



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Ecker Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

July 8, 2015

Betty Van Gheluwe, Administrator
St Luke's Elmore Long Term Care
PO Box 1270
Mountain Home, ID 83647-1270

Provider #: 135006

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

Dear Ms. Van Gheluwe:

On **June 30, 2015**, a Facility Fire Safety and Construction survey was conducted at **St. Luke's Elmore Long Term Care** 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 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

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Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign both Statement of Deficiencies and Plan of Correction, Form CMS-2567 and State Form, in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **July 21, 2015**. Failure to submit an acceptable PoC by **July 21, 2015**, may result in the imposition of civil monetary penalties by **August 10, 2015**.

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 and the state licensure survey report, State Form.

All references to federal regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **August 4, 2015**, (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 **August 4, 2015**. A change in the seriousness of the deficiencies on **August 4, 2015**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **August 4, 2015**, includes the following:

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Denial of payment for new admissions effective **September 30, 2015**.
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 **December 30, 2015**, 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 Mark P. Grimes, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, 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 **June 30, 2015**, 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>

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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 **July 21, 2015**. If your request for informal dispute resolution is received after **July 21, 2015**, 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.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. P. Grimes', with a long horizontal flourish extending to the right.

Mark P. Grimes, Supervisor
Facility Fire Safety and Construction

MPG/lj
Enclosures

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

Printed: 07/08/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 136006	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE NF WING B. WING _____	(X3) DATE SURVEY COMPLETED 06/30/2015
NAME OF PROVIDER OR SUPPLIER ST LUKE'S ELMORE LONG TERM CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 895 NORTH 6TH EAST MOUNTAIN HOME, ID 83647		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The facility is a single story Type V(111) wing attached to a Critical Access Hospital. The facility was built in 1965 with major renovations and additions in 1996-98, most of which were in the hospital portion of the building. Renovation to the nursing home was completed in 2004. The facility is fully sprinklered with a new sprinkler system installed in March 2009 and has a recently updated fire alarm system. Currently the facility is licensed for 38 SNF/NF beds. The following deficiencies were cited during the annual life safety code survey conducted on June 30, 2015. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70. The survey was conducted by: Nathan Elkins Health Facility Surveyor Facility Fire Safety & Construction	K 000		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4	K 025	Life Safety standard of maintaining smoke barriers, referencing a capped water pipe penetrating through an approximate 3 inch circular hold cut into the wall of the janitorial closet that was unsealed and would not resist the passage of smoke is now corrected by fire caulk sealing of the open area around the pipe. (see attachment A) Building Services Staff inspected the janitorial closets in the Long Term Care Unit for the potential of any other smoke barriers deficiencies; no other penetrations were found.	8/4/2015

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

Betty Van Theluwe

TITLE

Long Term Care Administrator

(X6) DATE

7-17-15

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 025	<p>Continued From page 1</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that smoke barriers were maintained. Failure to maintain smoke barriers could allow smoke and dangerous gases to pass freely between smoke compartments during a fire event. This deficient practice affected all residents, staff, and visitors on the date of survey. The facility is licensed for 38 SNF/NF beds and had a census of 20 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour on June 30, 2015 at approximately 11:00 AM, observation of the Janitor's closet located in the main dining room area revealed a capped water pipe penetrating through an approximate 3 inch circular hole cut into the wall that was unsealed and would not resist the passage of smoke. When asked, the Maintenance Supervisor stated the facility was unaware of the hole.</p> <p>Actual NFPA standard:</p> <p>19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour. Exception No. 1: Where an atrium is used, smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with Exception No. 2 to 8.2.5.6(1). Not less than two separate smoke compartments shall be provided on each floor. Exception No. 2*: Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems where an approved, supervised</p>	K 025	<p>Continued From page 1</p> <p>Visual inspection of potential smoke barrier penetrations will be added to the quarterly rounding inspections completed by the Building Services Manager.</p> <p>The corrective action will be monitored by the Building Services Manager through the quarterly rounding inspections and reported at quarterly survey readiness meetings. The Building Services Manager is responsible for overall and ongoing compliance.</p>	

