



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
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June 6, 2019

Joe Rudd Jr, Administrator
Life Care Center of Boise
808 North Curtis Road
Boise, ID 83706-1306

Provider #: 135038

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Mr. Rudd Jr:

On **May 29, 2019**, a Facility Fire Safety and Construction survey was conducted at **Life Care Center of Boise** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies. 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 **June 19, 2019**. Failure to submit an acceptable PoC by **June 19, 2019**, may result in the imposition of civil monetary penalties by **July 11, 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 **July 3, 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 **August 27, 2019**. A change in the seriousness of the deficiencies on **July 13, 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 **July 3, 2019**, includes the following:

Denial of payment for new admissions effective **August 29, 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 **November 29, 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 **May 29, 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:

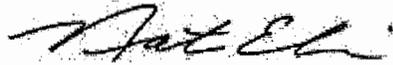
BFS Letters (06/30/11)

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

This request must be received by **June 19, 2019**. If your request for informal dispute resolution is received after **June 19, 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
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 05/29/2019
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BOISE	STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706
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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>INITIAL COMMENTS</p> <p>The facility is a single-story, Type V (111) building, built in 1967. It is fully sprinklered with smoke detection throughout, including sleeping rooms. In 1998 there was a major upgrade to the building including remodel and rehab addition. The Essential Electrical System is supplied by a diesel powered, on-site automatic generator. Currently the facility is licensed for 153 SNF/NF beds and had a census of 55 on the dates of the survey.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on May 28 - 29, 2019. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.</p> <p>The Survey was conducted by:</p> <p>Linda Chaney Health Facility Surveyor Facility Fire Safety and Construction</p>	K 000	<p>This Plan of Correction is required under Federal and State Regulations and statutes applicable to long-term care providers. This Plan of Correction does not constitute an admission of liability on part of the facility, and such liability is specifically denied. The submission of this Plan of Correction does not constitute agreement by the facility that the surveyors findings and/or conclusions constitute a deficiency, or that the scope and severity of the deficiencies cited are correctly applied.</p> <p style="text-align: center;">RECEIVED JUN 19 2019 FACILITY STANDARDS</p>	
K 223 SS=D	<p>Doors with Self-Closing Devices CFR(s): NFPA 101</p> <p>Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of:</p> <ul style="list-style-type: none"> * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required 	K 223	<p>Corrective Action:</p> <ol style="list-style-type: none"> 1. Door in the kitchen, identified in 2567, was replaced on 6-7-2019. 2. All other doors in the facility with self-closing devices have been inspected to ensure they closed properly and completely. <p>Identification: All residents and staff are identified as potentially being affected by this deficiency.</p> <p>Systemic Changes: Maintenance staff to continue to conduct annual inspections on all doors in the facility to ensure they operate properly.</p> <p style="text-align: right;">Continued on p. 2</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
<i>Joe F. Rudd Jr.</i>	Administrator	6-18-2019

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 223	<p>Continued From page 1</p> <p>smoke detection system; and</p> <p>* Automatic sprinkler system, if installed; and</p> <p>* Loss of power.</p> <p>18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, operational testing and interview, the facility failed to ensure self-closing doors in smoke barriers were free from obstruction and able to self-close when released from magnetic hold-open devices. Obstructing smoke barrier doors from self-closing as designed could allow smoke and dangerous gases to pass between smoke compartments during a fire. This deficient practice affected staff in the utility corridor and kitchen on the dates of the survey.</p> <p>Findings include:</p> <p>During the facility tour on May 29, 2019, from approximately 12:20 PM to 2:00 PM, observation and operational testing of the self-closing door between the kitchen dishwashing area and the corridor revealed it would not self-close when released from the magnetic hold open device. When in the process of closing, the door struck the frame preventing it from closing. When asked, the Maintenance Supervisor stated the facility was not aware the door was obstructed and would not close.</p> <p>Actual NFPA standard:</p> <p>NFPA 101</p> <p>19.2.2.2.7* Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier, or hazardous area enclosure shall be permitted to be held open only by an automatic release device</p>	K 223	<p>Monitor:</p> <p>Facility Administrator to review inspection documentation to ensure compliance.</p>	July 2, 2019

