



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

August 31, 2016

Michael Blauer, Administrator
St Luke's Elmore Long Term Care
PO Box 1270
Mountain Home, ID 83647

Provider #: 135006

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Mr. Blauer:

On **August 29, 2016**, 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 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 **September 13, 2016**. Failure to submit an acceptable PoC by **September 13, 2016**, may result in the imposition of civil monetary penalties by **October 3, 2016**.

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 will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **October 3, 2016**, (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 **October 3, 2016**. A change in the seriousness of the deficiencies on **October 3, 2016**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **October 3, 2016**, includes the following:

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Denial of payment for new admissions effective **November 29, 2016**.
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 **March 1, 2017**, 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 **August 29, 2016**, 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 **September 13, 2016**. If your request for informal dispute resolution is received after **September 13, 2016**, 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

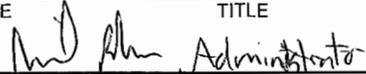
Printed: 08/30/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135006	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE NF WING B. WING _____	(X3) DATE SURVEY COMPLETED 08/29/2016
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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
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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 V(111) wing attached to a deemed 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. Currently there is no 2-hour separation of occupancy from the hospital to the nursing home. 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.</p> <p>The following deficiencies were cited during the annual life safety code survey conducted on August 29, 2016. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.</p> <p>The survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction</p> <p>Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction</p>	K 000		
K 025 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5</p>	K 025	<p style="text-align: right;">RECEIVED SEP 12 2016 FACILITY STANDARDS</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 9-9-16
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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 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 the continuity of smoke barriers were maintained. Failure to maintain smoke barriers could allow smoke and dangerous gases to pass between compartments, diminishing the ability to defend in place. This deficient practice affected 19 residents, staff and visitors on the date of the survey. The facility is licensed for 38 SNF/NF beds and had a census of 19 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on August 29, 2016 from approximately 1:00 PM to 3:00 PM, an above the ceiling inspection of the smoke barrier separating the nursing home from the hospital revealed the following unsealed penetrations breaching the smoke barrier:</p> <p>An approximately 1 foot by 3 foot hole broken through the smoke barrier. An approximately 3 inch diameter hole through the smoke barrier. An unsealed penetration of an HVAC duct approximately ten to twelve inches in diameter, with gaps ranging from 1 to 2 inches wide around the circumference of the duct. An approximately 6 inch by 6 inch hole through the smoke barrier. The smoke barrier access door was unable to self close and blocked by debris.</p> <p>When asked about the unsealed penetrations and openings in the smoke barrier wall, the Maintenance Supervisor stated he was not aware of these findings prior to the survey.</p> <p>Actual NFPA standard:</p>	K 025		

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K 025	Continued From page 2 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 automatic sprinkler system in accordance with 19.3.5.3 has been provided for smoke compartments adjacent to the smoke barrier. 8.3.2* Continuity. Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces. Exception: A smoke barrier required for an occupied space below an interstitial space shall not be required to extend through the interstitial space, provided that the construction assembly forming the bottom of the interstitial space provides resistance to the passage of smoke equal to that provided by the smoke barrier.	K 025		
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire	K 072		

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K 072	<p>Continued From page 3</p> <p>or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1 This Standard is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure doors in a means of egress were maintained free of obstacles or impediments. Failure to provide doors to a means of egress free of impediments could hinder evacuation during a fire or other emergency. This deficient practice affected staff and visitors on the date of the survey. The facility is licensed for 38 SNF/NF beds and had a census of 19 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on August 29, 2016 from approximately 10:00 AM to 12:00 PM, observation and operational testing of doors in the southwest wing revealed the following doors were equipped with keyed deadbolts and paddle operated passage locks, creating a non-single operational locking arrangement:</p> <p>Shower room #3 Rooms 27, 28, 29, 30, 32</p> <p>When asked, the Maintenance Supervisor stated he was not aware these doors required single-operational locks.</p> <p>Actual NFPA standard:</p> <p>19.2.1 General. Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7. Exception: As modified by 19.2.2 through</p>	K 072		

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K 072	Continued From page 4 19.2.11. 7.2.1.5.4* A latch or other fastening device on a door shall be provided with a releasing device having an obvious method of operation and that is readily operated under all lighting conditions. The releasing mechanism for any latch shall be located not less than 34 in. (86 cm), and not more than 48 in. (122 cm), above the finished floor. Doors shall be operable with not more than one releasing operation. Exception No. 1*: Egress doors from individual living units and guest rooms of residential occupancies shall be permitted to be provided with devices that require not more than one additional releasing operation, provided that such device is operable from the inside without the use of a key or tool and is mounted at a height not exceeding 48 in. (122 cm) above the finished floor. Existing security devices shall be permitted to have two additional releasing operations. Existing security devices other than automatic latching devices shall not be located more than 60 in. (152 cm) above the finished floor. Automatic latching devices shall not be located more than 48 in. (122 cm) above the finished floor. Exception No. 2: The minimum mounting height for the releasing mechanism shall not be applicable to existing installations.	K 072		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This Standard is not met as evidenced by: Based on observation, the facility failed to ensure the safe installation of electrical components in accordance with NFPA 70. Failure to maintain the	K 147		

