



IDAHO DEPARTMENT OF
HEALTH & WELFARE

.BRAD LITTLE – Governor
DAVE JEPPESEN– Director

TAMARA PRISOCK-- ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

October 15, 2019

Lisa Melchiorre, 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 Ms. Melchiorre:

On **October 8, 2019**, 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

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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 **October 28, 2019**. Failure to submit an acceptable PoC by **October 28, 2019**, may result in the imposition of civil monetary penalties by **November 19, 2019**.

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 12, 2019**, (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 **January 6, 2020**. A change in the seriousness of the deficiencies on **November 22, 2019**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **November 12, 2019**, includes the following:

Denial of payment for new admissions effective **January 8, 2020**.
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 8, 2020**, 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 8, 2019**, 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:

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<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

Go to the middle of the page to Information Letters section and click on State and select the following:

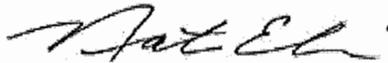
BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process
2001-10 IDR Request Form

This request must be received by **October 28, 2019**. If your request for informal dispute resolution is received after **October 28, 2019**, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135006	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE NF WING B. WING _____	(X3) DATE SURVEY COMPLETED 10/08/2019
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 21 on the dates of the survey. The following deficiencies were cited during the annual fire/life safety survey conducted on October 7 - 8, 2019. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70. The Survey was conducted by: Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction	K 000	RECEIVED RECEIVED OCT 28 2019 OCT 28 2019 ... FACILITY STANDARDS The Following constitutes the facility's response to the findings of the Department of Health and Welfare and does note constitute an admission of guilt or agreement of the facts alleged or conclusions set forth on the summary statement of deficiencies.	
K 222 SS=E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on	K 222	The Support Services Manager is ultimately responsible for ensuring special locking arrangements are in accordance with NFPA 101. <u>Immediate Steps taken:</u> Staff and Residents present at the time of survey could potentially be affected by the reported deficiencies. Temporary signage was posted to immediately correct deficiency and mitigate risk to residents and staff.	10/24/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Linda Chaney* TITLE *Chief Surveying Officer / CVO* (X6) DATE *10/25/19*

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 222	Continued From page 1 each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING	K 222	<u>Plan of Correction:</u> Permanent signs installed, stating "Push until alarm sounds, door can be opened in 15 seconds." Singage lettering size was reviewed to ensure compliance with the regulation. <u>QAPI Integration:</u> In order to ensure ongoing compliance signage for special locking arrangements will be reviewed during Environment of Care tours that occur every 6 months. Results of the Environment of Care tours will be reported to unit leadership for appropriate follow up, and reviewed at the Elmore Quality Safety Council and EOC Collaborative of the Population Health Area.		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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K 222	Continued From page 2 ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and operational testing, the facility failed to ensure special locking arrangements were in accordance with NFPA 101. Failure to provide required signage on exit doors equipped with delayed egress locking arrangements could hinder the safe evacuation of occupants during a fire or other emergency. This deficient practice affected 11 residents and staff on the dates of the survey. Findings include: During the facility tour on October 7, 2019, from approximately 2:00 PM to 3:30 PM, observation and operational testing of the exit door by resident room #20, revealed the door was equipped with a magnetic locking arrangement with a delayed egress component, but did not have the required signage stating: Push until alarm sounds, Door can be opened in 15 seconds. Actual NFPA standard: 7.2.1.6* Special Locking Arrangements. 7.2.1.6.1 Delayed-Egress Locking Systems. 7.2.1.6.1.1 Approved, listed, delayed-egress locking systems shall be permitted to be installed on door assemblies serving low and ordinary	K 222		

