



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

April 2, 2019

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 **March 26, 2019**, a Facility Fire Safety and Construction survey was conducted at Idaho State Veterans Home - Lewiston by the Bureau of Facility Standards/Department of Health & Welfare 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 the facility in compliance with 42 CFR Part 483, Subpart B, Long Term Care Requirements. Enclosed is a Statement of Deficiencies/Plan of Correction, CMS Form 2567, listing no Medicare/Medicaid deficiencies. This form is for your records only and does not need to be returned.

Also enclosed is a Statement of Deficiencies/Plan of Correction, State Form, 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. **WAIVER RENEWALS MAY BE REQUESTED ON THE PLAN OF CORRECTION. Please provide ONLY ONE completion date for each State Tag in column X5 (Complete Date), to signify when you allege that each tag will be back in compliance. After each deficiency has been answered and dated, the administrator should sign the State Form Statement of Deficiencies, in the space provided, and return the original to this office.**

Mark High, Administrator
April 2, 2019
Page 2 of 2

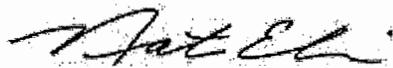
Your Plan of Correction (POC) for the deficiencies must be submitted by **April 15, 2019**.

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,
- Provide dates when corrected action will be completed.

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
Enclosures

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

Printed: 04/01/2019
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 03/26/2019
--	---	---	---

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	<p>INITIAL COMMENTS</p> <p>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 with a census of 55 on the date of the survey.</p> <p>The facility was found to be in substantial compliance during the annual fire/life safety survey conducted on March 26, 2019. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.</p> <p>The survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction</p>	K 000	<p>RECEIVED</p> <p>APR 15 2019</p> <p>FACILITY STANDARDS</p>	
-------	--	-------	---	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE NHA	(X6) DATE 4-12-19
---	---------------------	-----------------------------

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: 135133	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 03/26/2019
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) COMPLETE DATE
C 000	<p>INITIAL COMMENTS</p> <p>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.</p> <p>The following deficiency was cited during the annual fire/life safety survey conducted on March 26, 2019. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70 and IDAPA 16.03.02, Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities.</p> <p>The survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	C 000	<p style="text-align: center;">RECEIVED</p> <p style="text-align: center;">APR 15 2019</p> <p style="text-align: center;">FACILITY STANDARDS</p>	
C 228	<p>02.106,01,b Barriers to Natural/Man-Made Hazards</p> <p>b. Where natural or man-made hazards are present on the premises, the facility shall provide suitable fences, guards, and/or railings to isolate the hazard from the patient's/resident's environment.</p> <p>This RULE: is not met as evidenced by: Based on observation and interview, the facility failed to ensure the structure was maintained to assure the safety of residents, patients, staff and public. Failure to provide means of protection to natural or man-made risks through proper</p>	C 228	<p>C228</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? All residents and staff were affected by this deficient practice and the facility corrected the deficiency by installing a protective barrier and appropriate signage to the broken door while the replacement door is being shipped for installation.</p>	

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

TITLE

(X6) DATE



N/A

4-12-19

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 03/26/2019
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) COMPLETE DATE
	<p>barricades or preventative measures, has the potential to expose occupants to associated risks and/or injuries. This deficient practice affected those individuals using the shower room in the west wing of the facility on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 3/26/19 from 11:00 AM - 2:00 PM, observation of the door separating the interior of the shower room to the abutting bathroom in the west corridor, revealed the door was split and exposed an irregularly shaped, vertical break of the plastic laminate door skin, the full height of the door. Further observation of the door revealed two (2) pieces of construction "warning" tape were applied to the exposed break which was open to the shower room, but no protections were provided to prevent contact with the jagged edge of the laminate door skin.</p> <p>Interview of the Maintenance Director revealed he was not aware of the requirement to protect individuals from coming into contact with man-made risks.</p> <p>Actual IDAPA references:</p> <p>106. FIRE AND LIFE SAFETY. Buildings on the premises used as facilities shall meet all the requirements of local, state and national codes concerning fire and life safety standards that are applicable to health care facilities.</p> <p>01. General Requirements. General requirements for the fire and life safety standards for a health care facility are:</p> <p>a. The facility shall be structurally sound, maintained and equipped to assure the safety of patients/residents, employees and the public.</p> <p>b. Where natural or man-made hazards are present on the premises, the facility shall provide suitable fences, guards, and/or railings to isolate</p>		<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 residents within the facility have the potential to be affected by the same deficient practice the facility has educated all facility management for their daily room rounds and daily building inspections to place any potential hazards in the black maintenance book to be reviewed daily by the maintenance foreman.</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? Root cause analysis showed a breach in our communication in regards to the broken door and the need for a protective structure along with the appropriate warning signage therefore the facility has included an internal audit of the black maintenance book to assure all projects are properly prepared and repaired according to the regulatory requirement to ensure barriers are created to any natural/man-made hazards.</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? The maintenance supervisor will do facility wide audits of both the physical facility</p>	

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: 135133	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 03/26/2019
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) COMPLETE DATE
	the hazard from the patient ' s/resident ' s environment.		to identify any natural or manmade hazards as well as audits on the black maintenance log book to assure that all identified hazards are properly treated including protective barriers as needed. All results will be reported in Safety Committee Meeting monthly and those results will be included in the monthly QA meeting to ensure compliance. Completion Date: 04/15/2019	

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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

April 2, 2019

RECEIVED

APR 15 2019

FACILITY STANDARDS

Mark High, Administrator
Idaho State Veterans Home - Lewiston
821 21st Avenue
Lewiston, ID 83501-6389

Provider #: 135133

RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER

Dear Mr. High:

On **March 26, 2019**, an Emergency Preparedness survey was conducted at Idaho State Veterans Home - Lewiston 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

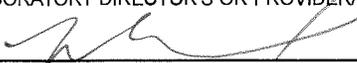
NE/lj
Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135133	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/26/2019
--	---	--	---

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
--------------------	--	---------------	---	----------------------

E 000	<p>Initial Comments</p> <p>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 backup Emergency Power Supply System (EPSS) generator is a spark-ignited, natural gas, with automatic transfer to propane. The facility is situated within a municipal fire district. The facility is currently licensed for 66 SNF/NF beds and had a census of 55 on the day of the survey.</p> <p>The facility was found to be in substantial compliance during the emergency preparedness survey conducted on March 26, 2019. 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>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	E 000	<p>RECEIVED</p> <p>APR 15 2019</p> <p>FACILITY STANDARDS</p>	
-------	---	-------	---	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE NHA	(X6) DATE 4-12-19
---	---------------------	-----------------------------

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.