



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

August 24, 2020

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 **August 10, 2020**, 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).

Gerald Bosen, Administrator
August 24, 2020
Page 2 of 4

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 **September 7, 2020**. Failure to submit an acceptable PoC by **September 7, 2020**, may result in the imposition of civil monetary penalties by **September 28, 2020**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.
- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567. If a State Form was issued as well, it should also be signed, dated and returned.

All references to federal regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Remedies may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **September 14, 2020**, (Opportunity to Correct). Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **November 8, 2020**. A change in the seriousness of the deficiencies on **September 24, 2020**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **September 14, 2020**, includes the following:

Gerald Bosen, Administrator
August 24, 2020
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Denial of payment for new admissions effective **November 4, 2020**.
42 CFR §488.417(a)

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **February 4, 2021**, 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 **August 10, 2020**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

Gerald Bosen, Administrator
August 24, 2020
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Go to the middle of the page to Information Letters section and click on State and select the following:

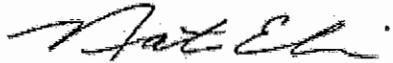
BFS Letters (06/30/11)

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

This request must be received by **September 7, 2020**. If your request for informal dispute resolution is received after **September 7, 2020**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosures

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

PRINTED: 08/21/2020
FORM APPROVED
OMB NO. 0938-0391

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 08/10/2020
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF TREASURE VALLEY			STREET ADDRESS, CITY, STATE, ZIP CODE 502 NORTH KIMBALL PLACE BOISE, ID 83704	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The facility is a single-story structure of Type V (111) construction, built in 1996. The building is fully sprinklered and is equipped with an interconnected fire alarm/smoke detection system. The Essential Electrical System (EES) is supplied by a diesel powered, on-site automatic generator. Currently the facility is licensed for 120 SNF beds and had a census of 78 on the date of the survey. The following deficiencies were cited during the annual fire/life safety survey conducted on August 10, 2020. 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: Linda Chaney Health Facility Surveyor Facility Fire Safety and 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 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure means of egress were	K 211	K211 SPECIFIC ISSUE: The obstructions in front of the door on 300 hallway to the courtyard have been moved and the exit is now clear. The gate in the court yard will be labeled as an exit and the magnetic lock will be tied into the fire alarm system. A key pad with a code will be placed to be able to override the lock. OTHER RESIDENTS: This door and gate can affect all residents who live on the 300 hallway in case of an emergency.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Jared Bos* TITLE *Executive Director* (X6) DATE *9-4-2020*

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 211	<p>Continued From page 1</p> <p>maintained in accordance with NFPA 101. Failure to maintain means of egress free of obstructions has the potential to hinder evacuation of residents during an emergency. This deficient practice had the potential to affect 19 residents and staff in the 300 wing of the facility.</p> <p>Findings include:</p> <p>During the facility tour on August 10, 2020, from approximately 11:30 AM to 2:30 PM, observation revealed the following exits were obstructed from full, instant use:</p> <p>1.) One of two exits from the 300 hallway to the courtyard was obstructed by six (6) arm chairs and a walker. The facility was aware of the items in front of the exit door, as stated by the Maintenance Supervisor.</p> <p>2.) The 300 hallway courtyard has a gate secured with a magnetic lock. The gate is not labeled with an exit sign, but is the only path of egress to the public way from the courtyard. Interview of the Maintenance Supervisor revealed the magnetic lock on the gate is controlled by a button at the nurse's station and is not interconnected to the fire alarm system. Nor is there a delayed egress component or keypad to override the lock with a code.</p> <p>Actual NFPA standard:</p> <p>NFPA 101 19.2 Means of Egress Requirements. 19.2.1 General. Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7, unless otherwise modified by 19.2.2 through 19.2.11. 7.1.10 Means of Egress Reliability.</p>	K 211	<p>Maintenance will be responsible to check and test the gate to ensure it is working properly. Staff on the 300 hallway have been in-serviced to not block the door to the courtyard with any obstructions to ensure a clear pathway in case of an emergency.</p> <p>SYSTEMIC CHANGES:</p> <p>Maintenance staff will document that courtyard gate lock and code system is working properly. The door will be tested monthly.</p> <p>MONITOR:</p> <p>The Maintenance Director or designee will document the courtyard gate is being tested and monitored. The Executive Director will do weekly checks for two months on the 300 hallway to ensure there are no obstructions blocking the exit door. Any concerns will be reviewed at the facility QAPI meeting and addressed as needed.</p> <p>DATE OF COMPLIANCE:</p> <p>September 14, 2020</p>	

