

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135141	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - TERRACES OF BOISE-MAPLE COTTAGE B. WING _____		(X3) DATE SURVEY COMPLETED 12/21/2016
NAME OF PROVIDER OR SUPPLIER TERRACES OF BOISE, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 5301 E WARM SPRINGS AVE BOISE, ID 83716		
(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>INITIAL COMMENTS</p> <p>The Facility is a single story Type V (III) that is approximately 12,465 square divided into two smoke compartments. The facility is fully sprinklered which contains both wet and dry systems with quick response heads throughout. The building has a manual fire alarm system with corridor smoke detection interconnected with the sprinkler flow switches and off-site monitored. The building is served by a diesel powered generator and fire dampers throughout. The facility initial Life Safety Code survey was conducted on December 21, 2016, in accordance with 42 CFR 483.70, Chapter 18 of the 2012 Edition of NFPA 101, the Life Safety Code and IDAPA 16.03.02 Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities.</p> <p>The facility was found to be in substantial compliance. The Surveyor conducting the survey was: Nate Elkins, Supervisor Facility Fire Safety & Construction Program, Bureau of Facility Standards, IDHW</p>	K 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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.

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001777	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 - TERRACES OF BOISE-MAPLE COTTAGE B. WING _____	(X3) DATE SURVEY COMPLETED 12/21/2016
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NAME OF PROVIDER OR SUPPLIER TERRACES OF BOISE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 5301 E WARM SPRINGS AVE BOISE, ID 83716
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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The Facility is a single story Type V (III) that is approximately 12,465 square divided into two smoke compartments. The facility is fully sprinklered which contains both wet and dry systems with quick response heads throughout. The building has a manual fire alarm system with corridor smoke detection interconnected with the sprinkler flow switches and off-site monitored. The building is served by a diesel powered generator and fire dampers throughout. The facility initial Life Safety Code survey was conducted on December 21, 2016, in accordance with 42 CFR 483.70, Chapter 18 of the 2012 Edition of NFPA 101, the Life Safety Code and IDAPA 16.03.02 Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities. The facility was found to be in substantial compliance. The Surveyor conducting the survey was: Nate Elkins, Supervisor Facility Fire Safety & Construction Program, Bureau of Facility Standards, IDHW</p>	C 000		
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Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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