



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – 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

REVISED COPY

November 5, 2015

Kenneth Shull, Administrator
Idaho State Veterans Home-- Lewiston
821 21st Avenue
Lewiston, ID 83501-6389

Provider #: 135133

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

Dear Mr. Shull:

On **October 26, 2015**, a Facility Fire Safety and Construction survey was conducted at **Idaho State Veterans Home - Lewiston** 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 revised 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

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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 **November 18, 2015**. Failure to submit an acceptable PoC by **November 18, 2015**, may result in the imposition of civil monetary penalties by **December 8, 2015**.

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 and the state licensure survey report, State Form.

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **November 30, 2015**, (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 30, 2015**. A change in the seriousness of the deficiencies on **November 30, 2015**,

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may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **November 30, 2015**, includes the following:

Denial of payment for new admissions effective **January 26, 2016**.
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 **April 26, 2016**, 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 Mark P. Grimes, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, 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 **October 26, 2015**, 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

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Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

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

Go to the middle of the page to Information Letters section and click on State and select the following:

BFS Letters (06/30/11)

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

This request must be received by **November 18, 2015**. If your request for informal dispute resolution is received after **November 18, 2015**, 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.

Sincerely,



Mark P. Grimes, Supervisor
Facility Fire Safety and Construction

MPG/lj
Enclosures

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

PRINTED: 11/17/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135133	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/26/2015
NAME OF PROVIDER OR SUPPLIER IDAHO STATE VETERANS HOME - LEWISTON			STREET ADDRESS, CITY, STATE, ZIP CODE 821 21ST AVENUE LEWISTON, ID 83501	
(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, protected non-combustible Type II(111) building that is fully sprinklered with a partial basement. The basement houses hot water heaters and air handling equipment. The facility was built in 1994. The facility is currently licensed for 66 SNF/NF beds. The following deficiencies were cited during the annual fire/life safety survey conducted on October 26, 2015. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70. The survey was conducted by: Nate Elkins Health Facility Surveyor Facility Fire Safety & Construction	K 000		
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4	K 025	K025-D What corrective action will be accomplished for those residents found to have been by the deficient practice? The deficient practice had the potential of affecting all 65 residents present on the day of survey. Maintenance Facility Foreman immediately ordered "Fire Putty" from Granger the day of survey. The product was received the following morning and the pipe was sealed with the putty by the afternoon following the survey.	

RECEIVED

NOV 20 2015

FACILITY STANDARD

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE

0007

(X6) DATE

11/13/15

11/12/2015

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 025	<p>Continued From page 1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that smoke barriers were maintained. Failure to maintain smoke barriers could allow smoke and dangerous gases to pass freely into concealed spaces above the ceiling inhibiting alarms and suppression system response during a fire event. This deficient practice affected staff and visitors on the date of survey. The facility is licensed for 66 SNF/NF beds with a census of 65 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour on October 26, 2015 between 2:00 PM and 5:00 PM, observation of the Server room located inside the dining room area revealed an approximate 3 inch pipe penetrating through the ceiling with communication wires running though the piping that was unsealed and would allow the passage of smoke into the concealed area above the ceiling. When asked about the unsealed penetration, the Maintenance Supervisor stated the facility was unaware the piping was not sealed. The finding was acknowledged by the Maintenance Supervisor and the Administrator at the exit conference.</p> <p>Actual NFPA standard:</p> <p>19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour. Exception No. 1: Where an atrium is used, smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with</p>	K 025	<p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken? Since all 65 residents present in the Home had the potential of being affected by the deficient practice, there is no need to identify other residents with the potential to be affected. Maintenance Facility Foreman immediately ordered "Fire Putty" from Granger the day of survey. The product was received the following morning and the pipe was sealed with the putty by the afternoon following the survey.</p> <p>What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur. Maintenance Facility Foreman will monitor smoke barrier penetrations monthly via his Monthly Building Inspection to ensure the deficient practice does not recur.</p>	

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K 025	Continued From page 2 Exception No. 2 to 8.2.5.6(1). Not less than two separate smoke compartments shall be provided on each floor. Exception No. 2*: Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.3 has been provided for smoke compartments adjacent to the smoke barrier. 8.3.2* Continuity. Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces. Exception: A smoke barrier required for an occupied space below an interstitial space shall not be required to extend through the interstitial space, provided that the construction assembly forming the bottom of the interstitial space provides resistance to the passage of smoke equal to that provided by the smoke barrier	K 025	How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place. Maintenance Facility Foreman will audit the deficient practice for compliance weekly x 4 for thirty days, bi-weekly x 2 for thirty days and then monthly x 1 for 30 days. In addition, report findings and review in QA monthly x three months. Include dates when corrective action will be completed. October 27, 2015	
K 070 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8	K 070	K070-E What corrective action will be accomplished for those residents found to have been by the deficient practice? The deficient practice had the potential of affecting those residents using the dining room the day of survey. Maintenance Facility Foreman immediately removed the "Fireplace" upon completion of the survey, 10/26/15.	

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K 070	<p>Continued From page 3</p> <p>This STANDARD is not met as evidenced by: Based upon observation and interview the facility failed to prohibit portable space heating devices. Failure to prohibit portable heating devices poses a significant risk to the facility due to the history of fires caused by space heaters. This deficient practice could potentially affect all residents, staff, and visitors using the dining room on the day of survey. The facility is licensed for 66 SNF/NF beds with a census of 65 on the day of survey.</p> <p>Findings include:</p> <p>During the facility tour on October 26, 2015 between 2:00 PM and 5:00 PM, observation revealed a portable electric/plug in fire place located in the Dining room. This device was observed to be a 12.5 AMP, 1500 Watt electrical fire place plugged into a wall receptacle and not affixed to a permanent location. When asked, the Maintenance Supervisor stated the facility was unaware the electric/plug in fire place was considered a portable space heater. This finding was acknowledged by the Maintenance Supervisor and the Administrator during the exit conference.</p> <p>Actual NFPA Standard:</p> <p>NFPA 101, the Life Safety Code, 2000 Edition</p> <p>19.7.8 Portable Space-Heating Devices. Portable space-heating devices shall be prohibited in all health care occupancies. Exception: Portable space-heating devices shall be permitted to be used in nonsleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C).</p>	K 070	<p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken? Since all 65 residents present in the Home had the potential of being affected by the deficient practice, the Maintenance Facility Foreman immediately removed the "Fireplace" upon completion of the survey, 10/26/15.</p> <p>What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur. The "Fireplace" was removed and will not be replaced. Maintenance Facility Foreman will monitor the Home for any other potential Portable Space Heating Devices during his monthly inspections.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place.</p>		

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			<p>Maintenance Facility Foreman will audit the deficient practice for compliance weekly x 4 for thirty days, bi-weekly x 2 for thirty days and then monthly x 1 for 30 days. In addition, report findings and review in QA monthly x three months.</p> <p>Include dates when corrective action will be completed. October 27, 2015</p>	