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K 147	<p>Continued From page 5</p> <p>safe installation of electrical components could result in fires by arcing or electrocution. This deficient practice affected staff and vendors of the communications room on the date of the survey. The facility is licensed for 38 SNF/NF beds and had a census of 19 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on August 29, 2016 from approximately 1:00 PM to 3:30 PM, an above the ceiling inspection at the communications closet revealed an open electrical conduit box with exposed wiring approximately 4 inches by 4 inches square.</p> <p>Actual NFPA standard:</p> <p>NFPA 70</p> <p>110.12 Mechanical Execution of Work. Electrical equipment shall be installed in a neat and workmanlike manner. (A) Unused Openings. Unused cable or raceway openings in boxes, raceways, auxiliary gutters, cabinets, cutout boxes, meter socket enclosures, equipment cases, or housings shall be effectively closed to afford protection substantially equivalent to the wall of the equipment. Where metallic plugs or plates are used with nonmetallic enclosures, they shall be recessed at least 6 mm (¼ in.) from the outer surface of the enclosure. (B) Subsurface Enclosures. Conductors shall be racked to provide ready and safe access in underground and subsurface enclosures into which persons enter for installation and maintenance. (AC) Integrity of Electrical Equipment and Connections. Internal parts of electrical</p>	K 147		

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K 147	Continued From page 6 equipment, including bursars, wiring terminals, insulators, and other surfaces, shall not be damaged or contaminated by foreign materials such as paint, plaster, cleaners, abrasives, or corrosive residues. There shall be no damaged parts that may adversely affect safe operation or mechanical strength of the equipment such as parts that are broken; bent; cut; or deteriorated by corrosion, chemical action, or overheating.	K 147		

St. Luke's Elmore Long Term Care Unit Corrective Action Plan for Idaho Health and Welfare 2567 Report received 9/6/2016

CORRECTIVE ACTION PLAN for 135006 Life Safety Survey

The Governing Body of St. Luke's Elmore Long Term Care Unit is accountable for immediate implementation of these Plans of Correction and has delegated direct oversight and responsibility to the St. Luke's Elmore Long Term Care Unit Administrator. Supporting the implementation are the Regional CEO, Medical Executive Committee (MEC) and related medical staff departments, and Hospital leadership. The Environment of Care committee has oversight responsibility related to this plan and is assigned to review all results and direct further action to assure improvement and to sustain this action. Our Leadership team is committed to do everything within our ability to ensure a successful implementation of the Plan of Correction.

See Corrective Action Plan for K 025

See Corrective Action Plan for K 072

See Corrective Action Plan for K 147

CORRECTIVE ACTION PLAN for K 025 (Dan Doherty, Building Services, is responsible for the completion of this corrective action plan)

1. The unsealed penetrations found in the smoke barrier will be sealed under the direction of the Building Services manager to restore continuity of the smoke barrier.

The Building Services manager will inspect other areas to ensure no similar conditions exist. He will be responsible to monitor for any gaps or openings not sealed during and after construction work is completed, working closely with contractors to monitor for compliance. Additionally, the high-risk areas above the Communications Rooms have been added to the Monthly Wall Penetration Inspection log.

Completion Date: 09/15/2016

Monitoring: Data collected from these audits will be reported to the facilities Environment of Care Committee and the LTC Quality Safety Council. This information is reported up to the St. Luke's Health System Board.

CORRECTIVE ACTION PLAN for K 072 (Dan Doherty, Building Services, is responsible for the completion of this corrective action plan)

1. The dual latching systems on the doors identified during survey (Shower room #3, rooms 27,28,29,30, and 32) will be modified to a one-latch device with a releasing mechanism having an obvious method of operation.

The Building Services manager will inspect all other doors in the Long Term Care Unit to ensure no similar conditions exist.

Completion Date: 09/30/2016

Monitoring: Data collected from these audits will be reported to the facilities Environment of Care Committee and the LTC Quality Safety Council. This information is reported up to the St. Luke's Health System Board.

CORRECTIVE ACTION PLAN for K 147 (Dan Doherty, Building Services, is responsible for the completion of this corrective action plan)

1. The open electrical conduit box will be sealed and closed.

The Building Services manager will inspect other areas to ensure no similar conditions exist. He will be responsible to monitor for any gaps or openings not sealed during and after construction work is completed, working closely with contractors to monitor for compliance. Additionally, the high-risk areas above the Communications Rooms have been added to the Monthly Wall Penetration Inspection log.

Completion Date: 09/15/2016

Monitoring: Data collected from these audits will be reported to the facilities Environment of Care Committee and the LTC Quality Safety Council. This information is reported up to the St. Luke's Health System Board.