



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

December 13, 2019

J.R. Burt, Administrator  
Advanced Health Care of Lewiston  
2852 Juniper Drive  
Lewiston, ID 83501

Provider #: 135145

**RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER  
LETTER**

Dear Mr. Burt:

On **December 6, 2019**, a Facility Fire Safety and Construction survey was conducted at **Advanced Health Care of 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

J.R. Burt, Administrator  
December 13, 2019  
Page 3 of 4

The remedy, which will be recommended if substantial compliance has not been achieved by **January 10, 2020**, includes the following:

Denial of payment for new admissions effective **March 6, 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 **June 6, 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 **December 6, 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:

J.R. Burt, Administrator  
December 13, 2019  
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:

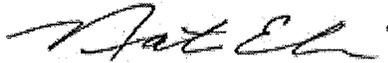
BFS Letters (06/30/11)

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

This request must be received by **December 26, 2019**. If your request for informal dispute resolution is received after **December 26, 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

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

Printed: 12/13/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135145</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ADVANCED HEALTHCARE LEWISTON B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/06/2019</b>
NAME OF PROVIDER OR SUPPLIER <b>ADVANCED HEALTH CARE OF LEWISTON</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2852 JUNIPER DRIVE LEWISTON, ID 83501</b>	
(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><b>INITIAL COMMENTS</b></p> <p>The facility consists of a single story, Type V (111) structure with hazardous area separations. The building is fully sprinklered with an interconnected fire alarm/smoke detection system, with beam detection in the open clear-story hallways housing resident rooms. The facility is separated into three smoke compartments and is equipped with a Type 2 medical gas system and Type 1 Emergency Power Supply System (EPSS) generator. Currently the facility is licensed for 34 SNF/NF beds with a census of 26 on the date of the survey.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on December 6, 2019. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Chapter 19, Existing Healthcare Occupancies, in accordance with 42 CFR 483.70.</p> <p>The survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety &amp; Construction Program</p>	K 000	<p>"This plan of correction is submitted as required under Federal and State regulations and statutes applicable to skilled nursing facilities. This plan of correction does not constitute an admission of liability, and such liability is hereby specifically denied. The submission of this plan does not constitute agreement by the facility that the surveyor's conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied."</p> <p>Please accept this plan of correction as our credible allegation of compliance.</p>	
K 325 SS=F	<p><b>Alcohol Based Hand Rub Dispenser (ABHR)</b> CFR(s): NFPA 101</p> <p>Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: *Corridor is at least 6 feet wide. *Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols. *Dispensers shall have a minimum of 4 foot horizontal spacing. *Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single</p>	K 325	<p>K325 Resident Specific: Please see systemic changes</p> <p>Other Residents: Please see systemic changes</p> <p>Systemic changes:</p>	

RECEIVED  
DEC 27 2019  
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 12/26/2019
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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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K 325	<p>Continued From page 1</p> <p>smoke compartment outside a storage cabinet, excluding one individual dispenser per room.</p> <p>*Storage in a single smoke compartment greater than five gallons complies with NFPA 30.</p> <p>*Dispensers are not installed within one inch of an ignition source.</p> <p>*Dispensers over carpeted floors are in sprinklered smoke compartments.</p> <p>*ABHR does not exceed 95 percent alcohol.</p> <p>*Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11).</p> <p>*ABHR is protected against inappropriate access.</p> <p>18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, observation and interview, the facility failed to ensure Alcohol Based Hand Rub (ABHR) dispensers were installed in accordance with NFPA 101. Failure to ensure ABHR dispensers are inspected and tested in accordance to the standard, has the potential to increase the risks associated with fires from flammable liquids. This deficient practice affected 26 residents and staff on the date of the survey.</p> <p>Findings include:</p> <p>During review of provided inspection and testing records conducted on 12/6/19 from 8:30 - 10:00 AM, records provided only documented a "monthly" inspection and no indication of what tasks were performed during replacement of the refill.</p> <p>During the facility tour conducted on 12/6/19 from 10:00 AM - 12:00 PM, observation of installed hand sanitizer dispensers revealed automatically</p>	K 325	<p>The dispensers will be inspected every time they are changed out and tested in accordance to the standard. All staff that inspects the dispensors have been in-serviced on the standard to ensure compliance.</p> <p>Monitors:</p> <p>The administrator or designee will perform weekly rounds times four to ensure the dispensors are inspected to the standard.</p> <p>The administrator will report the findings at the QAPI meeting and make changes to the above plan of correction as needed.</p> <p>Date of Compliance</p> <p>1/2/2020</p>	

