



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

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

DEBRA RANSOM, R.N., R.H.I.T., Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0009  
PHONE 208-334-6626  
FAX 208-364-1888

**CERTIFIED MAIL: 7012 1010 0002 0836 4209**

January 29, 2014

Michael Crowley, 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. Crowley:

On **January 22, 2014**, 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 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

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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 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 **February 11, 2014**. Failure to submit an acceptable PoC by **February 11, 2014**, may result in the imposition of civil monetary penalties by **March 3, 2014**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.
- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567 and the state licensure survey report, State Form.

All references to federal regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **February 26, 2014**, (Opportunity to Correct). Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **February 26, 2014**. A change in the seriousness of the deficiencies on **February 26, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by

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**February 26, 2014**, includes the following:

Denial of payment for new admissions effective **April 22, 2014**.  
42 CFR §488.417(a)

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **July 22, 2014**, 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 **January 22, 2014**, 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/NursingFa>

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[ilities/tabid/434/Default.aspx](#)

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

BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process  
2001-10 IDR Request Form

This request must be received by **February 11, 2014**. If your request for informal dispute resolution is received after **February 11, 2014**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



Mark P. Grimes, Supervisor  
Facility Fire Safety and Construction

MPG/lj  
Enclosures

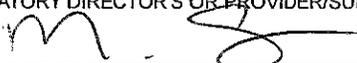
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 01/28/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135038</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/22/2014</b>
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NAME OF PROVIDER OR SUPPLIER <b>LIFE CARE CENTER OF BOISE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>808 NORTH CURTIS ROAD BOISE, ID 83706</b>
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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
K 000	<p><b>INITIAL COMMENTS</b></p> <p>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.</p> <p>The following deficiencies were cited during the annual life safety code survey conducted on January 22, 2014. 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>Tom Mroz CFI-II Health Facility Surveyor Facility Fire Safety and Construction</p>	K 000	<p style="text-align: center;"><b>RECEIVED</b> <b>FEB 11 2014</b> <b>FACILITY STANDARDS</b></p> <p><i>Preparation and/or execution of the plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies</i></p>	
K 062 SS=F	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This Standard is not met as evidenced by: Based on record review and interview, the facility failed to properly maintain the water based fire protection systems. The deficient practice affected all four smoke compartments, staff and all patients. The facility has the capacity for 153 beds with a census of 77 the day of survey.</p> <p>Findings include:</p>	K 062	<p><b>What Corrective actions will be accomplished for those residents/issues found to have been affected by the deficient practice.</b></p> <p>The 5 dry side wall pendant sprinklers that are dated 1997 will be replaced.</p> <p><b>How you will identify other residents/issues having the potential to be affected by the same deficient practice.</b></p> <p>All other sprinklers in the facility have been checked to ensure that they are not outdated. All other sprinkler heads are current.</p> <p>The 5 year sprinkle pipe inspection will be completed and if any issues are identified during that inspection they will be remedied in a timely manner.</p>	2/28/14  2/28/14  2/28/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>NHA</b>	(X6) DATE <b>2/10/14</b>
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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 062	Continued From page 1  1.) During record review of the facility's automatic sprinkler system's inspection and testing reports for the 12 month period prior to the day of survey on January 22, 2014 at 1:45 p.m., the inspection report notes "there were 5 dry side wall pendants that are dated 1997". Interview with the Maintenance Supervisor revealed the facility had not replaced the outdated sprinklers.  2.) During record review of the facility's sprinkler testing reports for the last 60 month period on January 22, 2014 at 1:45 p.m., the facility was unable to provide any documented 5 year internal piping inspection reports of the automatic sprinkler system. Interview with the Maintenance Supervisor revealed the facility was not aware of the 5 year internal piping inspection had not been performed.  Actual NFPA Standards:  Item 1) NFPA 101, 4.6.12.1 Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be continuously maintained in accordance with applicable NFPA requirements or as directed by the authority having jurisdiction.  NFPA 25, 1-4.4 The owner or occupant promptly shall correct or repair deficiencies, damaged parts, or impairments found while performing the inspection, test, and maintenance requirements of this standard. Corrections and repairs shall be	K 062	<b>What measures will be put in place or what systematic changes you will make to ensure that the deficient practice does not recur;</b>  The Maintenance Supervisor will be in-serviced on ensuring that all necessary test and inspection relating to the facility's automatic sprinkler system are conducted at the appropriate intervals and on when sprinkler heads become outdated and need to be replaced.  <b>How the corrective actions will be monitored to ensure the deficient practice will not recur.</b>  The Administrator will conducted monthly audits to ensure that the necessary tests and inspections of the automatic sprinkler system are being completed as required by the Life Safety Code Standards and that any out dated equipment is replaced. The results of these audits will be reported to the Performance Improvement Committee. The Performance Improvement Committee will make recommendations as to when to discontinue the audits.  The Administrator will ensure compliance.	2/28/14  2/28/14



