



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

June 17, 2019

Gerald Bosen, Administrator
Life Care Center of Treasure Valley
502 North Kimball Place
Boise, ID 83704-0608

Provider #: 135123

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Mr. Bosen:

On **June 4, 2019**, a Facility Fire Safety and Construction survey was conducted at **Life Care Center of Treasure Valley** 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

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 **July 1, 2019**. Failure to submit an acceptable PoC by **July 1, 2019**, may result in the imposition of civil monetary penalties by **July 22, 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 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 **September 2, 2019**. A change in the seriousness of the deficiencies on **July 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 **July 9, 2019**, includes the following:

Denial of payment for new admissions effective **September 4, 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 **December 4, 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 **June 4, 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:

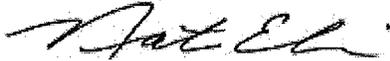
BFS Letters (06/30/11)

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

This request must be received by **July 1, 2019**. If your request for informal dispute resolution is received after **July 1, 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: 135123	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 06/04/2019
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF TREASURE VALLEY	STREET ADDRESS, CITY, STATE, ZIP CODE 502 NORTH KIMBALL PLACE BOISE, ID 83704
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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	INITIAL COMMENTS The facility is a single story, Type V(111) structure, originally constructed in 1996. The building is protected throughout by an automatic fire extinguishing system with interconnected fire alarm system. There is an on-site, diesel fired backup emergency power supply system (EPSS) generator. Currently the facility is licensed for 120 SNF/NF beds and had a census of 89 on the date of the survey. The following deficiencies were cited during the annual fire/life safety survey conducted on June 4, 2019. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70. The Survey was conducted by: Sam Burbank Health Facility Surveyor Fire Life Safety & Construction	K 000	<i>This Plan of Correction is submitted as required under Federal and State regulations and statutes applicable to long-term care providers. The Plan of Correction does not constitute agreement by the facility that the surveyors findings constitute a deficiency and/or that the scope and severity of the deficiencies cited are correctly applied.</i>	
K 291 SS=D	Emergency Lighting CFR(s): NFPA 101 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 observation, the facility failed to ensure doors equipped with special locking arrangements, were provided with battery powered emergency lighting. Failure to provide emergency lighting for doors equipped with delayed egress potentially hinders identification of	K 291	RECEIVED JUL - 1 2019 K291 FACILITY STANDARDS SPECIFIC ISSUE: The facility does have lights that are hooked to the emergency generator at our main entrance. These lights do illuminate the exit sign and the pathway to exit. OTHER RESIDENTS: As lighting can affect all residents during an emergency the facility will ensure that lighting is regularly checked to ensure proper function during and emergency.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Executive Director	(X6) DATE 7/1/19
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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 291	<p>Continued From page 1</p> <p>exits utilized for resident egress during an emergency. This deficient practice affected those residents and staff using the main front entry on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 6/4/19 from 11:00 AM - 3:00 PM, observation of the exit doors revealed all primary exits were equipped with magnetic locking arrangements, which included a delayed egress component. Further observation of the main entrance revealed this door did not have either battery powered backup emergency lighting, or illumination directly connected to the EPSS generator.</p> <p>Actual NFPA standard:</p> <p>19.2.9 Emergency Lighting. 19.2.9.1 Emergency lighting shall be provided in accordance with Section 7.9.</p> <p>7.9 Emergency Lighting. 7.9.1 General. 7.9.1.1* Emergency lighting facilities for means of egress shall be provided in accordance with Section 7.9 for the following: (1) Buildings or structures where required in Chapters 11 through 43 (2) Underground and limited access structures as addressed in Section 11.7 (3) High-rise buildings as required by other sections of this Code (4) Doors equipped with delayed-egress locks (5) Stair shafts and vestibules of smokeproof enclosures, for which the following also apply: (a) The stair shaft and vestibule shall be permitted to include a standby generator that is</p>	K 291	<p>SYSTEMIC CHANGES:</p> <p>Maintenance staff will document that emergency lighting is working and in good repair. Emergency generator will be tested annually at full load for a minimum of 90 minutes and results will be documented.</p> <p>MONITOR:</p> <p>The Executive Director or designee will ensure emergency lighting is being tested and monitored. The Maintenance Director will review test results and the effectiveness of the emergency lighting in the facility QAPI meeting. If any issues are identified they will be discussed and addressed as needed.</p> <p>DATE OF COMPLIANCE:</p> <p>July 9, 2019</p>	

