



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 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0009  
PHONE 208-334-6626  
FAX 208-364-1888

**CERTIFIED MAIL: 7012 3050 0001 2128 2637**

April 4, 2014

Greg Maurer, 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 Mr. Maurer:

On **April 1, 2014**, 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 and a similar State Form 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

Greg Maurer, Administrator  
April 4, 2014  
Page 2 of 4

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 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 **April 17, 2014**. Failure to submit an acceptable PoC by **April 17, 2014**, may result in the imposition of civil monetary penalties by **May 6, 2014**.

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 **May 6, 2014**, (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 **May 6, 2014**. A change in the seriousness of the deficiencies on **May 6, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **May 6, 2014**, includes the following:

Greg Maurer, Administrator  
April 4, 2014  
Page 3 of 4

Denial of payment for new admissions effective **July 1, 2014**.  
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 **October 1, 2014**, 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 **April 1, 2014**, 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>

Greg Maurer, Administrator  
April 4, 2014  
Page 4 of 4

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 **April 17, 2014**. If your request for informal dispute resolution is received after **April 17, 2014**, 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: 04/02/2014  
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  B. WING _____	(X3) DATE SURVEY COMPLETED  04/01/2014
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	<p>INITIAL COMMENTS</p> <p>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.</p> <p>The following deficiencies were cited during the annual life safety code survey conducted on April 1, 2014. 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>Mark Grimes, Supervisor Facility Fire Safety &amp; Construction IDHW</p> <p>Sam Burbank, Health Facility Surveyor Facility Fire Safety &amp; Construction IDHW</p> <p>Dan Holbrook, Health Facility Surveyor Facility Fire Safety &amp; Construction IDHW</p>	K 000		
K 029 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>One hour fire rated construction (with ¾ hour 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</p>	K 029	<p>1. ID Prefix Tag #K029, Life Safety Standard of self-closing doors, referencing the failure of two kitchen self closing doors has been corrected by: A) adjusting the tension on the closure of the door separating</p>	May 6, 2014

**RECEIVED**  
**APR 17 2014**  
**FACILITY STANDARDS**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

*Greg L. Mauer* Administrator April 15, 2014

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 029	<p>Continued From page 1</p> <p>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 upon 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 practice affected all residents in the skilled nursing smoke compartment and all visitors and staff in two of three building smoke compartments. The facility had a census of 19 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour on April 1, 2014 between 2:30 and 4:00 PM observation and operational testing revealed that two of four kitchen self closing doors would not close and latch when tested. The door separating the kitchen from SNF dining area would not close and latch when released from an open position. The door separating the kitchen prep area from the corridor would not self close due to cart storage in the path of the door. This hazardous area utilized the sprinkler option for protection, which requires the doors to self close and latch securely. When asked about the kitchen doors, the Manager of</p>	K 029	<p>the kitchen from the SNF dining area, and (B) relocating the stored cart out of the path of the closing door.</p> <p>2. All other doors in the resident's Long Term Care Unit have been inspected for any closure deficiencies. One other, Room 20, was found with a closure deficiency, which was corrected at the time of the survey.</p> <p>3. When doors are found not latching correctly the corrections will be addressed by the Maintenance department via a maintenance work order.</p> <p>4. Corrective action for the Long Term Care Unit doors will be monitored by the Maintenance department by adding the doors to the monthly maintenance checklist.</p>	

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K 029	Continued From page 2 Building Services was unaware these doors would not self close and latch.  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: (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 (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			

