



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

March 23, 2017

Josiah Dahlstrom, Administrator
Idaho State Veterans Home - Pocatello
1957 Alvin Ricken Drive
Pocatello, ID 83201-2727

Provider #: 135132

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Mr. Dahlstrom:

On **March 13, 2017**, a Facility Fire Safety and Construction survey was conducted at **Idaho State Veterans Home - Pocatello** 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 an isolated 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

Josiah Dahlstrom, Administrator
March 23, 2017
Page 2 of 4

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 **April 5, 2017**. Failure to submit an acceptable PoC by **April 5, 2017**, may result in the imposition of civil monetary penalties by **April 25, 2017**.

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 **April 17, 2017**, (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 **April 17, 2017**. A change in the seriousness of the deficiencies on **April 17, 2017**, may result in a change in the remedy.

Josiah Dahlstrom, Administrator
March 23, 2017
Page 3 of 4

The remedy, which will be recommended if substantial compliance has not been achieved by **April 17, 2017**, includes the following:

Denial of payment for new admissions effective **June 13, 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 **September 13, 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 **March 13, 2017**, 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:

Josiah Dahlstrom, Administrator
March 23, 2017
Page 4 of 4

<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 **April 5, 2017**. If your request for informal dispute resolution is received after **April 5, 2017**, 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: 03/22/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 03/13/2017
NAME OF PROVIDER OR SUPPLIER IDAHO STATE VETERANS HOME - POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1957 ALVIN RICKEN DRIVE POCATELLO, ID 83201	
(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, type II(111) fire resistive fully sprinklered building built in 1992-93. Smoke detection coverage is provided throughout the facility including sleeping rooms. There is a lower level mechanical room with interior and exterior access. Currently the facility is licensed for 66 SNF beds. The following deficiencies were cited during annual fire/life safety survey conducted on March 13, 2017. 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 & Construction	K 000		
K 291 SS=D	NFPA 101 Emergency Lighting 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 STANDARD is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to maintain emergency lighting. Failure to maintain emergency lighting could inhibit egress of residents during an emergency. This deficient practice affected residents utilizing the chapel, staff and visitors on the day of survey. The facility is licensed for 66 SNF/NF beds with a census of 52 on the date of survey.	K 291	K 291 • All emergency lighting in the facility was found to be operational except for 2 of 3 emergency lights found in the chapel. All lights were tested on February 13, 2017 and found to be functioning. The batteries were replaced 3/13/17 for the 2 lights that were not working and they have been tested and are functioning properly. • The industry standard of monthly audits will continue to	

RECEIVED
MAR 31 2017
FACILITY COMPLIANCE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *J. Ahlstrom* TITLE *Administrator* (X6) DATE *3/30/17*

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	Continued From page 1 Findings include: During the facility tour on March 13, 2017, from approximately 11:00 AM to 3:30 PM, observation and operational testing of the emergency lighting in the chapel found that two of the three emergency lights were non-operational. When asked, the Maintenance Supervisor stated the facility was unaware that the emergency lights were not working. Actual NFPA reference: NFPA 101, 19.2.9.1 Emergency lighting shall be provided in accordance with Section 7.9. 7.9.2.1* Emergency illumination shall be provided for a minimum of 1-1/2 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10.8 lux) and, at any point, not less than 0.1 ft-candle (1.1 lux), measured along the path of egress at floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (6.5 lux) and, at any point, not less than 0.06 ftcandle (0.65 lux) at the end of 11.2 hours. A maximum-to minimum illumination uniformity ratio of 40 to 1 shall not be exceeded. 7.9.2.7 The emergency lighting system shall be either continuously in operation or shall be capable of repeated automatic operation without manual intervention.	K 291	be performed to ensure they are functioning in case of emergency. <ul style="list-style-type: none"> The monthly audit from has been updated to include all emergency lights, separating the chapel lights as a whole into Chapel 1, 2 and 3 lights. Monthly audits document the status of each light. If it is found to be working, a date is placed in the audit. If it is not working a date and explanation of how it was fixed is documented. The maintenance team is aware of this standard and will conduct monthly audits. This corrective action will be monitored as the maintenance team will inform the QA committee of any concerns that are noted on their audits at the regular monthly meetings. <u>Corrective action completion date:</u>	03/14/17	
K 353 SS=D	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing	K 353	K 353 <ul style="list-style-type: none"> The 5 sprinkler heads found to have paint on them were cleaned by the maintenance director on 3/14/17. This 		

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K 353	<p>Continued From page 2</p> <p>Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure fire suppression system pendants were maintained free of obstructions such as paint or corrosion. Failure to maintain fire sprinkler pendants free of obstructions could hinder system performance during a fire event. This deficient practice affected residents utilizing the west shower room, staff and visitors on the date of the survey. The facility is licensed for 66 SNF/NF beds and had a census of 52 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour on March 13, 2017, from approximately 11:00 AM to 3:30 PM, observation of the west shower room revealed five (5) sprinkler heads were painted during a recent remodel. Interview of the Maintenance Supervisor revealed the facility was not aware the sprinkler</p>	K 353	<p>affected the west shower room.</p> <ul style="list-style-type: none"> All other sprinkler heads were inspected at the time of the Life Safety survey and there were no similar concerns noted to any. The Construction exit checklist has been modified to include a section to check sprinkler heads. This audit will be conducted with each construction project to identify the status of each sprinkler head and ensure they are clear from paint, dust or other debris. The sprinkler heads are also inspected annually with a contracted vendor. Any concerns are addressed immediately. The maintenance team is aware of this standard and will conduct audits as needed. This corrective action will be monitored as the maintenance team will inform the QA committee of any concerns that are noted on their audits at the regular monthly meetings. <p><u>Corrective action completion date:</u></p>	03/14/17	

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K 353	Continued From page 3 heads had been painted. Actual NFPA standard: NFPA 25 5.2.1 Sprinklers. 5.2.1.1* Sprinklers shall be inspected from the floor level annually. 5.2.1.1.1* Sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., upright, pendent, or sidewall). 5.2.1.1.2 Any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical damage (4) Loss of fluid in the glass bulb heat responsive element (5)*Loading (6) Painting unless painted by the sprinkler manufacturer	K 353			