



C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

IDAHO DEPARTMENT OF
HEALTH & WELFARE

DEBBY RANSOM, R.N., R.H.I.T. – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
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Boise, Idaho 83720-0009
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CERTIFIED MAIL: 7007 3020 0001 4044 7342

April 5, 2013

James L. Roberts, Administrator
Idaho State Veterans Home - Boise
320 Collins Road, 83702, PO Box 7765
Boise, ID 83707-7765

Provider #: 135131

Dear Mr. Roberts:

On **March 27, 2013**, 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, and a similar State Form 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 both

James L. Roberts, Administrator
April 5, 2013
Page 2 of 4

Statement of Deficiencies and Plan of Correction, Form CMS-2567 and State Form, in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **April 18, 2013**. Failure to submit an acceptable PoC by **April 18, 2013**, may result in the imposition of civil monetary penalties by **May 8, 2013**.

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.

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 **May 1, 2013**, (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 **May 1, 2013**. A change in the seriousness of the deficiencies on **May 1, 2013**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **May 1, 2013**, includes the following:

Denial of payment for new admissions effective **June 27, 2013**.
42 CFR §488.417(a)

James L. Roberts, Administrator
April 5, 2013
Page 3 of 4

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **September 27, 2013**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Mark P. Grimes, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **March 27, 2013**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

Go to the middle of the page to Information Letters section and click on State and select the following:

James L. Roberts, Administrator
April 5, 2013
Page 4 of 4

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 **April 18, 2013**. If your request for informal dispute resolution is received after **April 18, 2013**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,

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

Mark P. Grimes, Supervisor
Facility Fire Safety and Construction

MPG/dmj

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

Printed: 04/03/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135131	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 03/27/2013
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NAME OF PROVIDER OR SUPPLIER IDAHO STATE VETERANS HOME - BOISE	STREET ADDRESS, CITY, STATE, ZIP CODE 320 COLLINS ROAD. 83702 BOISE, ID 83707
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	<p>INITIAL COMMENTS</p> <p>The two story facility is Type II (111) fire resistive construction. The building is fully sprinklered, and there is a complete fire alarm/smoke detection system which was updated in 2003. There are multiple exits to grade, two hour corridor walls and the structure was built in 1978 with an addition completed in February 2004. The facility is licensed for 131 beds.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on March 27, 2013. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.</p> <p>The Survey was conducted by:</p> <p>Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction</p>	K 000	<p style="text-align: center;">RECEIVED APR 18 2013 FACILITY STANDARDS</p>	
K 038 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>This Standard is not met as evidenced by: Based upon observation and interview it was determined that the facility failed to ensure exit discharge was unobstructed to a public way. Failure to provide accessible exit discharge can prevent egress to a safe area by wheelchairs, beds and mobility impaired persons. The facility had a census of one hundred and twenty one</p>	K 038		<p>K038 Egress</p> <p>1. What corrective action(s) will be accomplished for those residents having the potential to be affected by the deficient practice? These exits are used for emergency exits only. Residents do not use these exits for daily use. They are marked for and used for use emergency only.</p> <p>2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken? Only in the event of an emergency evacuation these exits would be used to move residents from the building.</p> <p>3. What measure(s) will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur? We have started the process to install a hard surface. These areas will be formed and concrete walkways</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>James S. Roberts NHA</i>	TITLE <i>ADMINISTRATOR</i> (X6) DATE <i>4/18/2013</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 038	<p>Continued From page 1</p> <p>residents on the day of survey. These deficiencies affected all residents, staff and visitors present on the day of the survey.</p> <p>Findings include:</p> <p>1. During the facility tour on March 27, 2013 at 2:00 PM, observation revealed the hard surfaced exit discharge from the first floor east wing did not connect to a public way or parking area, there was approximately 150 feet of grassy surface to cross before a hard surface area was available. When asked if the facility had a policy to keep the exit discharges free of snow accumulation and other obstructions the Maintenance Supervisor stated that the facility did not have a policy for keeping exit discharges clear of impediments or obstructions.</p> <p>2. During the facility tour on March 27, 2013 at 2:10 PM, observation revealed the hard surfaced exit discharge from the corridor by room #301 did not connect to a public way or parking area, there was approximately 30 feet of grassy surface to cross before a hard surface area was available. When asked if the facility had a policy to keep the exit discharges free of snow accumulation and other obstructions the Maintenance Supervisor stated that the facility did not have a policy for keeping exit discharges clear of impediments or obstructions.</p> <p>3. During the facility tour on March 27, 2013 at 2:14 PM, observation revealed the hard surfaced exit discharge from the corridor by the library did not connect to a public way or parking area, there was approximately 30 feet of grassy surface to cross before a hard surface area was available. When asked if the facility had a policy to keep the exit discharges free of snow accumulation and</p>	K 038	<p>will be poured from the doorways to the front sidewalk and parking lot. The areas that this project will involve are the exit from the first floor east wing, the exit discharge from the corridor by room #301 and the exit discharge from the corridor by the library. Once these hard surfaces are installed, these exits will be kept clear of impediments or obstructions. For example snow and ice will be removed in the winter, leaves in the fall, etc.</p> <p>4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place and include the dates when the action will be completed?</p> <p>Pouring the sidewalks will be a permanent solution to the egress problem. However, it will take some time to complete. We are in the process of getting quotes and a start date and completion date.</p> <p>We would like to ask for an extension for K 038 as we do not feel that we can be certain that this project will be completed by May 1, 2013. We believe we can make the compliance date of June 1, 2013. We have a purchase order with Gafford Construction to complete this project. Depending on the weather conditions, the project may take longer than the deadline of May 1, 2013 to complete. (A copy of the purchase order for this project is attached.)</p> <p>5. Date Corrective action will be completed: June 1, 2013</p>	