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K 325	<p>Continued From page 2</p> <p>activated dispensers installed throughout the facility.</p> <p>Interview of the Administrator at approximately 12:15 PM, established he was not aware the documentation needed to include the tasks as identified in the standard.</p> <p>Actual NFPA standard:</p> <p>19.3.2.6* Alcohol-Based Hand-Rub Dispensers. Alcohol-based hand-rub dispensers shall be protected in accordance with 8.7.3.1, unless all of the following conditions are met:</p> <p>(1) Where dispensers are installed in a corridor, the corridor shall have a minimum width of 6 ft (1830 mm).</p> <p>(2) The maximum individual dispenser fluid capacity shall be as follows:</p> <p>(a) 0.32 gal (1.2 L) for dispensers in rooms, corridors, and areas open to corridors</p> <p>(b) 0.53 gal (2.0 L) for dispensers in suites of rooms</p> <p>(3) Where aerosol containers are used, the maximum capacity of the aerosol dispenser shall be 18 oz. (0.51 kg) and shall be limited to Level 1 aerosols as defined in NFPA30B, Code for the Manufacture and Storage of Aerosol Products.</p> <p>(4) Dispensers shall be separated from each other by horizontal spacing of not less than 48 in. (1220 mm).</p> <p>(5) Not more than an aggregate 10 gal (37.8 L) of alcohol hand-rub solution or 1135 oz (32.2 kg) of Level 1 aerosols, or a combination of liquids and Level 1 aerosols not to exceed, in total, the equivalent of 10 gal (37.8 L) or 1135 oz (32.2 kg), shall be in use outside of a storage cabinet in a single smoke compartment, except as otherwise provided in 19.3.2.6(6).</p> <p>(6) One dispenser complying with 19.3.2.6 (2) or</p>	K 325		

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K 325	Continued From page 3 (3) per room and located in that room shall not be included in the aggregated quantity addressed in 19.3.2.6(5). (7) Storage of quantities greater than 5 gal (18.9 L) in a single smoke compartment shall meet the requirements of NFPA 30, Flammable and Combustible Liquids Code. (8) Dispensers shall not be installed in the following locations: (a) Above an ignition source within a 1 in. (25 mm) horizontal distance from each side of the ignition source (b) To the side of an ignition source within a 1 in. (25mm) horizontal distance from the ignition source (c) Beneath an ignition source within a 1 in. (25 mm) vertical distance from the ignition source (9) Dispensers installed directly over carpeted floors shall be permitted only in sprinklered smoke compartments. (10) The alcohol-based hand-rub solution shall not exceed 95 percent alcohol content by volume. (11) Operation of the dispenser shall comply with the following criteria: (a) The dispenser shall not release its contents except when the dispenser is activated, either manually or automatically by touch-free activation. (b) Any activation of the dispenser shall occur only when an object is placed within 4 in. (100 mm) of the sensing device. (c) An object placed within the activation zone and left in place shall not cause more than one activation. (d) The dispenser shall not dispense more solution than the amount required for hand hygiene consistent with label instructions. (e) The dispenser shall be designed, constructed, and operated in a manner that ensures that accidental or malicious activation of the	K 325		

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K 325	Continued From page 4 dispensing device is minimized. (f) The dispenser shall be tested in accordance with the manufacturer ' s care and use instructions each time a new refill is installed.	K 325		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101  Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to ensure fire alarm systems were maintained in accordance with NFPA 72. Failure to conduct sensitivity testing on fire alarm systems has the potential to hinder system response during a fire event. This deficient practice affected 26 residents and staff on the date of the survey.  Findings include:  During review of facility fire alarm inspection records conducted on 12/6/19 from approximately 8:30 - 10:00 AM, no documentation was provided indicating a sensitivity testing of the smoke detectors was conducted after the first year of installation in 2018.  Actual NFPA standard:  NFPA 72 Chapter 14 Inspection, Testing, and Maintenance 14.4.5.3.1	K 345	K345  Resident Specific:  See systemic changes  Other Residents:  See systemic changes  Systemic Change Annual fire alarm inspection scheduled for 12/26/2019. Inspection to include sensitivity testing of the smoke detectors.  Monitors:  Administrator to ensure sensitivity testing of the smoke detectors annually. Administrator to report findings to the QAPI meeting and make changes to the above plan of correction as needed.  Date of Compliance:  1/2/2020	

