



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 4001**

June 18, 2014

James Roberts, Administrator  
Idaho State Veterans Home-- Boise  
PO Box 7765  
Boise, ID 83707-1765

Provider #: 135131

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

Dear Mr. Roberts:

On **June 4, 2014**, 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

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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 **July 1, 2014**. Failure to submit an acceptable PoC by **July 1, 2014**, may result in the imposition of civil monetary penalties by **July 21, 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 **July 9, 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 **July 9, 2014**. A change in the seriousness of the deficiencies on **July 9, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **July 9, 2014**, includes the following:

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Denial of payment for new admissions effective **September 4, 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 **December 4, 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 **June 4, 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/NursingFacilities/tabid/434/Default.aspx>

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

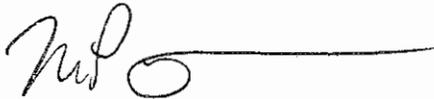
BFS Letters (06/30/11)

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

This request must be received by **July 1, 2014**. If your request for informal dispute resolution is received after **July 1, 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,

A handwritten signature in cursive script, appearing to read 'M.P. Grimes', followed by a long horizontal line extending to the right.

Mark P. Grimes, Supervisor  
Facility Fire Safety and Construction

MPG/ij  
Enclosures

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

Printed: 06/18/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135131</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/04/2014</b>
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NAME OF PROVIDER OR SUPPLIER <b>IDAHO STATE VETERANS HOME - BOISE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>320 COLLINS ROAD. 83702-4519 BOISE, ID 83707</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
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K 000	<p><b>INITIAL COMMENTS</b></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 131SNF beds.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on June 4, 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>Dan Holbrook Health Facility Surveyor</p>	K 000		
K 029 SS=F	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This Standard is not met as evidenced by: Based on observation, and interview the facility</p>	K 029	<p><b>K029</b></p> <p>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? No resident(s) were identified as being affected by this deficient practice.</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? All residents at the Idaho State Veterans Home -Boise have the potential to be affected by not having a smoke resisting partition separating the kitchen area</p>	July 1, 2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>James S. Roberts</i> NHA	TITLE ADMINISTRATOR	(X6) DATE 7/1/2014
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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 029	<p>Continued From page 1</p> <p>failed to protect a hazardous area. Failure to protect a hazardous area may cause the products of combustion to pass into another occupied area. This deficiency affected all residents, staff, and visitors. The facility is licensed for 131 SNF beds and had a census of 119 the day of the survey.</p> <p>Findings include:</p> <p>Observation on June 4, 2014 at 12:33 pm revealed the serving line was open to the kitchen and to the dining room. Investigation revealed no smoke resisting partition separating the kitchen area from the dining room. The Maintenance and Operations Manager acknowledged this finding during the survey. The Administrator and the Maintenance and Operations Manager discussed this finding with the surveyor during the exit interview.</p> <p>Actual NFPA reference:</p> <p>19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:</p> <ul style="list-style-type: none"> <li>(1) Boiler and fuel-fired heater rooms</li> <li>(2) Central/bulk laundries larger than 100 ft<sup>2</sup> (9.3 m<sup>2</sup>)</li> <li>(3) Paint shops</li> </ul>	K 029	<p>from the dining room. An automatic-closing smoke-resisting partition will be installed.</p> <p>3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? The ISVH-B will conduct a mandatory in-service no later than July 9, 2014; all staff will be made aware that in the event of a fire in the kitchen or dining area, all residents will be removed from the dining facility and kitchen area. Installation of an automatic-closing smoke resisting partition corrects the deficiency, and eliminates the possibility of the practice reoccurring.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur? Installation of the automatic-closing smoke-resisting partitions is a permanent fix eliminating the possibility of the deficiency reoccurring.</p> <p>5. Date Corrective Action will be completed: A letter requesting a one year extension has been submitted to Mark Grimes Supervisor of Facility Fire Safety and Construction. The letter was mailed on June 27, 2014 and verified receipt of letter by Mr. Grimes per phone call on July 1, 2014 at 11:50am. Installation of the automatic-closing smoke-resisting partition will be completed no later than July 1, 2015. (A one year extension was requested with Mark Grimes.)</p>	

