



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

IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

DEBBY RANSOM, R.N., R.H.I.T – Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: (208) 334-6626  
FAX: (208) 364-1888  
E-mail: [fsb@dhw.idaho.gov](mailto:fsb@dhw.idaho.gov)

February 15, 2012

Timothy Sayler, Administrator  
St. Joseph Regional Medical Center  
PO Box 816  
Lewiston, Idaho 83501

RE: St Joseph Regional Medical Center, Provider ID# 130003

Dear Mr. Sayler:

This is to advise you of the findings of the Medicare/Licensure Fire Life Safety Survey, which was concluded at St Joseph Regional Medical Center, on February 8, 2012.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicare deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;
2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;
4. 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,
5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Timothy Sayler, Administrator  
February 15, 2012  
Page 2 of 2

After each deficiency has been answered and dated, the administrator should sign both the CMS Form 2567 and State Form in the spaces provided on the bottom of the first pages of each of the respective forms and return the originals to this office by **February 28, 2012.**

Thank you for the courtesies extended to me during my visit. If you have any questions, please call our office at (208) 334-6626.

Sincerely,

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

MARK P. GRIMES  
Supervisor  
Facility Fire Safety and Construction Program

MPG/lj

Enclosure

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

Printed: 02/14/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>130003</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/08/2012</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER <b>ST JOSEPH REGIONAL MEDICAL CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>415 SIXTH STREET 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>Saint Joseph Regional Medical Center is a six story, type 1 building, fully sprinklered with fire alarm and smoke detection. The hospital is served by a type 1 emergency electrical system which is currently being upgraded and expanded. Medical gas and vacuum is provided by a level 1 system. The hospital is served by multiple exits to grade, two hour stair towers, and two hour horizontal exits to the attached administration/old hospital building.</p> <p>The facility has opted to utilize the categorical waiver for fire damper testing and will conform to the 2007 NFPA 90A requirements for six (6) year damper testing per CMS informational letter S&amp;C 10-04-LSC.</p> <p>The Hospital is licensed for 145 beds and had a census that ranged from 72 to 90 during the time period of the Life Safety Code Survey.</p> <p>The following deficiency was cited during a Life Safety Code survey conducted February 6-8, 2012. The facility was surveyed in accordance with 42 CFR 482.41.(b) and the standards within Chapter 19 Existing Health Care Occupancies of NFPA 101, the Life Safety Code, 2000 Edition.</p> <p>The surveyor conducting the survey was:</p> <p>Mark P. Grimes, Supervisor Facility Fire Safety &amp; Construction Program, IDHW</p>	K 000	<p style="text-align: center;"><b>RECEIVED</b> MAR 15 2012 <b>FACILITY STANDARDS</b></p>	
K 062	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA</p>	K 062		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>CEO</b>	(X6) DATE <b>5-5-12</b>
---	---------------------	----------------------------

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.

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

Printed: 02/14/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>130003</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/08/2012</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER <b>ST JOSEPH REGIONAL MEDICAL CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>415 SIXTH STREET 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 062	<p>Continued From page 1 25, 9.7.5</p> <p>This Standard is not met as evidenced by: Based upon observation and interview the facility failed to maintain the Automatic Fire Sprinkler System in a reliable operating condition, by allowing ordinary and quick response (QR) sprinkler heads to be intermixed in area or compartment. This deficient practice could prevent or delay the ordinary sprinkler heads from operating.</p> <p>Findings include:</p> <p>1) During the facility tour on 2/7/12 observation revealed mixed quick and ordinary response sprinkler heads in the cafeteria two QR heads were installed intermixed with ordinary heads. This was observed by the surveyor and acknowledged by the Director of Facilities Management.</p> <p>2) During the facility tour on 2/7/12 observation revealed mixed quick and ordinary response sprinkler heads in the Imaging waiting area one QR head was installed intermixed with ordinary heads. This was observed by the surveyor and acknowledged by the Director of Facilities Management.</p> <p>3) During the facility tour on 2/7/12 observation revealed a missing sprinkler head in the MRI electrical room. This was observed by the surveyor and acknowledged by the Director of Facilities Management.</p> <p>4) During the facility tour on 2/7/12 observation revealed mixed quick and ordinary response</p>	K 062	<p>Replaced two Q.R. heads with ordinary heads.</p> <p>Replaced one Q.R head with ordinary.</p> <p>Installed one Q.R. head in the MRI Electrical Room.</p>	<p>03/08/12</p> <p>03/08/12</p> <p>03/08/12</p>

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

Printed: 02/14/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>130003</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/08/2012</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER <b>ST JOSEPH REGIONAL MEDICAL CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>415 SIXTH STREET 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 062	<p>Continued From page 2</p> <p>sprinkler heads in the Operating Room Scrub area "C" a single QR head was installed intermixed with ordinary heads. This was observed by the surveyor and acknowledged by the Director of Facilities Management and the Operating Room Manager.</p> <p>5) During the facility tour on 2/7/12 observation revealed mixed quick and ordinary response sprinkler heads in the Operating Room Recovery area, a single QR head was installed intermixed with ordinary heads. This was observed by the surveyor and acknowledged by the Director of Facilities Management and the Operating Room Manager.</p> <p>6) During the facility tour on 2/7/12 observation revealed mixed quick and ordinary response sprinkler heads in the Central Sterile Supply Room. Approximately 50% of the heads were QR installed adjacent to the other side of the room with ordinary heads. This was observed by the surveyor and acknowledged by the Director of Facilities Management and the Operating Room Manager.</p> <p>7) During the facility tour of the Radiation-Oncology Center on 2/8/12 observation revealed mixed quick and ordinary response sprinkler heads in the CT room corridor. Two QR heads were installed intermixed with ordinary heads. This was observed by the surveyor and acknowledged by the Director of Facilities Management.</p> <p>The above findings were acknowledged by the Director of Facilities Management during the exit conference on February 8, 2012.</p>	K 062	<p>Replaced Q.R. head with ordinary head.</p> <p>Replaced one Q.R head with one ordinary head.</p> <p>Scheduled to replace the twelve ordinary heads with Q.R. heads. Work will be completed by 04/13/12.</p> <p>Replaced two Q.R. heads with ordinary heads.</p>	<p>03/08/12</p> <p>03/08/12</p> <p>03/08/12</p>

