) Entities providing services under arrangement.

(iii) Patients' physicians.

(iv) Volunteers.

*[For Hospices at §418.113(c):] The communication plan must include all of the following:

(1) Names and contact information for the following:

(i) Hospice employees.

(ii) Entities providing services under arrangement.

(iii) Patients' physicians.

(iv) Other hospices.

*[For OPOs at §486.360(c):] The communication plan must include all of the following:

(1) Names and contact information for the following:

(i) Staff.

(ii) Entities providing services under arrangement.

(iii) Volunteers.

(iv) Other OPOs.
<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>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>E 030</td>
<td>Continued From page 7 (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the facility failed to document a communication plan which included contact information for staff, resident physicians, other facilities and volunteers. Failure to have a communication plan which includes contact information for those parties assisting in the facility's response and recovery during a disaster, has the potential to hinder both internal and external emergency response efforts. This deficient practice affected 74 residents, staff and visitors on the date of the survey. Findings include: On 5/30/18 from 11:30 AM - 3:00 PM, review of provided emergency plan, policies and procedures, failed to reveal a communication plan that included contact information for volunteers and other LTC (Long Term Care Facilities). Reference: 42 CFR 483.73 (c) (1)</td>
<td>E 030</td>
<td>Corrective Action: 1. The facility Emergency Preparedness Training and Testing plan, based on the facility EP, has been reviewed, updated, and implemented per facility policy and procedure. 2. The facility Emergency Preparedness Training and Testing plan to be reviewed and updated annually. Identification: All residents, staff, and visitors are identified as possibly being affected by this deficiency. Continued on p. 9</td>
<td></td>
</tr>
</tbody>
</table>
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER:** Life Care Center of Boise

**STREET ADDRESS, CITY, STATE, ZIP CODE:** 808 North Curtis Road, Boise, ID 83706


<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>E 036</td>
<td>Continued From page 8</td>
<td>(E) Requirement is met as evidenced by:</td>
<td>E 036</td>
<td></td>
<td>Systemic Changes:</td>
<td></td>
</tr>
</tbody>
</table>

*For ICF/IID at §483.475(d):* Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h).

*For ESRD Facilities at §494.62(d):* Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing, and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing, and orientation program must be reviewed and updated at least annually. This REQUIREMENT is not met as evidenced by:

Based on record review and interview, it was determined the facility failed to provide an emergency prep training and testing program. Lack of a facility emergency training and testing program covering the emergency preparedness plan, policies and procedures, has the potential to hinder staff response during a disaster. This deficient practice affected 74 residents, staff, and visitors on the date of the survey.
Findings include:

On 5/30/18 from 2:00 - 2:30 PM, review of provided emergency plan, policies and procedures, found no documentation demonstrating the facility had a current testing program for staff based on training conducted of the emergency plan.

Interview of 4 of 4 staff conducted on 5/31/18 from 10:00 AM - 2:00 PM, established staff had not participated in any specific training or testing program on the emergency plan contents.

Corrective Action:

1. As noted in Corrective Action for E 036, facility EP Training Program related to EP policy and procedures has been reviewed and implemented as per policy and procedure. EP Training Program includes:
   a. Initial training of newly hired staff regarding EP and related policies and procedures.
   b. Ongoing training for existing staff on an annual basis.
   c. Testing of staff knowledge of EP policies and procedures presented.

Identification:
All residents, staff, and visitors are identified as possibly being affected by this deficiency.

Continued on p. 11
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:
135038  
(X2) MULTIPLE CONSTRUCTION  
A. BUILDING _________________  
B. WING _________________  
(X3) DATE SURVEY COMPLETED
05/31/2018  
(X4) COMPLETION DATE  

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

<table>
<thead>
<tr>
<th>ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>E037</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>E037</td>
</tr>
</tbody>
</table>

| PROVIDER'S PLAN OF CORRECTION  
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  

**Systemic Changes:**  
1. Facility SDC to update schedule of Emergency Preparedness Training and Testing and place schedule on calendar annually.  
3. Facility SDC to manage the documentation of Emergency Preparedness Training and Testing.  