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K 144	<p>Continued From page 3</p> <p>Record review on January 22, 2014 at 2:50 p.m., of the facility's generator inspection logs for the calendar year prior to the survey indicated that the facility had the generator programmed to automatically run under load on a weekly basis. The facility was not documenting the generator being tested under load on a monthly basis for a minimum of 30 minutes as required. Interview with the Maintenance Supervisor on January 22, 2014 at 2:50 p.m., revealed that the facility was unaware of the requirement for documenting the emergency generator to be tested under load on a monthly basis for a minimum of 30 minutes and the requirement to manually operate the transfer switch monthly.</p> <p>Actual NFPA Standards:</p> <p>NFPA 99, 3-4.4.1.1(b), 1. Generator sets shall be tested twelve (12) times a year with testing intervals between not less than 20 days or exceeding 40 days. Generator sets serving emergency and equipment systems shall be in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6.</p> <p>NFPA 110, 6-3.4. A written record of the EPSS inspections, tests, exercising, operation, and repairs shall be maintained on the premises.</p> <p>NFPA 110, 6-4.2 Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (a) Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating (b) Loading that maintains the minimum exhaust</p>	K 144	<p><b>What measures will be put in place or what systematic changes you will make to ensure that the deficient practice does not recur;</b></p> <p>The Maintenance Supervisor will be in-serviced on the requirement of documenting that the emergency generator is being tested under load on a monthly basis for a minimum of 30 minutes and the requirement to manually operate the transfer switch monthly. The Maintenance Supervisor will conduct and document the load testing of the emergency generator on a monthly basis in accordance with the NFPA standards.</p> <p><b>How the corrective actions will be monitored to ensure the deficient practice will not recur.</b></p> <p>The Administrator will conduct monthly audits to ensure that the load testing of the emergency generator is being done in accordance with the NFPA standards. The results of these audits will be reported to the</p> <p>Performance Improvement Committee. The Performance Improvement Committee will make recommendations as to when to discontinue the audits.</p> <p>The Administrator will ensure compliance.</p>	<p>2/28/14</p> <p>2/28/14</p> <p>2/28/14</p>

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K 144	Continued From page 4 gas temperatures as recommended by the manufacturer The date and time of day for required testing shall be decided by the owner, based on facility operations.  NFPA 110, 6-4.5 Level 1 and Level 2 transfer switches shall be operated monthly. The monthly test of a transfer switch shall consist of electrically operating the transfer switch from the standard position to the alternate position and then a return to the standard position.	K 144		

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C 000	<p><b>16.03.02 INITIAL COMMENTS</b></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 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.</p> <p>The following deficiencies were cited during the annual life safety code survey conducted on January 22, 2014. 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>Tom Mroz CFI-II Health Facility Surveyor Facility Fire Safety and Construction</p>	C 000	<p>C226</p> <p>Refer to plan of correction for Federal "K" tags on the CMS 2567 for 1. K062 Fire Sprinkler System 2. K144 Generator</p>	2/28/14
C 226	<p><b>02.106 FIRE AND LIFE SAFETY</b></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. This RULE: is not met as evidenced by: Refer to the following Federal "K" tags on the CMS - 2567:</p> <p>1. K062 Fire Sprinkler System</p>	C 226	<p>Refer to plan of correction for Federal "K" tags on the CMS 2567 for 1. K062 Fire Sprinkler System 2. K144 Generator</p>	<p><b>RECEIVED</b></p> <p><b>FEB 11 2014</b></p> <p><b>FACILITY STANDARDS</b></p>

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

*m. s.*

TITLE

*NHA*

(X6) DATE

*2/10/14*

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C 226	Continued From Page 1  2. K144 Generator	C 226		

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.