



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

BRAD LITTLE – Governor  
DAVE JEPPESEN – Director

TAMARA PRISOCK – ADMINISTRATOR  
DIVISION OF LICENSING & CERTIFICATION  
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

February 26, 2020

Rick Holloway, Administrator  
Idaho State Veterans Home - Boise  
PO Box 7765  
Boise, ID 83707

Provider #: 135131

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

Dear Mr. Holloway:

On **February 19, 2020**, 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. 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)

Rick Holloway, Administrator  
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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 **March 10, 2020**. Failure to submit an acceptable PoC by **March 10, 2020**, may result in the imposition of civil monetary penalties by **April 1, 2020**.

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 **March 25, 2020**, (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 19, 2020**. A change in the seriousness of the deficiencies on **April 4, 2020**, may result in a change in the remedy.

Rick Holloway, Administrator  
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The remedy, which will be recommended if substantial compliance has not been achieved by **March 25, 2020**, includes the following:

Denial of payment for new admissions effective **May 19, 2020**.  
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 **August 19, 2020**, 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 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 **February 19, 2020**, 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:

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<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:

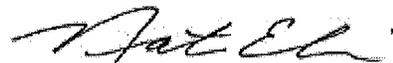
BFS Letters (06/30/11)

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

This request must be received by **March 10, 2020**. If your request for informal dispute resolution is received after **March 10, 2020**, 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/lj  
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135131</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - ENTIRE BUILDING</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/19/2020</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 BOISE, ID 83702</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 built in 1978, with an addition completed in February 2004. The East wing also houses an Assisted Living Domiciliary Unit that is separated by two-hour construction. The building is fully sprinklered with a complete fire alarm/smoke detection system which was updated in 2003. The facility has multiple exits to grade and the Emergency Power Supply System is supported by an on -site, diesel fired generator. The facility is currently licensed for 122 SNF/NF beds, and had a census of 102 on the date of the survey.</p> <p>The following deficiencies were cited during the annual fire/life safety code survey conducted on February 19, 2020. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Chapter 19, Existing Healthcare Occupancies, in accordance with 42 CFR 483.70 and 42 CFR 483.80.</p> <p>The survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	K 000	<p style="text-align: center;"><b>RECEIVED</b> FEB 26 2020 DIVISION OF VETERANS SERVICES IDAHO STATE VETERANS HOME • BOISE</p> <p style="text-align: center;"><b>RECEIVED</b> MAR 10 2020 FACILITY STANDARDS</p>	
K 311 SS=D	<p>Vertical Openings - Enclosure CFR(s): NFPA 101</p> <p>Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6.19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with</p>	K 311	<p><b>K 311</b></p> <p>A. The door listed was not in an area accessible to residents. A key was broken off in the door listed in the 2567 at the time of the survey, preventing the door from latching. The key was removed on the day of the survey and the door latched properly.</p>	3/6/2020

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Kurt J. Hollaway</i>	TITLE <i>Administrator</i>	(X6) DATE <i>3/9/2020</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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NAME OF PROVIDER OR SUPPLIER <b>IDAHO STATE VETERANS HOME - BOISE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>320 COLLINS ROAD BOISE, ID 83702</b>
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K 311	<p>Continued From page 1 construction providing at least a 2-hour fire resistance rating, also check this box.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, operational testing, the facility failed to ensure that stairwell doors communicating between floors would self-close and latch. Failure to provide doors communicating between floors which self-close and latch could allow fire, smoke and dangerous gases to pass between floors, potentially affecting the safe egress of residents. This deficient practice affected staff on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 2/19/20 from 1:00 - 3:00 PM, observation and operational testing of the lower stairwell door abutting the boiler room, leading from the basement to the upper level of the facility on the east side, revealed the door would not self-close and latch.</p> <p>Actual NFPA standard:</p> <p>NFPA 101</p> <p>19.3 Protection.</p> <p>19.3.1 Protection of Vertical Openings. Any vertical opening shall be enclosed or protected in accordance with Section 8.6, unless otherwise modified by 19.3.1.1 through 19.3.1.8.</p> <p>19.3.1.1 Where enclosure is provided, the construction shall have not less than a 1-hour fire resistance rating.</p> <p>19.3.1.7 A door in a stair enclosure shall be self-closing and shall normally be kept in the</p>	K 311	<p>B. All smoke doors have the potential to be affected.</p> <p>C. All smoke doors were examined for their ability to self-close, latch, and form a proper seal. All doors self-closed and formed an effective seal to prevent smoke, fire, and gases from passing by the door. A check of the smoke doors will be done on a monthly basis and documented on a checklist. Any door found to not function properly (self-close, latch, and seal) will be repaired immediately.</p> <p>D. The results from the monthly checks will be reported to the QA Committee each month.</p>	
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K 311	Continued From page 2 closed position, unless otherwise permitted by 19.3.1.8.  NFPA 80  6.1.4.2 Self-Closing Doors. 6.1.4.2.1 Self-closing doors shall swing easily and freely and shall be equipped with a closing device to cause the door to close and latch each time it is opened.	K 311		
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101  Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____  Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure fire suppression systems were maintained free of obstructions in accordance with NFPA 25. Failure to ensure fire suppression system pendants were not obstructed by paint or	K 353	<b>K 353</b>  A. The plastic covers on the two sprinkler heads in the walk-in coolers were removed at the time of the survey. The sprinkler head with paint on it was ordered on February 27, 2020 and, as it is a custom made size, was not readily available. It will be installed once it arrives.  B. All sprinkler heads have the potential to be affected.  C. Sprinkler heads are inspected annually in September each year by a licensed outside contractor for proper operation, placement, physical damage, the presence of corrosion, or foreign materials. The findings by the outside contractor are reported to the Maintenance	3/6/2020