Monitor:  
Facility Administrator / Designee to review Emergency Preparedness Training and Testing Schedule and documentation to ensure compliance.  
July 5, 2018  

Continued From page 10  
their expected roles.  
(ii) Provide emergency preparedness training at least annually.  
(iii) Maintain documentation of the training.  
(iv) Demonstrate staff knowledge of emergency procedures.  

*For Hospices at §418.113(d):* (1) Training. The hospice must do all of the following:  
(i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.  
(ii) Demonstrate staff knowledge of emergency procedures.  
(iii) Provide emergency preparedness training at least annually.  
(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.  

*For PRTFs at §441.184(d):* (1) Training program. The PRTF must do all of the following:  
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.  
(ii) After initial training, provide emergency preparedness training at least annually.  
(iii) Demonstrate staff knowledge of emergency procedures.  
(iv) Maintain documentation of all emergency preparedness training.  

*For PACE at §460.84(d):* (1) The PACE
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>E 037</td>
<td>Continued From page 11</td>
<td></td>
<td></td>
<td>E 037</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>organization must do all of the following:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(i) Initial training in emergency preparedness</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>policies and procedures to all new and existing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>staff, individuals providing on-site services under</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>arrangement, contractors, participants, and</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>volunteers, consistent with their expected roles.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(ii) Provide emergency preparedness training at</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>least annually.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(iii) Demonstrate staff knowledge of emergency</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>procedures, including informing participants of</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>what to do, where to go, and whom to contact in</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>case of an emergency.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(iv) Maintain documentation of all training.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*[For CORFs at §485.68(d):] (1) Training. The</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>CORF must do all of the following:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(i) Provide initial training in emergency</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>preparedness policies and procedures to all new</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>and existing staff, individuals providing services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>under arrangement, and volunteers, consistent</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>with their expected roles.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(ii) Provide emergency preparedness training at</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>least annually.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(iii) Maintain documentation of the training.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(iv) Demonstrate staff knowledge of emergency</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>procedures. All new personnel must be oriented</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>and assigned specific responsibilities regarding</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>the CORF's emergency plan within 2 weeks of</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>their first workday. The training program must</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>include instruction in the location and use of</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>alarm systems and signals and firefighting</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>equipment.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*[For CAHs at §485.625(d):] (1) Training program.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>The CAH must do all of the following:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(i) Initial training in emergency preparedness</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>policies and procedures, including prompt</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>reporting and extinguishing of fires, protection,</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>and where necessary, evacuation of patients,</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>personnel, and guests, fire prevention, and</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**Note:** The text continues on the next page.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:

135038

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(X3) DATE SURVEY COMPLETED
05/31/2018

NAME OF PROVIDER OR SUPPLIER
LIFE CARE CENTER OF BOISE

STREET ADDRESS, CITY, STATE, ZIP CODE
808 NORTH CURTIS ROAD
BOISE, ID 83706

E037 Continued From page 12

cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures.

*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually.

This REQUIREMENT is not met as evidenced by:

Based on record review and interview, it was determined the facility failed to provide an emergency prep training program. Lack of a training program on the emergency preparedness plan and policies for the facility, has the potential to hinder staff response during a disaster. This deficient practice affected 74 residents, staff and visitors on the date of the survey.

Findings include:

On 5/30/18 from 2:00 - 2:30 PM, review of provided emergency plan, policy and procedures, revealed no substantiating documentation demonstrating the facility had conducted a training program on the emergency preparedness
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:</th>
<th>(X2) MULTIPLE CONSTRUCTION A. BUILDING</th>
<th>(X3) DATE SURVEY COMPLETED</th>
</tr>
</thead>
<tbody>
<tr>
<td>135038</td>
<td></td>
<td>05/31/2018</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NAME OF PROVIDER OR SUPPLIER</th>
<th>STREET ADDRESS, CITY, STATE, ZIP CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>LIFE CARE CENTER OF BOISE</td>
<td>808 NORTH CURTIS ROAD BOISE, ID 83706</td>
</tr>
</tbody>
</table>

**SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)**

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>E037</td>
<td></td>
<td></td>
<td>Continued From page 13 plan, policies and procedures for existing staff and newly hired staff.</td>
<td>E037</td>
<td></td>
<td></td>
<td>Corrective Action:</td>
</tr>
</tbody>
</table>

Interview of the interim staff development coordinator on 5/30/18 from approximately 2:00 - 2:30 PM revealed the facility had not yet conducted a training for both existing and newly hired staff. Further interview of 2 of 2 staff on 5/31/18 from 8:30 - 10:00 AM revealed neither had gone through any training on the emergency plan.

