Madison Memorial Hospital
450 East Main Street
Rexburg, ID 83440-1629

CMS Certification Number: 130025

Re: Results of Sample Validation Survey

Dear Administrator:

The Centers for Medicare and Medicaid Services (CMS) is confirming the results of the sample validation survey, completed by the Bureau Of Facility Standards (State survey agency) at Madison Memorial Hospital. Enclosed you will find the results of your Health and Life Safety Code surveys (CMS Form 2567).

CMS finds that your facility is in compliance with all the Medicare Conditions of Participation and will continue to be certified as meeting Medicare requirements. We have forwarded a copy of this letter and the findings from the survey to the accrediting organization, DNV.

It is not a requirement to submit a plan of correction; if you choose to not submit a plan a correction, please sign and date the first page of the Form CMS-2567 and return to CMS and BFS:

Centers for Medicare and Medicaid Services
Lynnette Osias, Division of Certification and Enforcement
701 Fifth Avenue, Suite 1600, Mail Stop 400
Seattle, Washington 98104

Debby Ransom
Bureau of Facility Standards
PO Box 83720
Boise, ID 83720

Under federal disclosure rules, findings of the inspection, including the plan of correction submitted by the facility, become publicly disclosable (if requested) within ninety days (90 days) of completion.

Therefore, if you wish to submit your plans for correcting the standard deficiencies cited on the CMS 2567, please do so within 10 days of the receipt of this letter. Plans of Corrections
must contain the following elements:

- The plan for correcting each specific deficiency cited;
- The plan should address improving the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- All plans of correction must demonstrate how the facility has incorporated its improvement actions into its Quality Assessment and Performance Improvement (QAPI) program, addressing improvements in its systems in order to prevent the likelihood of the deficient practice reoccurring. The plan must include the monitoring and tracking procedures to ensure the plan of correction is effective and that specific deficiencies cited remain corrected and/or in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable plan of correction.

We thank you for your cooperation, and look forward to working with you on a continuing basis in the administration of the Medicare program. All correspondence and questions should be directed to CMS_RO10_CEB@cms.hhs.gov, Attn: Validation

Sincerely,

Certification & Enforcement Branch
Centers for Medicare & Medicaid Services

Enclosure(s)

cc: Bureau Of Facility Standards
Office of the State Fire Marshal
CMS Central Office
DNV
June 25, 2018

Rachel Gonzales, Administrator
Madison Memorial Hospital
450 East Main Street
Rexburg, ID 83440

RE: CMS Certification Number 130025

Dear Ms. Gonzales:

Section 1865 of the Social Security Act (the Act) provides that entities accredited by Centers for Medicare & Medicaid (CMS) — recognized national accrediting organizations may be deemed to meet the applicable Medicare Conditions of Participation, Conditions for Coverage, or Conditions for Certification.

Section 1864 of the Act authorizes the Secretary to enter into an agreement with State health or other appropriate agencies to conduct, on a selective sampling basis or in response to a substantial allegation of noncompliance, surveys of deemed status providers or suppliers subject to Medicare certification requirements. CMS uses such surveys as a means of validating the accrediting organization’s survey and accreditation process. In Idaho, Medicare validation surveys of accredited deemed providers and suppliers are conducted by the Bureau of Facility Standards. This agency, under agreement with CMS, surveys providers and suppliers subject to certification to determine compliance with the applicable Medicare conditions.

Your facility has been selected for a sample validation survey. This is an unannounced survey following procedures established by CMS.

In accordance with the provisions of 42 CFR §488.7(b), your facility must authorize:

1) The validation survey by the State Survey Agency to take place; and

2) The State Survey Agency to monitor the correction of substantial noncompliance found through the validation survey.
You may also be requested to provide or verify additional information required by CMS for general certification purposes by a member of the survey team.

During the validation survey, the State agency will determine compliance with Medicare health and safety requirements applicable to your type of facility. The survey team will require access to all areas of the facility, observe patient services or procedures to assist them in their compliance determination, ask questions of facility staff and may also request facility documents to review.

If the validation survey results in a finding by the CMS Regional Office that a deemed status provider or supplier is not in substantial compliance with one or more Medicare conditions, the provider or supplier will no longer be deemed to meet Medicare conditions and may be subject to termination of its provider or supplier agreement, in accordance with 42 CFR §488.7(d).

Additionally, in accordance with 42 CFR §401.133, a copy of the Medicare validation survey findings will be subject to public disclosure after the facility has been given an opportunity to review the findings, present comments to CMS, and submit a plan of correction for deficiencies cited. In those cases where the deemed status provider or supplier is not required to submit an acceptable plan of correction, the provider or supplier may voluntarily submit one. In the latter case the plan of correction will not be reviewed for acceptability but may be released along with the validation survey findings.

If you have any questions regarding this letter, please telephone Dennis Kelly, NLTC Co-Supervisor at (208) 334-6626, option #4.

Sincerely,

DEBBY RANSOM, RN, RHIT, CHIEF
Bureau of Facility Standards

Enclosures

ec: Patrick Thrift, Survey & Certification Manager Region X
June 11, 2018

To Whom it May Concern:

Certain types of providers and suppliers may be deemed in compliance with the appropriate Medicare Conditions of Participation or Conditions for Coverage or Conditions for Certification program by submitting evidence of accreditation from a Centers for Medicare & Medicaid Services (CMS)-approved Medicare accreditation program. CMS may subsequently, in accordance with Section 1864 of the Act, conduct, either on a selective sampling basis or in response to a substantial allegation of noncompliance, surveys of deemed status providers/suppliers. CMS uses such surveys as a means of validating the accrediting organization’s survey and accreditation process.

In signing this form, I acknowledge that I have been advised that Madison Memorial Hospital has been selected for a validation survey. Furthermore, I acknowledge that, in accordance with the provisions of 42 CFR §488.7(b), I must authorize:

1) The validation survey by the State Survey Agency to take place; and

2) The State Survey Agency to monitor the correction of substantial noncompliance found through the validation survey.

[Signature]
Signature of Authorizing Individual

[Printed/Typed Name]
Printed/Typed Name of Authorizing Individual

Madison Memorial Hospital
Name of Provider/Supplier

6.25.18
Date
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES  

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  
(X1) PROVIDER/SUPPLIER/CIL IDENTIFICATION NUMBER.  
130025  

(X2) MULTIPLE CONSTRUCTION  
A. BUILDING  
R. WING  

(X3) DATE SURVEY COMPLETED  
06/28/2018  

NAME OF PROVIDER OR SUPPLIER  
MADISON MEMORIAL HOSPITAL  

STREET ADDRESS, CITY, STATE, ZIP CODE  
450 EAST MAIN STREET  
REXBURG, ID 83440  

(ID) PREFIX TAG  
TAO  

SUMMARY STATEMENT OF DEFICIENCIES  
(FACILITIES MUST BE PREPARED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  

A000  

RECEIVED  
AUG 13 2018  
FACILITY STANDARDS  

A000  

INITIAL COMMENTS  
The following deficiencies were cited during the Federal Medicare validation survey conducted at your hospital on 6/25/18 to 6/28/18. The surveyors conducting the Federal Medicare validation survey were:  
Gary Gullas, RN, HFS, Team Lead  
Nancy Bax, RN, BSN, HFS  
James Brown, RN, HFS  
Brian Osborn, RN, HFS  
Sam Burbank, CF11, FFSC  
The following acronyms were used in this report:  
AAMI - Association for the Advancement of Medical Instrumentation  
AORN - Association of periOperative Registered Nurses  
ASC - Ambulatory Surgery Center  
BUN - Blood Urea Nitrogen  
CF0 - Chief Nursing Officer  
CHF - Congestive Heart Failure  
CNO - Chief Nursing Officer  
CST - Certified Surgical Technician  
DM - Diabetes Mellitus  
ED - Emergency Department  
ESRD - End Stage Renal Disease  
EVS - Environmental Services  
HIPAA - Health Insurance Portability and Accountability Act  
ICU - Intensive Care Unit  
LDR - Labor and Delivery  
MBU - Mother Baby Unit  
MS - Medical Surgical  
NICU - Neonatal Intensive Care Unit  
Pt - Patient  
PTA - Physical Therapist Assistant  

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

DIRECTOR  
RISK MGT/COMPLIANCE  
8/10/18  

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 patient(s). (See instructions). Except for nursing homes, the findings stated above are disclosed to the public one year 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 disclosed 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is required to continued program participation.
A.000 Continued From page 1

<table>
<thead>
<tr>
<th>Event ID:</th>
<th>A.000</th>
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<tr>
<td>POC - Plan of Care</td>
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<td>PRN - As Needed</td>
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<tr>
<td>QTL - Quality Team Lead</td>
<td></td>
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<tr>
<td>RN - Registered Nurse</td>
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**A.084**

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<td>CFR(s): 482.12(e)(1)</td>
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The governing body must ensure that the services performed under a contract are provided in a safe and effective manner.

This **STANDARD** is not met as evidenced by:

Based on staff interview, review of contracts, and job descriptions, it was determined the hospital's Governing Body failed to ensure contracted security services were provided in a safe and effective manner. This resulted in confusion as to the role of police who provided hospital security services. Findings include:

The hospital contracted with the City of Rexburg's police department to provide "security and other services." The agreement, dated 4/06/15, referred to a document titled "Madison Memorial Hospital/Protection Force Proposal." The proposal stated the police department would provide 1 armed duty police officer and 1 Rexburg Police Department vehicle. The agreement stated the police department would provide "All weapons, equipment and uniforms for Officers..." The agreement further stated, "All personnel assigned to coverage will be fully certified to act as sworn officers of the Rexburg Police Department."

A job description for police who worked security was not present. Neither the agreement nor other documents defined the specific duties of...
A084 Continued From page 2

Officers stationed at the hospital. Neither the agreement nor other documents limited officers' ability to intervene with patients. For example, the agreement stated the police department would provide weapons and equipment. However, no document specified how police would use those weapons and equipment in the hospital. No document specified limits on the use of force for officers interacting with patients and visitors who exhibited belligerent or threatening behaviors.