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K 029	Continued From page 2 (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.  3.3.13.2 Area, Hazardous. An area of a structure or building that poses a degree of hazard greater than that normal to the general occupancy of the building or structure, such as areas used for the storage or use of combustibles or flammables; toxic, noxious, or corrosive materials; or heat-producing appliances.	K 029		
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5	K 056	K056 1, 2, &3 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? No residents were identified as being affected by the deficient practice. 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? All residents at the Idaho State Veterans	July 1, 2015

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K 056	Continued From page 3  This Standard is not met as evidenced by: Based on observation and interview the facility failed to protect the exterior canopy or roof of combustible construction extending greater than four feet with an automatic fire sprinkler system. Failure to provide protection allows fire to develop unabated and spread into attic and interstitial spaces and can also block exits. This affects all residents, staff, and visitors. The facility is licensed for 131 SNF beds and had a census of 119 the day of survey.  Findings include:  1. Observation on June 4, 2014 at 12:06 pm revealed an un-sprinklered roof observed from the ground to be greater than four feet deep of combustible construction over the emergency exit discharge from physical therapy. This finding was observed and acknowledged by the Maintenance and Operations Manager.  2. Observation on June 4, 2014 at 12:38 pm revealed an un-sprinklered roof of combustible construction measuring four feet, eight inches over the exit discharge of the man-door near the loading dock. This finding was observed and acknowledged by the Administrator and Maintenance and Operations Manager.  3. Observation on June 4, 2014 at approximately 5:10 revealed an un-sprinklered roof of combustible construction, measuring four feet, four and one half inches near the dock stairs side of the building. This finding was observed and acknowledged by the Administrator and the	K 056	Home -Boise have the potential to be affected by not having sprinklers protecting canopy overhangs in excess of four feet. Automatic sprinklers will be installed and tied into the automatic sprinkler system 3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? No smoking signs will be installed in all areas that have an overhang of more than 4 feet with no automatic sprinkler system. The signage will be in place no later than July 1, 2014. Installation of automatic sprinklers corrects the deficiency, and eliminates the possibility of the practice reoccurring. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur? Installation of automatic sprinklers is a permanent fix eliminating the possibility of the deficiency reoccurring. 5. Date Corrective Action will be completed: A letter requesting a one year extension has been submitted to Mark Grimes Supervisor of Facility Fire Safety and Construction. The letter was mailed on June 27, 2014 and verified receipt of letter by Mr. Grimes per phone call on July 1, 2014 at 11:50am. Installation of the sprinkler heads will be completed no later than July 1, 2015. (A one year extension was requested with Mark Grimes.)		

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K 056	Continued From page 4 Maintenance and Operations Manager.  Actual NFPA reference:  NFPA 101 19.3.5.1 Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Exception: In Type I and Type II construction, where approved by the authority having jurisdiction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specified areas where the authority having jurisdiction has prohibited sprinklers, without causing a building to be classified as nonsprinklered.  NFPA 13 - 1999 5-13 Special Situations. 5-13.8* Exterior Roofs or Canopies. 5-13.8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 ft (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.	K 056			
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  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  This Standard is not met as evidenced by: Based on observation the facility failed to	K 062	K062 (1, 2, 3, &4) 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? There were no residents affected by the deficiency. 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective	July 9, 2014	

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K 062	<p>Continued From page 5</p> <p>maintain the fire sprinkler system. Failure to maintain the fire sprinkler system may allow a fire to grow unabated. This failure effects all residents, staff, and visitors. The facility is licensed for 131 SNF beds and had census of 119 the day of the survey.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Observation on June 4, 2014 at 12:00 pm revealed the sprinkler head in the arts and crafts room storage closet has receded into the attic and has lost the trim cap . This condition creates an opening through which products of combustion may pass. The Maintenance and Operations Manager acknowledged this finding.</li> <li>2. Observation on June 4, 2014 at 3:15 pm revealed the sprinkler head in the office conference room has the incorrect escutcheon installed. This condition creates an opening through which products of combustion may pass. The Maintenance and Operations Manager acknowledged this finding.</li> <li>3. Observation on June 4, 2014 at 3:16 pm revealed the sprinkler head in the office safe room has the incorrect escutcheon installed. This condition creates an opening through which products of combustion may pass. The Maintenance and Operations Manager acknowledged this finding.</li> <li>4. Observation on June 4, 2014 at 3:22 pm revealed the administrative waiting room sprinkler head has dropped. This condition creates an opening through which products of combustion may pass. The Maintenance and Operations Manager acknowledged this finding.</li> </ol>	K 062	<p>action(s) will be taken?</p> <p>All residents at the Idaho State Veterans Home -Boise have the potential to be affected by not having escutcheon plates with recessed or flush type sprinklers on all sprinklers throughout the facility. The Maintenance Supervisor has contacted our fire suppression system contractor to make the necessary repairs to all necessary sprinkler heads and escutcheon plates. All necessary repairs to the sprinkler heads and escutcheon plates will be made no later than July 9,2014.</p> <p>3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</p> <p>The inspection will be included on the Maintenance Supervisor's preventative maintenance calendar. The Maintenance Supervisor has added Inspection of Sprinkler System and Escutcheon plates to the preventative maintenance calendar to be inspected on a monthly basis.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur?</p> <p>The Maintenance Supervisor has created a preventative maintenance calendar. The Maintenance Supervisor will meet with the Home Administrator monthly to review the preventative maintenance calendar, the Home Administrator will initial off</p>	