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K 223	Continued From page 2 that complies with 7.2.1.8.2. The automatic sprinkler system, if provided, and the fire alarm system, and the systems required by 7.2.1.8.2, shall be arranged to initiate the closing action of all such doors throughout the smoke compartment or throughout the entire facility. 7.2.1.8.2 In any building of low or ordinary hazard contents, as defined in 6.2.2.2 and 6.2.2.3, or where approved by the authority having jurisdiction, door leaves shall be permitted to be automatic-closing, provided that all of the following criteria are met: (1) Upon release of the hold-open mechanism, the leaf becomes self-closing. (2) The release device is designed so that the leaf instantly releases manually and, upon release, becomes self-closing, or the leaf can be readily closed. (3) The automatic releasing mechanism or medium is activated by the operation of approved smoke detectors installed in accordance with the requirements for smoke detectors for door leaf release service in NFPA 72, National Fire Alarm and Signaling Code. (4) Upon loss of power to the hold-open device, the hold-open mechanism is released, and the door leaf becomes self-closing.	K 223		
K 232 SS=F	Aisle, Corridor, or Ramp Width CFR(s): NFPA 101 Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5.	K 232	Corrective Action: 1. Wall sconces identified in the 2567 have been removed from the facility corridors. 2. The fire extinguisher boxes in the facility corridors have been modified to comply with the regulation. 3. The three (3) "chart boxes" identified in the 2567 have been removed from the facility corridors. 4. The Life Care media sign identified in the 2567 has been removed from the corridors. Continued on p. 4	

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K 232	<p>Continued From page 3 19.2.3.4, 19.2.3.5 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain corridor exit access free of protruding objects exceeding four (4) inches. Failure to maintain projections from corridor walls to less than 4" hinders the protection of persons who are blind or have low vision from being injured. This deficient practice affected 55 residents and staff on the dates of the survey.</p> <p>Findings include:</p> <p>During the facility tour on May 29, 2019, from approximately 12:20 PM to 2:00 PM, observation of the exit access corridors revealed the following projections from the corridor wall exceeding the 4 inches allowed by ADA Standards:</p> <ol style="list-style-type: none"> 1.) Wall sconce tin vases with silk greenery projected approximately 10 inches at a height of approximately 60 inches from the floor. Wall sconce tin vases were in every corridor throughout the facility. 2.) Fire extinguisher boxes projected approximately 4-1/2 inches at a height of approximately 42 inches. Fire Extinguisher boxes were in every corridor throughout the facility. 3.) A total of three (3) chart boxes projected approximately 6-1/2 inches at a height of approximately 44-3/4 inches from the floor. One in each of the resident room corridors. 4.) One (1) Life Care media sign outside of the physical therapy room projected approximately 5 inches from the wall at 71-1/2 inches from the floor. <p>When asked, the Maintenance Supervisor stated the facility was unaware of the requirements for non-continuous projections in the corridor.</p>	K 232	<p>Identification: All residents and staff are identified as potentially being affected by this deficiency.</p> <p>Systemic Changes: Maintenance staff to conduct monthly inspections of facility corridors to ensure there are no objects protruding from the walls more than 4".</p> <p>Monitor: Facility Administrator to review monthly inspection documentation to ensure compliance.</p>	July 2, 2019	

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K 232	Continued From page 4 Actual NFPA Standard: 19.2.3.4* Any required aisle, corridor, or ramp shall be not less than 48 in. (1220 mm) in clear width where serving as means of egress from patient sleeping rooms, unless otherwise permitted by one of the following: (1) Aisles, corridors, and ramps in adjunct areas not intended for the housing, treatment, or use of inpatients shall be not less than 44 in. (1120 mm) in clear and unobstructed width. (2) *Where corridor width is at least 6 ft (1830 mm), non-continuous projections not more than 6 in. (150 mm) from the corridor wall, above the handrail height, shall be permitted. (3) Exit access within a room or suite of rooms complying with the requirements of 19.2.5 shall be permitted. (4) Projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in. (1525 mm). (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c)*The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment (5) *Where the corridor width is at least 8 ft (2440 mm), projections into the required width shall be permitted for fixed furniture, provided that all of the following conditions are met:	K 232			

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K 232	<p>Continued From page 5</p> <p>(a) The fixed furniture is securely attached to the floor or to the wall.</p> <p>(b) The fixed furniture does not reduce the clear unobstructed corridor width to less than 6 ft (1830 mm), except as permitted by 19.2.3.4(2).</p> <p>(c) The fixed furniture is located only on one side of the corridor.</p> <p>(d) The fixed furniture is grouped such that each grouping does not exceed an area of 50 ft² (4.6 m²).</p> <p>(e) The fixed furniture groupings addressed in 19.2.3.4(5)(d) are separated from each other by a distance of at least 10 ft (3050 mm).</p> <p>(f)*The fixed furniture is located so as to not obstruct access to building service and fire protection equipment.</p> <p>(g) Corridors throughout the smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the fixed furniture spaces are arranged and located to allow direct supervision by the facility staff from a nurses' station or similar space.</p> <p>(h) The smoke compartment is protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.8.</p>	K 232		
K 291 SS=F	<p>Emergency Lighting CFR(s): NFPA 101</p> <p>Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9.18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to provide monthly and annual emergency lighting test documentation. Failure to test the</p>	K 291	<p>Corrective Action:</p> <ol style="list-style-type: none"> 1. Inspection of facility emergency lighting units and 30 second functional testing of same has been conducted and documented. Monthly inspections will be conducted on an ongoing basis. 2. Functional testing of facility emergency lighting units for 90 minute duration has been conducted and documented. Annual testing will be conducted on an ongoing basis. <p style="text-align: right;">Continued on p. 7</p>	