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K 211	Continued From page 2	K 211			
K 222 SS=F	<p>7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.</p> <p>Egress Doors CFR(s): NFPA 101</p> <p>Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation.</p>	K 222	<p>K 222</p> <p>SPECIFIC ISSUE:</p> <p>All door signs that had faded in the sun have been replaced.</p> <p>OTHER RESIDENTS:</p> <p>All door signs have been checked and if needed they have been replaced. Currently all door signs are legible.</p> <p>SYSTEMIC CHANGES:</p> <p>Maintenance staff will do monthly checks of all door signs as part of the preventive maintenance program to ensure all signs are legible and in good repair.</p> <p>MONITOR:</p> <p>The Executive Director or designee will ensure the legibility of the door signs. Monthly the Maintenance Director will review the signs for signs of fading or other damage. If</p>		

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K 222	<p>Continued From page 3</p> <p>18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system.</p> <p>18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted.</p> <p>18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system.</p> <p>18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure special locking arrangements were in accordance with NFPA 101. Failure to provide required signage on exit doors equipped with delayed egress locking arrangements could hinder the safe evacuation of occupants during a fire or other emergency. This deficient practice affected 78 residents and staff on the dates of the survey.</p> <p>Findings include:</p>	K 222	<p>any issues are identified they will be discussed and addressed as needed at the monthly QAPI meeting.</p> <p>DATE OF COMPLIANCE: September 14, 2020</p>	

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K 222	<p>Continued From page 4</p> <p>During the facility tour on August 10, 2020, from approximately 11:30 AM to 2:30 PM, observation and operational testing of exit doors throughout the facility, revealed the doors were equipped with delayed egress, magnetic locking arrangements. However, the required signage stating: Push until alarm sounds, Door can be opened in 15 seconds, had faded in the sun to the point it was no longer legible. When asked, the Maintenance Supervisor stated the facility was aware the signs needed to be replaced and new signs were already on order.</p> <p>Actual NFPA standard:</p> <p>7.2.1.6* Special Locking Arrangements. 7.2.1.6.1 Delayed-Egress Locking Systems. 7.2.1.6.1.1 Approved, listed, delayed-egress locking systems shall be permitted to be installed on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6 or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 11 through 43, provided that all of the following criteria are met: (1) The door leaves shall unlock in the direction of egress upon actuation of one of the following: (a) Approved, supervised automatic sprinkler system in accordance with Section 9.7 (b) Not more than one heat detector of an approved, supervised automatic fire detection system in accordance with Section 9.6 (c) Not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6 (2) The door leaves shall unlock in the direction of</p>	K 222			

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K 222	Continued From page 5 egress upon loss of power controlling the lock or locking mechanism. (3)*An irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions: (a) The force shall not be required to exceed 15 lbf (67 N). (b) The force shall not be required to be continuously applied for more than 3 seconds. (c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening. (d) Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only. (4)*A readily visible, durable sign in letters not less than 1 in. (25 mm) high and not less than 1/8 in. (3.2 mm) in stroke width on a contrasting background that reads as follows shall be located on the door leaf adjacent to the release device in the direction of egress: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS (5) The egress side of doors equipped with delayed-egress locks shall be provided with emergency lighting in accordance with Section 7.9.	K 222			



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

August 24, 2020

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 **August 10, 2020**, 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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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E 000	<p>Initial Comments</p> <p>The facility is a single-story structure of Type V (111) construction, built in 1996. The building is fully sprinklered and is equipped with an interconnected fire alarm/smoke detection system. The Essential Electrical System (EES) is supplied by a diesel powered, on-site automatic generator. Currently the facility is licensed for 120 SNF beds and had a census of 78 on the date of the survey.</p> <p>The facility was found to be in substantial compliance during the annual Emergency Preparedness Survey conducted on August 10, 2020. 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>Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction</p>	E 000			

RECEIVED
SEP 03 2020
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Linda Chaney TITLE Executive Director (X6) DATE 9-4-2020

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