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K 038	Continued From page 2 other obstructions the Maintenance Supervisor stated that the facility did not have a policy for keeping exit discharges clear of impediments or obstructions. Actual NFPA Standard: 19.2.1 General. Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7. Exception: As modified by 19.2.2 through 19.2.11. 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. 7.7.1* Exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way. Exception No. 1: This requirement shall not apply to interior exit discharge as otherwise provided in 7.7.2. Exception No. 2: This requirement shall not apply to rooftop exit discharge as otherwise provided in 7.7.6. Exception No. 3: Means of egress shall be permitted to terminate in an exterior area of refuge as provided in Chapters 22 and 23.	K 038		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD 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	K 050	K050 Fire Drills 1. What corrective action(s) will be accomplished for those residents having the potential to be affected by the deficient practice? All residents have the potential to be affected by the deficient practice. Better scheduling of fire drills will be accomplished by adding the fire drills to the maintenance scheduling calendar. This will be done by the Maintenance and Operations Supervisor.	

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K 050	Continued From page 3 assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This Standard is not met as evidenced by: Based on record review and interview it was determined that the facility did not conduct one drill per shift per quarter. Failure to adequately conduct drills for all shifts can result in staff not being trained to react appropriately in an emergency. The facility had a census of one hundred and twenty one residents on the day of survey. This deficiency affected all residents, staff and visitors present on the day of the survey. Findings include: During record review on March 27, 2013 at 10:05 AM, the facility was unable to provide documentation for conducting drills for the 3rd shift during the second and third quarters, and all three shifts during the fourth quarter during the previous twelve month period. When questioned about the documentation for the drills the Maintenance Supervisor stated that he was unable to provide any further documentation.	K 050	2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken? Careful scheduling will be set up to assure that all three work shifts will be covered for fire drills. This will make sure we cover day shift, evening shift and NOC shift. The drills will be on three consecutive days at unexpected times under varying conditions to prevent overlapping of shifts. 3. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur? A copy of each fire drill will be kept in the maintenance supervisor's records as well as a copy being kept in the administrator's office. This record will reflect the date and times that the drills were held. The report generated by the Fire Panel Printer will also be pulled, printed and attached to the maintenance supervisor's records. A duplicate of this report will also be kept in the administrator's office. 4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place and include the dates when the action will be completed. Fire drills will be done every two months. Care will be taken to make sure that all quarters are covered. Better record keeping will help assure prompt scheduling of fire drills. The new fire drill procedure will start April 24, 2013 and end on April 26, 2013. These will be held at unexpected times under varying conditions over these three days. 5. Date Corrective action will be completed: May 1, 2013	
K 070 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8	K 070	K070 Space Heater 1. What corrective action(s) will be accomplished for those residents having the potential to be affected by the deficient practice? The portable space heater was immediately removed from the area. No other portable space heaters were identified in use. 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?	

