October 22, 2018

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 October 12, 2018, 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 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 **November 5, 2018.** Failure to submit an acceptable PoC by **November 5, 2018,** may result in the imposition of civil monetary penalties by **November 26, 2018.**

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;

- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,

- Include dates when corrective action will be completed.

- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567. If a State Form was issued as well, it should also be signed, dated and returned.

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

Remedies may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **November 16, 2018,** (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 **November 16, 2018.** A change in the seriousness of the deficiencies on **November 16, 2018,** may result in a change in the remedy.
October 22, 2018

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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
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Your Plan of Correction (PoC) for the deficiencies must be submitted by November 5, 2018. Failure to submit an acceptable PoC by November 5, 2018, may result in the imposition of civil monetary penalties by November 26, 2018.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.
- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567. If a State Form was issued as well, it should also be signed, dated and returned.

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

Remedies may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by November 16, 2018, (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 November 16, 2018. A change in the seriousness of the deficiencies on November 16, 2018, may result in a change in the remedy.
The remedy, which will be recommended if substantial compliance has not been achieved by November 16, 2018, includes the following:

Denial of payment for new admissions effective January 12, 2019. 
42 CFR §488.417(a)

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on April 12, 2019, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Nate Elkins, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, option 3; Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on October 12, 2018, 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:
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 November 5, 2018. If your request for informal dispute resolution is received after November 5, 2018, 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  

STATEMENT OF DEFICIENCIES  
AND PLAN OF CORRECTION  

(X1) PROVIDER/SUPPLIER/CLA  
IDENTIFICATION NUMBER:  
135006  

(X2) MULTIPLE CONSTRUCTION  
A. BUILDING 01 - ENTIRE NF WING  
B. WING  

(X3) DATE SURVEY COMPLETED  
10/12/2018  

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 deemed Hospital. The facility was  
built in 1965 with renovations 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. The Essential  
Electrical System is supplied by a diesel powered,  
on-site automatic generator. Currently the facility  
is licensed for 38 SNF/NF beds and had a census  
of 19 on the dates of the survey.  

The following deficiencies were cited during the  
annual life safety code survey conducted on  
October 11 - 12, 2018. The facility was surveyed  
under the LIFE SAFETY CODE, 2012 Edition,  
Existing Health Care Occupancy, in accordance  
with 42 CFR 483.70, and 42 CFR 483.80.  

The Survey was conducted by:  
Linda Chaney  
Health Facility Surveyor  
Facility Fire Safety & Construction  

K 100 The Building Services Manager is ultimately  
responsible for ensuring a facility water  
management plan is developed and  
implemented based on a facility specific risk  
assessment.  

All residents could potentially be affected by  
this citation.  

Based on record review, and interview, the  
facility failed to develop and implement a water  
management plan.  

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE  

TITLE  

(K8) DATE  

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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<tr>
<td>K 100</td>
<td>Continued From page 1</td>
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<tr>
<td>K 100</td>
<td>Plan of Correction:</td>
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**Summary Statement of Deficiencies**

**K 100** Continued From page 1

Management plan based on a facility specific risk assessment. Failure to develop and implement a facility specific water management plan could increase risk of growth and spread of Legionella and other opportunistic pathogens in building water systems. This deficient practice could potentially affect all residents, visitors and staff on the dates of the survey.

Findings include:

During the review of facility records on October 12, 2017, from approximately 8:00 AM to 12:00 PM, no documentation of a facility risk assessment, could be produced. When asked, the Maintenance Supervisor stated the facility was aware of the requirement for a water management plan and had been working on it.

**Actual Standard:**

42 CFR § 483.80 Infection control.

The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

**Additional Reference:**


**K 211** Means of Egress - General

**Means of Egress - General**

- Review of water management risk assessment for St. Luke's Elmore to ensure risks specific to the local facility are accounted for and mitigation efforts identified, including local resources available to the facility.
- Collaborated with System Infection Prevention and Building Services to expand the local water management risk assessment to include all risks. This collaboration standardizes mitigation efforts and identifies local resources available to the facility.
- Control measures were developed and put into place for risks identified in the facility Risk Assessment.
- Review of water management risk assessment and update to mitigation efforts to be completed annually.

**QAPI Integration:**

- The completed Risk Assessment will be reported to the Quality Safety Council and EOC committees.
- The water management plan and accompanying risk assessment will be reviewed annually at the above named committees.