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K 222	Continued From page 3 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 11 through 43, provided that all of the following criteria are met: (1) The door leaves shall unlock in the direction of egress upon actuation of one of the following: (a) Approved, supervised automatic sprinkler system in accordance with Section 9.7 (b) Not more than one heat detector of an approved, supervised automatic fire detection system in accordance with Section 9.6 (c) Not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6 (2) The door leaves shall unlock in the direction of egress upon loss of power controlling the lock or locking mechanism. (3)*An irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions: (a) The force shall not be required to exceed 15 lbf (67 N). (b) The force shall not be required to be continuously applied for more than 3 seconds. (c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening. (d) Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only. (4)*A readily visible, durable sign in letters not less than 1 in. (25 mm) high and not less than 1/8 in. (3.2 mm) in stroke width on a contrasting	K 222		

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K 222	Continued From page 4 background that reads as follows shall be located on the door leaf adjacent to the release device in the direction of egress: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS (5) The egress side of doors equipped with delayed-egress locks shall be provided with emergency lighting in accordance with Section 7.9.	K 222	The Support Services Manager is ultimately responsible for ensuring corridor exit access is free of obstructions.	10/16/19
K 232 SS=F	Aisle, Corridor, or Ramp Width CFR(s): NFPA 101 Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to maintain corridor exit access free of obstructions. Failure to maintain exit access width in the path of travel, could hinder the safe evacuation of residents during a fire or other emergency. This deficient practice affected 21 residents and staff on the dates of the survey. Findings include: During the facility tour on October 7, 2019, from approximately 2:00 PM to 3:30 PM, observation of the exit access corridors revealed wall mounted computer monitors that projected from the corridor wall 7-1/2 inches at a height of	K 232	<u>Immediate Steps taken:</u> Staff and Residents present at the time of survey could potentially be affected by the reported deficiencies. Removal of the identified obstructions was coordinated immediately. <u>Plan of Correction:</u> Wall mounted computers were removed from corridors. <u>QAPI Integration:</u> In order to ensure ongoing compliance, exit access requirements will be reviewed during Environment of Care tours that occur every 6 months. Results of the Environment of Care tours will be reported to unit leadership for appropriate follow up, and reviewed at the Elmore Quality Safety Council and EOC Collaborative of the Population Health Area.	

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K 232	Continued From page 5 approximately 48 - 60 inches from the floor. These computer monitors were in every corridor throughout the facility, exceeding the 4 inches allowed. Actual NFPA Standard: 19.2.3.4* Any required aisle, corridor, or ramp shall be not less than 48 in. (1220 mm) in clear width where serving as means of egress from patient sleeping rooms, unless otherwise permitted by one of the following: (1) Aisles, corridors, and ramps in adjunct areas not intended for the housing, treatment, or use of inpatients shall be not less than 44 in. (1120 mm) in clear and unobstructed width. (2) *Where corridor width is at least 6 ft (1830 mm), non-continuous projections not more than 6 in. (150 mm) from the corridor wall, above the handrail height, shall be permitted. (3) Exit access within a room or suite of rooms complying with the requirements of 19.2.5 shall be permitted. (4) Projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in. (1525 mm). (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c)*The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment	K 232			

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K 232	Continued From page 6 (5) *Where the corridor width is at least 8 ft (2440 mm), projections into the required width shall be permitted for fixed furniture, provided that all of the following conditions are met: (a) The fixed furniture is securely attached to the floor or to the wall. (b) The fixed furniture does not reduce the clear unobstructed corridor width to less than 6 ft (1830 mm), except as permitted by 19.2.3.4(2). (c) The fixed furniture is located only on one side of the corridor. (d) The fixed furniture is grouped such that each grouping does not exceed an area of 50 ft ² (4.6 m ²). (e) The fixed furniture groupings addressed in 19.2.3.4(5)(d) are separated from each other by a distance of at least 10 ft (3050 mm). (f)*The fixed furniture is located so as to not obstruct access to building service and fire protection equipment. (g) Corridors throughout the smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the fixed furniture spaces are arranged and located to allow direct supervision by the facility staff from a nurses' station or similar space. (h) The smoke compartment is protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.8.	K 232			
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire	K 353	The Support Services Manager is ultimately responsible for ensuring fire suppression systems were maintained in accordance with NFPA 25.	11/08/19	

