



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

October 10, 2019

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 **October 2, 2019**, 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 one that comprises a pattern 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 you allege that each tag will be back in compliance.

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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 **October 23, 2019**. Failure to submit an acceptable PoC by **October 23, 2019**, may result in the imposition of civil monetary penalties by **November 14, 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,
- 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 **November 6, 2019**, (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 **December 31, 2019**. A change in the seriousness of the deficiencies on **November 16, 2019**, 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 6, 2019**, includes the following:

Denial of payment for new admissions effective **January 2, 2020**.
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 2, 2020**, 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 2, 2019**, 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:

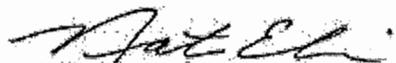
BFS Letters (06/30/11)

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

This request must be received by **October 23, 2019**. If your request for informal dispute resolution is received after **October 23, 2019**, 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

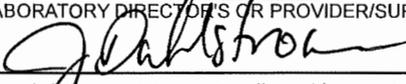
NE/lj
Enclosures

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 10/02/2019
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NAME OF PROVIDER OR SUPPLIER IDAHO STATE VETERANS HOME - POCATELL	STREET ADDRESS, CITY, STATE, ZIP CODE 1957 ALVIN RICKEN DRIVE POCATELLO, ID 83201
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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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K 000	<p>INITIAL COMMENTS</p> <p>The facility is a single story, type II (111) fire resistive structure which features a lower level mechanical room and was originally constructed in 1992. The building is fully sprinklered, with an interconnected fire alarm/smoke detection system. There is both an on-site, spark-ignited Emergency Power Supply System (EPSS) generator and piped in medical gas. Currently the facility is licensed for 66 SNF beds, and had a census of 56 on the date of the survey.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on October 2, 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 surveyor conducting the survey was:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	K 000	<p>Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists.</p> <p>This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.</p> <p style="text-align: center;">RECEIVED OCT 24 2019 FACILITY STANDARDS</p>	
K 353 SS=D	<p>Sprinkler System - Maintenance and Testing CFR(s): NFPA 101</p> <p>Sprinkler System - Maintenance and Testing 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>	K 353	<p>K 353</p> <ul style="list-style-type: none"> All fire suppression pendants throughout the home were found to be operational. However, three (3) were found to be corroded and/or painted. None of the residents were affected by the 3 sprinkler heads in question but all could have been. All fire suppression pendants were audited on the day of the survey and no other pendants were found to be corroded or painted. The 3 fire suppression pendants found to be affected, have been replaced. 	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 10/23/19
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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.

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NAME OF PROVIDER OR SUPPLIER IDAHO STATE VETERANS HOME - POCATELL		STREET ADDRESS, CITY, STATE, ZIP CODE 1957 ALVIN RICKEN DRIVE POCATELLO, ID 83201		
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K 353	<p>Continued From page 1</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 REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure that fire suppression system pendants were maintained in accordance with NFPA 25. Failure to ensure sprinkler pendants were maintained free of obstructions such as paint, dirt and corrosion, has the potential to hinder system response during a fire event. This deficient practice affected the 19 residents and staff on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 10/2/19 from 11:00 AM - 2:00 PM, observation of the following installed fire suppression pendants were corroded and/or painted:</p> <ul style="list-style-type: none"> - The resident shower room north of the central Nurse's station had one (1) sprinkler head observed to be corroded with non-factory applied paint. - The main Kitchen area above the dishwashing station was observed to have two (2) corroded heads. Further observation revealed 1 of the 2 also had non-factory applied paint on the deflector. <p>Actual NFPA standard:</p> <p>NFPA 25 5.2* Inspection. 5.2.1 Sprinklers.</p>	K 353	<ul style="list-style-type: none"> • The maintenance team has been educated regarding this regulation and are aware of the requirement to keep all fire suppression pendants (fire sprinkler heads) free from corrosion and/or paint. Each fire sprinkler will be audited annually to verify they are not corroded or painted. • The QA team is aware of this standard and will request a review of all audits/testing reports from the maintenance team and facility vendors to verify the reports show no concerns that have not been addressed. <p><u>Corrective action completion date:</u></p>	11/1/19

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K 353	Continued From page 2 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		
K 923 SS=E	Gas Equipment - Cylinder and Container Storage CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than	K 923	K 923 <ul style="list-style-type: none"> The 2 oxygen cylinders stored in the oxygen storage room were not part of the home's oxygen supply/inventory and were promptly removed from the facility. Any resident experiencing an emergent episode requiring use of oxygen would have had oxygen readily accessible through the home's emergency oxygen located on the crash cart near the nurse's station. No residents were affected by this deficient practice. The oxygen storage and transfill room will only be used for oxygen and equipment that belongs to the 	