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K 070	<p>Continued From page 4</p> <p>This Standard is not met as evidenced by: Based on observation and interview it was determined that the facility did not ensure that the use of portable space heaters was prohibited or tested to ensure that the heating element did not exceed 212 degrees Fahrenheit in nonsleeping staff and employee areas. The use of portable heating devices have historically been the cause of fires. The facility had a census of one hundred and twenty one residents on the day of survey. This deficiency affected five residents and six staff members in one of fourteen smoke compartments.</p> <p>Findings include:</p> <p>During the tour of the facility on March 27, 2013 at 12:55 PM, observation of the main office revealed a portable space heater that was in operation. This was observed and noted by the Maintenance Supervisor and Surveyor. When questioned by the Surveyor the Maintenance Supervisor stated that he did not test the temperature of the heating element to ensure that it did not exceed 212 degrees Fahrenheit.</p> <p>Actual NFPA Standard:</p> <p>Chapter 19 EXISTING HEALTH CARE OCCUPANCIES 19.7.8 Portable Space-Heating Devices. Portable space-heating devices shall be prohibited in all health care occupancies. Exception: Portable space-heating devices shall be permitted to be used in nonsleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C).</p>	K 070	<p>Residents do not occupy the Business Office as they only go there to take care of personal or financial business.</p> <p>3. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur? We have created a monthly work order that will be done by the maintenance staff each month. The scope of this work order will be to check the facility for portable space heaters throughout the facility. A copy of sample work order is attached. We will also cover the policy regarding space heaters (not being allowed in the facility) in the form of an In-Service. The policy will be discussed at our next All Staff Meeting scheduled for April 25th at 2:15pm. All staff who attend this meeting will sign the In-Service sheet. The space heater policy will also be posted on each unit so that those staff not able to attend the All Staff meeting on the 25th will read the policy and sign the in-service sheet indicating they have read said policy.</p> <p>4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place and include the dates when the actin will be completed. The monthly work orders will be turned in at the end of each month by the maintenance staff and will be held in the maintenance office for a period of six months. The topic of portable space heaters will be covered during upcoming Fire and Safety in-services which are held every quarter.</p> <p>5. Date Corrective action will be completed: May 1, 2013</p>	

Bureau of Facility Standards

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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2.</p> <p>The two story facility is Type II (111) fire resistive construction. The building is fully sprinklered, and there is a complete fire alarm/smoke detection system which was updated in 2003. There are multiple exits to grade, two hour corridor walls and the structure was built in 1978 with an addition completed in February 2004. The facility is licensed for 131 beds.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on March 27, 2013. The facility was surveyed under IDAPA 16.03.02, Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities.</p> <p>The surveyor conducting the survey was:</p> <p>Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction</p>	C 000	<p style="text-align: center;">RECEIVED APR 18 2013 FACILITY STANDARDS</p>	
C 226	<p>02.106 FIRE AND LIFE SAFETY</p> <p>106. FIRE AND LIFE SAFETY. Buildings on the premises used as facilities shall meet all the requirements of local, state and national codes concerning fire and life safety standards that are applicable to health care facilities.</p> <p>This Rule is not met as evidenced by: Refer to the following Federal "K" tags on the CMS - 2567:</p>	C 226		Please Refer to Plan of Correction Form CMS-2567 (02-99) for K038, K050, and K070.

Idaho form
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

James S. Roberts NHA

TITLE

ADMINISTRATOR

(X6) DATE

4/18/2013

Bureau of Facility Standards

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C 226	Continued From Page 1 1. K038 Exit discharge. 2. K050 Fire drills. 3. K070 Portable space heater.	C 226		
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