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K 345	Continued From page 5 Sensitivity shall be checked within 1 year after installation. 14.4.5.3.2 Sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with 14.4.5.3.3. 14.4.5.3.3 After the second required calibration test, if sensitivity tests indicate that the device has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years.	K 345		
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101  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. a) Date sprinkler system last checked  b) Who provided system test  c) Water system supply source  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 fire suppression system pendants were maintained free of obstructions such as paint or	K 353	K353  Resident Specific:  See systemic changes  Other Residents:  See systemic changes  Systemic Changes:  The pendant in the soiled linen room has been removed and replaced with a head that is free of obstructions.  Monitors:  The administrator or designee will inspect the fire suppression system pendants weekly times four to ensure they are free of obstructions. The administrator will report findings to the QAPI meeting and make	

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K 353	Continued From page 6 corrosion. Failure to maintain fire sprinkler pendants free of obstructions, has the potential to hinder system response during a fire event. This deficient practice affected staff on the date of the survey.  Findings include:  During the facility tour conducted on 12/6/19 from 10:30 AM - 12:00 PM, observation of the soiled holding room adjacent to the main nurse's station, revealed the fire suppression system pendant in the ceiling was painted with non-factory applied paint, covering the frangible bulb of the pendant.  Actual NFPA standard:  5.2* Inspection. 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 5.2.1.1.3* Any sprinkler that has been installed in the incorrect orientation shall be replaced.	K 353	changes to the above plan of correction as needed.  Date of Compliance:  1/2/2020	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101	K 914		

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K 914	Continued From page 7  Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to one month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to ensure facility resident care area electrical receptacles were maintained in accordance with NFPA 99. Failure to test resident care area electrical receptacles annually has the potential to hinder system response during an emergency that encompasses a loss of power. This deficient practice affected 26 residents and staff on the date of the survey.  Findings include:  During review of provided maintenance documents conducted on 12/6/19 from 8:30 - 10:00 AM, documentation indicated outlet testing	K 914	K914  Resident specific:  See systemic changes  Other Residents:  See systemic changes  Systemic Changes:  The hospital grade receptacles have been maintained and tested in accordance with the standard.  Monitors:  Administrator will ensure all hospital grade receptacles are maintained and tested in accordance to the standard annually. Administrator will report findings to the QAPI meeting and make changes to the above plan of correction as needed.  Date of Compliance:  1/2/2020	

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K 914	<p>Continued From page 8</p> <p>had been performed for a "voltage" test and a "visual" test, but no other testing was documented for polarity, continuity or retention.</p> <p>Actual NFPA standard:</p> <p>NFPA 99 Chapter 6 Electrical Systems</p> <p>6.3.3.2 Receptacle Testing in Patient Care Rooms. 6.3.3.2.1 The physical integrity of each receptacle shall be confirmed by visual inspection. 6.3.3.2.2 The continuity of the grounding circuit in each electrical receptacle shall be verified. 6.3.3.2.3 Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed. 6.3.3.2.4 The retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 g (4 oz).</p> <p>6.3.4.1 Maintenance and Testing of Electrical System. 6.3.4.1.1 Where hospital-grade receptacles are required at patient bed locations and in locations where deep sedation or general anesthesia is administered, testing shall be performed after initial installation, replacement, or servicing of the device. 6.3.4.1.2 Additional testing of receptacles in patient care rooms shall be performed at intervals defined by documented performance data. 6.3.4.1.3 Receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at</p>	K 914		

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

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135145</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ADVANCED HEALTHCARE LEWISTON B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/06/2019</b>
NAME OF PROVIDER OR SUPPLIER <b>ADVANCED HEALTH CARE OF LEWISTON</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2852 JUNIPER DRIVE LEWISTON, ID 83501</b>		
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K 914	Continued From page 9 intervals not exceeding 12 months.	K 914		
K 918 SS=F	<p>Electrical Systems - Essential Electric System CFR(s): NFPA 101</p> <p>Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by:</p>	K 918	<p>K918</p> <p>Resident Specific:</p> <p>See systemic changes</p> <p>Other Residents:</p> <p>See systemic changes</p> <p>Systemic Changes:</p> <p>Annual inspection scheduled with cummins. inspection to include fuel testing.</p> <p>Monitors:</p> <p>The administrator or designee will ensure annual inspection of the generator to include fuel inspection. Administrator will report findings to the QAPI meeting and make changes to the above plan of correction as needed.</p> <p>Date of Compliance</p> <p>1/2/2020</p>	