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K 353	<p>Continued From page 7 Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure fire suppression systems were maintained in accordance with NFPA 25. Failure to inspect suppression system components has the potential to hinder system performance during a fire event and/or render the facility not fully sprinklered after an activation or repair. This deficient practice affected 21 residents and staff on the dates of the survey.</p> <p>Findings include:</p> <p>1.) During review of provided facility inspection and testing records conducted on October 7, 2019, from approximately 8:30 AM - 2:00 PM, documentation for a fourth quarter, 2018 waterflow alarm flow test could not be produced. When asked, at approximately 1:00 PM, the Manager of Building Services stated the facility was unaware waterflow alarm devices were required to be tested quarterly.</p>	K 353	<p><u>Immediate Steps Taken:</u> Staff and Residents present at the time of survey could potentially be affected by the reported deficiencies. Immediate actions to minimize potential affect of deficiencies included review of redundant fire safety systems in place.</p> <p><u>Plan of Correction:</u></p> <p>Water Alarm Flow Testing: Established contract with outside vendor to supply water alarm flow testing, and continue to provide testing on a quarterly basis moving forward.</p> <p>Sprinkler Head Maintenance: Outside contractor to review and replace sprinklers heads that do not meet requirements.</p> <p>Wet Sprinkler Gauges, Valves, and Tamper Switches: Monthly inspections of wet sprinkler gauges, valves, and tamper switches added to monthly preventative maintenance rosters.</p>	

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K 353	<p>Continued From page 8</p> <p>2.) During the facility tour on October 7, 2019, from approximately 2:00 PM to 3:30 PM, observation of sprinkler pendants throughout the facility revealed upright pendant deflectors had paint on them. After discovery of the painted sprinkler pendants in multiple resident rooms, support services and corridors, it was deemed to be systemic. When asked, at approximately 3:00 PM, the Manager of Building Services stated the facility was unaware the sprinkler pendant deflectors had been painted.</p> <p>3.) During review of provided facility inspection and testing records conducted on October 7, 2019, from approximately 8:30 AM - 2:00 PM, documentation provided did not show evidence of monthly inspections of wet sprinkler gauges, valves, and tamper switches. When asked, at approximately 1:00 PM, the Manager of Building Services stated the facility was unaware suppression system gauges, valves and tamper switches were required to be visually inspected and documented monthly.</p> <p>Actual NFPA standard: NFPA 25</p> <p>1.) 5.3.3 Waterflow Alarm Devices. 5.3.3.1 Mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly.</p> <p>2.) 5.2.1 Sprinklers. 5.2.1.1* Sprinklers shall be inspected from the floor level annually. 5.2.1.1.1* Sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall</p>	K 353	<p><u>QAPI Integration:</u> In order to ensure ongoing compliance with fire suppression systems maintenance the following reviews will be conducted.</p> <p>Waterflow alarm flow testing: The Support Services Manger will review documentation each quarter to ensure appropriate testing completed. In addition documentation will be reviewed at least annually during St. Luke's internal compliance monitoring process. Results of the internal monitoring review will be reported to Elmore Quality and Safety Council and additional committees/councils as appropriate.</p> <p>Sprinkler Head Maintenance: Sprinkler heads will be reviewed during Environment of Care tours that occur every 6 months, to ensure compliance with regulations. Results of the Environment of Care tours will be reported to unit leadership for appropriate follow up, and reviewed at the Elmore Quality Safety Council and EOC Collaborative of the Population Health Area.</p>	