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K 291	<p>Continued From page 6</p> <p>emergency lighting could inhibit egress of residents during an emergency. This deficient practice affected 55 residents and staff on the dates of the survey.</p> <p>Findings include:</p> <p>During record review on May 28, 2019, from approximately 11:30 AM to 3:00 PM, no documentation could be produced for thirty (30) second monthly testing of the emergency lighting. In addition, no documentation could be produced to indicate a ninety (90) minute annual test of the emergency lighting had been conducted. When asked, the Maintenance Supervisor stated the facility was unaware the tests were not completed, or documentation maintained.</p> <p>Actual NFPA reference:</p> <p>NFPA 101 19.2.9 Emergency Lighting. 19.2.9.1 Emergency lighting shall be provided in accordance with Section 7.9. 7.9.3 Periodic Testing of Emergency Lighting Equipment. 7.9.3.1 Required emergency lighting systems shall be tested in accordance with one of the three options offered by 7.9.3.1.1, 7.9.3.1.2, or 7.9.3.1.3. 7.9.3.1.1 Testing of required emergency lighting systems shall be permitted to be conducted as follows: (1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, except as otherwise permitted by 7.9.3.1.1(2). (2)*The test interval shall be permitted to be</p>	K 291	<p>Identification: All residents and staff are identified as potentially being affected by this deficiency.</p> <p>Systemic Changes: Maintenance staff educated as to the regulation requiring monthly and annual inspections, functional testing, and documentation of these tasks for the facility emergency lighting units.</p> <p>Monitor: Facility Administrator to review monthly and annual inspection documentation to ensure compliance.</p>	July 2, 2019	

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K 291	Continued From page 7 extended beyond 30 days with the approval of the authority having jurisdiction. (3) Functional testing shall be conducted annually for a minimum of 1-1?2 hours if the emergency lighting system is battery powered. (4) The emergency lighting equipment shall be fully operational for the duration of the tests required by 7.9.3.1.1(1) and (3). (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. 7.9.3.1.2 Testing of required emergency lighting systems shall be permitted to be conducted as follows: (1) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall be provided. (2) Not less than once every 30 days, self-testing/self-diagnostic battery-operated emergency lighting equipment shall automatically perform a test with a duration of a minimum of 30 seconds and a diagnostic routine. (3) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall indicate failures by a status indicator. (4) A visual inspection shall be performed at intervals not exceeding 30 days. (5) Functional testing shall be conducted annually for a minimum of 1-1?2 hours. (6) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall be fully operational for the duration of the 1-1?2-hour test. (7) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. 7.9.3.1.3 Testing of required emergency lighting systems shall be permitted to be conducted as follows: (1) Computer-based, self-testing/self-diagnostic	K 291		

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K 291	Continued From page 8 battery-operated emergency lighting equipment shall be provided. (2) Not less than once every 30 days, emergency lighting equipment shall automatically perform a test with a duration of a minimum of 30 seconds and a diagnostic routine. (3) The emergency lighting equipment shall automatically perform annually a test for a minimum of 1-172 hours. (4) The emergency lighting equipment shall be fully operational for the duration of the tests required by 7.9.3.1.3(2) and (3). (5) The computer-based system shall be capable of providing a report of the history of tests and failures at all times.	K 291			
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the	K 324	Corrective Action: Semi- annual inspection and cleaning of the kitchen hood has been scheduled for 8-28-2019. Identification: All residents and staff are identified as potentially being affected by this deficiency. Systemic Changes: 1. Maintenance staff educated regarding compliance with semi-annual inspection and cleaning of kitchen hood. 2. Maintenance staff to ensure inspections and cleanings are scheduled on a semi-annual basis. Monitor: Facility Administrator to review schedule for kitchen hood inspection and cleaning, and documentation to ensure compliance.	July 2, 2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 05/29/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706	
(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 324	<p>Continued From page 9 corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a semi-annual inspection of the Kitchen hood was conducted in accordance with NFPA 96. Failure to conduct semi-annual inspections and cleaning as required of cooking ventilation systems could increase the risk of fires due to excessive build-up of grease laden vapors. This deficient practice affected staff in the kitchen on the dates of the survey.</p> <p>Findings include:</p> <p>Review of inspection records on May 28, 2019, from approximately 11:30 AM to 3:00 PM, revealed the kitchen hood inspection/cleaning was completed in January 2018 and March 2019. However, no documentation could be produced for a second inspection/cleaning in 2018. When asked, the Maintenance Supervisor stated the facility did not complete the second semi-annual kitchen hood inspection and cleaning in 2018.</p> <p>Actual NFPA standard:</p> <p>NFPA 96</p> <p>11.4* Inspection for Grease Buildup The entire exhaust system shall be inspected for grease buildup by a properly trained, qualified, and certified person(s) acceptable to the authority</p>	K 324		

