



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

March 8, 2019

Rick Holloway, 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. Holloway:

On **March 5, 2019**, 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) Completion Date to signify when

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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 21, 2019**. Failure to submit an acceptable PoC by **March 21, 2019**, may result in the imposition of civil monetary penalties by **April 12, 2019**.

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 **April 9, 2019**, (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 **June 3, 2019**. A change in the seriousness of the deficiencies on **April 19, 2019**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **April 9, 2019**, includes the following:

Denial of payment for new admissions effective **June 5, 2019**.  
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 **September 5, 2019**, 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 **March 5, 2019**, 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:

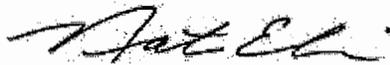
BFS Letters (06/30/11)

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

This request must be received by **March 21, 2019**. If your request for informal dispute resolution is received after **March 21, 2019**, 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  
Enclosure

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

Printed: 03/08/2019  
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 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/05/2019</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 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 117 on the dates of the survey.</p> <p>The following deficiencies were cited during the annual fire/life safety code survey conducted on March 4 and 5, 2019. 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><b>RECEIVED</b></p> <p><b>MAR 15 2019</b></p> <p><b>FACILITY STANDARDS</b></p>	
K 325 SS=F	<p>Alcohol Based Hand Rub Dispenser (ABHR) CFR(s): NFPA 101</p> <p>Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing</p>	K 325		<p><b>K 325</b></p> <p>A. The Alcohol-Based Hand Rub (ABHR) dispenser replacement testing form was revised on the day of the survey to reflect compliance with 2012 NFPA 101 19.3.2.6.</p> <p>B. All ABHR dispensers have the potential to be affected.</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Kevin J. Ashewy</i>	TITLE <i>Administrator</i>	(X6) DATE <i>3/14/2019</i>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 325	<p>Continued From page 1</p> <ul style="list-style-type: none"> <li>* Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room.</li> <li>* Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30</li> <li>* Dispensers are not installed within 1 inch of an ignition source</li> <li>* Dispensers over carpeted floors are in sprinklered smoke compartments</li> <li>* ABHR does not exceed 95 percent alcohol</li> <li>* Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11)</li> <li>* ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485</li> </ul> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure Alcohol-Based Hand Rub (ABHR) dispensers were maintained in accordance with NFPA 101. Failure to test and document operation of ABHR dispensers under manufacturer's recommendations and in accordance with the standard, has the potential of increasing the risk of fires from flammable liquids. This deficient practice affected 117 residents, staff and visitors on the dates of the survey.</p> <p>Findings include:</p> <p>1) During review of provide maintenance and inspection records conducted on 3/04/19 from 1:00 - 1:30 PM, records for refilling of ABHR dispensers demonstrated the documented information provided was the date the refill was replaced, the location of the dispenser and the initials of the individual replacing the refill. Further review of the documentation failed to establish</p>	K 325	<p>C. Testing of ABHR units will be completed each time a new refill is installed. The results of this testing will be documented on the replacement testing form.</p> <p>D. The audit findings will be reported to the QA Committee each month.</p> <p>E. Compliance date 3-18-2019.</p>	
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K 325	<p>Continued From page 2 what, if any, procedures or operational testing was being performed during this process.</p> <p>Interview of the Housekeeping Supervisor revealed he was not aware of any additional documentation of functional tests required.</p> <p>2) During the facility tour conducted on 3/04/19 from 1:00 - 3:00 PM and 3/05/19 from 9:45 -10:00 AM, observation of installed ABHR dispensers revealed manual dispensers were primarily installed throughout the facility, with the exception of three (3) automatically activated dispensers installed in the dining room of the facility.</p> <p>Actual NFPA standard:  NFPA 101</p> <p>19.3.2.6* Alcohol-Based Hand-Rub Dispensers. Alcohol-based hand-rub dispensers shall be protected in accordance with 8.7.3.1, unless all of the following conditions are met:</p> <p>(1) Where dispensers are installed in a corridor, the corridor shall have a minimum width of 6 ft (1830 mm).</p> <p>(2) The maximum individual dispenser fluid capacity shall be as follows:</p> <p>(a) 0.32 gal (1.2 L) for dispensers in rooms, corridors, and areas open to corridors (b) 0.53 gal (2.0 L) for dispensers in suites of rooms</p> <p>(3) Where aerosol containers are used, the maximum capacity of the aerosol dispenser shall be 18 oz. (0.51 kg) and shall be limited to Level 1 aerosols as defined in NFPA30B, Code for the</p>	K 325		
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K 325	<p>Continued From page 3</p> <p>Manufacture and Storage of Aerosol Products.</p> <p>(4) Dispensers shall be separated from each other by horizontal spacing of not less than 48 in. (1220 mm).</p> <p>(5) Not more than an aggregate 10 gal (37.8 L) of alcohol-based hand-rub solution or 1135 oz (32.2 kg) of Level 1 aerosols, or a combination of liquids and Level 1 aerosols not to exceed, in total, the equivalent of 10 gal (37.8 L) or 1135 oz (32.2 kg), shall be in use outside of a storage cabinet in a single smoke compartment, except as otherwise provided in 19.3.2.6(6).</p> <p>(6) One dispenser complying with 19.3.2.6 (2) or (3) per room and located in that room shall not be included in the aggregated quantity addressed in 19.3.2.6(5).</p> <p>(7) Storage of quantities greater than 5 gal (18.9 L) in a single smoke compartment shall meet the requirements of NFPA 30, Flammable and Combustible Liquids Code.</p> <p>(8) Dispensers shall not be installed in the following locations:</p> <p>(a) Above an ignition source within a 1 in. (25 mm) horizontal distance from each side of the ignition source</p> <p>(b) To the side of an ignition source within a 1 in. (25mm) horizontal distance from the ignition source</p> <p>(c) Beneath an ignition source within a 1 in. (25 mm) vertical distance from the ignition source</p> <p>(9) Dispensers installed directly over carpeted floors shall be permitted only in sprinklered smoke compartments.</p> <p>(10) The alcohol-based hand-rub solution shall not exceed 95 percent alcohol content by volume.</p> <p>(11) Operation of the dispenser shall comply with the following criteria:</p> <p>(a) The dispenser shall not release its contents except when the dispenser is activated, either</p>	K 325		
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K 325	Continued From page 4 manually or automatically by touch-free activation. (b) Any activation of the dispenser shall occur only when an object is placed within 4 in. (100 mm) of the sensing device. (c) An object placed within the activation zone and left in place shall not cause more than one activation. (d) The dispenser shall not dispense more solution than the amount required for hand hygiene consistent with label instructions. (e) The dispenser shall be designed, constructed, and operated in a manner that ensures that accidental or malicious activation of the dispensing device is minimized. (f) The dispenser shall be tested in accordance with the manufacturer ' s care and use instructions each time a new refill is installed.	K 325		
K 345 SS=D	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101  Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure that fire alarm systems were maintained free of obstructions that would hinder activation during a fire. Impeding detection appliance sensors from identifying incipient fires, has the potential to decrease facility response during these events. This deficient practice affected staff and vendors working in and around the facility boiler room.	K 345	<b>K 345</b>  A. The tape was removed from the smoke detector on the day of the survey. It had been placed there when contractors were welding in the basement area to install new boilers. B. All smoke detectors have the potential to be affected. C. A visual inspection of facility smoke detectors will be done anytime hot work is performed in that area. They are inspected annually by an outside contractor and the results of these inspections are documented on their report forms. D. The results of the inspections will be reported to the QA Committee each month that either hot work was performed or at the time of the annual inspection. E. Compliance date 3-18-2019.	