**Date of Compliance:** 11/12/18

**K 211** The Building Services Manager is ultimately responsible for ensuring the means of egress is continuously maintained free of obstructions in accordance with NFPA 101.
K 211 Continued From page 2
Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by:
Based on observation, and interview, the facility failed to ensure means of egress were provided in accordance with NFPA 101. Failure to maintain means of egress free of obstruction has the potential to hinder evacuation of residents during an emergency. This deficient practice had the potential to affect 19 residents, staff and visitors on the dates of the survey.

Findings include:

During the facility tour on October 12, 2018, from approximately 12:00 PM to 2:00 PM, observation revealed the two (2) gates from the covered patio area to the public way were secured with pad locks. When asked, the Maintenance Supervisor stated the facility was unaware the gates were restricting access to the public way, and only Maintenance staff had keys to the pad locks.

Actual NFPA standard:

NFPA 101
19.2 Means of Egress Requirements.
19.2.1 General. Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7, unless otherwise modified by 19.2.2 through 19.2.11.
7.1.10 Means of Egress Reliability.
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<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X6) COMPLETION DATE</th>
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| K 211             | Continued From page 3  
1.1.10.1 General. Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. | K 211           | The Building Services Manager is ultimately responsible for ensuring required horizontal distance between alcohol-based hand-rub dispensers (ABHR) is maintained per NFPA guidelines. |                      |
| K 325             | Alcohol Based Hand Rub Dispenser (ABHR)  
* 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 smoke compartment outside a storage cabinet, excluding one individual dispenser per room  
* Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30  
* Dispensers are not installed within 1 inch of an ignition source  
* Dispensers over carpeted floors are in sprinklered smoke compartments  
* ABHR does not exceed 95 percent alcohol  
* Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11)  
* ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485  
This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure Alcohol Based Hand Rub Dispensers (ABHR) were | K 325           | All residents could potentially be affected by this citation.  
Plan of Correction:  
- On 10/16/18 the hand sanitizer dispenser identified during the facility tour was moved to the other side of the resident's door to ensure compliance with the 48-inch minimum distance requirement.  
- ABHR dispensers throughout the facility were evaluated to ensure compliance.  
QAPI Integration:  
- This will be reported to the Quality Safety Council and EOC committees.  
- Ongoing compliance will be monitored via EOC tours that occur every 6 months, and gaps in compliance shared with the above named committees.  
Date of Compliance: 10/16/18 |                      |
K 325 Continued From page 4

installed in accordance with NFPA 101. Failure to maintain required horizontal distance between dispensers could result in excessive flammable liquids in a tight area, increasing fire intensity during a fire event. This deficient practice affected 19 residents, staff and visitors on the date of the survey.

Findings include:

During the facility tour on October 12, 2018, from approximately 12:00 PM to 2:00 PM, observation of the ABHR dispensers in the corridor outside of resident rooms #17 and #18 revealed they were installed with approximately 30" of horizontal space between them. When asked, the Maintenance Supervisor stated the facility was unaware their installation was outside of compliance.

Actual NFPA standard:

NFPA 101

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:

1. Where dispensers are installed in a corridor, the corridor shall have a minimum width of 6 ft (1830 mm).
2. The maximum individual dispenser fluid capacity shall be as follows:
   (a) 0.32 gal (1.2 L) for dispensers in rooms, corridors, and areas open to corridors.
   (b) 0.53 gal (2.0 L) for dispensers in suites of rooms.
3. Where aerosol containers are used, the maximum capacity of the aerosol dispenser shall
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<td>K 325</td>
<td>Continued From page 5 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. (4) Dispensers shall be separated from each other by horizontal spacing of not less than 48 in. (1220 mm). (5) Not more than an aggregate 10 gal (37.8 L) of alcohol-based 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). (6) One dispenser complying with 19.3.2.6 (2) or (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. (25 mm) 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...</td>
<td>K 325</td>
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K 325 Continued From page 6

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 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 345 The Building Services Manager is ultimately responsible for ensuring fire alarm systems are maintained in accordance with NFPA 72.

All residents could potentially be affected by this citation.