A police officer, working security at the hospital, was interviewed on 6/26/18 beginning at 6:25 PM. He was in uniform and was armed. He stated a police officer was assigned to work 10 hours per day, 7 days per week at the hospital. He stated he thought the hospital had a job description for him as a security officer, but he was not sure. He stated, except for HIPPA training, he had not received specific training or orientation by the hospital, such as who was responsible to direct staff when patients displayed negative behaviors. He stated he did not know what system the hospital used for restraints.

The Engineering Manager was interviewed on 6/28/18 beginning at 2:30 PM. He stated the hospital had not developed job descriptions or training requirements for police officers who worked security at the hospital.

The hospital did not define the scope of services for contracted police officers.

A 396 NURSING CARE PLAN

The hospital must ensure that the nursing staff
### Statement of Deficiencies and Plan of Correction

<table>
<thead>
<tr>
<th>Provider/Supplier/PCA Identification Number</th>
<th>Number of Patients (10 of 27)</th>
<th>Patient IDs</th>
<th>Deficiency Description</th>
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<tr>
<td>130025</td>
<td>10</td>
<td>#18, #19, #29, #30, #35, #39, #41, #45, #46, and #47</td>
<td>Nursing care plan not developed for each patient</td>
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**Summary Statement of Deficiencies**

Based on review of facility policy, medical records, and staff interview, it was determined the facility failed to ensure comprehensive POCs were developed for 10 of 27 patients admitted to inpatient or observation units and whose care plans were reviewed. This resulted in a lack of direction to staff caring for these patients.

**Findings**

- The hospital's policy "Med/Surg/ICU Plan of Care, effective 1/19/18, stated "Each patient will have a Plan of Care initiated by the admitting nurse and assigned in Cerner [electronic medical record]. Goals and Outcomes will be identified according to review of:" |
  - Diagnosis
  - Assessment
  - Physician Orders
  - Patient needs and requirements during stay
  - Criteria for patient's discharge
  - Discharge planning begins at the time of admission
  - Results of diagnostic tests"

   This policy was not followed. Examples include:

- Patient #18 was a 20 year old female admitted to the hospital on 3/07/18 at 7:41 PM, with a primary diagnosis of bipolar depression. Additional diagnoses included heroin abuse affecting pregnancy in third trimester and late prenatal care affecting pregnancy in third trimester.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
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<tr>
<th>(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER</th>
<th>(X2) MULTIPLE CONSTRUCTION A. BUILDING</th>
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<td>06/28/2018</td>
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<th>STREET ADDRESS, CITY, STATE, ZIP CODE</th>
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<tr>
<td>MADISON MEMORIAL HOSPITAL</td>
<td>450 EAST MAIN STREET REXBURG, ID 83440</td>
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<th>PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>Days COMPLETION DATE</th>
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<tbody>
<tr>
<td>A 396</td>
<td></td>
<td>Continued From page 4 Patient #18 left against medical advice on 3/08/18 at 8:55 PM. Her record was reviewed. Patient #18's record included a &quot;History and Physical Report&quot; dated 3/07/18 at 7:50 PM. The report stated &quot;Upon admission, patient name had a nervous breakdown. A lot of her triggers from before came up and she wanted to leave AMA [against medical advice]. Currently she is really anxious, she is upset, claustrophobic, and feels trapped. She does feel some withdrawal symptoms coming up; mostly joint pain, myalgia, fatigue and restlessness.&quot; Patient #18's record included a POC. The section of the POC titled &quot;Nursing&quot; included the plan &quot;Knowledge Deficit Plan of Care,&quot; initiated on 3/08/18 at 6:54 PM. The outcomes on the POC included ability to understand the POC and medications. Interventions included identifying barriers to learning, assessing readiness to learn, assessing understanding of her condition, and instructing on disease process. It did not state what disease process would be taught. Patient #18's nursing POC did not include a plan, outcomes, or interventions related to her pregnancy, heroin abuse, withdrawal symptoms, pain, or anxiety. During an interview on 6/28/18 at 9:20 AM, the Director of Medical/Surgical Services and the QTL reviewed Patient #18's record and confirmed her POC did not include plans to address her pregnancy, heroin abuse, withdrawal symptoms, pain, or anxiety. Patient #18's nursing care plan was incomplete. 2. Patient #29 was a 19 year old female admitted</td>
<td>A 396</td>
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1 OCM CAS 2017/22 W8 Previous Versions Obsolete Event ID: m7n08311 | Family ID: 10WQ | If continuation sheet, Page 5 of 30
A 396 Continued From page 5
to the hospital on 5/07/18 at 3:22 PM, with a primary diagnosis of pneumonia. Additional diagnoses included suicide attempt, depression, and migraine headache. She was transferred to a psychiatric hospital on 5/10/18 at 2:10 PM. Her record was reviewed.

Patient #29's record included a POC. It did not include a nursing POC. The section of the POC titled "Interdisciplinary" included the plan "Ineffective Airway Clearance," initiated on 5/08/18 at 5:57 AM. The outcomes on the POC related to maintaining her airway. There were no interventions on her POC. The POC did not include a plan, outcomes, or interventions related to Patient #29's suicidal thoughts, depression, or migraine headache.

During an interview on 6/28/18 at 9:25 AM, the Director of Medical/Surgical Services and the QTL reviewed Patient #29's record and confirmed her POC did not include plans to address her suicidal thoughts, depression, or migraine headache.

Patient #29's nursing care plan was incomplete.

3. Patient #30 was a 65 year old female who presented to the ED on 3/29/18 at 11:58 PM, and was admitted to the hospital on 3/30/18 at 1:53 PM, with a primary diagnosis of pulmonary emboli (blood clots in the lungs). Additional diagnoses included hypoxia (deficiency in the amount of oxygen reaching body tissue), respiratory distress, and nausea. Patient #30 died on 4/01/18 at 10:34 AM. Her record was reviewed.

Patient #30's orders included a hydromorphone pump which allowed her to self-administer pain management medication.
### A396

Continued From page 6

Medication intravenously. Her record included a pain assessment dated 3/31/18 at 9:00 PM. It documented left rib pain rated as a 10 on a scale of 0 to 10, with 10 being the worst pain.

Patient #30's record included a POC. The section of the POC titled "Nursing" included the plan "Activity Intolerance Plan of Care," initiated on 3/30/18 at 5:27 AM. The outcomes on the POC included increased activity tolerance. Interventions included assessing signs and symptoms of activity tolerance, providing undisturbed rest, and teaching self-monitoring, and pursed lip breathing.

Patient #30's POC did not include a plan, outcomes, or interventions related to nausea or pain.

During an interview on 6/28/18 at 9:15 AM, the Director of Medical/Surgical Services and the QTL reviewed Patient #30's record and confirmed her POC did not include plans to address her nausea or pain.

Patient #30's nursing care plan was incomplete.

4. Patient #35 was a 69 year old male admitted to the hospital on 6/24/18 at 10:27 PM, with a primary diagnosis of hypokalemia (low blood level of potassium). Additional diagnoses included abdominal pain and nausea and vomiting. He was discharged on 6/25/18 at 11:25 AM. His record was reviewed.

Patient #35's record included a Morse fall risk assessment completed on 6/25/18 at 8:03 AM. His Morse fall risk score was 45. The hospital's policy "Fall Prevention Procedure," effective
A 396 Continued From page 7

7/05/17, stated a score of 45 or greater demonstrated a high fall risk.

Patient #35's record included a POC. It did not include a nursing POC. The section of the POC titled "Interdisciplinary" included the plan "Impaired Tissue Integrity," initiated on 6/25/18 at 5:35 AM. The outcome on the POC stated "Verbalize Understanding of Condition and Causative Factors." There were no interventions on his POC. The POC did not include a plan, outcomes, or interventions related to Patient #35's pain, nausea and vomiting, or risk of falling.

During an interview on 6/28/18 at 8:40 AM, the Director of Medical/Surgical Services and the OTL reviewed Patient #35's record and confirmed his POC did not include plans to address his pain, nausea and vomiting, or risk of falling.

Patient #35's nursing care plan was incomplete.

5. Patient #39 was a 63 year old male admitted to the hospital on 6/24/18 at 4:19 PM, with a primary diagnosis of altered mental status. Additional diagnoses included DM type I and left foot pain. He was a current patient as of 6/28/18. His record was reviewed.

Patient #39's record included assessments of his risk of falling. An assessment completed on 6/24/18 at 7:12 PM, included a score of 45, indicating a high fall risk. His documented fall risk elevated to 70 on 6/25/18, and 85 on 6/26/18. Patient #39's record included a physical therapy assessment dated 6/25/18 at 4:34 PM. The assessment stated "Pt struggles with all mobility and movement. Pt requires significant assist with all transfers and gait. Pt is a fall risk." A
### A.396  Continued From page 8

Progress note dated 6/25/18 at 8:03 PM, signed by an RN, stated Patient #39 fell to the floor from his bed.

Patient #39's record included a POC. It did not include a nursing POC. The section of the POC titled "Interdisciplinary" included the plan "Knowledge Deficit...Patient [with] Cognitive or Sensory Limitation," initialed on 6/25/18 at 6:00 AM. The outcome on the POC stated "Participates in therapeutic regime." Interventions included "Barriers to Learning...Difficulty concentrating, Hearing deficit." Patient #39's POC did not include a plan, outcomes, or interventions related to his diabetes, pain, or risk of falling.

During an interview on 6/28/18 at 9:05 AM, the Director of Medical/Surgical Services and the QTL reviewed Patient #39's record and confirmed his POC did not include plans to address his diabetes, pain, or risk of falling.

Patient #39's nursing care plan was incomplete.

6. Patient #41 was a 50 year old male admitted to the hospital on 6/21/18 at 10:03 AM, with a primary diagnosis of cyclic vomiting syndrome. Additional diagnoses included left shoulder pain, dehydration, and diabetes. He was discharged on 6/27/18. His record was reviewed.

Patient #41's record included an "Adult Nutrition Initial Assessment/Plan" dated 6/21/18, signed by the Registered Dietician. It stated "Pt stated appetite poor over 5 days PTA [prior to admission], reported 12-15# Wt [weight] loss over 5 days." Under recommendations to physicians it stated Patient #41 had a high
A 396 Continued From page 9

nutrition risk.