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

Printed: 02/14/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>130003</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/08/2012</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER <b>ST JOSEPH REGIONAL MEDICAL CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>415 SIXTH STREET 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 062	<p>Continued From page 3</p> <p>Actual NFPA standard: NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 1998 Edition 2-4.1.1*</p> <p>Replacement sprinklers shall have the proper characteristics for the application intended. These include the following:</p> <ul style="list-style-type: none"> <li>(a) Style</li> <li>(b) Orifice size and K-factor</li> <li>(c) Temperature rating</li> <li>(d) Coating, if any</li> <li>(e) Deflector type (e.g., upright, pendant, sidewall)</li> <li>(f) Design requirements</li> </ul> <p>Exception No. 1: Spray sprinklers shall be permitted to replace old-style sprinklers.</p> <p>Exception No. 2: Replacement sprinklers for piers and wharves shall comply with NFPA 307, Standard for the Construction and Fire Protection of Marine Terminals, Piers, and Wharves.</p> <p>2-4.1.3* Special and Quick-Response Sprinklers. Special and quick-response sprinklers as defined by NFPA 13, Standard for the Installation of Sprinkler Systems, shall be replaced with sprinklers of the same make, model, orifice, size, temperature range and thermal response characteristics, and K-factor.</p> <p>Exception: If the special or quick-response sprinkler is no longer manufactured, a special or quick-response sprinkler with comparable performance characteristics shall be installed.</p> <p>A-2-4.1.3 It is imperative that any replacement sprinkler have the same characteristics as the sprinkler being replaced. If the same temperature range, response characteristics, spacing requirements, flow rates, and K-factors cannot be obtained, a</p>	K 062		

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

Printed: 02/14/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>130003</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/08/2012</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER <b>ST JOSEPH REGIONAL MEDICAL CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>415 SIXTH STREET 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 062	Continued From page 4 sprinkler with similar characteristics should be used, and the system should be evaluated to verify the sprinkler is appropriate for the intended use. With regard to response characteristics, matching identical Response Time Index (RTI) and conductivity factors is not necessary unless special design considerations are given for those specific values.	K 062		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>130003</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/08/2012</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER <b>ST JOSEPH REGIONAL MEDICAL CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>415 SIXTH STREET 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) COMPLETE DATE
B 000	<p>16.03.14 Initial Comments</p> <p>Saint Joseph Regional Medical Center is a six story, type 1 building, fully sprinklered with fire alarm and smoke detection. The hospital is served by a type 1 emergency electrical system which is currently being upgraded and expanded. Medical gas and vacuum is provided by a level 1 system. The hospital is served by multiple exits to grade, two hour stair towers, and two hour horizontal exits to the attached administration/old hospital building.</p> <p>The facility has opted to utilize the categorical waiver for fire damper testing and will conform to the 2007 NFPA 90A requirements for six (6) year damper testing per CMS informational letter S&amp;C 10-04-LSC.</p> <p>The Hospital is licensed for 145 beds and had a census that ranged from 72 to 90 during the time period of the Life Safety Code Survey.</p> <p>The facility was surveyed February 6-8, 2012 in accordance with 42 CFR 482.41.(b) and the standards within Chapter 19 Existing Health Care Occupancies of NFPA 101, the Life Safety Code, 2000 Edition. and IDAPA 16.03.14 Rules and Minimum Standards for Hospitals in Idaho.</p> <p>The surveyor conducting the survey was:</p> <p>Mark P. Grimes, Supervisor Facility Fire Safety &amp; Construction Program, IDHW</p>	B 000		
BB161	<p>16.03.14.510 Fire and Life Safety Standards</p> <p>Buildings on the premises used as a hospital shall meet all the requirements of local, state, and national codes concerning fire and life safety</p>	BB161	<p><i>Refer to CMS Form 2567 4/13/12</i></p>	

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

*[Handwritten Signature]*

TITLE

*3* *CEO*

(X8) DATE

*3-15-12*

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>130003</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/08/2012</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>ST JOSEPH REGIONAL MEDICAL CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>415 SIXTH STREET 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) COMPLETE DATE
BB161	<p>Continued From Page 1</p> <p>that are applicable to hospitals. General Requirements. General requirements for the fire and life safety standards for a hospital are that: The hospital shall be structurally sound and shall be maintained and equipped to assure the safety of patients, employees, and the public. On the premises of all hospitals where natural or man-made hazards are present, suitable fences, guards, and railings shall be provided to protect patients, employees, and the public. This RULE: is not met as evidenced by: Refer to the following deficiency identified on Federal Form 2567</p> <p>K062 Sprinkler system maintenance - mixed heads</p>	BB161		

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.