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

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K 353	Continued From page 9 be installed in the correct orientation (e.g., upright, pendent, or sidewall). 5.2.1.1.2 Any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical damage (4) Loss of fluid in the glass bulb heat responsive element (5) *Loading (6) Painting unless painted by the sprinkler manufacturer 3.) Chapter 5 Sprinkler systems. 5.1.2 Valves and connections: Valves and fire department connections shall be inspected, tested, and maintained in accordance with chapter 13. 5.24 gauges. 5.2.4.1 Gauges on wet pipe sprinkler systems shall be inspected monthly to ensure that they are in good condition and that normal water supply pressure is being maintained. 5.2.4.2 Gauges on dry, preaction, and deluge systems shall be inspected weekly to ensure that normal air and water pressure are being maintained. Chapter 13 Valves, Valve Components, and Trim 13.3.2 Inspection 13.3.2.1 Valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly. 13.3.2.2 The valve inspection shall verify that the valves are in the following condition: (1) In the normal open or closed position (2) Sealed, locked, or supervised (3) accessible (4) Provided with correct wrenches (5) free from external leaks (6) Provided with applicable identification 14.4.1.1 Alarm valves and system riser check	K 353	Wet Sprinkler Gauges, Values, and Tamper Switches inspections: The Support Services Manger will review documentation each month to ensure appropriate inspections completed. In addition documentation will be reviewed at least annually during St. Luke's internal compliance monitoring process. Results of the internal monitoring review will be reported to Elmore Quality and Safety Council and additional committees/councils as appropriate.	

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K 353	Continued From page 10 valves shall be externally inspected monthly and shall verify the following: (1) The gauges indicate normal supply water pressure is being maintained (2) The valve is free of physical damage (3) All valves are in the appropriate open or closed position (4) The retarding chamber or alarm drains are not leaking.	K 353		
K 907 SS=F	Gas and Vacuum Piped Systems - Maintenance Pr CFR(s): NFPA 101 Gas and Vacuum Piped Systems - Maintenance Program Medical gas, vacuum, WAGD, or support gas systems have documented maintenance programs. The program includes an inventory of all source systems, control valves, alarms, manufactured assemblies, and outlets. Inspection and maintenance schedules are established through risk assessment considering manufacturer recommendations. Inspection procedures and testing methods are established through risk assessment. Persons maintaining systems are qualified as demonstrated by training and certification or credentialing to the requirements of AASE 6030 or 6040. 5.1.14.2.1, 5.1.14.2.2, 5.1.15, 5.2.14, 5.3.13.4.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure positive pressure gas central piping systems and medical-surgical vacuum systems have a documented maintenance program. Failure to inventory, inspect, and maintain these systems, by a qualified person, could result in fire, explosion, or a lack of system performance as designed. This deficient practice	K 907	The Support Services Manager is ultimately responsible for ensuring positive pressure gas central piping systems and medical-surgical vacuum systems have a documented maintenance program. <u>Immediate Steps Taken:</u> Staff and Residents present at the time of survey could potentially be affected by the reported deficiencies. Immediate actions to minimize potential affect of deficiencies included a review of redundant fire safety systems in place. <u>Plan of Correction:</u> Building Services created a maintenance program, which includes a written inventory and completion of annual testing based on manufacturer's guidelines and NFPA 99 requirements. Testing to be completed by Norco.	

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K 907	Continued From page 11 affected all residents and staff on the dates of the survey. Findings include: During record review on October 7, 2019, from approximately 8:30 AM to 2:00 PM, no documentation of a written maintenance program for the positive pressure gas central piping systems and medical-surgical vacuum system could be located. When asked about the missing documentation, the Manager of Building Services stated the facility was unaware of this requirement. Actual NFPA standard: NFPA 99 5.1.14.2.1* General. Health care facilities with installed medical gas, vacuum, WAGD, or medical support gas systems, or combinations thereof, shall develop and document periodic maintenance programs for these systems and their subcomponents as appropriate to the equipment installed. 5.1.14.2.2 Maintenance Programs. 5.1.14.2.2.1 Inventories. Inventories of medical gas, vacuum, WAGD, and medical support gas systems shall include at least all source subsystems, control valves, alarms, manufactured assemblies containing patient gases, and outlets. 5.1.14.2.2.2* Inspection Schedules. Scheduled inspections for equipment and procedures shall be established through the risk assessment of the facility and developed with consideration of the original equipment manufacturer recommendations and other recommendations as required by the authority having jurisdiction.	K 907	<u>QAPI Integration:</u> Support Services Manager will review the testing results annually. In addition documentation will be reviewed at least annually during St. Luke's internal compliance monitoring process. Results of the internal monitoring review will be reported to Elmore Quality and Safety Council and additional committees/councils as appropriate.	10/23/19 Pen + ink Change LC per Lisa Admin. 10/30/19 @ 2:45pm