Reference:
42 CFR 483.73 (d) (1)

Additional Reference: E-0036

E039 | EP Testing Requirements | SS=F | CFR(s): 483.73(d)(2) | E039 |

(2) Testing. The [facility, except for LTC facilities, RNHCls and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCls and OPOs] must do all of the following:

"[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:

(i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a

Corrective Action:
1. Facility to conduct a table top exercise.
2. Facility to conduct a full-scale community-based exercise.
3. Facility team to conduct analysis of exercises and review the documentation of those exercises and revise EP as needed.

Identification:
All residents, staff, and visitors are identified as possibly being affected by this deficiency.

Systemic Changes:
1. Facility to review and update EP annually and plan two (2) exercises (table top and full-scale community based) to test the EP each year.
2. Facility staff to be inserviced regarding the regulation to conduct testing exercises and training for respective exercises.

Continued on p. 15
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**X1)** PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER: 
135038

**X2)** MULTIPLE CONSTRUCTION 
A. BUILDING 
B. WING

**X3)** DATE SURVEY COMPLETED: 
05/31/2018

**NAME OF PROVIDER OR SUPPLIER**
LIFE CARE CENTER OF BOISE

**STREET ADDRESS, CITY, STATE, ZIP CODE**
808 NORTH CURTIS ROAD 
BOISE, ID 83706

<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>PREFIX</th>
<th>TAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>E 039</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**SUMMARY STATEMENT OF DEFICIENCIES**
(Each deficiency must be preceded by full regulatory or LSC identifying information)

Continued From page 14

<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>PREFIX</th>
<th>TAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>E 039</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**PROVIDER’S PLAN OF CORRECTION**
(Each corrective action should be cross-referenced to the appropriate deficiency)

Monitor: 
Facility Administrator / Designee to review Emergency Preparedness Training and Testing Exercises and documentation related to those exercises to ensure compliance

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>E 039</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**COMPLETION DATE**

July 5, 2018
E 039 Continued From page 15

Preparedness readiness of the facility. Failure to participate in a full-scale or tabletop exercise event has the potential to reduce the facility's effectiveness to provide continuation of care to residents during an emergency. This deficient practice affected 74 residents, staff and visitors on the date of the survey.

Findings include:

On 5/30/18 from 10:30 AM - 1:30 PM, review of provided emergency plan documents, revealed the facility failed to document completion of two (2) full-scale exercises, testing the effectiveness of the emergency preparedness plan, policies and procedures.

Reference:

42 CFR 483.73 (d) (1).
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

**Provider/Supplier/CUA Identification Number:**
135038

**Building: 01 - Entire Building**

**Date Survey Completed:**
05/31/2018

**Name of Provider or Supplier:**
Life Care Center of Boise

**Street Address, City, State, Zip Code:**
808 North Curtis Road
Boise, ID 83706

**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, with a census of 74 on the date of the survey.

The following deficiencies were cited during the annual life safety code survey conducted on May 30 and 31, 2018. 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:

Sam Burbank  
Health Facility Surveyor  
Facility Fire Safety & Construction

**K 100 DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**LABORATORY DIRECTOR’S OR PROVIDER/SUPPLIER REPRESENTATIVE’S SIGNATURE**

**DEFICIENCY R E C O R D E D**

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.

**LABORATORY DIRECTOR’S OR PROVIDER/SUPPLIER REPRESENTATIVE’S SIGNATURE**

---

**Corrective Action:**

1. The facility has a Water Management Program and has an ongoing testing schedule for Legionella as directed. The results of each of those tests have been negative for Legionella.