Patient #41's record included a POC. It did not include a section titled "Nursing." The section of the POC titled "Interdisciplinary" included the plan "Ineffective Coping," initiated on 6/21/18 at 5:35 PM. The outcomes on the POC stated "Verbalize Awareness of Own Coping," "Verbalize Feelings and Meet Psychological Needs," "Assess Current Situation Accurately," and "Use Effective Coping Strategies." Interventions included "Identify Individual Stressors," "Encourage Verbalization of Fears, Anxieties," and "Provides for Gradual Implementation of Lifestyle changes." Patient #41's POC did not include a plan, outcomes, or interventions to address his vomiting, pain, or high nutrition risk.

During an interview on 6/28/18 at 8:50 AM, the Director of Medical/Surgical Services and the QTL reviewed Patient #41's record and confirmed his POC did not include plans to address his vomiting, pain, or high nutrition risk.

Patient #41's nursing care plan was incomplete.

7. Patient #45 was an 82 year old female admitted to the hospital on 4/22/18, with a diagnosis of a fall. Additional diagnoses included hyperkalemia and acute renal failure. She was discharged on 4/23/18. Her record was reviewed.

Patient #45's record included a "History and Physical" dated 4/22/18 at 10:03 AM. The report stated "The patient has had a long-term issue with renal disease. Most recently, she has had an elevation in her BUN and creatinine. She had been stopped on all renal toxic medication, and it did not improve. She has had a generalized
A 396 Continued From page 10 decline. She has recently been diagnosed with severe CHF."

Patient #45's record included a POC. The POC did not include a section titled "Nursing". The section of the POC titled "Interdisciplinary" included the plan "Risk for Injury". The POC did not include problems or interventions related to Patient #45's renal failure and CHF.

During an interview on 6/28/18 beginning at 10:58 AM, the Director of Medical/Surgical Services and the QTL reviewed Patient #45's record and confirmed her POC did not include problems or interventions related to her renal failure and CHF.

Patient #45's POC was incomplete.

8. Patient #46 was a 65 year old male admitted to the hospital on 3/15/18, with a diagnosis of ischemic necrosis of right foot. Additional diagnoses included DM and ESRD. He was discharged on 3/19/18. His record was reviewed

Patient #46's record included an undated document titled "Problems". The document included the following problems:
- Hypertension.
- Left ventricular failure (heart failure).
- DM with complications.
- Muscle weakness.

Patient #46's record included a POC. The POC did not include a section titled "Nursing". The section of the POC titled "Interdisciplinary" included the plan "Impaired Tissue Integrity". This was the only plan listed under interdisciplinary. The POC did not include a
A396 Continued From Page 11

Problems or interventions related to Patient #46's DM, heart failure, hypertension, or muscle weakness.

During an interview on 6/28/18 beginning at 10:30 AM, the Director of Medical/Surgical Services and the QTL reviewed Patient #46 POC and confirmed his POC did not include problems or interventions related to DM, heart failure, or muscle weakness. She also stated it is the expectation that these issues would be addressed on Patient #46's POC.

Patient #46's POC was incomplete.

Patient #19 was a 67 year old female admitted to the hospital on 5/27/18, with diagnoses of hypoxia and dehydration. She was discharged on 5/28/18. Her record was reviewed.

Patient #19's record included a "History and Physical Reports" dated 5/27/18 at 12:54 AM. The report listed the following problems under the section titled "Assessment/Plan":

- Acute kidney injury
- Hypotension
- Encephalopathy acute
- Respiratory failure acute
- Chronic Pain

Patient #19's record included a POC. The POC did not include a section titled "Nursing". The POC did not include a problems or interventions related to Patient #19's acute kidney injury, hypotension, encephalopathy, respiratory failure, or chronic pain.

During an interview on 6/28/18 beginning at 11:05
AM, the Director of Medical/Surgical Services and the QTL reviewed Patient #19's record and confirmed her POC did not include problems or interventions related to her acute kidney injury, hypotension, encephalopathy, respiratory failure, or chronic pain.

Patient #19's POC was incomplete.

10. Patient #47 was an 86-year-old female admitted to the hospital on 6/27/18, with a diagnosis of CVA. Additional diagnoses included hypertensive urgency and speech impairment. She was a current inpatient at the time of survey.

Patient #47's medical record included a history and physical, dated 6/27/18, signed by the physician, which included the secondary diagnosis of "hypertensive urgency and speech impairment."

Patient #47's medical record included a nursing POC, dated 6/27/18, signed by an RN. The POC included the identified issue "Impaired Communication." The POC did not address Patient #47's hypertensive urgency and speech impairment.

The MS/ICU Clinical Coordinator was interviewed on 6/28/18, beginning at 2:45 PM, and Patient #47's medical record was reviewed in her presence. She confirmed Patient #47's nursing POC did not address her hypertensive urgency and speech impairment.

Patient #47's nursing POC was incomplete.

A non-employee licensed nurses who are working...
In the hospital must adhere to the policies and procedures of the hospital. The director of nursing service must provide for the adequate supervision and evaluation of the clinical activities of non-employee nursing personnel which occur within the responsibility of the nursing services.

This STANDARD is not met as evidenced by:

Based on contract review and staff interview, it was determined the hospital failed to ensure supervision and evaluation of non-employee hemodialysis nursing personnel. This had the potential for poor patient outcomes due to lack of contracted personnel oversight. Findings include:

A hospital contract "ACUTE DIALYSIS SERVICES AGREEMENT," dated 9/2012, stated "All Dialysis Center staff providing Services at the Hospital shall comply with all applicable infection control policies, quality assurance programs and other policies and programs which have been provided to the Dialysis Center in writing." This contract was not followed.

The Director of MS/ICU was interviewed on 6/27/18, beginning at 7:49 AM. When asked who supervised and evaluated non-employee hemodialysis nursing personnel, she stated she was unsure. The Director of MS/ICU confirmed there was no active oversight of contracted hemodialysis nursing personnel.

The Director of Quality Improvement was interviewed on 6/28/18, beginning at 2:35 PM, and the hemodialysis contract was reviewed in her presence. When asked what hospital policies, quality assurance programs, or programs were provided to the contracted hemodialysis nursing employees, she stated she
### Statement of Deficiencies and Plan of Correction

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<td>MADISON MEMORIAL HOSPITAL</td>
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#### 10 Prefix TAQ

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<tr>
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#### A398

Continued From page 14

was unsure. When asked if the CNO supervised and evaluated contracted hemodialysis nursing personnel, the Director of Quality Improvement stated no and confirmed there was no active oversight.

Non-employee hemodialysis nursing personnel were not supervised or evaluated.

#### A724

A724

Physical Therapy staff did an audit of their supplies on 6/29/18 and pulled all outdated supplies. It was found that the supplies that were moved during construction had not been in the rotation for use so some of them had outdated. The new storage area that was created as part of the construction did not have outdated supplies. An audit of physical therapy supplies was conducted on 8/6/18, by the Risk Manager. Future outdated supply audits have been set up for once a month by to insure that no items will out date for the following year.

- 1 package of Curity iodaform - expired 12/2016
- 3 packages of steri-strips - expired 9/2016
- 1 package of Replicare Thin - expired 5/2016
### Summary Statement of Deficiencies

**A724** Continued From page 15

- 1 box of Acticoat - expired 9/2017
- 1 box of Acticoat - expired 4/2015
- 1 box of Acticoat - expired 10/2017
- 1 box of Tegaderm - expired 2/2018
- 1 box of Tegaderm - expired 10/2017
- 2 boxes of Tegaderm - expired 9/2016
- 1 box of Tegaderm - expired 11/2013
- 1 package of Tegaderm - expired 2/2018
- 5 packages of Xeroform gauze - expired 6/2016
- 1 package of Fibracol Plus - expired 5/2014
- 1 box of Mepitel - expired 9/2017

The Director of Therapy Services was interviewed on 6/28/18, beginning at 11:05 AM. When asked who was responsible for ensuring wound care supplies were not outdated, he stated "all employees, but primarily [name], PTA." When asked if he provided oversight to ensure expired wound care supplies were not available for patient use, he confirmed he did not and acknowledged there was no formal process in place.

The quality and safety of the outpatient therapy services department's wound care supplies were not ensured.

### Infection Control Program

**A749**

1. On July 2, 2018, the Executive Director of Ancillary Services, conducted training with all Environmental Services Techs to clean the top of infant warmers/beds, pt room headboards, pt room shelving, hanging pictures, clocks, Omnicell, ice machine and any surface that might collect dust.

The Environmental Services Lead Supervisor added, to the already established, spot check of every shift and every day random room checks to check all surfaces. Dust wands and stepstools were purchased on 8/6/18 in order to facilitate above the head cleaning.
hospital policy review, and staff interview, it was determined the hospital failed to ensure the Infection Control Officer developed a system for identifying potential infections for patients and personnel. This had the potential for inadequate interventions to mitigate environmental and surgical infection control issues. Findings include:

The hospital failed to ensure environmental and surgical infection control issues were identified and addressed. Examples include:

1. Hospital sanitary conditions for patients, visitors, and staff were not maintained.
   a. A tour of the NICU was conducted with the CNO and NICU charge nurse on 6/28/18, beginning at 9:05 AM. During the tour, the following infection control issues were noted:
      i. A thick layer of dust was noted on shelving directly above multiple infant warmers/beds and the blanket warmer.
      ii. A refrigerator, used to store breast milk, was noted to have accumulation of debris inside the grooves of the gasket and shelves. The NICU charge nurse was interviewed on 6/28/18, beginning at 9:05 AM and when asked whose responsibility to clean the refrigerator, she stated she did not know.
      iii. A hospital policy "Infection Control - Neonatal Intensive Care Unit (NICU);" effective date 11/10/17, stated "All NICU isolettes/Omnibeds/open warmers shall be cleaned and disinfected before any new infants are admitted according to the

ii. On 7/16/18, two new refrigerators were purchased for the Medical & Surgical unit. On 8/6/18, the Executive Director of Ancillary Services, added cleaning all patient fridges to the cleaning responsibilities of the Dietary Aid's. Each day, when they restock the food supplies in each fridge, they have been taught to wipe down the inside and outside of each refrigerator. The NICU and MBU nurses have been reminded, on July 2, 2018, by the Director of Perinatal Services, of their responsibility to daily wipe out the breast milk fridge. On July 2, 2018, the CNO, also communicated to all nursing directors that it is their responsibility to ensure that each fridge is regularly checked for cleanliness. On July 7, 2018, a nursing staff communication e-mail was sent stating the CNA's are to assist with ensuring the refrigerators are deeply cleaned weekly. The nursing directors have assigned a weekly check of the fridges to the night shift staff.
A 749 Continued From page 17

department/manufacturer protocol and direction." This policy was not followed.