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K 907	Continued From page 12 5.1.14.2.2.3 Inspection Procedures. The facility shall be permitted to use any inspection procedure(s) or testing methods established through its own risk assessment. 5.1.14.2.2.4 Maintenance Schedules. Scheduled maintenance for equipment and procedures shall be established through the risk assessment of the facility and developed with consideration of the original equipment manufacturer recommendations and other recommendations as required by the authority having jurisdiction. 5.1.14.2.2.5 Qualifications. Persons maintaining these systems shall be qualified to perform these operations. Appropriate qualification shall be demonstrated by any of the following: (1) Training and certification through the health care facility by which such persons are employed to work with specific equipment as installed in that facility (2) Credentialing to the requirements of ASSE 6040, Professional Qualification Standard for Medical Gas Maintenance Personnel (3) Credentialing to the requirements of ASSE 6030, Professional Qualification Standard for Medical Gas Systems Verifiers 5.1.14.2.3 Inspection and Testing Operations. 5.1.14.2.3.1 General. The elements in 5.1.14.2.2.2 through 5.1.15 shall be inspected or tested as part of the maintenance program as follows: (1)*Medical air source, as follows: (a) Room temperature (b) Shaft seal condition (c) Filter condition (d) Presence of hydrocarbons (e) Room ventilation (f) Water quality, if so equipped (g) Intake location (h) Carbon monoxide monitor calibration	K 907		

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K 907	Continued From page 13 (i) Air purity (j) Dew point (2)*Medical vacuum source - exhaust location (3) WAGD source - exhaust location (4)*Instrument air source - filter condition (5)*Manifold sources (including systems complying with 5.1.3.5.10, 5.1.3.5.11, 5.1.3.5.12, and 5.1.3.5.13), as follows: (a) Ventilation (b) Enclosure labeling (6) Bulk cryogenic liquid source inspected in accordance with NFPA 55, Compressed Gases and Cryogenic Fluids Code (7) Final line regulation for all positive pressure systems - delivery pressure (8)*Valves - labeling (9)*Alarms and warning systems-lamp and audio operation (10) Alarms and warning systems, as follows: (a) Master alarm signal operation (b) Area alarm signal operation (c) Local alarm signal operation (11)*Station outlets/inlets, as follows: (a) Flow (b) Labeling (c) Latching/delatching (d) Leaks 5.1.14.2.3.2 Manufactured Assemblies Employing Flexible Connection(s) Between the User Terminal and the Piping System. (A) Non-stationary booms and articulating assemblies, other than head walls utilizing flexible connectors, shall be tested for leaks, per manufacturer ' s recommendations, every 18 months or at a duration as determined by a risk assessment. (B) The system pressure to non-stationary booms and articulating arms shall be maintained at operating pressure until each joint has been	K 907		