2. Water Management Program has been reviewed and updated.

3. Facility-based Risk Assessment for waterborne pathogens has been updated and completed.

4. Control Measures and Testing Protocols, based on the Risk Assessment, have been reviewed, updated, and implemented as necessary.

**Identification:**

All residents, staff, and visitors are identified as potentially being affected by this deficiency.

Continued on p. 2
K 100 Continued From page 1

measures based on that assessment and
determine necessary testing protocols, limits the
facility's ability to prevent transmission of
waterborne pathogens. This deficient practice
affected 74 residents, staff and visitors on the
date of the survey.

Findings include:

During review of provided water management
documentation conducted on 5/30/18 from
approximately 9:30 - 10:00 AM, documentation
failed to identify the facility had conducted a risk
assessment, identified appropriate control
measures and determine what, if any, testing
protocols would be established.

Interview of the Maintenance Director established
that the water management plan had been
initiated by the former maintenance director, but
he did not have any documentation of and was
unable to substantiate if any further development
of the plan had been completed.

CFR standard:
42 CFR 483.80

§ 483.80 Infection control.
The facility must establish and maintain an
infection control program designed to provide a
safe, sanitary, and comfortable environment and
to help prevent the development and
transmission of disease and infection.

Additional reference:
Center for Medicaid/Medicare Services S & C
letter 17-30

K 161 Building Construction Type and Height
SS=D CFR(s): NFPA 101

Systemic Changes:
1. Water Management Program reviewed
   and updated as noted in Corrective
   Action.
2. Maintenance Supervisor to conduct
testing and implement control measures
   as prescribed in Water Management
   Program and according to facility policy
   and procedure.

Monitor:
1. Facility Administrator to review
documentation related to testing and
control measures on a monthly basis
ongoing
2. Findings to be reviewed in facility QA
   and Infection Control meetings.

POC on p. 3

K 100

July 5, 2018

If continuation sheet Page 2 of 13
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

**X1 PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:**

135038

**X2 MULTIPLE CONSTRUCTION**

A. BUILDING 01 - ENTIRE BUILDING

B. WING

**X3 DATE SURVEY COMPLETED:**

05/31/2018

**NAME OF PROVIDER OR SUPPLIER:**

LIFE CARE CENTER OF BOISE

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

808 NORTH CURTIS ROAD

BOISE, ID 83706

**K 161 Continued From page 2**

Building Construction Type and Height
2012 EXISTING
Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7
19.1.6.4, 19.1.6.5

Construction Type
1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered
2 II (111) One story non-sprinklered
sprinklered

Maximum 3 stories

3 III (000) Not allowed

4 III (241) Maximum 2 stories sprinklered

5 IV (2HH)

6 V (111)

7 III (200) Not allowed

8 V (000) Maximum 1 story sprinklered

Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5)

Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.

**Corrective Action:**

1. Area identified in 2567 as #1 has been sealed as needed.
2. Area identified in 2567 as #2 has been sealed as needed.

**Identification:**

All residents, staff, and visitors are identified as possibly being affected by this deficiency.

**Systemic Changes:**

1. Facility Maintenance Supervisor to inspect work by outside contractors, that may have necessitated penetration of any facility structure, to ensure that penetrations are sealed to maintain the smoke resistive properties of the structure.
2. Facility Maintenance Supervisor to conduct monthly inspections of facility to ensure no penetrations are unsealed.

**Monitor:**

1. Administrator / IDT Designee to review monthly inspections for compliance.
2. Reviews to occur on a monthly basis ongoing.

**COMPLETION DATE:**

July 5, 2018
This REQUIREMENT is not met as evidenced by:

Based on observation and interview, the facility failed to ensure that the fire and smoke resistive properties of the structure were maintained. Failure to maintain rated construction assemblies, has the potential to allow fire, smoke and dangerous gases to pass into unprotected concealed spaces and between compartments. This deficient practice potentially affected 22 residents staff and visitors in 1 of 5 smoke compartments on the date of the survey.

