



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

C.L. "BUTCH" OTTER – Governor  
RUSSELL S. BARRON – 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

December 22, 2017

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 **December 14, 2017**, 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 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

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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 **January 4, 2018**. Failure to submit an acceptable PoC by **January 4, 2018**, may result in the imposition of civil monetary penalties by **January 24, 2018**.

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 **January 18, 2018**, (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 **January 18, 2018**. A change in the seriousness of the deficiencies on **January 18, 2018**, 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 **January 18, 2018**, includes the following:

Denial of payment for new admissions effective **March 14, 2018**.  
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 **June 14, 2018**, 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 **December 14, 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:

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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:

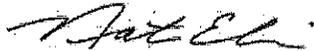
BFS Letters (06/30/11)

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

This request must be received by **January 4, 2018**. If your request for informal dispute resolution is received after **January 4, 2018**, 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: 12/21/2017  
FORM APPROVED  
OMB NO. 0938-0391

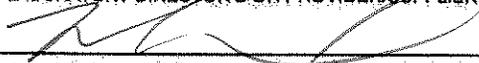
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135133</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/14/2017</b>
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NAME OF PROVIDER OR SUPPLIER <b>IDAHO STATE VETERANS HOME - LEWISTON</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>821 21ST AVENUE LEWISTON, ID 83501</b>
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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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E 000	Initial Comments  The facility is a two story, fire resistive building. The plans were approved in 1994. A full NFPA 13 compliant fire sprinkler system is installed and there is smoke detection throughout. The facility is situated within a municipal fire district. The facility is currently licensed for 66 SNF/NF beds and had a census of 56 on the day of the survey.  The facility was found to be in substantial compliance during the emergency preparedness survey conducted on December 13 and 14, 2017. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.  The Survey was conducted by:  Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	E 000		
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**RECEIVED**  
JAN 04 2018  
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <i>Nursing Home Administrator</i>	(X6) DATE <i>1/3/18</i>
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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.

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

Printed: 12/21/2017  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135133</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b> - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/14/2017</b>
NAME OF PROVIDER OR SUPPLIER <b>IDAHO STATE VETERANS HOME - LEWISTON</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>821 21ST AVENUE LEWISTON, ID 83501</b>		
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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 December 12, 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:  Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction	K 000	<p style="text-align: center;"><b>RECEIVED</b></p> <p style="text-align: center;">JAN 04 2018</p> <p style="text-align: center;"><b>FACILITY STANDARDS</b></p>	
K 161 SS=D	Building Construction Type and Height CFR(s): NFPA 101  Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1. I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2. II (111) One story non-sprinklered. Maximum 3 stories sprinklered 3. II (000) Not allowed non-sprinklered 4. III (211) Maximum 2 stories sprinklered 5. IV (2HH) 6. V (111) 7. III (200) Not allowed non-sprinklered	K 161		K161 SS=D NFPA 101 Building Construction Type and Height 2012 EXISTING Building Construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7, 19.1.6.4, 19.1.6.5 Construction Type

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE Nursing Home Administrator (X6) DATE 1/3/18

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135133</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - ENTIRE BUILDING</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/14/2017</b>
NAME OF PROVIDER OR SUPPLIER <b>IDAHO STATE VETERANS HOME - LEWISTON</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>821 21ST AVENUE LEWISTON, ID 83501</b>		
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K 161	<p>Continued From page 1</p> <p>8. V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5)</p> <p>Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure the fire resistive properties of the structure were maintained. Failure to maintain required fire coatings on steel support structures has the potential to decrease the rated assembly and cause premature structural failure. This deficient practice affected staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on December 13, 2017 from approximately 12:00 PM to 3:00 PM, observation of the steel support structure of the basement mechanical space revealed the steel I-beams were missing the protective coating(s) as follows:</p> <p>Two areas of approximately 8 inches by 12 inches Four areas of approximately 6 inches by 6 inches One area of approximately 1 inch by 36 inches Two areas of approximately 8 inches by 10 inches</p> <p>Further evaluation of on-site plans revealed the protective coating was part of a system involved</p>	K 161	<p><b>What corrective action will be accomplished for those residents found to have been by the deficient practice?</b> All residents, staff and visitors were affected by this deficient practice and the facility corrected the deficiency by ordering and applying Cafco Fire resistive mat to the affected areas.</p> <p><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 applied and re-inspected the entire mechanical room to ensure proper application of the Cafco Fire Resistive Mat.</p> <p><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, original application in one section of the mechanical room was faulty as well as chipping/marring from re-modeling/improvement projects that had occurred in the home. Maintenance has amended the</p>	

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K 161	Continued From page 2 in the three-hour rating of the floor assembly supporting the structure above.  Actual NFPA standard:  19.1.6.1 Health care occupancies shall be limited to the building construction types specified in Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7. (See 8.2.1.) 8.2.1.2* NFPA 220, Standard on Types of Building Construction, shall be used to determine the requirements for the construction classification.  NFPA 220 5.1.2.1 Structural elements, floors, and bearing walls shall have a fire resistance rating not less than the fire resistance rating required for the structural element, bearing or nonbearing wall, floor, or roof they support. [5000:7.2.7.2.1]	K 161	contractor checklist for end of project inspections to include auditing of fire protectant affected areas such as the steel i-beam in the mechanical room.  <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 protectant areas including mechanical room monthly (x3). All results will be reported to QA monthly (x3) to ensure compliance.  <b>Completion Date: 1/15/18</b>	