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K 907	Continued From page 14 examined for leakage by effective means of leak detection that is safe for use with oxygen. (C) Safe working condition of the flexible assemblies shall be confirmed. (D) D.I.S.S. connectors internal to the boom and assemblies shall be checked for leakage. (E) Leaks, if any, shall be repaired (if permitted), or the components replaced (if required), and the equipment retested prior to placing the equipment back into service. (F) Additional testing of non-stationary booms or articulating arms shall be performed at intervals defined by documented performance data. 5.1.14.3 Medical Gas and Vacuum Systems Information and Warning Signs. 5.1.14.3.1 The gas content of medical gas and vacuum piping systems shall be labeled in accordance with 5.1.11.1. 5.1.14.3.2 Labels for shutoff valves shall be in accordance with 5.1.11.2 and updated when modifications are made changing the areas served. 5.1.14.4 Medical Gas and Vacuum Systems Maintenance and Record Keeping. See B.5.2. 5.1.14.4.1 Permanent records of all tests required by 5.1.12.3.1 through 5.1.12.3.14 shall be maintained in the organization ' s files. 5.1.14.4.2 The supplier of the bulk cryogenic liquid system shall, upon request, provide documentation of vaporizer(s) sizing criteria to the facility. 5.1.14.4.3 An annual review of bulk system capacity shall be conducted to ensure the source system has sufficient capacity. 5.1.14.4.4 Central supply systems for nonflammable medical gases shall conform to the following: (1) They shall be inspected annually. (2) They shall be maintained by a qualified	K 907		

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K 907	Continued From page 15 representative of the equipment owner. (3) A record of the annual inspection shall be available for review by the authority having jurisdiction. 5.1.14.4.5 A periodic testing procedure for nonflammable medical gas and vacuum and related alarm systems shall be implemented. 5.1.14.4.6 Whenever modifications are made that breach the pipeline, any necessary installer and verification test specified in 5.1.12 shall be conducted on the downstream portions of the medical gas piping system. 5.1.14.4.7 Procedures, as specified, shall be established for the following: (1) Maintenance program for the medical air compressor supply system in accordance with the manufacturer's recommendations (2) Facility testing and calibration procedure that ensures carbon monoxide monitors are calibrated at least annually or more often if recommended by the manufacturer (3) Maintenance program for both the medical-surgical vacuum piping system and the secondary equipment attached to medical-surgical vacuum station inlets to ensure the continued good performance of the entire medical-surgical vacuum system (4) Maintenance program for the WAGD system to ensure performance 5.1.14.4.8 Audible and visual alarm indicators shall meet the following requirements: (1) They shall be periodically tested to determine that they are functioning properly. (2) Records of the test shall be maintained until the next test is performed. 5.1.14.4.9 Medical-surgical vacuum station inlet terminal performance, as required in 5.1.12.3.10.4, shall be tested as follows: (1) On a regular preventive maintenance	K 907			

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K 907	Continued From page 16 schedule as determined by the facility maintenance staff (2) Based on flow of free air (NI/min or SCFM) into a station inlet while simultaneously checking the vacuum level 5.1.15* Category 1 Maintenance. Facilities shall have a routine maintenance program for their piped medical gas and vacuum systems. 5.2 Category 2 Piped Gas and Vacuum Systems. 5.2.1* Applicability. These requirements shall apply to health care facilities that qualify for Category 2 systems as referenced in Chapter 4. 5.2.1.1 Section 5.2 through 5.2.12 shall apply to new health care facilities or facilities making changes that alter the piping. 5.2.1.2 Subsection 5.2.13 5.2.14* Category 2 Maintenance. Facilities shall have a routine maintenance program for their piped medical gas and vacuum systems. 5.3.13.4.2 A periodic testing procedure for Category 3 gas and vacuum systems and related alarm systems shall be implemented.	K 907		



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK – ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

October 15, 2019

Lisa Melchiorre, 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 Ms. Melchiorre:

On **October 8, 2019**, 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/lj
Enclosure

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E 000	<p>Initial Comments</p> <p>The facility is a single-story Type V (111) wing, attached to a deemed Hospital. The facility was built in 1965 with 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 21 on the dates of the survey.</p> <p>The facility was found to be in substantial compliance during the annual Emergency Preparedness Survey conducted on October 7 - 8, 2019. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.</p> <p>The Survey was conducted by:</p> <p>Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction</p>	E 000			

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

TITLE

(X6) 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.