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K 353	<p>Continued From page 3</p> <p>the protective caps used for installations, has the potential to hinder system performance during a fire event. This deficient practice affected staff in the main Kitchen on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 2/19/20 from 1:00 - 2:30 PM, observation of the installed fire suppression system pendants revealed the following obstructions:</p> <ul style="list-style-type: none"> <li>- The frangible sensing bulbs of the sprinkler pendants installed in two (2) of the walk-in coolers, were still covered with the plastic protective caps from the replacement installation of these pendants.</li> </ul> <p>When the Maintenance Supervisor was asked at approximately 1:45 PM if he was aware of the protective caps still covering the frangible bulbs of the two identified pendants, he stated he was not aware they had not been removed by the vendor after completion of the replacement.</p> <ul style="list-style-type: none"> <li>- One (1) fire suppression system pendant at the west corridor entrance was observed to have non-factory applied paint on the deflector.</li> </ul> <p>Actual NFPA standard:</p> <p>NFPA 25</p> <p>5.2* Inspection. 5.2.1 Sprinklers. 5.2.1.1* Sprinklers shall be inspected from the floor level annually. 5.2.1.1.1* Sprinklers shall not show signs of leakage; shall be free of corrosion, foreign</p>	K 353	<p>Director during the inspection and the written report is kept on file in the Maintenance office.</p> <p>D. The results of the inspections will be reported to the QA Committee at the time of the annual inspection.</p>	

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K 353	Continued From page 4 materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., upright, pendent, or sidewall). 5.2.1.1.2 Any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical damage (4) Loss of fluid in the glass bulb heat responsive element (5)*Loading (6) Painting unless painted by the sprinkler manufacturer 5.2.1.1.3* Any sprinkler that has been installed in the incorrect orientation shall be replaced.	K 353		
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101  Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2  This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure safe electrical installations in accordance with NFPA 70. Failure to provide approved enclosures for electrical installations, has the potential to allow contact with live parts resulting in severe injury or electrocution. This deficient practice affected staff on the date of the survey.	K 511	<b>K 511</b> A. The covers on the four electrical junction boxes were not covered as they are under 50 volts and more than 8 feet from the ground. One of the junction boxes had no wires in it. The covers for all four junction boxes were installed the day after the survey completed (February 20, 2020).  B. All electrical or data junction boxes have the potential to be affected.	3/6/2020

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K 511	<p>Continued From page 5</p> <p>Findings include:</p> <p>During the facility tour conducted on 2/19/20 from 1:00 - 2:30 PM, observation of the basement level of the facility revealed the following electrical installations with exposed wiring:</p> <ul style="list-style-type: none"> <li>- At the Boiler room, three (3) open four inch by four inch electrical junction boxes.</li> <li>- At the Central Supply room one (1) open four inch by four inch electrical junction box.</li> </ul> <p>Actual NFPA standard:</p> <p>NFPA 70</p> <p>110.27 Guarding of Live Parts. (A) Live Parts Guarded Against Accidental Contact. Except as elsewhere required or permitted by this Code, live parts of electrical equipment operating at 50 volts or more shall be guarded against accidental contact by approved enclosures or by any of the following means: (1) By location in a room, vault, or similar enclosure that is accessible only to qualified persons. (2) By suitable permanent, substantial partitions or screens arranged so that only qualified persons have access to the space within reach of the live parts. Any openings in such partitions or screens shall be sized and located so that persons are not likely to come into accidental contact with the live parts or to bring conducting objects into contact with them. (3) By location on a suitable balcony, gallery, or platform elevated and arranged so as to exclude unqualified persons. (4) By elevation of 2.5 m (8 ft) or more above the floor or other working surface.</p>	K 511	<p>C. The junction boxes have been identified and the presence of covers will be verified any time electrical or data cabling work is completed to be sure all junction boxes have covers installed. Maintenance staff have been instructed to verify junction boxes are covered once work is completed regardless of whether they are high or low voltage systems or whether they are below or above 8 feet from the ground. The Maintenance Director or designee will complete an annual inspection of all junction boxes at the same time as the receptacle inspections.</p> <p>D. The results from these reviews will be presented at the QA meeting immediately following the inspection.</p>	



