IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK– ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
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September 14, 2015

Curtis Maier, Administrator
St Luke's Jerome
709 North Lincoln Avenue
Jerome, ID 83338

RE: St Luke's Jerome, Provider # 131310

Dear Mr. Maier:

This is to advise you of the findings of the Medicare/Licensure Fire Life Safety Survey, which was concluded at your facility, St Luke's Jerome, on September 4, 2015.

Enclosed is your copy of a Statement of Deficiencies/Plan of Correction, State form, which states that no State deficiencies were noted at the time of the survey.

Also enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicare 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.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **September 28, 2015**, and keep a copy for your records.

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

Sincerely,

MARK P. GRIMES
Supervisor
Facility Fire Safety and Construction Program

MPG/lj

Enclosures

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	131310	A. BUILDING 01 - ENTIRE HOSPITAL B. WING _____	09/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKE'S JEROME	709 NORTH LINCOLN AVENUE JEROME, ID 83338

(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	K 000	K 000	9/23/2015

The hospital building is a single story structure with a partially finished basement that was originally constructed in 1951. The basic construction type for the hospital building is protected non-combustible. Since its original construction, the building has undergone several renovations and a major addition to the ED/Radiology/Main entry. The building is provided with partial sprinkler coverage in portions of the lower (i.e., basement) level and on the main level in the ED/Radiology/Main Entry addition only. There are two exits from each level to grade plus additional exits to the exterior from the main level at dietary service, the Radiology suite, and the ED Suite. Interior finish of corridors is class A and emergency power is provided by an on-site diesel powered automatic generator set.

The following deficiencies were cited during the annual fire/life safety survey conducted on September 4, 2015. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 485.623.

The Survey was conducted by:

Sam Burbank
Health Facility Surveyor
Facility Fire Safety and Construction

Please accept this plan of correction as St. Luke's Jerome (SLJ) allegation of compliance.

RECEIVED
SEP 25 2015

K 047	NFPA 101 LIFE SAFETY CODE STANDARD	K 047	

Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Curtis Maier (CURTIS MAIER)	ADMINISTRATOR	9/25/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 047	Continued From page 1 This Standard is not met as evidenced by: Based on observation, the facility failed to ensure that exit signage was clear and identifiable. Failure to properly identify the clear path of egress would hinder evacuation during and emergency. The facility is licensed for 25 Hospital beds and had a census of 8 on the date of the survey. Findings include: 1) During the facility tour conducted on September 4, 2015 from 11:45 AM to 3:45 PM, observation of the exit discharge area at the west side of the building entering the ramp to the clinic, the installed exit sign above the ramp provided no clear direction of travel. 2) During the facility tour conducted on September 4, 2015 from 11:45 AM to 3:45 PM, observation of two (2) exit signs installed in the emergency suite revealed the directional arrows pointed to dead end walls, not to an exit. Actual NFPA standard: 7.10.1.2* Exits. Exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign readily visible from any direction of exit access. 7.10.1.4* Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. Sign placement shall be such that no point in an exit access corridor is in excess of 100 ft (30 m) from the nearest externally illuminated	K 047	K 047 1. An exit sign has been installed in the west side of the building entering the ramp to provide clear direction of travel. 2. Two new exit signs have been installed in the emergency suite providing clear direction of travel into an exit corridor. Environment of Care tour of the entire facility was conducted by Safety Officer, building services manager, to ensure exit signs provided appropriate directional egress. Environment of Care tours will continue monthly by assigned staff with results tracked and reported to the chair of the Environment of Care Committee. The findings have been reported to the Building Services Department. The full survey and corrective actions will be reported to the Environment of Care Committee.	9/23/15