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K 324	Continued From page 10 having jurisdiction and in accordance with Table 11.4. 11.6 Cleaning of Exhaust Systems 11.6.1 Upon inspection, if the exhaust system is found to be contaminated with deposits from grease-laden vapors, the contaminated portions of the exhaust system shall be cleaned by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction.	K 324		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide documentation of required fire drills, one per shift per quarter. Failure to perform fire drills on each shift quarterly could result in confusion and hinder the safe evacuation of residents during a fire event. This deficient practice affected 55 residents and staff on the dates of the survey. Findings include:	K 712	Corrective Action: Fire Drills have been scheduled through the rest of the year for each shift to participate in a fire drill quarterly. Scheduling fire drills for the upcoming year to continue with each year. Identification: All residents and staff are identified as potentially being affected by this deficiency. Systemic Changes: 1. Maintenance Supervisor educated regarding requirement to schedule fire drills with each shift quarterly. 2. Maintenance Supervisor to conduct fire drills with each shift quarterly as scheduled Monitor: Facility Administrator to review annual inspection and testing documentation to ensure compliance.	July 2, 2019

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K 712	Continued From page 11 During record review on May 28, 2019, from approximately 11:30 AM to 3:00 PM, fire drill documentation revealed the facility failed to perform and document fire drills first quarter 2019, second and third shifts, second quarter 2018/2019, third quarter 2018 and fourth quarter 2018. When asked, the Maintenance Supervisor stated the facility had not completed the fire drills. Actual NFPA standard: 19.7.1.6 Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions.	K 712		
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are	K 914	Corrective Action: 1. All non-hospital grade electrical receptacles, in resident rooms, have been inspected and tested. Repairs / replacement completed as necessary. 2. Inspection and testing has been scheduled for the upcoming 12 month period also. Identification: All residents and staff are identified as potentially being affected by this deficiency. Systemic Changes: 1. Maintenance staff educated regarding the regulation to inspect and test non-hospital grade electrical receptacles, in resident rooms, annually. 2. Maintenance staff to schedule and conduct annual inspection and testing of non-hospital grade electrical receptacles in resident rooms. Continued on p. 13	

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K 914	<p>Continued From page 12</p> <p>maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results.</p> <p>6.3.4 (NFPA 99)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure electrical receptacles installed in resident rooms were maintained in accordance with NFPA 99. Failure to test non-hospital grade receptacles in resident rooms every 12 months has the potential to limit the availability of reliable power and hinder the ability to shelter in place during a power outage or other emergency. This deficient practice affected 55 residents and staff on the dates of the survey.</p> <p>Findings include:</p> <p>During review of facility maintenance and inspection records conducted on May 28, 2019, from approximately 11:30 AM to 3:00 PM, no documentation could be provided to indicate the facility was testing non-hospital grade receptacles in resident rooms annually. When asked, the Maintenance Supervisor stated the facility was unaware non-hospital grade receptacles in resident rooms were required to be tested annually.</p> <p>Actual NFPA standard:</p> <p>NFPA 99</p> <p>6.3.4.1.3 Receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months.</p>	K 914	<p>Monitor:</p> <p>Facility Administrator to review annual inspection and testing documentation to ensure compliance.</p>	July 2, 2019