A container of concentrated Virex II 256 [a chemical disinfectant] was noted at the NICU nurses station. The manufacturers' instruction for use for the Virex II 256 stated "for use on hard, non-porous surfaces" and "minimum contact time of 10 minutes."

Two spray bottles of Virex II 256 were noted at the nurses station. The spray bottles were partially filled, with no date indicating when they were mixed. The NICU charge nurse was interviewed on 6/28/18, beginning at 9:15 AM. When asked what the Virex II 256 was used for, she stated it was for saturating the infant warmers/beds and mattresses (a porous surface) following patient discharge and PRN. The NICU charge nurse stated she would saturate the inside of the warmer and mattress with Virex II 256 and let the chemical stand for 8 minutes prior to wiping it off.

The CNO was interviewed on 6/28/18, beginning at 9:20 AM. He confirmed the presence of thick dust in the NICU, the soiled condition of the NICU breast milk storage refrigerator, and the use of Virex II 256 that did not follow the manufacturers' instruction for use.

The NICU failed to ensure environmental infection control issues were identified and addressed.

b. A tour of the MBU was conducted with the CNO on 6/28/18, beginning at 8:37 AM. During the tour, the following infection control issues were noted:

iii. Upon further investigation with the Isolette/Omnibed/open warmer manufacturer it was discovered that these bed mattresses are non-porous and the use of Virex II 256 is an approved chemical for appropriately cleaning them. It was also discovered that the nurses are not the ones who clean these patient beds. The Environmental Service Techs, who conduct this cleaning, were instructed on 8/6/18 of the importance of dating any container with the date it was mixed.

iv. A statement was added to the already existing "Infection Prevention Program - General" policy on 8/8/18 for how to disinfect the electronic tablets used by patients. We have designated a "clean cupboard" where once these electronic tablets have been appropriately sanitized they will be stored.

v. An interview with the "Floor Techs" confirmed that the carpet in the physical therapy department is on a standing
A 749 Continued From page 18

i. A thick layer of dust was noted to all horizontal surfaces above approximately 6 feet in height, including:

- patient room headboards
- patient room and unit shelving
- hanging pictures
- clocks
- medication Omnicell (medication dispensing device)
- ice machine

ii. The unit patient/visitor refrigerator was noted to have accumulated debris inside the grooves of the gasket. Additionally, the gasket was torn and in disrepair. The refrigerator shelves were noted to be stained and had accumulated debris as well. The MBU QTL was interviewed on 6/28/18, beginning at 8:46 AM. When asked whose responsibility it was to clean the refrigerator, she stated she did not know.

The CNO was interviewed on 6/28/18, beginning at 9:21 AM. He confirmed the lack of dust control on the unit and the disrepair and lack of cleanliness of the patient/visitor refrigerator.

The MBU failed to ensure environmental infection control issues were identified and addressed.

c. A tour of the MS/ICU was conducted with the MS/ICU Clinical Coordinator on 6/27/18, beginning at 1:30 PM. A thick layer of dust was noted to all horizontal surfaces above approximately 6 feet in height, including:

- refrigerators
- patient room and unit shelving

vi. On 8/9/18, our infection preventionist, visited with the chair manufacture, couch manufacture, and the curtain manufacture to get the recommended specification for how to appropriately clean each of these items. Training was conducted on 8/10/18 by the infection preventionist with our environmental service techs on this process. The infection control cleaning policy was updated on 8/10/18.

vii. On 8/10/18, the ice machine plastic shrouds have been replaced with new ones and the 2 ice machines on the Medical/Surgical unit have been replaced. On 8/10/18, the...
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<td>A749</td>
<td></td>
<td>MADISON MEMORIAL HOSPITAL</td>
<td>450 East Main Street, Rexburg, ID 83440</td>
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**Summary Statement of Deficiency**

The MS/ICU Clinical Coordinator was interviewed on 6/27/18, beginning at 2:10 PM. She confirmed the lack of dust control on the unit.

The MS/ICU failed to ensure environmental infection control issues were identified and addressed.

d. A tour of the outpatient infusion center was conducted with the Director of Infusion Services on 6/28/18, beginning at 9:45 AM. During the tour, the following infection control issues were noted:

i. The unit patient/visitor refrigerator was noted to have accumulated debris inside the grooves of the gasket. The refrigerator shelves were noted to be stained and had accumulated debris. The Director of Infusion Services confirmed the refrigerator needed to be cleaned.

ii. The Director of Infusion Services stated patients in the outpatient unit could use hospital-provided electronic tablets to watch television and/or movies. When asked how these tablets were disinfected between patients, she stated they were cleaned with wipes. A stack of approximately 10 electronic tablets were noted in a cabinet, but it could not be determined which were clean and which were dirty. When asked if there was a policy or procedure which governed how these tablets were disinfected between patients, the Director of Infusion Services stated no.

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**Provider's Plan of Correction**

Engineering Manager, added the cleaning of the ice machines as a preventative maintenance for the engineering staff to perform a 90 day internal deep clean and the Executive Director of Ancillary Services has added a daily cleaning of the outside of the ice machines to the environmental service techs. daily cleaning tasks.

viii. On 8/3/18, Steris conducted a 4 hour onsite training with the surgical techs and nursing staff on the current appropriate procedures to follow when sterilizing equipment. Through this training, it was discovered that there was confusion about whether we "flash" sterilize or not. Upon further investigation, the process we have been following is not "flash" sterilizing, which during the survey was communicated. The process we use for sterilization at the Surgery Center has been integrated into the same process we use at the hospital.
A 749

Continued From page 20

The outpatient infusion center failed to ensure environmental infection control issues were identified and addressed.

e. A tour of the outpatient therapy department was conducted with the Director of Therapy Services and an EVS intern on 6/28/18, beginning at 10:35 AM. The unit consisted of several rooms and narrow hallways with a large, open therapy suite containing multiple pieces of therapy equipment. The unit had a large therapy pool and a room where wound care/debridement was performed, both adjacent to the therapy suite. The common areas and therapy suite were covered by carpet. When asked how the carpet in the unit was cleaned, the EVS intern stated he was unsure. A record of carpet maintenance for the unit was requested, but not provided by the end of the survey.

The outpatient therapy department failed to ensure environmental infection control issues were identified and addressed.

f. A hospital tour was conducted with the MS/ICU Clinical Coordinator, Director of MS/ICU, Executive Director of Ancillary Services, and EVS Supervisor on 6/27/18, beginning at 2:45 PM. During the tour, the following infection control issues were noted:

i. Numerous cloth chairs, couches, and patient-privacy curtains were noted throughout the hospital in patient rooms and exam rooms. When asked how these cloth items were disinfected, the EVS Supervisor stated they were sprayed with Virex II 256 and allowed to dry.

ix. On 7/6/18, a formal communication was sent out reminding staff covered drinks may be permitted at the nursing desk, but food is not to be kept at or eaten at the nurses desk. On 8/8/18, the sections of the The Infection Control - Neonatal Intensive Care Unit, Infection Control - LDR & MBU, and Infection Control - Med/Surg/ICU policies dealing with food and drinks at the nursing stations has been clarified and combined into the facility-wide "Infection Prevention Program - General" policy to include that no food is to be eaten or stored at the nurses station. Drinks may be permitted only if they are covered. On 8/10/18, this policy was sent for all clinical staff required read. We also sent a formal communication out to our staff on 8/10/18.
A 749 Continued From page 21
Virex II 256 manufacturer's instruction for use stated it was to be used on "hard, non-porous surfaces" with a "minimum contact time of 10 minutes."

The EVS Supervisor, during the tour, confirmed the cloth items were not being disinfected with Virex II 256 according to manufacturers' instructions for use.

ii. Numerous ice machines were noted in multiple departments throughout the hospital. All ice machines observed had a buildup of minerals, discoloration, and debris noted to their ice dispensing plastic shrouds. It was unclear if the ice machines were sanitary for patient/visitor use.

The Director of Engineering Services and EVS Manager were interviewed together on 6/27/18, beginning at 2:45 PM. The Director of Engineering Services stated the ice machines underwent routine maintenance every 90 days, but confirmed they were "not cleaned as much as should be." Documentation of the ice machines cleaning schedule was requested from the EVS Manager, but was not provided by the end of the survey.

The hospital failed to ensure environmental infection control issues were identified and addressed.

2. Outpatient surgical center instrumentation sterilization was not maintained.

"AORN Guidelines for Perioperative Practice," 2015 edition, stated "Recommendation VII - Immediate use steam sterilization (IUSS) should be kept to a minimum and should be used only in
A 749 Continued From page 22

selected clinical situations and in a controlled manner. Immediate use steam sterilization should not be used as a substitute for sufficient instrument inventory. Sterilizer manufacturers’ written instructions should be followed and reconciled with packaging and device manufacturers’ instructions for sterilization.” This guideline was not followed.

The May 2018 IUSS log for surgical instrumentation was reviewed. The log documented IUSS of surgical equipment on the following days:

- 5/01/18: 5 times
- 5/03/18: 3 times
- 5/08/18: 5 times
- 5/09/18: 1 time
- 5/10/18: 1 time
- 5/15/18: 5 times
- 5/21/18: 4 times
- 5/23/18: 4 times

The Surgical Center Manager was interviewed on 6/26/18, beginning at 8:40 AM, and the IUSS log was reviewed in her presence. She stated the surgery center used IUSS “daily for time saving.” When asked what nationally recognized guidelines the surgery center followed for surgical procedures and instrumentation sterilization, she stated “AAMI and AORN.” The Surgical Center Manager stated IUSS was mainly used for a specific physician’s “surgical eye trays.” When asked who made the decision to utilize IUSS for physician convenience, she stated her supervisor; the Director of Ambulatory Care Services.