Findings include:

During the facility tour conducted on May 30, 2018 from approximately 11:00 AM to 12:30 PM, the following unsealed penetrations were revealed:

1) One (1) unsealed penetration approximately two inches in diameter, which contained seven (7) data cables, which passed through the wall of the server room into the suspended ceiling area of the corridor.

2) One (1) unsealed hole approximately two inches by three inches in the northwest wall of the Medical records storage in the 300 hall, which exposed the interior wall cavity.

When asked, the Maintenance Director stated he had not been aware of these penetrations prior to the survey.

Actual NFPA standard:

19.1.6 Minimum Construction Requirements.
19.1.6.1 Health care occupancies shall be limited to the building construction types specified in
### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/Clinic Identification Number:**

135038

**Multiple Construction:**

A. Building 01 - Entire Building

B. Wing

**Date Survey Completed:**

05/31/2018

### Name of Provider or Supplier

LIFE CARE CENTER OF BOISE

808 NORTH CURTIS ROAD

BOISE, ID 83706

### Summary Statement of Deficiencies

(Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARIZED STATEMENT OF DEFIENCIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>K 161</td>
<td>Continued From page 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7. (See 8.2.1.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>8.2 Construction and Compartmentation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>8.2.1 Construction.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>8.2.1.1 Buildings or structures occupied or used in accordance with the individual occupancy chapters, Chapters 11 through 43, shall meet the minimum construction requirements of those chapters.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>8.2.2.2 Fire compartments shall be formed with fire barriers that comply with Section 8.3.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>8.3.5.6 Membrane Penetrations.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>8.3.5.6.1 Membrane penetrations for cables, cable trays, conduits, pipes, tubes, combustion vents and exhaust vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a membrane of a wall, floor, or floor/ceiling assembly constructed as a fire barrier shall be protected by a firestop system or device and shall comply with 8.3.5.1 through 8.3.5.5.2.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Identification

All residents, staff, and visitors are identified as possibly being affected by this deficiency.

### Systemic Changes

Facility Maintenance Supervisor to conduct monthly inspections of the emergency lighting to ensure they are operating properly.

### Corrective Action

Battery Back-Up Emergency Lighting has been installed at each exit of the facility.

**Identification:**

All residents, staff, and visitors are identified as possibly being affected by this deficiency.

**Systemic Changes:**

Facility Maintenance Supervisor to conduct monthly inspections of the emergency lighting to ensure they are operating properly.

**Corrective Action:**

Battery Back-Up Emergency Lighting has been installed at each exit of the facility.

**Identification:**

All residents, staff, and visitors are identified as possibly being affected by this deficiency.

**Systemic Changes:**

Facility Maintenance Supervisor to conduct monthly inspections of the emergency lighting to ensure they are operating properly.

**Corrective Action:**

Battery Back-Up Emergency Lighting has been installed at each exit of the facility.

**Identification:**

All residents, staff, and visitors are identified as possibly being affected by this deficiency.

**Systemic Changes:**

Facility Maintenance Supervisor to conduct monthly inspections of the emergency lighting to ensure they are operating properly.

Continued on p. 6
SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

K 291 Continued From page 5
affected 74 residents staff and visitors on the date of the survey.

Findings include:

During the facility tour conducted on May 30, 2018 from 10:30 AM to 3:00 PM, observation of exit doors revealed all exits were equipped with magnetic locking arrangements, which included a delayed egress component. Further observation established the facility was not providing battery backup emergency lighting for illumination of the means of egress to any of these exits.

Actual NFPA standard:

19.2.9 Emergency Lighting.
19.2.9.1 Emergency lighting shall be provided in accordance with Section 7.9.

7.9 Emergency Lighting.
7.9.1 General.
7.9.1.1* Emergency lighting facilities for means of egress shall be provided in accordance with Section 7.9 for the following:
(1) Buildings or structures where required in Chapters 11 through 43
(2) Underground and limited access structures as addressed in Section 11.7
(3) High-rise buildings as required by other sections of this Code
(4) Doors equipped with delayed-egress locks
(5) Stair shafts and vestibules of smokeproof enclosures, for which the following also apply:
  (a) The stair shaft and vestibule shall be permitted to include a standby generator that is installed for the smokeproof enclosure mechanical ventilation equipment.
  (b) The standby generator shall be permitted to

Monitor:
1. Administrator / IDT Designee to review monthly inspections for compliance.
2. Reviews to occur on a monthly basis ongoing.

