



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

October 28, 2016

Mark High, 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. High:

On **October 17, 2016**, 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 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 **November 10, 2016**. Failure to submit an acceptable PoC by **November 10, 2016**, may result in the imposition of civil monetary penalties by **November 30, 2016**.

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 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 21, 2016**, (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 21, 2016**. A change in the seriousness of the deficiencies on **November 21, 2016**, 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 **November 21, 2016**, includes the following:

Denial of payment for new admissions effective **January 17, 2017**.  
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 17, 2017**, 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 **October 17, 2016**, 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:

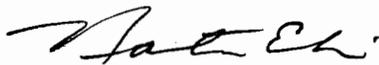
BFS Letters (06/30/11)

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

This request must be received by **November 10, 2016**. If your request for informal dispute resolution is received after **November 10, 2016**, 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: 10/27/2016  
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  10/17/2016
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 17, 2016. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.	K 000		
K 064 SS=F	The survey was conducted by:  Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction NFPA 101 LIFE SAFETY CODE STANDARD  Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure fire extinguishers were installed per NFPA 10. Failure to install fire extinguishers at the proper height could hinder emergency response by staff. This deficient practice affected 60 residents, staff and visitors on the date of the survey. The facility is licensed for 66 SNF/NF beds and had a census of 60 on the day of the survey.	K 064	K064 NFPA 101 Life Safety Code Standard – portable fire extinguishers shall be installed, inspected and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10.18.3.5.6, 19.3.5.6  <b>What corrective action will be accomplished for those residents found to have been by the deficient practice?</b>	

RECEIVED  
NOV - 2 2016  
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE Administrator \_\_\_\_\_ (X6) DATE 11-1-2016

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 064	Continued From page 1  Findings include:  During the facility tour on October 17, 2016, from approximately 2:00 PM to 6:00 PM, examination of fire extinguishers installed in the following areas revealed the height from the floor to the top of the extinguishers was approximately 63" which exceeded the sixty inch (60") maximum height requirement: - Dining Room - Canteen - Kitchen - Corridor near receiving -West Wing corridor by resident room W1	K 064	All residents, staff and visitors were affected by this deficient practice and the facility corrected the deficiency by reinstalling the fire extinguishers found at sixty-three (63") inches at or below the maximum height of sixty inches (60").  <b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken?</b> Since all residents within the facility have the potential to be affected by the same deficient practice the facility has also audited and re-installed each fire extinguisher within the facility at the mandated sixty inch (60") standard.	
	-West Wing corridor next to Library -North Wing corridor between resident rooms N4 and N6 -North Wing corridor next to resident room N9 -Corridor across from Pharmacy -East Wing corridor next to resident room E1 Based on the quantity found in multiple locations, the condition was deemed widespread and further documentation was unnecessary. When asked, the Maintenance Supervisor stated the facility was not aware of the height requirement for fire extinguishers.  Actual NFPA standard:  NFPA 10 1-6.10 Fire extinguishers having a gross weight not exceeding 40 lb (18.14 kg) shall be installed so that the top of the fire extinguisher is not more than 5 ft (1.53 m) above the floor. Fire extinguishers having a gross weight greater than 40 lb (18.14 kg) (except wheeled types) shall be so installed that the top of the fire extinguisher is		<b>What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur.</b> Root cause analyses showed that, new fire extinguishers had been purchased recently in the facility which were taller than the previous fire extinguishers which pushed them over the standard of sixty inches (60").	

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K 064	Continued From page 2 not more than 31/2 ft (1.07 m) above the floor. In no case shall the clearance between the bottom of the fire extinguisher and the floor be less than 4 in. (10.2 cm)	K 064	Maintenance has marked the mounting areas for the fire extinguishers and noted the maximum height allowable for mounted fire extinguishers to ensure that any replacement fire extinguishers will not exceed the standard of sixty inches (60").  <b>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.</b> The Maintenance supervisor or designee will do facility wide audits of the facility fire extinguishers to ensure proper mounting/height requirements monthly (x3). All results will be reported to QA monthly (x3) to ensure compliance.  <b>Completion Date: 11/15/16</b>		