The following devices, and their manufacturers’
A 749

continued from page 23

Instructions for use regarding IUSS, were identified as part of the surgical eye trays:

- Ambler ophthalmic capsule polishers, ophthalmic forceps, ophthalmic manipulators, choppers, and hooks, cannulas, and ophthalmic gauges and corneal markers - "Immediate use steam sterilization (IUSS) should only be used for emergency reprocessing and should not be used for routine sterilization processing of instruments."

- Katena Reusable Ophthalmic Instruments - "Do not use flash [IUSS] sterilization to save time or as a substitute for standard instrument reprocessing. Flash sterilization cycling is designed to manage unanticipated, urgent needs for instruments."

A CST was interviewed on 6/26/18, beginning at 10:35 AM. She stated the surgery center had "2 sets of instruments for eyes, but could perform up to 15 eye procedures per day requiring these trays." When asked how these 2 trays were sterilized to accommodate the high number of procedures, the CST stated they were "flashed." When asked the reason these 2 trays underwent IUSS, she stated "used for cutting down drying time for cases and for physician convenience."

The Director of Quality Improvement was interviewed on 6/27/18, beginning at 9:00 AM, and the outpatient surgery center IUSS log was...
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES  

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  

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NAME OF PROVIDER OR SUPPLIER  
MADISON MEMORIAL HOSPITAL  

STREET ADDRESS, CITY, STATE, ZIP CODE  
450 EAST MAIN STREET  
REXBURG, ID 83440  

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<td>Reviewed in her presence. When asked for a policy which governed the hospital's use of IUSS, she stated &quot;we don't flush here.&quot; The Director of Quality Improvement stated she was surprised the outpatient surgery center utilized IUSS for physician convenience.</td>
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The Director of Ambulatory Care Services was interviewed on 6/27/18, beginning at 10:15 AM. When asked why IUSS was used for physician convenience at the outpatient surgery center, she stated additional surgical eye trays were needed.

The Director of Ambulatory Care Services stated the hospital identified this issue in January 2018. When asked if the issue was identified 6 months ago, why the IUSS was still occurring, she stated it was due to an issue with the surgical eye tray purchasing contracts. When asked who was responsible for the surgical eye tray purchasing contracts, the Director of Ambulatory Care Services stated "the Director of Materials Management."

The Director of Materials Management was interviewed on 6/27/18, beginning at 11:50 AM. When asked if he was responsible for the surgical eye tray purchasing contracts, he stated no. The Director of Materials Management stated he was unaware of any issues with surgical eye trays and had no knowledge he had been tasked with acquiring new ones. He stated he was unsure if the CFO was aware of this issue or if any purchase requests had been sent to him.

The CFO was interviewed on 6/28/18, beginning at 2:41 PM. He stated he was unaware of any request or need for additional surgical eye trays. The CFO stated he would look into the matter and order new trays immediately if warranted.
continued from page 25

The outpatient surgery center did not follow nationally recognized guidelines and manufacturers’ instruction for use regarding surgical instrumentation sterilization.

3. Staff food and/or drinks were present in patient care areas.

   a. A hospital policy "Infection Control - Neonatal Intensive Care Unit (NICU)," effective date 11/10/17, stated "Food is not allowed in the NICU area...Drinks should not be at the infant’s bedside or in view of patient or visitors."

   A tour of the NICU was conducted with the CNO on 6/28/18, beginning at 8:37 AM. During the tour, 2 staff drinks without lids and 1 partially eaten pastry were noted at the nurses station. These food items were in view of patients/visitors.

   b. A hospital policy "Infection Control - Med/Surg/ICU," effective date 9/12/17, stated "Drinks with lids are allowed only when personnel are unable to take a break but must be kept in drawers or under the counter."

   A tour of the MS/ICU was conducted with the MS/ICU Clinical Coordinator on 6/27/18, beginning at 1:30 PM. During the tour, 3 staff drinks without lids were noted at the nurses station.

   c. A hospital policy "Infection Control - LDR & MBU," effective date 4/26/18, stated "Drinks with lids are allowed only when personnel are unable to take a break but must be kept in drawers or under the counter."
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<th>PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (INCLUDING EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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<tr>
<td>A749</td>
<td>Continued From page 26</td>
<td>A tour of the LDR &amp; MBU was conducted with the CNO on 6/28/18, beginning at 9:21 AM. During the tour, 1 staff drink without a lid was noted at the nurses station. The CNO was interviewed on 6/28/18, beginning at 9:21 AM. He confirmed staff food and/or drinks should not be present in patient care areas. Hospital staff failed to ensure personal food and/or drinks were not present in patient care areas.</td>
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<tr>
<td>A1077</td>
<td>INTEGRATION OF OUTPATIENT SERVICES</td>
<td>CFR(s): 482.54(a) Outpatient services must be appropriately organized and integrated with inpatient services. This STANDARD is not met as evidenced by: Based on hospital organizational chart review, surgical services meeting minutes review, and staff interview, it was determined the outpatient surgical center was not appropriately organized and integrated with inpatient surgical services. This had the potential for hospital employee confusion and impaired continuity of patient care. Findings include: The hospital organizational chart, dated January 2018, listed the following on its chain-of-command:  - &quot;Ambulatory Care Services&quot; provided oversight to &quot;Visiting Specialties,&quot; &quot;[name] Clinic,&quot; and &quot;Infusion Therapy.&quot; - &quot;Surgical Services&quot; provided oversight to</td>
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A1077 On July 30, 2018, the Surgery Center Manager began reporting to the CNO vs. to the Director of Ambulatory Care Services in order to provide clinical oversight. This is reflected on the organizational chart.
### Statement of Deficiencies and Plan of Correction

**Provider/Supplier Identification Number:** 130025  
**Multiple Construction:** A. Building  
**Date Survey Completed:** 06/28/2018

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### MADISON MEMORIAL HOSPITAL

**Name of Provider or Supplier:** MADISON MEMORIAL HOSPITAL  
**Street Address, City, State, Zip Code:** 450 East Main Street, Rexburg, ID 83440

This organizational chart was not accurate.

The Surgical Center Manager, who was directly in charge of the hospital's outpatient surgical center, was interviewed on 6/26/18, beginning at 8:40 AM. She stated she did not have a clinical background and would rely on her charge nurses for clinical issues. The Surgical Center Manager stated the outpatient surgical center and inpatient surgical services were not integrated. She stated staff meetings between the two departments were separate and employees of the 2 departments rarely covered shifts between each other. Additionally, the Surgical Center Manager stated the outpatient surgical center and inpatient surgical services utilized 2 different sets of policies to drive their practice. She stated the hospital was in the process of merging the 2 policy sets into a single, cohesive reference. When asked who she reported to, the Surgical Center Manager stated "[name]. Director of Outpatient Services." When asked if the Director of Outpatient Services was clinical, she stated no.

The Director of Surgical Services was interviewed on 6/27/18, beginning at 6:45 AM. When asked what her role was in regard to the outpatient surgical center, she stated none. The Director of Surgical Services stated she dealt exclusively with inpatients, not outpatients. She stated the outpatient surgical center "had no oversight" and the nurses who practiced there had to rely on each other for assistance. The Director of Surgical Services stated it was an area of concern that the Director of Outpatient Services was not clinical, the manager below her was not.
### Statement of Deficiencies and Plan of Correction

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**Name of Provider or Supplier:**

**Madison Memorial Hospital**

**Street Address, City, State, Zip Code:**

450 East Main Street

Rexburg, ID 83440

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**Clinical, and her supervisor, the CFO, was not clinical. The Director of Surgical Services voiced frustration regarding lack of inclusiveness between the outpatient surgical center and inpatient surgical services.**

The inpatient surgical services supervising CST was interviewed on 6/27/18, beginning at 7:06 AM. She stated inpatient surgical services had been trying to get their CSTs to train the outpatient surgical center CSTs since January 2018. When asked why, the supervising CST stated the outpatient surgical center CSTs believed "they don't have to follow guidelines since they're a freestanding ASC." She confirmed the outpatient surgical center and inpatient surgical services used 2 different sets of policies which was confusing to staff.

Surgical Services meeting minutes, dated March 2018, stated "Here and the surgery center. When someone is asked to go to the surgery center to work, remember their process flow is a little different. Be sure to over communicate and get clarification of their expectations. It is being reported that we don't clean, wash instruments and move fast enough. [Director of Surgical Services] has requested from [Surgical Center Manager] that she allow some brief orientation time to follow [CST name] or [CST name] to better understand the process. Let's not have a turf war. With some communication and orientation we will all be on track."

The Director of Ambulatory Care Services was interviewed on 6/27/18, beginning at 10:15 AM. When asked if she went by the title "Director of Outpatient Services," she stated no. The Director of Ambulatory Care Services stated she, not the...
Director of Surgical Services, was over the outpatient surgical center. When asked if she had a clinical background, she stated no. When asked who the outpatient surgical center nurses would turn to for clinical questions, she stated the charge nurses or CNO. The Director of Ambulatory Care Services confirmed the hospital's organizational chart was not accurate. She stated the hospital was attempting to hire a clinical staff member to oversee both the outpatient surgical center and inpatient surgical services, but confirmed that had not yet happened.

The hospital's outpatient surgical center was not integrated with inpatient surgical services.
The hospital is a three (3) story protected, Type II (222) structure that was originally constructed in 1978. The facility has completed several additions/renovations, most recently in 2008. The building is protected throughout by an automatic fire extinguishing system with an integrated fire alarm and smoke detection system. There are multiple exits to grade on the first floor and eight (8) remotely located protected stairwells. The facility is located in a municipal fire district with both county and state EMS support services available. Emergency power is provided by an on-site diesel powered, Emergency Power Supply System (EPSS) generator. The facility is currently licensed for 69 hospital beds.

The facility includes an off-site Surgery Center of Type V(111) construction. The center includes two (2) operating rooms and is one-hour separated from an attached doctor's office. It is fully sprinklered and protected throughout with an interconnected fire alarm/smoke detection system. Emergency power is provided by an on-site diesel powered, EPSS generator.