COMPLETION DATE
July 5, 2018
**SUMMARY STATEMENT OF DEFICIENCIES**

(Each deficiency must be preceded by full regulatory or LSC identifying information)

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix</th>
<th>TAG</th>
<th>Corrective Action</th>
<th>Identification</th>
<th>Systemic Changes</th>
<th>Monitor</th>
</tr>
</thead>
</table>
| K 291 | SS-F | CFR(s): NFPA 101 | Exit / Directional signs have been installed at locations noted in 2567. | All residents, staff, and visitors are identified as possibly being affected by this deficiency. | Facility Maintenance Supervisor to conduct monthly inspections of the exit / directional signs to ensure they are operating properly. | Administrator / IDT Designee to review monthly inspections for compliance.  
2. Reviews to occur monthly ongoing |
| K 293 | | | | | | |
| K 293 | Continued From page 7 of travel unclear when these doors closed under activation of the fire alarm. 2) The bulkhead above the east path of travel in the 200 corridor located at rooms 207/208, the exit sign was missing on one side of the solid smoke doors, rendering continued path of travel unclear when these doors closed under activation of the fire alarm. Actual NFPA standard: 7.10.1.2 Exits. 7.10.1.2.1* Exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign that is readily visible from any direction of exit access. |
| K 923 | Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than 300 cubic feet. | K 293 | Oxygen storage room has been re-arranged and labeling affixed to the wall to more clearly define “FULL” and “EMPTY” storage spaces. |

**Identification:**
All residents are identified as possibly being affected by this deficiency.

**Systemic Changes:**
1. Inservice education provided to facility staff regarding proper storage of oxygen tanks. 2. Facility Maintenance Supervisor to conduct monthly inspections of the oxygen storage to ensure compliance.

**Monitor:**
1. Administrator / IDT Designee to review monthly inspections for compliance. 2. Reviews to occur on a monthly basis ongoing. July 5, 2018
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER: 135038

(X2) MULTIPLE CONSTRUCTION
A. BUILDING 01 - ENTIRE BUILDING
B. WING __________________

(X3) DATE SURVEY COMPLETED 05/31/2018

NAME OF PROVIDER OR SUPPLIER
LIFE CARE CENTER OF BOISE

STREET ADDRESS, CITY, STATE, ZIP CODE
808 NORTH CURTIS ROAD
BOISE, ID 83706

ID PREFIX TAG
K923

PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(FORM CMS-2567(02-99) Previous Versions Obsolete)
### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/Clinic Identification Number:** 135038

**Multiple Construction**

- **Building 01 - Entire Building**
- **Wing**

**Date Survey Completed:** 05/31/2018

**Name of Provider or Supplier:** Life Care Center of Boise

**Street Address, City, State, Zip Code:**
808 North Curtis Road
Boise, ID 83706

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
</tr>
</thead>
<tbody>
<tr>
<td>K 923</td>
<td>Continued From page 9</td>
<td></td>
</tr>
</tbody>
</table>

- **Summary Statement of Deficiencies**
  - **Actual NFPA Standard:**
    - **NFPA 99**
    - **11.6.5 Special Precautions - Storage of Cylinders and Containers.**
      - **11.6.5.1 Storage shall be planned so that cylinders can be used in the order in which they are received from the supplier.**
      - **11.6.5.2 If empty and full cylinders are stored within the same enclosure, empty cylinders shall be segregated from full cylinders.**
      - **11.6.5.3 Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed in a rapid manner.**

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
</tr>
</thead>
<tbody>
<tr>
<td>K 926</td>
<td>Gas Equipment - Qualifications and Training</td>
<td></td>
</tr>
</tbody>
</table>

- **SS=E CFR(s): NFPA 101**

- **Identification:**

<table>
<thead>
<tr>
<th>Systemic Changes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. In-service education provided to facility staff regarding the risks associated with oxygen storage, handling, or use.</td>
</tr>
<tr>
<td>2. Annual continuing education to be provided to facility staff regarding the risks associated with oxygen storage, handling, or use.</td>
</tr>
</tbody>
</table>

**Corrective Action:**
- Facility staff have received in-service education regarding the risks associated with oxygen storage, handling, or use.