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K 918	<p>Continued From page 10</p> <p>Based on record review and interview, the facility failed to ensure the EPSS generator was inspected and tested in accordance with NFPA 110. Failure to test for monthly load and conduct annual fuel-inspections for diesel-fired generators, has the potential to hinder system response during an emergency such as a loss of power. This deficient practice affected 26 residents and staff on the date of the survey.</p> <p>Findings include:</p> <p>During review of provided inspection and testing records conducted on 12/6/19 from 8:30 -10:00 AM, records did not demonstrate an annual fuel test had been performed on the diesel fuel-fired generator and the monthly load documentation, did not demonstrate a value for the available load of the test, only a column marked "30%" and the written description in that column of "No".</p> <p>Interview of the Administrator at approximately 11:45 AM established that the vendor performing the annual inspection did not test the fuel during the inspection, but tested the oil.</p> <p>Actual NFPA standard:</p> <p>NFPA 110</p> <p>8.3 Maintenance and Operational Testing. 8.3.8 A fuel quality test shall be performed at least annually using tests approved by ASTM standards.</p> <p>8.4.2* Diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the</p>	K 918		

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K 918	Continued From page 11 manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS nameplate kW rating	K 918		
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: Based on record review, and interview, the facility failed to ensure staff participation in training on the risks associated with the storage, handling and use of medical gases and their cylinders. Failure to ensure all direct-care staff involved with the application, maintenance and handling of medical gases are trained on safety and the risks associated with the use of oxygen, has the potential to expose residents to those hazards. This deficient practice potentially affected oxygen dependent residents and staff on the date of the survey.  Findings include:  During review of provided inservice training records conducted on 12/6/2019 from 8:30 - 10:00 AM, documentation provided failed to demonstrate all direct-care staff completed training on oxygen safety and the risks associated with medical gases.	K 926	K926  Resident Specific:  See systemic changes  Other Residents:  See systemic changes  Systemic Changes:  The facility to provide continuing education including safety guidelines and usage requirements of medical gases and cylinders.  Monitors:  The administrator or designee will perform weekly audits times four to ensure all new hires have been properly in serviced on handling of medical gases and cylinders. All current staff will be in serviced by compliance date on the proper handling of medical gases and cylinders. The administrator will report findings to the QAPI meeting and make changes to the above plan of correction as needed.  Date of Compliance:  1/8/2020	

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K 926	Continued From page 12  Interview of the Administrator at approximately 10:45 AM, established that all direct care staff had not participated in medical gas safety training.  Actual NFPA standard:  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 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		



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

December 13, 2019

J.R. Burt, Administrator  
Advanced Health Care of Lewiston  
2852 Juniper Drive  
Lewiston, ID 83501

Provider #: 135145

**RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER**

Dear Mr. Burt:

On **December 6, 2019**, an Emergency Preparedness survey was conducted at **Advanced Health Care of Lewiston** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with 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. 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. **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.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **December 26, 2019**. Failure to submit an acceptable PoC by **December 26, 2019**, may result in the imposition of civil monetary penalties by **January 17, 2020**.

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 10, 2020**, (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 . A change in the seriousness of the deficiencies on **January 27, 2020**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **January 10, 2020**, includes the following:

Denial of payment for new admissions effective **March 6, 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.

J.R. Burt, Administrator

December 13, 2019

Page 3 of 4

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **June 6, 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 **December 6, 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:

<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

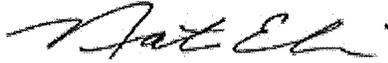
2001-10 IDR Request Form

J.R. Burt, Administrator  
December 13, 2019  
Page 4 of 4

This request must be received by **December 26, 2019**. If your request for informal dispute resolution is received after **December 26, 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,

A handwritten signature in black ink, appearing to read "Nate Elkins".