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K 291	Continued From page 2 installed for the smokeproof enclosure mechanical ventilation equipment. (b) The standby generator shall be permitted to be used for the stair shaft and vestibule emergency lighting power supply. 7.9.2.4 Emergency generators providing power to emergency lighting systems shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. Stored electrical energy systems, where required in this Code, other than battery systems for emergency luminaires in accordance with 7.9.2.5, shall be installed and tested in accordance with NFPA 111, Standard on Stored Electrical Energy Emergency and Standby Power Systems. K 293 SS=D Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure means of egress signage was properly maintained. Failure to provide exit signs which are clear and identifiable has the potential to confuse residents and hinder egress during an emergency. This deficient practice affected residents and staff using the D-wing day room on	K 291	<p>K 293</p> <p>SPECIFIC ISSUE:</p> <p>The exit sign in the D-wing dayroom has been turned and is pointing properly to the appropriate exit.</p> <p>OTHER RESIDENTS:</p> <p>All exit sign in the facility have been checked and they all are pointing to appropriate exits so that during an emergency they will direct properly.</p> <p>SYSTEMIC CHANGES:</p> <p>Maintenance staff will do monthly checks of all exit signs as part of the preventive maintenance program to ensure all signs are pointing in the</p>	

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K 293	Continued From page 3 the date of the survey. Findings include: During the facility tour conducted on 6/4/19 from approximately 2:00 - 3:00 PM, observation of the D-wing day room, revealed the door leading to the courtyard was marked "Not and Exit", however the door leading to the corridor was equipped with an internally illuminated exit sign that had been turned ninety (90) degrees, or perpendicular to the wall face, making identification of this exit path unclear. Actual NFPA standard: 7.10.1.2 Exits. 7.10.1.2.1* Exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign that is readily visible from any direction of exit access.	K 293	right directions to direct in case of an emergency. MONITOR: The Executive Director or designee will ensure control measures and testing protocols of the exit signs will be completed. Monthly the Maintenance Director will review the effectiveness of the control measures. If any issues are identified they will be discussed and addressed as needed at the monthly QAPI meeting. DATE OF COMPLIANCE: July 9, 2019		
K 374 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal	K 374	K374 SPECIFIC ISSUE: The facility has replaced the doors that were not closing properly. The new doors have been installed and meet the needed standard.		

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K 374	<p>Continued From page 4 doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and operational testing, the facility failed to ensure smoke and fire barriers were maintained to limit the transfer of smoke, fire and dangerous gases between compartments. Failure to ensure smoke barrier doors limit the transfer of smoke, has the potential to hinder egress and the ability to shelter in place. This deficient practice affected 22 residents and staff in 2 of 8 smoke compartments on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 6/4/19 from 11:00 AM - 12:00 PM, observation and operational testing of the cross corridor smoke barrier doors located in the "A" wing outside room 117, revealed these doors were obstructed from fully self-closing by a recent repair and left a gap of approximately 3/4 inch to 1 inch when closed.</p> <p>Actual NFPA standard:</p> <p>19.3.7.8* Doors in smoke barriers shall comply with 8.5.4 and all of the following: (1) The doors shall be self-closing or automatic-closing in accordance with 19.2.2.2.7. (2) Latching hardware shall not be required (3) The doors shall not be required to swing in the direction of egress travel.</p> <p>8.5.4.1* Doors in smoke barriers shall close the opening, leaving only the minimum clearance necessary for proper operation, and shall be without louvers or grilles. The clearance under</p>	K 374	<p>OTHER RESIDENTS:</p> <p>All other smoke barrier doors have been checked and found to be working in proper order to ensure resident safety.</p> <p>SYSTEMIC CHANGES:</p> <p>Maintenance will check all smoke barrier doors on a monthly basis to ensure that they close and are working properly.</p> <p>MONITOR:</p> <p>The Executive Director or designee will ensure doors are being checked and maintained properly. Monthly the Maintenance Director will review these checks on the smoke barrier doors. If any issues are identified they will be discussed and addressed at the monthly QAPI meeting as needed.</p> <p>DATE OF COMPLIANCE:</p> <p>July 9, 2019</p>		