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 047	Continued From page 2 sign and is not in excess of the marked rating for internally illuminated signs. Exception: Signs in exit access corridors in existing buildings shall not be required to meet the placement distance requirements.	K 047		
K 062	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 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that sprinkler heads were not of mixed type and response in a compartment. Dissimilar heads in a covered area could affect the system capability to control fires in incipient stages. The facility is licensed for 25 Hospital beds and had a census of 8 on the date of the survey. Findings include: During the facility tour conducted on September 4, 2015 from 11:45 AM to 3:45 PM, observation of Storage Room #4 and the Employee Breakroom adjacent to Elevator "G" revealed: standard response high-temperature/high hazard sprinkler heads mixed with quick response, ordinary hazard sprinkler heads; one (1) at each location. Further inspection demonstrated neither location was exposed to a high temperature hazard. Interview of the Maintenance Director found he had not been aware these mixed heads were present.	K 062	**K 062** An audit of the facility to identify mixed sprinkler heads within the same smoke compartment will be conducted. All identified mixed sprinkler heads will be replaced no later than November 2nd. The findings have been reported to Building Services Department. The full survey and corrective actions will be reported to the Environment of Care Committee on a monthly basis until EOC committee determines appropriate resolution of the identified issues. Completion dates for all identified issues will be no later than November 2nd.	11/2/15

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K 062	Continued From page 3	K 062		

Actual NFPA standard:

NFPA 13
5-3.1.4 Temperature Ratings.
5-3.1.4.2
The following practices shall be observed to provide sprinklers of other than ordinary temperature classification unless other temperatures are determined or unless high-temperature sprinklers are used throughout [see Tables 5-3.1.4.2(a) and (b) and Figure 5-3.1.4.2].
(1) Sprinklers in the high-temperature zone shall be of the high-temperature classification, and sprinklers in the intermediate-temperature zone shall be of the intermediate-temperature classification.
(2) Sprinklers located within 12 in. (305 mm) to one side or 30 in. (762 mm) above an uncovered steam main, heating coil, or radiator shall be of the intermediate-temperature classification.
(3) Sprinklers within 7 ft (2.1 m) of a low-pressure blowoff valve that discharges free in a large room shall be of the high-temperature classification.
(4) Sprinklers under glass or plastic skylights exposed to the direct rays of the sun shall be of the intermediate-temperature classification.
(5) Sprinklers in an unventilated, concealed space, under an uninsulated roof, or in an unventilated attic shall be of the intermediate-temperature classification.
(6) Sprinklers in unventilated show windows having high-powered electric lights near the ceiling shall be of the intermediate-temperature classification.
(7) Sprinklers protecting commercial-type cooking equipment and ventilation systems shall be of the high- or extra-high-temperature

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K 062	Continued From page 4 classification as determined by use of a temperature-measuring device. (See 4-9.6.) 5-4.5.3 Where residential sprinklers are installed in a compartment as defined in 1-4.2, all sprinklers within the compartment shall be of the fast-response type that meets the criteria of 1-4.5.1(a)1.	K 062		
K 072	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This Standard is not met as evidenced by: Based on observation and operational testing, the facility failed to ensure that exit doors were free of impediments to their instant use. Failure to provide instant use for exits would hinder evacuation during an emergency. The facility is licensed for 25 Hospital beds and had a census of 8 on the day of the survey. Findings include: During the facility tour conducted on September 4, 2015 from 11:45 AM to 3:45 PM, observation and operational testing of the exit door of the southeast exit from the OB suite found it was equipped with a electronic controlled keypad without a delayed egress component. Actual NFPA standard:	K 072	**K 072** The electronic controlled keypad without delayed egress has been replaced with a delayed egress lock meeting all aspects to NFPA 101, 7.2.1.6.1 An initial audit will take place to ensure that no other issue is present in the facility. Periodic audits will take place to ensure ongoing compliance and early identification of any potential issues. The findings have been reported to the Building Services Department. The full survey and corrective actions will be reported to the Environment of Care Committee on a monthly basis until EOC Committee determines appropriate resolution of the identified issues. Completion date for all identified issues will be no later than November 2nd.	

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K 072	Continued From page 5	K 072		

7.2.1.5.6*
Devices shall not be installed in connection with any door on which panic hardware or fire exit hardware is required where such device prevents or is intended to prevent the free use of the door for purposes of egress.
Exception: This requirement shall not apply where otherwise provided in 7.2.1.6.

7.2.1.6 Special Locking Arrangements.
7.2.1.6.1 Delayed-Egress Locks.
Approved, listed, delayed-egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met.
(a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6.
(b) The doors shall unlock upon loss of power controlling the lock or locking mechanism.
(c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only.

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K 072	Continued From page 6 Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) * On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS	K 072		