The following deficiencies were cited during the validation survey conducted in accordance with 42 CFR 488.7 (b) from June 25, 2018 to June 28, 2018. The facility was surveyed under the Life Safety Code, 2012 Edition, Existing Health Care Occupancy and the Emergency Preparedness Rule as adopted by CMS.

The survey was conducted by:
Sam Burbank
Health Facility Surveyor
### Continued From page 1

**Facility Fire Safety & Construction Plan Based on All Hazards Risk Assessment**

CFR(s): 482.15(a)(1)-(2)

1. **Emergency Plan**: The facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:

   1. Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.*

   * [For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents.

   * [For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients.

   2. Include strategies for addressing emergency events identified by the risk assessment.

   * [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice’s ability to provide care.

This STANDARD is not met as evidenced by:

Based on record review and interview, it was determined the facility failed to develop an Emergency Preparedness program that included a relevant facility based and community based...
### Summary of Deficiencies

**E006** Continued From page 2  
Risk assessment. Failure to provide a risk assessment which includes relevant community hazards, has the potential to focus staff training and resources on hazards that are not site specific. This deficient practice affected patients, staff and visitors on the date(s) of the survey.

Findings include:

1. **On 6/25/18 from 2:30 - 3:30 PM**, review of the provided emergency plan, policies and procedures, revealed the facility HVA (Hazard Vulnerability Analysis) failed to include geographically relevant information for both Tornadoes and Volcanoes. Further review of the nearest county all-hazard mitigation plan and the state EMS provided hazard analysis, revealed both assessments considered Tornadoes and Volcanoes as a geographically relevant hazards for the area.

2. **On 6/26/18 from 2:00 - 2:30 PM**, interview of 3 of 3 staff members identified a potential risk of both Tornadoes and Volcanic activity as relevant to the facility's geographic location and its potential for disasters.

**Reference:**  
42 CFR 482.15 (a) (1) - (2)

**Development of EP Policies and Procedures**

(cfR(s): 482.15(b)

(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**IDENTIFICATION NUMBER:**

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<th>[X] PROVIDER/SUPPLIER/CUA</th>
<th>[X] MULTIPLE CONSTRUCTION</th>
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**STREET ADDRESS, CITY, STATE, ZIP CODE**

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<tr>
<th>NAME OF PROVIDER OR SUPPLIER</th>
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<tbody>
<tr>
<td>MADISON MEMORIAL HOSPITAL</td>
<td>450 EAST MAIN STREET REXBURG, ID 83440</td>
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**ID PREFIX TAG**

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<td>(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE EFFICIENCY)</td>
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**SUMMARY STATEMENT OF DEFICIENCIES**

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**DATE SURVEY COMPLETED**

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<td>06/28/2018</td>
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**E013**

Continued From page 3

**E013**

On 7/6/18, the Emergency Management Plan was updated to include the risk of volcanoes as a risk in our service area. We have adopted as part of our Emergency Management Plan an all hazards approach and we refer to our HVA to identify each year what "high" risk areas we should focus on.
E 013 Continued From page 4

based on the Emergency Plan, that aligned with a facility and community based risk assessment. Development of policies and procedures which are not aligned with the HVA, fails to provide identified hazards and confusion of training to identified risks. This deficient practice potentially affected patients, staff and visitors on the date(s) of the survey.

Findings include:

On 6/26/18 from 10:00 AM - 12:00 PM, review of provided policies and procedures revealed procedures contained in the plan for the risk of a Tornado, but the HVA failed to identify this as a potential risk. Further evaluation of the nearest county all-hazard mitigation plan also found consideration of Volcanoes as a risk to the area, but not identified in the HVA or the policies and procedures.

Reference:
42 CFR 482.15 (b)

Additional Reference:
E - 0006

E 018
Procedures for Tracking of Staff and Patients

[(b) Policies and procedures. The facilities must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

#### (X1) PROVIDER/SUPPLIER/LOCATION IDENTIFICATION NUMBER

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#### (X2) MULTIPLE CONSTRUCTION

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### NAME OF PROVIDER OR SUPPLIER

**MADISON MEMORIAL HOSPITAL**

<table>
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#### (X4) ID PREFIX TAG

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<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
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<tbody>
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<td>(FACILITY DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSS IDENTIFYING INFORMATION)</td>
<td>PROVIDER'S PLAN OF CORRECTION (FACILITY CORRECTIVE ACTION SHOULD REFER TO THE APPROPRIATE DEFICIENCY)</td>
</tr>
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</table>

#### E018 Continued From page 5

address the following:

(2) A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location.

*For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IID at §483.475(b), PACE at §460.84(b):*

Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location.

*For PRTF's at §441.184(b), LTC at §483.73(b), ICF/IID at §483.475(b), PACE at §460.84(b):*

Policies and procedures.

- (i) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance.

- (v) A system to track the location of hospice employees on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location.

*For CMHCs at §485.920(b):*

Policies and procedures. (v) A system to track the location of hospice employees on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location.

On 8/9/18, our Emergency/Disaster Director, Facilities Manager, and Risk Manager met and identified that we can track on-duty staff using our JBDEV staffing program. Patients are tracked using our Cerner software. We also incorporated the HICS 252 form as a downtime form to track on-duty staff. We have the HICS 253 form we can use to track volunteers that are on-duty. We have the HICS 254 form we can use for downtime to track patients. We have the HICS 260 form we can use in the event of an evacuation. We have reference these documents in our Emergency Management Plan (we call it our Disaster Plan) and where to find them. We also outlined in our...
E 018  Continued From page 6

procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.

"[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records.

"[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients.

This STANDARD is not met as evidenced by:

Based on record review, it was determined the facility failed to provide a policy for tracking of staff and sheltered residents during an emergency. Lack of a tracking policy for sheltered staff and patients has the potential to hinder continuity of care and essential services during an emergency. This deficient practice has the potential to affect the patients, staff and visitors in the facility on the date(s) of the survey.

Findings include:

On 6/25/18 from 8:30 - 10:30 AM, review of provided emergency plan, policies and procedures, failed to demonstrate the facility had in place a system to track the location of on-duty staff and patients sheltered in the facility during an emergency.

Emergency Management Plan if we have an need for patient over flow, we can use the Day Surgery area, the Infusion Therapy area, and the MBU2 area to see and treat patients. We have an unfinished shell space that can be used to house staff that are unable to leave the facility in the event of an emergency activation. We also own 8 homes that if they are vacant can also be used for staff lodging.
<table>
<thead>
<tr>
<th>E 018</th>
<th>Continued From page 7</th>
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<tbody>
<tr>
<td>Reference:</td>
<td>42 CFR 482.15(b)(2)</td>
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</table>

E 022 Policies/Procedures for Sheltering in Place

- CFR(s): 482.15(b)(4)

[(4) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:]

- (4) A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. ([4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility].

* [For Inpatient Hospices at §418.113(b)] Policies and procedures

- (5) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following:

  - (1) A means to shelter in place for patients, hospice employees who remain in the hospice. This STANDARD is not met as evidenced by:

    - Based on record review, it was determined the facility failed to provide a policy, procedure or plan for sheltering in place. Failure to provide a plan for sheltering in place has the potential to leave patients and staff without resources for providing continuity of care during an emergency. This deficient practice affected patients, staff and...
E 022 Continued From page 8
visitors on the date(s) of the survey.

Findings include:

On 6/26/18 from 8:30 - 10:00 AM, review of
provided emergency plan, policies and
procedures, failed to reveal information contained
in the documentation for sheltering in place.

Reference:
42 CFR 482.15 (b) (4)

E 026 Roles Under a Waiver Declared by Secretary

(8) [(6), (6)(C)(iv), (7), or (9)] The role of the
facility under a waiver declared by the Secretary,
in accordance with section 1135 of the Act, in the
provision of care and treatment at an alternate
care site identified by emergency management
officials.

"[For RINHGs at §403.748(b)] Policies and
procedures. (8) The role of the RINHI under a
waiver declared by the Secretary, in accordance
with section 1135 of Act, in the provision of care
at an alternative care site identified by emergency
management officials.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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<th>NAME OF PROVIDER OR SUPPLIER</th>
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<tr>
<td>MADISON MEMORIAL HOSPITAL</td>
<td>450 EAST MAIN STREET, REXBURG, ID 83440</td>
</tr>
</tbody>
</table>

### E 026
Continued From page 9

This STANDARD is not met as evidenced by:

Based on record review, it was determined the facility failed to document their role under an 1135 waiver as declared by the Secretary and the provisions of care as required under this action if identified by emergency management officials. Failure to plan for alternate means of care and the role under an 1135 waiver has the potential to limit facility options during an emergency. This deficient practice potentially affects reimbursement and continuity of care for the patients, staff and visitors housed on the date(s) of the survey along with the available surge needs of the community during a disaster.

Findings include:

On 6/28/18 from 8:30 AM - 12:00 PM, review of the provided emergency plan, policies and procedures, did not demonstrate the role of the facility under the declaration of an 1135 waiver, should that condition be enacted by the Secretary.

Reference:

42 CFR 482.15 (b) (8)

### E 036

EP Training and Testing

CFR(s): 482.15(d)

(d) Training and testing. The (facility) must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must

On 8/9/18, we created the "Request to Operate Under a CMS 1135 Waiver Procedure (Disaster Plan)" to outline the role of Madison Memorial Hospital under the 1135 waiver requirement.
E 036 Continued From page 10
be reviewed and updated at least annually.

*For ICF/IID at §483.475(d):] Training and
testing. The ICF/IID must develop and maintain
an emergency preparedness training and testing
program that is based on the emergency plan set
forth in paragraph (a) of this section, risk
assessment at paragraph (a)(1) of this section,
policies and procedures at paragraph (b) of this
section, and the communication plan at
paragraph (c) of this section. The training and
testing program must be reviewed and updated at
least annually. The ICF/IID must meet the
requirements for evacuation drills and training at
§483.470(h).