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K 062	Continued From page 6 Actual NFPA reference:  101 Life Safety Code  13.12-1* General. A sprinkler system installed in accordance with this standard shall be properly inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, to provide at least the same level of performance and protection as designed.  13.3.3-2.7.2* Escutcheon plates used with a recessed or flush-type sprinkler shall be part of a listed sprinkler assembly.	K 062	the calendar to verify the ISVH-B is in compliance.  5. Date corrective action will be completed: All necessary repairs to the sprinkler heads and escutcheon plates will be made no later than July 9, 2014.	
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2  This Standard is not met as evidenced by: Based on observation the facility failed to meet national electrical code. This deficiency may overload the wiring and cause a fire. The deficiency affected two of fourteen smoke compartments, 44 residents, staff, and visitors. The facility is licensed for 131 SNF beds and had a census of 119 on the day of survey.  Findings include:  1. Observation on June 4, 2014 at 11:34 of room 305 revealed an oxygen concentrator was plugged into a relocatable power tap. This finding was acknowledged and corrected by the Maintenance and Operations Manager during the	K 147	K147 (1,2 & 3) 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The residents affected by the deficiency will be safe from possible medical equipment stopping operation due to accidental shutting off, or overloading of power strips. 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? All residents at the Idaho State Veterans Home -Boise have the potential to be affected by improper use of power strips. Each resident room in the facility will be inspected for improper use of power strips.	June 4, 2014

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CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 06/18/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135131</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/04/2014</b>
NAME OF PROVIDER OR SUPPLIER <b>IDAHO STATE VETERANS HOME - BOISE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>320 COLLINS ROAD. 83702-4519 BOISE, ID 83707</b>		
(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 147	<p>Continued From page 7 survey.</p> <p>2. Observation on June 4, 2014 at 11:35 of room 307 revealed an oxygen concentrator was plugged into a relocatable power tap. This finding was acknowledged by the Maintenance and Operations Manager during the survey.</p> <p>3. Observation on June 4, 2014 at 1:55 of room 233 revealed an oxygen concentrator was plugged into a relocatable power tap. This finding was acknowledged by the Maintenance and Operations Manager during the survey.</p> <p>Actual NFPA reference NFPA 70 National Electrical Code 400.8 Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of 368.8. (5) Where concealed by walls, floors, or ceilings or located above suspended or dropped ceilings (6) Where installed in raceways, except as otherwise permitted in this Code  110.3 Examination, Identification, Installation, and Use of Equipment.</p>	K 147	<p>Written in-service has been drawn up and issued to all staff for mandatory review. All deficiencies have been corrected.</p> <p>3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? Inspection will be included on the Maintenance Supervisor's preventative maintenance calendar. The Maintenance Supervisor has added Inspection of power strips and outlets to the preventative maintenance calendar to be inspected on a quarterly basis.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur? The Maintenance Supervisor has created a preventative maintenance calendar. The Maintenance Supervisor will meet with the Home Administrator monthly to review the preventative maintenance calendar, the Home Administrator will initial off the calendar to verify the ISVH-B is in compliance.</p> <p>5. Date corrective action will be completed: All deficiencies have been corrected.</p>	