**Identification:**
- All residents, staff, and visitors are identified as possibly being affected by this deficiency.

**Systemic Changes:**
- In-service education provided to facility staff regarding the risks associated with oxygen storage, handling, or use.
- Annual continuing education to be provided to facility staff regarding the risks associated with oxygen storage, handling, or use.

**Provider's Plan of Correction**

- **Identification:**
  - All residents, staff, and visitors are identified as possibly being affected by this deficiency.

**Systemic Changes:**

1. In-service education provided to facility staff regarding the risks associated with oxygen storage, handling, or use.
2. Annual continuing education to be provided to facility staff regarding the risks associated with oxygen storage, handling, or use.

Continued on p. 11
# Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLIA Identification Number:** 135038

**Deficiency:** 11.5.2.1.2 - Personnel concerned with the application and maintenance of medical gases and others who handle medical gases and the cylinders that contain the medical gases shall be trained on the risks associated with their handling and use.

**Findings:**

- Records provided did not demonstrate continuing training was performed for the risks associated with oxygen and its use.
- Interview of 4 of 4 staff members revealed none had participated in any continuing education program on the risks associated with the storage, handling or use of medical gases such as oxygen.

**Actual NFPA Standard:**

NFPA 99
11.5.2 Gases in Cylinders and Liquefied Gases in Containers.
11.5.2.1 Qualification and Training of Personnel.
11.5.2.1.1 Personnel concerned with the application and maintenance of medical gases and others who handle medical gases and the cylinders that contain the medical gases shall be trained on the risks associated with their handling and use.
11.5.2.1.2 Health care facilities shall provide programs of continuing education for their personnel.
11.5.2.1.3 Continuing education programs shall include periodic review of safety guidelines and usage requirements for medical gases and their cylinders.

**Plan of Correction:**

1. Facility SOC to monitor in-service records to ensure oxygen education and training is completed annually and as otherwise prescribed by policy.
2. Administrator / IDT Designee to review in-service records for compliance.
3. Record review to occur on a monthly basis for three (3) months and annually thereafter.

**Completion Date:** July 5, 2018

**Correction on p. 12**
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**Name of Provider or Supplier:** Life Care Center of Boise  
**Street Address, City, State, Zip Code:** 808 North Curtis Road, Boise, ID 83706

**Provider Identification Number:** 135038

**Multiple Construction**

**Building 01 - Entire Building**

**Date Survey Completed:** 05/31/2018

**Summary Statement of Deficiencies**

(Each deficiency must be preceded by full regulatory or LSC identifying information)

**Corrective Action:**

Fan identified in 2567 has been repaired and is fully functional.

**Identification:**

All residents, staff, and visitors are identified as possibly being affected by this deficiency.

**Systemic Changes:**

Facility maintenance Supervisor to conduct monthly inspection of fan identified in 2567 to ensure it is operating properly.

**Monitor:**

1. Administrator / IDT Designee to review monthly inspection for compliance.
2. Reviews to occur on a monthly basis ongoing.

**Completion Date:** July 5, 2018

---

**Deficiency:** Transferring of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transferring of High Pressure Gaseous Oxygen Used for Respiration. Transferring of any gas from one cylinder to another is prohibited in patient care rooms. Transferring to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transferring to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99).

**Actual NFPA Standard:** NFPA 99

9.3.7.5.3.2 Mechanical exhaust shall be at a rate
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>K 927</td>
<td></td>
<td></td>
<td>Continued From page 12 of 1 L/sec of airflow for each 300 L (1 cfm per 5 ft³ of fluid) designed to be stored in the space and not less than 24 L/sec (50 cfm) nor more than 235 L/sec (500 cfm).</td>
<td></td>
</tr>
</tbody>
</table>