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K 374	Continued From page 5 the bottom of a new door shall be a maximum of 3.4 in. (19 mm).	K 374			
K 521 SS=F	8.5.4.4* Doors in smoke barriers shall be self-closing or automatic-closing in accordance with 7.2.1.8 and shall comply with the provisions of 7.2.1. HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that installed fire dampers were maintained. Failure to repair dampers which fail during a maintenance inspection and testing, has the potential to allow smoke, fire and dangerous gases to pass between smoke compartments during a fire. This deficient practice potentially affected residents and staff in 8 of 8 smoke compartments. Findings include: During review of provided maintenance and inspection records conducted on 6/4/19 from 8:30 - 10:30 AM, records indicated a damper testing was completed on March 29, 2017. Results from	K 521	K 521 SPECIFIC ISSUE: The smoke dampers that need repaired have been identified and outside company employed to have them repaired. All of the smoke dampers that were not working have been repaired or replaced. OTHER RESIDENTS: All other smoke dampers were found to be in proper working order. SYSTEMIC CHANGES: These smoke dampers will be checked as scheduled and if any are found to be not working properly at the next scheduled inspection they will be repaired at that time.		

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K 521	<p>Continued From page 6 that inspection and testing indicated 13 failed fire dampers.</p> <p>Interview of the Maintenance Director on 6/4/19 at approximately 10:30 AM revealed he was not aware of any repairs having been completed on these 13 failed dampers.</p> <p>Actual NFPA standard:</p> <p>NFPA 101 19.5.2 Heating, Ventilating, and Air-Conditioning. 19.5.2.1 Heating, ventilating, and air-conditioning shall comply with the provisions of Section 9.2 and shall be installed in accordance with the manufacturer ' s specifications, unless otherwise modified by 19.5.2.2.</p> <p>9.2 Heating, Ventilating, and Air-Conditioning. 9.2.1 Air-Conditioning, Heating, Ventilating Ductwork, and Related Equipment. Air-conditioning, heating, ventilating ductwork, and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems, or NFPA 90B, Standard for the Installation of Warm Air Heating and Air-Conditioning Systems, as applicable, unless such installations are approved existing installations, which shall be permitted to be continued in service.</p> <p>NFPA 90A 5.4.8 Maintenance. 5.4.8.1 Fire dampers and ceiling dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives.</p>	K 521	<p>MONITOR:</p> <p>The Maintenance Director or designee will ensure that the smoke dampers are checked according to the scheduled inspections. After each inspection the maintenance Director will review the inspection results. If any issues are identified they will be discussed and addressed at the monthly QAPI meeting as needed.</p> <p>DATE OF COMPLIANCE:</p> <p>July 9, 2019</p>		