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

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K 147	Continued From page 8 (A) Examination. In judging equipment, considerations such as the following shall be evaluated: (1) Suitability for installation and use in conformity with the provisions of this Code FPN: Suitability of equipment use may be identified by a description marked on or provided with a product to identify the suitability of the product for a specific purpose, environment, or application. Suitability of equipment may be evidenced by listing or labeling. (2) Mechanical strength and durability, including, for parts designed to enclose and protect other equipment, the adequacy of the protection thus provided (3) Wire-bending and connection space (4) Electrical insulation (5) Heating effects under normal conditions of use and also under abnormal conditions likely to arise in service (6) Arcing effects (7) Classification by type, size, voltage, current capacity, and specific use (8) Other factors that contribute to the practical safeguarding of persons using or likely to come in contact with the equipment (B) Installation and Use. Listed or labeled equipment shall be installed and used in accordance with any instructions included in the listing or labeling.	K 147		

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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 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 June 4, 2014. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70 and IDAPA 16 Title 03 Chapter 22 - Residential Care or Assisted Living Facilities In Idaho.</p> <p>The Survey was conducted by:</p> <p>Dan Holbrook Health Facility Surveyor</p>	C 000	<p><b>RECEIVED</b></p> <p><b>JUL - 1 2014</b></p> <p><b>FACILITY STANDARDS</b></p>	
C 226	<p><b>02.106 FIRE AND LIFE SAFETY</b></p> <p><b>106. FIRE AND LIFE SAFETY.</b> 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 form 2567</p> <p>K29 Hazardous Area Protection K56 Sprinkler Coverage</p>	C 226	<p>C 226</p> <p>Please refer to K 062 and K 147 on completed FORM CMS-2567(02-99)</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

TITLE

(X6) DATE

*James S. Roberts* NHA

ADMINISTRATOR

7/1/14

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C 226	Continued From Page 1  K62 Sprinkler Maintenance K147 Electrical Code	C 226		
C 434	02.120,10,c  c. Plug adaptors and multiple outlets are prohibited. This RULE: is not met as evidenced by: Based on observation the facility failed to meet national electrical code. This deficiency may overload the wiring and cause a fire. The deficiency affected one of fourteen smoke compartments, 44 residents, staff, and visitors. The facility is licensed for 131 SNF beds and had a census of 119 on the day of survey.  Findings include  Observation on June 4, 2014 at 2:05 pm in room 224 revealed an ungrounded multi-plug adapter powering a TV and a refrigerator. This finding was acknowledged and corrected by the Maintenance and Operations Manager during the survey.  Actual Reference  IDAPA 16.03.02  120. EXISTING BUILDINGS. These standards shall be applied to all currently licensed health care facilities. Any minor alterations, repairs, and maintenance shall meet these standards. In the event of a change in ownership of a facility, the entire facility shall meet these standards prior to issuance of a new license. (1-1-88)  10. Electrical and Lighting. All electrical and lighting installation shall be in accordance with the National Electrical Code (1984 ed.) and as follows:	C 434	C 434  1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The residents affected by the deficiency will be safe from a possible fire hazard due to the overloading of power strips. 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? All residents at the Idaho State Veterans Home – Boise have the potential to be affected by improper use of power strips. Each resident room in the facility will be inspected for improper use of power strips. An in-service has been written and issued to all staff for mandatory review. All deficiencies have been corrected. 3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? Inspection will be included on the maintenance supervisor's preventative maintenance calendar. The maintenance supervisor has added inspection of power strips and outlets to the preventative maintenance calendar to be inspected on a quarterly basis.	June 4, 2014

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

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C 434	Continued From Page 2  (1-1-88) a. All electrical equipment intended to be grounded shall be grounded. (1-1-88) b. Frayed cords, broken plugs, and the like shall be repaired or replaced. (1-1-88) c. Plug adaptors and multiple outlets are prohibited. (1-1-88) d. Extension cords shall be U.L. approved, adequate in size (wire gauge), and limited to temporary usage. Also, only one (1) line-operated electrical appliance can be connected to an extension cord. (1-1-88)	C 434	4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur? The maintenance supervisor has created a preventative maintenance calendar. The maintenance supervisor will meet with the home administrator monthly to review the preventative maintenance calendar, the home administrator will initial off the calendar to verify the ISVH-B is in compliance. 5. The deficiency was corrected on June 4, 2014.	

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