*[For ESRD Facilities at §494.62(d):] Training,
testing, and orientation. The dialysis facility must
develop and maintain an emergency
preparedness training, testing and patient
orientation program that is based on the
emergency plan set forth in paragraph (a) of this
section, risk assessment at paragraph (a)(1) of
this section, policies and procedures at paragraph
(b) of this section, and the communication plan at
paragraph (c) of this section. The training, testing
and orientation program must be reviewed and
updated at least annually.

This STANDARD is not met as evidenced by:
Based on record review, it was determined the
facility failed to provide current emergency prep
training and testing program. Lack of an
emergency training and testing program on the
emergency preparedness plan and policies for
the facility, has the potential to hinder staff
response during a disaster. This deficient practice
affected all patients, staff and visitors on the
data(s) of the survey.

E 036 7/19/18 Our Disaster Plan
(Emergency Management Plan)
was sent out to all staff for
required read. All hospital
personnel will be oriented when
they are hired on their specific
roles and responsibilities in a
disaster during new employee
orientation. A emergency
management course has been
added to every employee's
computer learning system
assignment. They have also been
assigned a review of the HVA to
help prepare for identified Risks
and Hazards. Administration,
Public Relations Specialist, Safety
Officer, Education Manager are
required to take the following
NIMS Courses: IS-100 HC -
Introduction to the Incident
Command System for
Healthcare/Hospitals,
IS-200 HC - Applying ICS to
Healthcare Organizations, and
IS-700 A - National Incident
Management System (NIMS).
Department directors and
managers are required to take:
IS-100 HC; IS-200 HC; IS-700 A.
Testing/Certification of other
employees that are needed will be
determined based on job
responsibilities.
### Statement of Deficiencies and Plan of Correction

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<td>Madison Memorial Hospital</td>
<td>450 East Main Street, Rexburg, ID 83440</td>
</tr>
</tbody>
</table>

**E 036** Continued From page 11

Findings include:

On 6/25/18 from 9:00 - 10:30 AM, review of provided emergency plan, policies and procedures failed to demonstrate any training program in place that included testing of staff's knowledge of the emergency plan and its contents.

Reference:

42 CFR 482.15 (d)

E 037 EP Training Program

CFR(s): 482.15(d)(1)

1. Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following:

   - (I) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.
   - (II) Provide emergency preparedness training at least annually.
   - (III) Maintain documentation of the training.
   - (IV) Demonstrate staff knowledge of emergency procedures.

   [*For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:*] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following:

   - (I) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles.
   - (II) Provide emergency preparedness training at
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<tr>
<th>E 037</th>
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<tr>
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<td>least annually.</td>
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<td>(iii) Maintain documentation of the training.</td>
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<td>(iv) Demonstrate staff knowledge of emergency procedures.</td>
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<td></td>
<td>* [For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:</td>
</tr>
<tr>
<td></td>
<td>(i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.</td>
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<td></td>
<td>(ii) Demonstrate staff knowledge of emergency procedures.</td>
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<td>(iii) Provide emergency preparedness training at least annually.</td>
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<td>(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.</td>
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<td>* [For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:</td>
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<td>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.</td>
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<td></td>
<td>(ii) After initial training, provide emergency preparedness training at least annually.</td>
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<td>(iii) Demonstrate staff knowledge of emergency procedures.</td>
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<td>(iv) Maintain documentation of all emergency preparedness training.</td>
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</table>

**E 037**

7/19/18 Our Disaster Plan (Emergency Management Plan) was sent out to all staff for required read. All hospital personnel will be oriented when they are hired on their specific roles and responsibilities in a disaster during new employee orientation. A emergency management course has been added to every employee's computer learning system assignment. They have also been assigned a review of the HVA to help prepare for identified Risks and Hazards. Administration, Public Relations Specialist, Safety Officer, Education Manager are required to take the following NIMS Courses: IS-100.HC - Introduction to the Incident Command System for Healthcare/Hospitals, IS-200.HC - Applying ICS to Healthcare Organizations, and IS-700.A - National Incident Management System (NIMS). Department directors and managers are required to take: IS-100.HC; IS-200.HC; IS-700.A. Testing/Certification of other employees that are needed will be determined based on job responsibilities.
E 037 Continued from page 13

The Safety/Disaster Committee have developed annual drill plans and will conduct a test of the Madison Memorial Hospital Disaster Plan at least bi-annually. The EOC will be tested at least annually. We take all hazards risk-based approach to our emergency drills. We utilize our HVA to determine what drills we will do each year. Actual activation of the plan can be used in lieu of a planned drill. Following the test, the Safety/Disaster Committee evaluate the plan and make corrections and improvements in policies and procedures, as they deem necessary. Drills may be done in coordination with community exercises.
and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.

(ii) Provide emergency preparedness training at least annually.

(iii) Maintain documentation of the training.

(iv) Demonstrate staff knowledge of emergency procedures.

"[For CMHCs at §485.920(d):] (I) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually.

This STANDARD is not met as evidenced by:

Based on record review and interview, it was determined the facility failed to provide an emergency preparedness training program. Lack of a training program on the emergency preparedness plan and policies for the facility, has the potential to hinder staff response during a disaster. This deficient practice affected patients, staff and visitors on the date(s) of the survey.

Findings include:

On 6/26/18 from 9:00 AM - 12:00 PM, review of provided emergency plan, policy and procedures,
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<td></td>
<td>revealed no substantiating documentation demonstrating the facility provided a staff training program on the emergency preparedness plan, policies and procedures for existing and newly hired staff.</td>
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<td>Interview of the Education Coordinator revealed the facility had not yet implemented a staff training program on the Emergency Preparedness plan.</td>
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<tr>
<td></td>
<td>Reference: 42 CFR 482.15 (d) (1)</td>
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<td>Additional Reference: E-0036</td>
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### DEPARTMENT OF HEALTH AND HUMAN SERVICES

### CENTERS FOR MEDICARE & MEDICAID SERVICES

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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<td>130025</td>
<td>A. BUILDING 02 - ENTIRE HOSPITAL</td>
<td>06/28/2018</td>
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</table>

**NAME OF PROVIDER OR SUPPLIER**

Madison Memorial Hospital

**STREET ADDRESS, CITY, STATE, ZIP CODE**

450 East Main Street

**RECEIVED**

AUG 13 2018

**FACILITY STANDARDS**

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**INITIAL COMMENTS**

The hospital is a three (3) story protected, Type II (222) structure that was originally constructed in 1978. The facility has completed several additions/renovations, most recently in 2008. The building is protected throughout by an automatic fire extinguishing system with an integrated fire alarm and smoke detection system. There are multiple exits to grade on the first floor and eight (8) remotely located protected stairwells. Emergency power is provided by an on-site diesel powered, Emergency Power Supply System (EPSS) generator. The facility is currently licensed for 69 hospital beds.

The facility includes an off-site Surgery Center of Type V(111) construction. The center includes two (2) operating rooms and is one-hour separated from an attached doctor's office. It is fully sprinklered and protected throughout with an interconnected fire alarm/smoke detection system. Emergency power is provided by an on-site diesel powered, EPSS generator.

The following deficiencies were cited during the validation survey conducted in accordance with 42 CFR 488.7 (b), from June 25, 2018 to June 28, 2018. The facility was surveyed under the Life Safety Code, 2012 Edition, Existing Health Care Occupancy and the Emergency Preparedness Rule as adopted by CMS.

The survey was conducted by:

Sam Burbank
Health Facility Surveyor
Facility Fire Safety & Construction

---

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

**TITLE**

**Note:** 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 disclosed 90 days following the date of survey whether or not a plan of correction is provided. 110 days following the date these documents are made available to the facility program participation.
<table>
<thead>
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<th>K100</th>
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<tr>
<td>CFR(s): NFPA 101</td>
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<tr>
<td>General Requirements - Other</td>
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<tr>
<td>List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This STANDARD is not met as evidenced by:</td>
<td></td>
</tr>
<tr>
<td>Based on observation, the facility failed to ensure the heliport on site was provided with appropriate protections in accordance with NFPA 418. Failure to sign heliport landing areas with signs prohibiting smoking as required, has the potential to expose flammable fuels and liquids associated with aircraft to ignition sources. This deficient practice affected all patients, staff and visitors on the date(s) of the survey.</td>
<td></td>
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<tr>
<td>Findings include:</td>
<td></td>
</tr>
<tr>
<td>During the facility tour conducted on 6/26/18 from 8:45 - 10:00 AM, observation of the heliport landing area outside the Emergency Room (ER) entrance, revealed the area was not posted with &quot;NO SMOKING&quot; signs at the access and egress points of the heliport.</td>
<td></td>
</tr>
<tr>
<td>Actual NFPA standard:</td>
<td></td>
</tr>
<tr>
<td>NFPA 418 Standard for Heliports 2011 Edition</td>
<td></td>
</tr>
<tr>
<td>4.6</td>
<td></td>
</tr>
<tr>
<td>4.6 No Smoking</td>
<td></td>
</tr>
<tr>
<td>4.6.1 No smoking shall be permitted within 50 ft (15.2 m) of the landing pad edge.</td>
<td></td>
</tr>
</tbody>
</table>

K100
On 8/10/18, "No Smoking" signs were installed around the access and egress points around the heliport landing area outside the Emergency Room (ER) entrance in order to prevent exposure of flammable fuels and liquids associated with aircraft to ignition sources.
<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE CROSSED REFERENCE TO THE APPROPRIATE REGULATORY OR LIC IDENTIFYING INFORMATION)</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSSED REFERENCE TO THE APPROPRIATE EFFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>K 100</td>
<td>Continued From page 2 4.6.2 NO SMOKING signs shall be erected at access/egress points to the heliport.</td>
<td>K 100</td>
<td></td>
</tr>
<tr>
<td>K 161</td>
<td>Building Construction Type and Height CFR(s): NFPA 101 Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), II (332), II (222) Any number of stories non-sprinklered and sprinkled 2 II (111) non-sprinklered One story Maximum 3 stories sprinkled 3 II (000) non-sprinklered Not allowed 4 III (211) sprinkled Maximum 2 stories 5 IV (21H) 6 V (111) 7 III (200) non-sprinklered Not allowed 8 V (000) sprinklered Maximum 1 story Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5)</td>
<td>K 161</td>
<td></td>
</tr>
</tbody>
</table>
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>STREET ADDRESS, CITY, STATE, ZIP CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>K161</td>
<td>130025</td>
<td>450 EAST MAIN STREET REXBURG, ID 83440</td>
</tr>
</tbody>
</table>

**Note:**
- **ID:** 130025
- **PREFIX:** TA0

**SUMMARY STATEMENT OF DEFICIENCIES**

- Based on observation and interview, the facility failed to ensure the fire and smoke resistive properties of the structure were maintained. Failure to maintain rated construction assemblies, has the potential to allow fire, smoke and dangerous gases to pass into unprotected concealed spaces and between compartments. This deficient practice potentially affected all patients, staff and visitors in on the date(s) of the survey.