Plan of Correction:
- On 10/12/18 an appointment was scheduled for sensitivity testing with Simplex Grinnell.
- On 10/17/18 Simplex Grinnell provided documentation that the sensitivity testing was in fact completed on 12/15/17.
- Sensitivity testing documentation was added to the facilities binder.
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<tr>
<td>K345</td>
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<td>Continued From page 7 to conduct sensitivity testing on non-addressable fire alarm systems could hinder system response during a fire event. This deficient practice affected 19 residents, staff and visitors on the dates of the survey. Findings include: During review of facility fire alarm inspection records conducted on October 11, 2018, from approximately 1:30 PM to 4:00 PM, no documentation could be produced to indicate sensitivity testing of the smoke detectors was conducted within the last five years. Interview of the Maintenance Supervisor revealed the facility was not aware a sensitivity test was required for their non-addressable fire alarm system. Actual NFPA standard: NFPA 72 Chapter 14 Inspection, Testing, and Maintenance 14.4.5.3.1 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.</td>
<td>K345</td>
<td>Plan of Correction Continued: Facility will ensure testing is completed within 5 years of date of last test – due by 12/15/22 QAPI Integration: This will be reported to the Quality Safety Council and EOC committees.</td>
<td>10/17/18</td>
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K 363 Continued From page 8

Corridor - Doors
Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.

19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485
Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.

The Building Services Manager is ultimately responsible for ensuring to maintain doors that protect corridor openings.

One resident had the potential to be affected by this citation.

Plan of Correction:
- Patient room doors throughout the facility were evaluated to ensure compliance.
- On 11/01/18 a new door was ordered on priority with expected delivery and installation in January 2019.
- On 11/5/18 an astragal strip was added to the affected door.

QAPI Integration:
- This will be reported to the Quality Safety Council and EOC committees
- A random sampling of doors will be inspected to ensure compliance with allowable gaps during the environment of care tours completed every 6 months.

Results of these tours will be reported to the above named committees for review.

Date of Compliance: 11/5/18
K 363 Continued From page 9

This REQUIREMENT is not met as evidenced by:
Based on observation, operational testing, and interview the facility failed to maintain doors that protect corridor openings. Failure to maintain corridor doors could allow smoke and dangerous gases to pass freely, preventing defend in place. This deficient practice has the potential to affect 1 resident, staff, and visitors on the date of the survey.

Findings include:

During the facility tour on October 12, 2018, from approximately 12:00 PM to 2:00 PM, observation and operational testing of the door to resident room #14 revealed an approximately 5/8" gap between the face of the door and the frame of the door when fully closed. When asked, the Maintenance Supervisor stated the facility was not aware the maximum distance between the face of the door and frame is 1/2" when fully closed.

Actual NFPA Standards:

NFPA 101
19.3.6.3* Corridor Doors.
19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be doors constructed to resist the passage of smoke and shall be constructed of materials such as the following:
(1) 1-3/4 in. (44 mm) thick, solid-bonded core wood
(2) Material that resists fire for a minimum of 20 minutes
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**ST LUKE'S ELMORE LONG TERM CARE**

- STREET ADDRESS: 895 NORTH 6TH EAST
- CITY: MOUNTAIN HOME
- STATE: ID
- ZIP: 83647

**ID**

- PREFIX: 135006
- TAG: 01 - ENTIRE NF WING

**DATE SURVEY COMPLETED**

- 10/12/2018
October 22, 2018

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

Provider #: 135006

RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER

Dear Mr. Blauer:

On October 12, 2018, an Emergency Preparedness survey was conducted at St Luke's Elmore Long Term Care by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. Your facility was found to be in substantial compliance with Federal regulations during this survey.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, which states that the facility complies with the requirements of CFR 42, 483.70(a) of the federal requirements. This form is for your records only and does not need to be returned.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact this office at (208) 334-6626, option 3.

Sincerely,

Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/ij
Enclosure
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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<tr>
<th>(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
<th>(X3) DATE SURVEY COMPLETED</th>
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<td>10/12/2018</td>
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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

**SUMMARY STATEMENT OF DEFICIENCIES**

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<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>(XS) COMPLETION DATE</th>
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<td>Initial Comments</td>
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The facility is a single-story Type V (111) wing attached to a deemed Hospital. The facility was built in 1965 with renovations 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. The Essential Electrical System is supplied by a diesel powered, on-site automatic generator. Currently the facility is licensed for 38 SNF/NF beds and had a census of 19 on the dates of the survey.

The facility was found to be in substantial compliance during the initial Emergency Preparedness Survey conducted on October 11 - 12, 2018. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.

The Survey was conducted by:

Linda Chaney
Health Facility Surveyor
Facility Fire Safety & Construction

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

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.