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K 345	Continued From page 5  Findings include:  During the facility tour conducted on 3/04/19 from 1:00 - 3:00 PM, a heat detector located above the new boiler installation was observed to have the sensing area of the detector taped over. At the time of this observation, the Maintenance Director stated the vendor would tape off this unit during their hot work activity. Further observation of this space did not establish any hot work activity being performed at the time of the survey.  Actual NFPA standard:  NFPA 72  14.3 Inspection.  14.3.1* Unless otherwise permitted by 14.3.2 visual inspections shall be performed in accordance with the schedules in Table 14.3.1 or more often if required by the authority having jurisdiction. 14.3.2 Devices or equipment that is inaccessible for safety considerations (e.g., continuous process operations, energized electrical equipment, radiation, and excessive height) shall be permitted to be inspected during scheduled shutdowns if approved by the authority having jurisdiction.  14.3.3 Extended intervals shall not exceed 18 months.  14.3.4 The visual inspection shall ensure that there are no changes that effect equipment performance	K 345		
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101	K 353		

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K 353	<p>Continued From page 6</p> <p>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.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</p> <p>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 observation, the facility failed to ensure fire suppression systems were maintained in accordance with NFPA 25. Failure to maintain fire suppression systems has the potential to hinder system response during a fire event. This deficient practice affected 40 residents, staff and visitors on the dates of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 3/04/19 from 1:00 - 3:00 PM and 3/05/19 from 10:00 - 11:00 AM, observation of installed fire suppression system sprinkler pendants revealed the following:</p> <p>a. One (1) painted sprinkler above the door in the basement level IT storage room b. Two (2) corroded sprinklers in the Main</p>	K 353	<p><b>K 353</b></p> <p>A. Painted sprinkler head in IT Storage room will be replaced during Quarterly inspection. Compliance date 3-13-2019</p> <p>Two corroded sprinkler heads will be replaced during Quarterly inspection. Compliance date 3-13-2019</p> <p>Three corroded sprinkler heads in the Two West shower room will be replaced during the Quarterly inspection. Compliance date 3-13-2019</p> <p>B. All sprinkler heads have the potential to be affected.</p> <p>C. Sprinkler heads are inspected annually 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 Director during the inspection and the written report is kept on file in the Maintenance office.</p> <p>D. The reports of the outside contractor will be presented to the QA Committee the month after the reviews are completed and a copy of the report will be included in the QA minutes.</p> <p>E. Compliance date 03-18-2019</p>	
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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 353	<p>Continued From page 7</p> <p>Laundry</p> <p>c. Three (3) corroded sprinklers in the Two West shower room</p> <p>Actual NFPA standard:</p> <p>NFPA 25</p> <p>2-2 Inspection.</p> <p>2-2.1 Sprinklers.</p> <p>2-2.1.1*</p> <p>Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.</p> <p>Exception No. 1*: Sprinklers installed in concealed spaces such as above suspended ceilings shall not require inspection.</p> <p>Exception No. 2: Sprinklers installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown.</p>	K 353		
K 511 SS=E	<p>Utilities - Gas and Electric</p> <p>CFR(s): NFPA 101</p> <p>Utilities - Gas and Electric</p> <p>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.</p> <p>18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2</p>	K 511	<p><b>K 511</b></p> <p>A. The relocatable power tap was removed from the dining hall on the day of the survey.</p> <p>The relocatable power tap was removed from the Canteen on the day of the survey.</p> <p>B. All electrical appliances/devices which are not hard wired to an electrical source have the potential to be affected.</p>	