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K 923	<p>Continued From page 3</p> <p>or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING."</p> <p>Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather.</p> <p>11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, the facility failed to ensure oxygen cylinders were maintained in accordance with NFPA 99. Failure to segregate oxygen cylinders in storage has the potential to inadvertently use the incorrect cylinder during an emergency requiring supplemental oxygen. This deficient practice affected those residents requiring supplemental oxygen treatment and staff on the dates of the survey.</p> <p>During the facility tour conducted on 10/2/19 from 11:00 AM - 2:00 PM, observation of the oxygen storage and transfill room in the northwest wing of the facility, revealed two (2) oxygen cylinders stored in a rack, one with a plastic protective cover for the valve connection and one without. Further observation failed to establish any additional indication of whether the cylinders were full or empty.</p>	K 923	<ul style="list-style-type: none"> Any empty tanks used in transfilling oxygen will be labeled with an "empty" tag when the tank is empty and all other tanks will be in use until they are labeled as "empty. Staff that use the oxygen room for transfilling oxygen have been made aware of this change and will label empty tanks as appropriate. The maintenance staff will audit use of this system on a weekly basis to ensure that oxygen is readily accessible in an emergency and empty tanks are not used in an emergency. The results of these weekly audits will be taken to the monthly QA committee and ongoing audits will be adjusted as deemed appropriate by the QA Committee. <p><u>Corrective action completion date:</u></p>	11/1/19

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K 923	Continued From page 4 At approximately 11:45 AM, the charge nurse was asked at this storage location to describe how to identify if the cylinders were full or empty. She stated the tank would need to have a valve attached to determine the level. When asked further the purpose of the protective plastic cap, she stated the one with the cap would be considered full and the one without would be considered empty. Actual NFPA standard: NFPA 99 11.6.5 Special Precautions - Storage of Cylinders and Containers. 11.6.5.1 Storage shall be planned so that cylinders can be used in the order in which they are received from the supplier. 11.6.5.2 If empty and full cylinders are stored within the same enclosure, empty cylinders shall be segregated from full cylinders. 11.6.5.3 Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed in a rapid manner.	K 923	<p>K 926</p> <ul style="list-style-type: none"> All staff are educated upon hire, regarding the risks associated with the storage, handling and use of medical gases and their cylinders. Continuing education will be provided annually in October of each year. Any resident living in the facility has the potential to be affected by this deficient practice. Staff will be educated by the maintenance team/designee regarding the risks associate with the storage, handling and use of medical gases and their cylinders. The Staff Development Coordinator will track the education to ensure that all staff utilizing the oxygen tanks and accessing the storage/transfilling room are provided education upon hire and annually thereafter. Concerns related to the SDC audits will be brought to the monthly QA committee for review and remedy as deemed necessary by the committee. <p><u>Corrective action completion date:</u></p>	11/1/19
K 926 SS=E	Gas Equipment - Qualifications and Training CFR(s): NFPA 101 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 926		

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

Printed: 10/09/2019
FORM APPROVED
OMB NO. 0938-0391

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K 926	<p>Continued From page 5</p> <p>Based on record review, and interview, the facility failed to ensure continuing education and staff training was provided on the risks associated with the storage, handling and use of medical gases and their cylinders. Failure to provide training of safety and the risks associated with medical gases, hinders staff response and affects those residents utilizing supplemental oxygen. This deficient practice potentially affected oxygen dependent residents and staff on the date of the survey.</p> <p>Findings include:</p> <p>During review of provided inservice training records conducted on 10/2/2019 from 8:45 - 11:00 AM, records were not available demonstrating a continual education program conducted on the safety guidelines for medical gases.</p> <p>Interview of the Building Facilities Foreman at approximately 10:45 AM, established that only an initial orientation training was conducted and not an on-going, continual program.</p> <p>Actual NFPA standard:</p> <p>NFPA 99 11.5.2 Gases in Cylinders and Liquefied Gases in Containers. 11.5.2.1 Qualification and Training of Personnel. 11.5.2.1.1* Personnel concerned with the application and maintenance of medical gases and others who handle medical gases and the cylinders that contain the medical gases shall be trained on the risks associated with their handling and use. 11.5.2.1.2 Health care facilities shall provide programs of continuing education for their</p>	K 926		