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K 521	Continued From page 7	K 521		
K 914 SS=F	<p>NFPA 80 Chapter 19 Installation, Testing, and Maintenance of Fire Dampers 19.5 Maintenance. 19.5.3 If the damper is not operable, repairs shall begin without delay.</p> <p>Electrical Systems - Maintenance and Testing CFR(s): NFPA 101</p> <p>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 maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure resident room electrical receptacles were maintained properly. Failure to test resident room electrical receptacles annually</p>	K 914	<p>K 914</p> <p>SPECIFIC ISSUE:</p> <p>Maintenance staff have test all electrical receptacles and they are in proper working order.</p> <p>OTHER RESIDENTS:</p> <p>All areas were included in these tests of the electrical receptacles.</p> <p>SYSTEMIC CHANGES:</p> <p>Maintenance staff will test all electrical receptacles annual as part of the facility preventative maintenance program. These tests will be documented in the Tels system and reviewed as needed.</p>	

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K 914	<p>Continued From page 8</p> <p>has the potential to hinder system response during an emergency that encompasses a loss of power. This deficient practice affected 89 residents and staff on the date of the survey.</p> <p>Findings include:</p> <p>During review of provided maintenance documents conducted on 6/4/19 from 8:30 - 10:30 AM, no documentation was available demonstrating an annual test conducted on resident room outlets.</p> <p>Interview of the Maintenance Director on 6/4/19 at approximately 10:30 AM established he had not yet completed an annual test on resident room outlets and was not sure how often this testing was required.</p> <p>Actual NFPA standard:</p> <p>NFPA 99 Chapter 6 Electrical Systems</p> <p>6.3.3.2 Receptacle Testing in Patient Care Rooms. 6.3.3.2.1 The physical integrity of each receptacle shall be confirmed by visual inspection. 6.3.3.2.2 The continuity of the grounding circuit in each electrical receptacle shall be verified. 6.3.3.2.3 Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed. 6.3.3.2.4 The retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 g (4 oz).</p>	K 914	<p>MONITOR:</p> <p>The Maintenance Director or designee will ensure control measures and testing protocols of the electrical receptacles will be completed. Monthly the Maintenance Director will review the effectiveness of the control measures after the annual tests. If any issues are identified they will be discussed and addressed in the monthly QAPI meeting as needed.</p> <p>DATE OF COMPLIANCE:</p> <p>July 9, 2019</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135123	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED 06/04/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF TREASURE VALLEY			STREET ADDRESS, CITY, STATE, ZIP CODE 502 NORTH KIMBALL PLACE BOISE, ID 83704		
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K 914	Continued From page 9 6.3.4.1 Maintenance and Testing of Electrical System. 6.3.4.1.1 Where hospital-grade receptacles are required at patient bed locations and in locations where deep sedation or general anesthesia is administered, testing shall be performed after initial installation, replacement, or servicing of the device. 6.3.4.1.2 Additional testing of receptacles in patient care rooms shall be performed at intervals defined by documented performance data. 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.	K 914			



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

June 17, 2019

Gerald Bosen, Administrator
Life Care Center of Treasure Valley
502 North Kimball Place
Boise, ID 83704-0608

Provider #: 135123

RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER

Dear Mr. Bosen:

On **June 4, 2019**, an Emergency Preparedness survey was conducted at Life Care Center of Treasure Valley 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135123	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/04/2019
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E 000	<p>Initial Comments</p> <p>The facility is a single story, Type V(111) structure, originally constructed in 1996 and is located within a municipal fire district, having both state and county EMS services available. The building is protected throughout by an automatic fire extinguishing system with interconnected fire alarm system. There is an on-site, diesel fired backup emergency power supply system (EPSS) generator. Currently the facility is licensed for 120 SNF/NF beds and had a census of 89 on the date of the survey.</p> <p>The facility was found to be in substantial compliance during the emergency preparedness survey conducted on June 4, 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 Fire Life Safety & Construction</p>	E 000	<p style="text-align: center;">RECEIVED</p> <p style="text-align: center;">JUL - 1 2019</p> <p style="text-align: center;">FACILITY STANDARDS</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *David Bo* TITLE *Executive Director* (X6) DATE *7/1/19*

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.