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

Printed: 03/08/2019  
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 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/05/2019</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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K 511	<p>Continued From page 8</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure safe electrical installations in accordance with NFPA 70. Use of relocatable power taps (RPT) with large appliances or equipment not within its listed assembly, has been historically linked to arc fires in facilities. This deficient practice potentially affected those residents, staff and visitors using the main Dining Hall and Cantina on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 3/04/19 from 1:30 - 2:30 PM, observation of installed electrical systems revealed the following:</p> <p>The main Dining Hall was observed to be using a RPT to supply power to a commercial coffee grinder and a water pump to the commercial coffee maker.</p> <p>The Cantina pantry was observed to be using a RPT for power supply to both a full size freezer and a full size refrigerator.</p> <p>Actual NFPA standard:</p> <p>NFPA 70</p> <p>110.2 Approval. The conductors and equipment required or permitted by this Code shall be acceptable only if approved. Informational Note: See 90.7, Examination of Equipment for Safety, and 110.3, Examination, Identification, Installation, and Use of Equipment. See definitions of Approved, Identified, Labeled, and Listed.</p> <p>110.3 Examination, Identification, Installation, and Use of Equipment.</p>	K 511	<p>C. The presence of relocatable power taps will be assessed during monthly reviews of other fire/life safety monitors. If any are found, they will be immediately removed. Staff will be re-educated on not using such devices.</p> <p>D. The results from these reviews will be presented at the monthly QA meetings.</p> <p>E. Compliance date: 3-14-2019</p>	
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K 511	<p>Continued From page 9</p> <p>(A) Examination. In judging equipment, considerations such as the following shall be evaluated:</p> <p>(1) Suitability for installation and use in conformity with the provisions of this Code</p> <p>Informational Note: 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. Special conditions of use or other limitations and other pertinent information may be marked on the equipment, included in the product instructions, or included in the appropriate listing and labeling information. Suitability of equipment may be evidenced by listing or labeling.</p> <p>(2) Mechanical strength and durability, including, for parts designed to enclose and protect other equipment, the adequacy of the protection thus provided</p> <p>(3) Wire-bending and connection space</p> <p>(4) Electrical insulation</p> <p>(5) Heating effects under normal conditions of use and also under abnormal conditions likely to arise in service</p> <p>(6) Arcing effects</p> <p>(7) Classification by type, size, voltage, current capacity, and specific use</p> <p>(8) Other factors that contribute to the practical safeguarding of persons using or likely to come in contact with the equipment</p> <p>(B) Installation and Use. Listed or labeled equipment shall be installed and used in accordance with any instructions included in the listing or labeling.</p> <p>Additional reference:</p>	K 511		

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K 511	Continued From page 10 UL 1363 Standard for Relocatable Power Taps	K 511		



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

March 8, 2019

Rick Holloway, Administrator  
Idaho State Veterans Home - Boise  
PO Box 7765  
Boise, ID 83707-1765

Provider #: 135131

**RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER**

Dear Mr. Holloway:

On **March 5, 2019**, an Emergency Preparedness survey was conducted at Idaho State Veterans Home - Boise by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. Your facility was found to be in substantial compliance with Federal regulations during this survey.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, which states that the facility complies with the requirements of CFR 42, 483.70(a) of the federal requirements. This form is for your records only and does not need to be returned.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact this office at (208) 334-6626, option 3.

Sincerely,

Nate Elkins, Supervisor  
Facility Fire Safety and Construction

NE/lj  
Enclosure

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E 000	<p>Initial Comments</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 located in a municipal fire district and has both state and county EMS support services available. The facility is currently licensed for 122 SNF/NF beds, and had a census of 117 on the dates of the survey.</p> <p>The facility was found to be in substantial compliance during the Emergency Preparedness Survey conducted on March 4 and 5, 2019. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.</p> <p>The survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	E 000	<p style="text-align: center;"><b>RECEIVED</b></p> <p style="text-align: center;"><b>MAR 15 2019</b></p> <p style="text-align: center;"><b>FACILITY STANDARDS</b></p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Sam Burbank</i>	TITLE <i>Surveyor</i>	(X6) DATE <i>3/14/19</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.