Nate Elkins, Supervisor  
Facility Fire Safety and Construction

NE/lj  
Enclosures

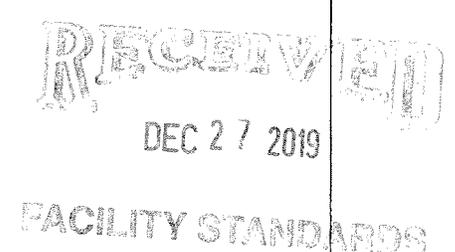
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E 000	Initial Comments  The facility consists of a single story, Type V (111) structure with hazardous area separations and is located within a municipal fire district, with both county and state EMS services available. The building is fully sprinklered with an interconnected fire alarm/smoke detection system, with beam detection in the open clear-story hallways housing resident rooms. The facility is separated into three smoke compartments and is equipped with a Type 2 medical gas system and Type 1 Emergency Power Supply System (EPSS) generator. Currently the facility is licensed for 34 SNF/NF beds with a census of 26 on the date of the survey.  The following deficiencies were cited during the Emergency Preparedness survey conducted on December 6, 2019. 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 & Construction Program	E 000	  E030 Resident Specific:  See systemic changes  Other Residents:  See systemic changes  Systemic Changes:  The emergency communication plan has been updated to include resident physicians and volunteers.  Monitors:  Administrator to ensure the emergency communication plan to include resident physicians and volunteers. Administrator will report findings to the QAPI and make changes to the above plan of correction as needed.  Date of Compliance:  1/2/2020	
E 030 SS=E	Names and Contact Information CFR(s): 483.73(c)(1)  [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:]  (1) Names and contact information for the following:	E 030		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 12/26/2019
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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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E 030	<p>Continued From page 1</p> <p>(i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers.</p> <p>*[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers.</p> <p>*[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers.</p> <p>*[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices.</p> <p>*[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following:</p>	E 030		

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E 030	<p>Continued From page 2</p> <p>(i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers.</p> <p>*[For OPOs at §486.360(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to document a communication plan which included contact information for resident physicians and applicable volunteer agencies. Failure to have a communication plan which includes contact information for those parties capable of assisting in the facility's response and recovery during a disaster, has the potential to hinder both internal and external emergency response efforts. This deficient practice affected all housed residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>On 12/6/19 from 8:45 - 11:00 AM, review of the provided EP policies and procedures, failed to demonstrate a communication plan that included contact information for resident physicians and volunteers or their respective agencies.</p> <p>Reference: 42 CFR 483.73 (c) (1)</p>	E 030			
E 041	Hospital CAH and LTC Emergency Power	E 041			

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NAME OF PROVIDER OR SUPPLIER <b>ADVANCED HEALTH CARE OF LEWISTON</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2852 JUNIPER DRIVE LEWISTON, ID 83501</b>		
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E 041 SS=F	Continued From page 3 CFR(s): 483.73(e)  (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section.  §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section.  §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated.  482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code.  482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan	E 041	E041  Resident Specific:  See systemic changes  Other Residents:  See systemic changes  Systemic Changes:  Emergeny generator inspection and testing updated to include the load output.  Monitors:  Administrator or designee will monitor load bank testing to ensure it includes the load output weekly times 4. The administrator will report the findings to QAPI meeting and make changes to the above plan of correction as needed.  Date of Compliance:  1/2/2020	

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135145</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/06/2019</b>
NAME OF PROVIDER OR SUPPLIER <b>ADVANCED HEALTH CARE OF LEWISTON</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2852 JUNIPER DRIVE LEWISTON, ID 83501</b>		
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E 041	Continued From page 4 for how it will keep emergency power systems operational during the emergency, unless it evacuates.  *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: <a href="http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html">http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html</a> . If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011.	E 041		

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E 041	<p>Continued From page 5</p> <p>(ix) TIA 12-2 to NFPA 101, issued October 30, 2012.</p> <p>(x) TIA 12-3 to NFPA 101, issued October 22, 2013.</p> <p>(xi) TIA 12-4 to NFPA 101, issued October 22, 2013.</p> <p>(xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, the facility failed to ensure EPSS generators were maintained and available to provide backup emergency power during a disaster. Failure to document available load testing as described in the standard, has the potential to hinder response to emergencies such a loss of power. This deficient practice affected all residents, staff and visitors housed in the facility on the date of the survey.</p> <p>Findings include:</p> <p>During review of provided maintenance and inspection records conducted on 12/6/19 from 8:30 - 10:30 AM, records for monthly load testing did not indicate the amount of load output during the test, only a "No" in the column marked "30%".</p> <p>Reference: 42 CFR 483.73 (e) (1)</p>	E 041			