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K 926	Continued From page 6 personnel. 11.5.2.1.3 Continuing education programs shall include periodic review of safety guidelines and usage requirements for medical gases and their cylinders.	K 926		
K 927 SS=E	Gas Equipment - Transfilling Cylinders CFR(s): NFPA 101 Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and operational testing, the facility failed to ensure transfilling of medical gases such as oxygen, were performed properly. Failure to ensure mechanical ventilation in transfilling locations was operational as designed, has the potential to create an oxygen-rich environment which increases the risk for fires and explosions. This deficient practice affected 19 residents and staff on the date of the survey. Findings include: During the facility tour conducted on 10/2/19 from 11:00 AM - 4:00 PM, observation and operational testing by the Building Facilities Foreman of the mechanical ventilation in the oxygen transfill location by the 400 hall, established the fan was	K 927	<p>K 927</p> <ul style="list-style-type: none"> • There were no residents found to have been affected by this deficient practice. • All filters in the home are set up with a regular maintenance schedule and checked/changed quarterly (or more often if needed). The filter in the oxygen room was changed immediately and resulted in improved ventilation of that space. The filter was not on the quarterly audit and has been added to the list and will be changed out quarterly. • The maintenance team will change out this filter each quarter. The housekeeping staff will also clean and dust the room each month to ensure dust is not built up in the room. • The maintenance director will share the regular audits with the QA committee monthly to review any noted concerns for review and remedy as deemed necessary by the committee. <p><u>Corrective action completion date:</u></p>	11/1/19

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K 927	Continued From page 7 operational, but lacked exhaust airflow when tested with a single sheet of note paper and a single bath tissue placed against the grille. Actual NFPA standard: NFPA 99 9.3.7.5.3.2 Mechanical exhaust shall be at a rate of 1 L/sec of airflow for each 300 L (1 cfm per 5 ft3 of fluid) designed to be stored in the space and not less than 24 L/sec (50 cfm) nor more than 235 L/sec (500 cfm).	K 927		
K 930 SS=E	Gas Equipment - Liquid Oxygen Equipment CFR(s): NFPA 101 Gas Equipment - Liquid Oxygen Equipment The storage and use of liquid oxygen in base reservoir containers and portable containers comply with sections 11.7.2 through 11.7.4 (NFPA 99). 11.7 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure liquid, or cryogenic, oxygen cylinders were secured in accordance with NFPA 99. Failure to ensure cryogenic oxygen cylinders are secured by either a cart or chain, has the potential to expose residents and staff to the risks associated when cryogenic oxygen that comes in contact with skin or a hydrocarbon. This deficient practice affected 19 residents and staff on the date of the survey. Findings include: During the facility tour conducted on 10/2/19 from 11:00 AM - 2:00 PM, observation of the oxygen transfill and storage room, revealed one (1)	K 930	K 930 <ul style="list-style-type: none">• There were no residents found to have been affected by this deficient practice and the tank in question was removed.• The oxygen storage and transfill room is removed from the general population of the home, reducing residents that could be affected to those within the vicinity.• All tanks required to be securely restrained to prevent tipping over will be secured. Staff frequenting this room have been educated regarding the matter. The tank in question is not part of the home's inventory and has been returned to the appropriate vendor.• Random weekly audits of the oxygen room will be conducted by the maintenance team to ensure tanks are always appropriately secured. The maintenance director will share the regular audits with the QA committee monthly to review any noted concerns for review and remedy as deemed necessary by the committee. <u>Corrective action completion date:</u>	11/1/19

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

Printed: 10/09/2019
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 10/02/2019
NAME OF PROVIDER OR SUPPLIER IDAHO STATE VETERANS HOME - POCATELL		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 930	Continued From page 8 cryogenic oxygen cylinder was not secured by a chain or placed in a rack or cart. Actual NFPA standard: 11.7.3 Container Storage, Use, and Operation. 11.7.3.1* Containers shall be stored, used, and operated in accordance with the manufacturer ' s instructions and labeling. 11.7.3.2 Containers shall not be placed in the following areas: (1) Where they can be tipped over by the movement of a door (2) Where they interfere with foot traffic (3) Where they are subject to damage from falling objects (4) Where exposed to open flames and high-temperature devices 11.7.3.3* Liquid oxygen base reservoir containers shall be secured by one of the following methods while in storage or use to prevent tipping over caused by contact, vibration, or seismic activity: (1) Securing to a fixed object with one or more restraints (2) Securing within a framework, stand, or assembly designed to resist container movement (3) Restraining by placing the container against two points of contact	K 930		



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

October 10, 2019

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

Provider #: 135132

RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER

Dear Mr. Dahlstrom:

On **October 2, 2019**, an Emergency Preparedness survey was conducted at Idaho State Veterans Home - Pocatello 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

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

PRINTED: 10/28/2019
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 _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/02/2019
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	
E 000	<p>Initial Comments</p> <p>The facility is a single story, type II (111) fire resistive structure which features a lower level mechanical room and was originally constructed in 1992. The building is fully sprinklered, with an interconnected fire alarm/smoke detection system. The facility is located within a municipal fire district, with both county and state EMS services available. There is both an on-site, spark-ignited Emergency Power Supply System (EPSS) generator and piped in medical gas. Currently the facility is licensed for 66 SNF beds, and had a census of 56 on the date of the survey.</p> <p>The facility was found to be in substantial compliance during the Emergency Preparedness Survey conducted on October 2, 2019. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.</p> <p>The surveyor conducting the survey was:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	E 000			

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

TITLE

(X6) DATE

10/23/2019

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.