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K 918	<p>Continued From page 7</p> <p>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure the Emergency Power Supply System (EPSS) generator was maintained in accordance with NFPA 110. Failure to perform required maintenance and testing of emergency generators has the potential to hinder system performance during emergencies such as a loss of power. This deficient practice affected 102 residents and staff on the date of the survey.</p> <p>Findings include:</p> <p>During the review of provided EPSS generator maintenance and inspection records conducted on 2/19/20 from 8:45 - 11:00 AM, no records were available indicating the facility had performed a four-hour load test on the EPSS generator set. When asked at approximately 10:30 AM about the missing load test documentation, the Maintenance Supervisor stated he was not aware the test was required when the monthly exercise met the criteria of thirty percent of the EPS rating.</p> <p>Actual NFPA standard:</p> <p>NFPA 110</p> <p>Chapter 8 Routine Maintenance and Operational Testing</p> <p>8.4.9* Level 1 EPSS shall be tested at least once within every 36 months.</p> <p>8.4.9.1 Level 1 EPSS shall be tested continuously for the duration of its assigned class (see Section 4.2).</p> <p>8.4.9.2 Where the assigned class is greater than</p>	K 918		
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K 918	Continued From page 8 4 hours, it shall be permitted to terminate the test after 4 continuous hours.	K 918		



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Rick Holloway, Administrator  
Idaho State Veterans Home - Boise  
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**RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER**

Dear Mr. Holloway:

On **February 19, 2020**, an Emergency Preparedness 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 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. 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.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **March 10, 2020**. Failure to submit an acceptable PoC by **March 10, 2020**, may result in the imposition of civil monetary penalties by **April 1, 2020**.

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 **March 25, 2020**, (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 . A change in the seriousness of the deficiencies on **April 11, 2020**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **March 25, 2020**, includes the following:

Denial of payment for new admissions effective **May 19, 2020**.  
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 **August 19, 2020**, 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 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 **February 19, 2020**, 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:

BFS Letters (06/30/11)

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

Rick Holloway, Administrator

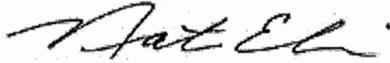
February 26, 2020

Page 4 of 4

This request must be received by **March 10, 2020**. If your request for informal dispute resolution is received after **March 10, 2020**, 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,

A handwritten signature in black ink, appearing to read "Nate Elkins".

Nate Elkins, Supervisor  
Facility Fire Safety and Construction

NE/lj  
Enclosures

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

Printed: 02/25/2020  
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. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/19/2020</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 BOISE, ID 83702</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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E 000	Initial Comments  The two-story facility is Type II (111) fire resistive construction built in 1978, with an addition completed in February 2004. The East wing also houses an Assisted Living Domiciliary Unit that is separated by two-hour construction. The building is fully sprinklered with a complete fire alarm/smoke detection system which was updated in 2003. The facility has multiple exits to grade and the Emergency Power Supply System is supported by an on-site, diesel fired generator. The facility is located in a municipal fire district, with both state and county EMS services available. The facility is currently licensed for 122 SNF/NF beds, and had a census of 102 on the date of the survey.  The following deficiency was cited during the Emergency Preparedness Survey conducted on February 19, 2020. 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 and Construction	E 000	<p><b>RECEIVED</b></p> <p><b>FEB 26 2020</b></p> <p>DIVISION OF VETERANS SERVICES IDAHO STATE VETERANS HOME • BOISE</p> <p><i>RECEIVED</i></p> <p><i>MAR 10 2020</i></p> <p><i>FACILITY STANDARDS</i></p>	
E 041 SS=F	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e)  (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section.  §483.73(e), §485.625(e)	E 041	<p><b>E 041</b></p> <p>A. The full load test for the generator was completed on February 28, 2020. A copy of this inspection is available on request.</p> <p>B. There is only one generator needing testing.</p>	3/6/2020

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Scott L. Holleney</i>	TITLE <i>Administrator</i>	(X6) DATE <i>3/9/2020</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.

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

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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 BOISE, ID 83702</b>		
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E 041	<p>Continued From page 1</p> <p>(e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section.</p> <p>§482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated.</p> <p>482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code.</p> <p>482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates.</p> <p>*[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C.</p>	E 041	<p>C. The three-year generator four hour load bank test will be put on our preventive maintenance schedule.</p> <p>D. The results from this test will be presented at the immediately following the test.</p>	

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E 041	Continued From page 2 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: <a href="http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html">http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html</a> . If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009. This REQUIREMENT is not met as evidenced	E 041		

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E 041	<p>Continued From page 3</p> <p>by: Based on record review and interview, the facility failed to ensure the emergency and standby power systems were maintained and available to provide subsistence as required under the rule. Failure to ensure Emergency Power Supply System (EPSS) generators are maintained and tested in accordance with NFPA 99 and NFPA 110, potentially hinders the facility's ability to provide continuity of care during an emergency to the 102 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During review of the EPSS generator maintenance and testing logs conducted on 2/19/20 from 8:45 - 11:00 AM, documentation failed to show a 4-hour load test was performed in the past three years. When asked about the missing testing documentation at approximately 10:30 AM, the Maintenance Supervisor stated he was not aware a four-hour load test was required when the monthly generator exercise met the criteria of meeting the EPS rating of thirty percent.</p> <p>Reference: 42 CFR 483.73 (e) (1)</p>	E 041		