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K 038 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>This STANDARD is not met as evidenced by: Based upon observation and interview the facility failed to ensure immediate exit access without the use of tool or a key from the egress side. This practice can accidentally trap residents, staff and visitors in the event of a fire and prevent escape. This deficient practice potentially affected two residents and several staff in two locations, north wing, and the south wing of the LTCU. The facility had a census of 19 on the day of the survey.</p> <p>Findings include:</p> <p>1. During the facility tour between 1:30 and 3:00 PM the Physical therapy treatment room (#18) was observed to be equipped with a double sided keyed deadbolt lock, which could be locked by key on the egress side. This locking configuration could accidentally lock an individual inside resulting in blocked exit access. The room was capable of treatment of two (or more) residents simultaneously. When staff CNA was questioned about the lock and keys, staff stated the lock was not used and had no idea where the key was located. Administrative staff stated the key was located at the nurse station and under control of the charge nurse.</p> <p>2. During the facility tour on April 1, 2014</p>	K 038	<p>1.ID Prefix tag #K038, Life Safety Standard of readily accessible exits, referencing #1, the Physical Therapy treatment room (#18) double sided, keyed, deadbolt lock, and #2, the Sleep center control room (#34) two-sided, keyed deadbolt lock has been corrected by: (A) the removal of the deadbolt locks on room #18 door and room #34 door.</p> <p>2. A subsequent inspection of the other doors in the same area, shows five other doors (business occupancy rooms) have the same deadbolt configuration and allow only authorized staff access. However two other doors, (#31 and #33) were identified as resident/patient treatment rooms that have the same deficient double sided, keyed, deadbolt lock configuration that could accidentally lock a person inside, resulting in a blocked exit access. Corrective actions include the removal of the deadbolt configuration and replacement of the door lever with a standard, keyed, lever access entry, and a single action exit lever without the need for both locks.</p> <p>3. A follow-up inspection after the corrective actions for room #18, #31, and #33 will verify the proper operation of the resident/patient treatment room doors to ensure completion of the corrections.</p> <p>4. Corrective action will be monitored by intermittent visual examination by the Maintenance department of the single action lever exits on the three doors to ensure no recurrence of deadbolt configuration usage.</p>	May 6, 2014

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K 038	Continued From page 4 between 2:30 and 4:00 PM observation of the sleep center observation and control room (#34) exit access door was equipped with a magnetic access control device (request to exit) and an additional two sided keyed deadbolt lock. This locking configuration could accidentally lock an individual inside resulting in blocked exit access.  Actual NFPA standard: NFPA 101 - 2000  19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1: Door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. (See 19.1.1.1.5 and 19.2.2.2.5.) Exception No. 2*: Delayed-egress locks complying with 7.2.1.6.1 shall be permitted, provided that not more than one such device is located in any egress path. Exception No. 3: Access-controlled egress doors complying with 7.2.1.6.2 shall be permitted.	K 038		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  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 25, 9.7.5	K 062	1. ID Prefix tag #K062, Life Safety Standard of sprinkler heads not being blocked, in reference to resident/patient room #19, has been corrected by the removal of an accordion type door that was blocking the sprinkler coverage from the exterior of the closet.	May 6, 2014

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K 062	<p>Continued From page 5</p> <p>This STANDARD is not met as evidenced by: Based upon observation the facility failed to ensure sprinkler heads are not blocked where provided to cover a hazard. By blocking a sprinkler head, a fire can gain intensity and overwhelm or exceed the system design of light hazard. This deficient practice affected one resident in one of three smoke compartments. The facility had a census of 19 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour on April 1, 2014 between 1:30 and 3:00 PM observation of room 19 revealed a built in closet with sprinkler coverage from the exterior. The closet had an accordion door installed that would block coverage of the closet by the sprinkler head.</p> <p>Actual NFPA Standard: NFPA 25 1999 Edition 1-4.5*</p> <p>The building owner or occupants shall not make changes in the occupancy, the use or process, or the materials used or stored in the building without evaluation of the fire protection systems for their capability to protect the new occupancy, use, or materials. The evaluation shall consider factors that include, but are not limited to, the following:</p> <ul style="list-style-type: none"> <li>(a) Occupancy changes such as converting office or production space into warehousing</li> <li>(b) Process or material changes such as metal stamping of molded plastics</li> <li>(c) Building revisions such as relocated walls, added mezzanines, and ceilings added below sprinklers</li> </ul>	K 062	<p>2. A subsequent inspection of the other resident/patient rooms showed no other like deficiencies.</p> <p>3. Following the corrective action to room #19, an annual follow-up inspection by the Maintenance Department will verify the assurance of no recurrence.</p> <p>3. Corrective action will be monitored by the Maintenance Department via intermittent visual examination of the sprinkler head coverage into the closet.</p>		