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K 918 SS=F	<p>Electrical Systems - Essential Electric System CFR(s): NFPA 101</p> <p>Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.</p> <p>Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.</p> <p>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility</p>	K 918	<p>Corrective Action:</p> <ol style="list-style-type: none"> Weekly inspections of emergency generator being performed and documented. Emergency generator being exercised each month, under load on a monthly basis and documented. The three-year, continuous four-hour exercise test was conducted on 6-24-2017. Documentation of this test was sent to Surveyor. <p>Identification: All residents and staff are identified as potentially being affected by this deficiency.</p> <p>Systemic Changes:</p> <ol style="list-style-type: none"> Maintenance Supervisor educated regarding emergency generator inspection, testing, and documentation requirements. Maintenance Supervisor to conduct emergency generator inspections and testing weekly and monthly and schedule with generator service provider. <p>Monitor: Facility Administrator to review weekly and monthly inspection documentation to ensure compliance.</p>	July 2, 2019	

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K 918	<p>Continued From page 14</p> <p>failed to ensure the generator for the EES (Essential Electrical System) was maintained in accordance with NFPA 110. Failure to inspect and test EES generators could result in a lack of system reliability during a power loss. This deficient practice affected 55 residents and staff on the dates of the survey.</p> <p>Findings include:</p> <p>1.) During review of the facility generator inspection and testing records on May 28, 2019, from approximately 11:30 AM to 3:00 PM, the facility failed to provide weekly generator inspection logs for 25 of 52 weeks during the time frame of May 2018 to May 2019. Additionally, the facility could not produce a monthly load test for January 2019.</p> <p>2.) During review of the facility generator inspection and load testing records on May 28, 2019, from approximately 11:30 AM to 3:00 PM, no documentation could be produced for a three-year, four-hour load test.</p> <p>When asked, the Maintenance Supervisor stated the facility was unaware of the missing generator inspection and testing documentation.</p> <p>Actual NFPA standard:</p> <p>NFPA 110 8.4 Operational Inspection and Testing. 8.4.1* EPSSs, including all appurtenant components, shall be inspected weekly and exercised under load at least monthly. 8.4.2* Diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust</p>	K 918			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 918	Continued From page 15 gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS nameplate kW rating 8.4.9* Level 1 EPSS shall be tested at least once within every 36 months. 8.4.9.1 Level 1 EPSS shall be tested continuously for the duration of its assigned class (see Section 4.2). 8.4.9.2 Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 continuous hours. 8.4.9.3 The test shall be initiated by operating at least one transfer switch test function and then by operating the test function of all remaining ATs, or initiated by opening all switches or breakers supplying normal power to all ATs that are part of the EPSS being tested. 8.4.9.4 A power interruption to non-EPSS loads shall not be required. 8.4.9.5 The minimum load for this test shall be as specified in 8.4.9.5.1, 8.4.9.5.2, or 8.4.9.5.3. 8.4.9.5.1 For a diesel-powered EPS, loading shall be not less than 30 percent of the nameplate kW rating of the EPS. A supplemental load bank shall be permitted to be used to meet or exceed the 30 percent requirement. 8.4.9.5.2 For a diesel-powered EPS, loading shall be that which maintains the minimum exhaust gas temperatures as recommended by the manufacturer. 8.4.9.5.3 For spark-ignited EPSSs, loading shall be the available EPSS load. 8.4.9.6 The test required in 8.4.9 shall be permitted to be combined with one of the monthly tests required by 8.4.2 and one of the annual tests required by 8.4.2.3 as a single test. 8.4.9.7 Where the test required in 8.4.9 is	K 918			

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K 918	Continued From page 16 combined with the annual load bank test, the first 3 hours shall be at not less than the minimum loading required by 8.4.9.5 and the remaining hour shall be at not less than 75 percent of the nameplate kW rating of the EPS.	K 918			



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK – ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
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3232 Elder Street
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Boise, ID 83720-0009
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June 6, 2019

Joe Rudd Jr, Administrator
Life Care Center of Boise
808 North Curtis Road
Boise, ID 83706-1306

Provider #: 135038

RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER

Dear Mr. Rudd Jr:

On **May 29, 2019**, an Emergency Preparedness survey was conducted at Life Care Center of 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 facility is a single-story, Type V (111) building, built in 1967. It is fully sprinklered with smoke detection throughout, including sleeping rooms. In 1998 there was a major upgrade to the building including remodel and rehab addition. The Essential Electrical System is supplied by a diesel powered, on-site automatic generator. Currently the facility is licensed for 153 SNF/NF beds and had a census of 55 on the dates of the survey.</p> <p>The facility was found to be in substantial compliance during the annual Emergency Preparedness Survey conducted on May 28 - 29, 2019. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.</p> <p>The surveyor conducting the survey was:</p> <p>Linda Chaney Health Facility Surveyor Facility Fire Safety and Construction</p>	E 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.