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K 025	Continued From page 2 automatic sprinkler system in accordance with 19.3.5.3 has been provided for smoke compartments adjacent to the smoke barrier. 8.3.6 Penetrations and Miscellaneous Openings in Floors and Smoke Barriers. 8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: (1) The space between the penetrating item and the smoke barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (2) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (3) Where designs take transmission of vibration into consideration, any vibration isolation shall meet one of the following conditions: a. It shall be made on either side of the smoke barrier. b. It shall be made by an approved device that is designed for the specific purpose.	K 025		
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour	K 029	Life Safety standard of self-closing doors, referencing the failure of the kitchen self-closing door and the	8/4/2015

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K 029	<p>Continued From page 3</p> <p>fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This Standard is not met as evidenced by: Based on observation, operational testing and interview the facility failed to ensure hazardous areas are properly protected with self closing doors that latch. Failure to ensure self closing doors would allow smoke and fire products to enter exit access corridors and affect egress. This deficient affected all residents, staff and visitors on the date of survey. The facility is licensed for 38 SNF/NF beds with a census of 20 on the day of the survey.</p> <p>Findings include:</p> <p>1.) During the facility tour on June 30, 2015 between at approximately 10:00 AM, observation and operational testing revealed the door separating the kitchen from the corridor connecting the skilled nursing and the hospital would not close and latch properly when released from the magnetic hold-open device. When asked about the kitchen doors, the Maintenance Supervisor Manager stated the facility was unaware of the door would not self close and latch.</p>	K 029	<p>Continued From page 3</p> <p>Janitorial closet door have been corrected by adjusting the tension on the closure of the kitchen door and adding a self closure to the janitorial closet door.</p> <p>Building Services staff inspected the doors in the Long Term Care Unit for any closure deficiencies; no other deficiencies were found.</p> <p>Visual inspection of the kitchen doors and janitorial closet doors will be added to the quarterly rounding inspections completed by the Building Services Manager.</p> <p>The corrective action will be monitored by the Building Services Manager through the quarterly rounding inspections and reported at quarterly survey readiness meetings. The Building Services Manager is responsible for overall and ongoing compliance.</p>	

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K 029	<p>Continued From page 4</p> <p>2.) During the facility tour on June 30, 2015 at approximately 11:00 AM, observation and operational testing of the Janitor's closet door from the dining room revealed the door was not on a self-closure. The room was measured to be greater than 50 square feet and was used for storage of combustible materials/supplies deemed hazardous. When asked about the door, the Maintenance Supervisor stated the facility was unaware the room was a hazardous area and that a self closing door was needed.</p> <p>Actual NFPA Standard: NFPA 101 - 2000 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:</p> <ol style="list-style-type: none"> (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction 	K 029		

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K 029	Continued From page 5 (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		
K 143 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that proper signage was displayed at the transfilling station. Failure to provide proper signage could result in accidental injury and property damage. This deficient practice affected staff and visitors on the day of survey. The facility is licensed for 38 SNF/NF	K 143	Life Safety standard of maintaining a safe environment, through proper signage, referencing the broken "Transfer Filling Station" sign has been corrected by fixing and attaching the sign to the door. (see attachment B) Building Services staff inspected the signage in the Long Term Care Unit for any other deficiencies; no other deficiencies were found. Visual inspection of the signage will be added to the quarterly rounding inspections. The corrective action will be monitored by the Building Services Manager through the quarterly rounding inspections and reported at quarterly survey readiness meetings. The Building Services Manager is responsible for overall and ongoing compliance.	8/4/2015

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K 143	<p>Continued From page 6 beds with a census of 20 on the date of survey.</p> <p>Findings include:</p> <p>During the facility tour on June 30, 2015 at approximately 12:00 PM, observation of the outside transfilling location of liquid oxygen revealed no signage conspicuously displayed on the gate of the enclosure to caution personnel of the hazardous area. When asked, the Maintenance Supervisor stated the sign was broken prior to the survey date.</p> <p>Actual NFPA standard:</p> <p>8-6.2.5.2 Transferring Liquid Oxygen. Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows:</p> <p>(a) Separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; and</p> <p>(b) The area is mechanically ventilated, is sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) The area is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted.</p> <p>Transferring shall be accomplished utilizing equipment designed to comply with the performance requirements and producers of CGA Pamphlet P-2.6, Transfilling of Low-Pressure Liquid Oxygen to be Used for Respiration, and adhering to those procedures.</p> <p>The use and operation of small portable liquid oxygen systems shall comply with the requirements of CGA Pamphlet P-2.7, Guide for</p>	K 143		

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K 143	Continued From page 7 the Safe Storage, Handling and Use of Portable Liquid Oxygen Systems in Health Care Facilities.	K 143		