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K 062	Continued From page 6 (d) Removal of heating systems in spaces with piping subject to freezing Exception: Where an occupant, management firm, or managing individual has received the authority for inspection, testing, and maintenance in accordance with the Exception to 1-4.2, the occupant, management firm, or managing individual shall comply with 1-4.5.	K 062		
K 075 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5  This STANDARD is not met as evidenced by: Based upon observation and interview the facility failed to store highly combustible materials in a safe manner. The facility was storing three- 32 gallon capacity trash and soiled linen receptacles in an exit access corridor. This deficient practice potentially affected all residents, visitors and staff in one of three smoke compartments. The facility had a census of 19 on the day of the survey.  Findings include:	K 075	1. ID Prefix tag #K075,Life Safety Standard of soiled linen or trash collection receptacles not exceeding 32 gallons in any 64 sq ft area has been corrected by the removal of two of the previously existing containers to other areas of the facility. The single plywood base with casters has been destroyed 2. A subsequent inspection of other like areas in the facility showed no other like deficiencies. 3. The single plywood base on casters, which gave credence to the deficient practice of multiple containers on one platform, in one area, has been destroyed, helping to prevent a recurrence. 4. Corrective action will be monitored by subsequent quarterly "Environment of Care" tour audits by the EOC Committee will inspect the facility to ensure no recurrence of high combustible materials exceeding the square footage limit.	May 6, 2014

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K 075	<p>Continued From page 7</p> <p>During the facility tour on April 1, 2014 between 1:30 and 3:30 PM observation revealed three 32 gallon capacity Rubbermaid type trash containers on a single plywood base with casters, being stored in the alcove between shower two and the exit access corridor. When asked about where these containers were stored the Manager of Building Services indicated the location we observed adjacent to the exit access corridor. When asked if he was aware of the volume and space requirements outside of a hazardous area, he indicated he was not.</p> <p>Actual NFPA Standard:</p> <p>NFPA 101-2000 19.7.5.5 Soiled linen or trash collection receptacles shall not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gal/ft<sup>2</sup> (20.4 L/m<sup>2</sup>). A capacity of 32 gal (121 L) shall not be exceeded within any 64-ft<sup>2</sup> (5.9-m<sup>2</sup>) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) shall be located in a room protected as a hazardous area when not attended. Exception: Container size and density shall not be limited in hazardous areas.</p>	K 075			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001190</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: <b>01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/01/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ST LUKE'S ELMORE LONG TERM CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>895 NORTH 6TH EAST MOUNTAIN HOME, ID 83647</b>
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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) COMPLETE DATE
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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2.</p> <p>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.</p> <p>The following deficiencies were cited during the annual life safety code survey conducted on April 1, 2014. 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>Mark Grimes, Supervisor Facility Fire Safety &amp; Construction IDHW</p> <p>Sam Burbank, Health Facility Surveyor Facility Fire Safety &amp; Construction IDHW</p> <p>Dan Holbrook, Health Facility Surveyor Facility Fire Safety &amp; Construction IDHW</p>	C 000		
C 226	02.106 FIRE AND LIFE SAFETY	C 226	Refer to Federal Form OMB No. 098-0391 for Plan of Correction for Survey dated 4/1/14.	

**RECEIVED**  
**APR 17 2014**  
**FACILITY STANDARDS**

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
<i>Greg E. Mauer</i>	ADMINISTRATOR	APR 15 2014

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001190</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: <b>01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/01/2014</b>
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C 226	<p>Continued From page 1</p> <p>106. FIRE AND LIFE SAFETY. Buildings on the premises used as facilities shall meet all the requirements of local, state and national codes concerning fire and life safety standards that are applicable to health care facilities. This Rule is not met as evidenced by: Refer to deficiencies listed on the federal form 2567:</p> <p>K029 Hazardous Area Doors Close and Latch Securely K038 Locks Requiring Keys K062 Sprinkler Maintenance K075 Combustible Storage</p>	C 226		