**Findings include:**

- During the facility tour conducted on 6/26/18 at the main hospital, from 8:45 AM to 12:00 PM and the off-site Surgery Center from 2:00 - 3:30 PM, the following areas revealed unsealed penetrations:
  - **% Two (2) approximately six inch diameter electrical and data cabling conduits, passing through the 1-hour wall in the Mechanical Room across from the Steiner Conference room.**
  - An approximately two foot by three foot hole in the interior wall of the Mechanical/Electrical Room, located in the back service corridor on the second floor.
  - An above the ceiling inspection at the Surgery Center revealed a three inch unsealed cabling conduit passing through the one-hour wall separating the adjoining doctor's office.

**On 7/25/18, the unsealed penetration in the mechanical room across from the Steiner Conference room and the unsealed cabling conduit penetration at the surgery center were both filled.** An inspection of the above the ceiling was completed on 8/8/18. An "Above the Ceiling Work Permit" has been created and will be used for any work done above the ceiling in order to prevent future unsealed penetrations from occurring.
Inquiry of the Engineering Manager revealed he was not aware of these unsealed penetrations prior to the survey date.

Actual NFPA standard:

- 19.1.6 Minimum Construction Requirements.
- 19.1.6.1 Health care occupancies shall be limited to the building construction types specified in Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7. (See 8.2.1.)

Emergency Lighting

Emergency Lighting

Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9, 18.2.9.1, 19.2.9.1. Failure to provide emergency lighting for doors equipped with delayed egress potentially hinders identification of exits affecting patient egress during an emergency. This deficient practice affected all patients, staff and visitors on the date(s) of the survey.

Findings include:

During the facility tour conducted on 6/26/18 from 9:30 AM to 3:30 PM, observation of exit doors revealed exit doors at the stairwells in Med Surg and the exit door at the MBU/NICU were equipped with magnetic locking arrangements.
### Statement of Deficiencies and Plan of Correction

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Identification Number</th>
<th>Address</th>
<th>City, State, Zip Code</th>
<th>Date Survey Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>K291</td>
<td>TA0</td>
<td>130025</td>
<td></td>
<td>450 EAST MAIN STREET</td>
<td>REXBURG, ID 83440</td>
<td>09/28/2018</td>
</tr>
</tbody>
</table>

#### (K1) Summary of Deficiencies

**K 291** Continued from page 5

which included a delayed egress component. Further observation established the facility was not providing battery backup emergency lighting for illumination of the means of egress to these exits.

- **Actual NFPA standard:**
  - 19.2.9 Emergency Lighting:
    - 19.2.9.1 Emergency lighting shall be provided in accordance with Section 7.9.
  - 7.9 Emergency Lighting:
    - 7.9.1 General:
      - 7.9.1.1 Emergency lighting facilities for means of egress shall be provided in accordance with Section 7.9 for the following:
        1. Buildings or structures where required in Chapters 11 through 43
        2. Underground and limited access structures as addressed in Section 11.7
        3. High-rise buildings as required by other sections of this Code
        4. Doors equipped with delayed-egress locks
        5. Stair shafts and vestibules of smokeproof enclosures, for which the following also apply:
          - (a) The stair shaft and vestibule shall be permitted to include a standby generator that is installed for the smokeproof enclosure mechanical ventilation equipment.
          - (b) The standby generator shall be permitted to be used for the stair shaft and vestibule emergency lighting power supply.

- **K 321** Hazardous Areas - Enclosure
  - CFR(s): NFPA 101
Continued From page 6

Hazardous Areas - Enclosure

Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resistant partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door.

Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.

<table>
<thead>
<tr>
<th>Area</th>
<th>Automatic Sprinkler</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boiler and Fuel-Fired Heater Rooms</td>
<td>N/A</td>
</tr>
<tr>
<td>Launderies (larger than 100 square feet)</td>
<td></td>
</tr>
<tr>
<td>Repair, Maintenance, and Paint Shops</td>
<td></td>
</tr>
<tr>
<td>Soiled Linen Rooms (exceeding 64 gallons)</td>
<td></td>
</tr>
<tr>
<td>Trash Collection Rooms (exceeding 64 gallons)</td>
<td></td>
</tr>
<tr>
<td>Combustible Storage Rooms/Spaces (over 50 square feet)</td>
<td></td>
</tr>
<tr>
<td>Laboratories (if classified as Severe Hazard - see K322)</td>
<td></td>
</tr>
</tbody>
</table>

This STANDARD is not met as evidenced by:

Based on observation and operational testing, the facility failed to ensure protections for hazardous area doors were maintained. Failure of hazardous area doors to fully close and latch has the potential to allow fire, smoke and dangerous gases to pass into corridors, hindering the safe egress of patients. This deficient practice affected all patients, staff and visitors on the date(s) of the survey.
### K321 Continued From page 7

Findings include:

During the facility tour conducted on 6/28/18 from 8:45 AM - 12:00 PM, observation and operational testing of the following doors revealed the doors would not fully close and latch when activated:

- Door into the Soiled Linen located in the corridor on the west side of the Surgery department on the 1st floor.
- 1 of 2 doors entering the main Laundry from the corridor.

Actual NFPA standard:

19.3.2 Protection from Hazards.

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 8.7.1.

19.3.2.1.3 The doors shall be self-closing or automatic-closing.

19.3.2.1.5 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. Rooms with soiled linen in volume exceeding 64 gal (242 L)
6. Rooms with collected trash in volume exceeding 64 gal (242 L)
7. Rooms or spaces larger than 50 ft² (4.6 m²), including repair shops, used for storage of combustible supplies and equipment in quantities

K321

On 7/9/18, Fire Door Solutions conducted a facility-wide inspection of all fire/smoke doors and on 8/14/18, we were able to fix the soil linen door on the west side of the surgery department and the doors entering the main laundry area have been adjusted. We have a contract now with Fire Door Solutions to do a quarterly fire door inspection and adjust any doors that may be out of alignment.
## Summary Statement of Deficiencies

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix Tag</th>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>K321</td>
<td>continued from page 8</td>
<td>deemed hazardous</td>
<td></td>
</tr>
<tr>
<td>K324</td>
<td>Cooking Facilities</td>
<td>CFR(s): NFPA 101</td>
<td></td>
</tr>
</tbody>
</table>

### Detailed Description

- **Cooking Facilities**
  - Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:
    - Residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2
    - Cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or
    - Cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.
  - Cooking facilities protected according to NFPA 95 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor.
  - Cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2.

This **STANDARD** is not met as evidenced by:

- Based on observation, the facility failed to ensure cooking exhaust hood suppression systems were maintained in accordance with NFPA 95 and NFPA 17A. Failure to replace the protective caps for suppression system pendants in exhaust hoods, has the potential to allow grease laden vapors to coat system components and impede

---

**Continued from page 8**

- On 6/29/18, the protective caps for the pendants were properly placed. Training was done on 8/8/18 with the food service employees to have them visually inspect and ensure the protective caps are in place each week when they clean the hoods.
### Statement of Deficiencies and Plan of Correction

<table>
<thead>
<tr>
<th>Statement of Deficiencies and Plan of Correction</th>
<th>Provider/Suppliers/CAOs Identification Number.</th>
<th>Multiple Construction</th>
<th>Date Survey Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>K 324 Continued From page 9</td>
<td>130025</td>
<td>A. Building 02 - Entire Hospital</td>
<td>06/28/2018</td>
</tr>
</tbody>
</table>

**Summary Statement of Deficiencies**

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix Tag</th>
<th>Provider's Plan of Correction</th>
<th>Actual NFPA Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>K 324</td>
<td></td>
<td></td>
<td>10.2.6 Automatic fire-extinguishing systems shall be installed in accordance with the terms of their listing, the manufacturer’s instructions, and the following standards where applicable:</td>
</tr>
<tr>
<td>(1)</td>
<td>NFPA 12</td>
<td></td>
<td>(1) NFPA 12</td>
</tr>
<tr>
<td>(2)</td>
<td>NFPA 13</td>
<td></td>
<td>(2) NFPA 13</td>
</tr>
<tr>
<td>(3)</td>
<td>NFPA 17</td>
<td></td>
<td>(3) NFPA 17</td>
</tr>
<tr>
<td>(4)</td>
<td>NFPA 17A</td>
<td></td>
<td>(4) NFPA 17A</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>NFPA 17A</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>4.3.1.5 All discharge nozzles shall be provided with caps or other suitable devices to prevent the entrance of grease vapors, moisture, or other foreign materials into the piping.</td>
</tr>
</tbody>
</table>

**Findings include:**

- Findings include:
- During the facility tour conducted on 6/26/18 from approximately 1:00 - 3:30 PM, observation of the exhaust hood fire suppression system at the main Kitchen and the Paragon grill, revealed two protective caps for the pendants in each of the respective suppression systems of the two hoods, were not in place.

**Actual NFPA Standard:**

NFPA 96

10.2.6 Automatic fire-extinguishing systems shall be installed in accordance with the terms of their listing, the manufacturer’s instructions, and the following standards where applicable:

1. NFPA 12
2. NFPA 13
3. NFPA 17
4. NFPA 17A

NFPA 17A

4.3.1.5 All discharge nozzles shall be provided with caps or other suitable devices to prevent the entrance of grease vapors, moisture, or other foreign materials into the piping.
<table>
<thead>
<tr>
<th>K325</th>
<th>Continued From page 10 unless all conditions are met:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Corridor is at least 6 feet wide</td>
</tr>
<tr>
<td></td>
<td>• Maximum individual dispenser capacity is 0.32</td>
</tr>
<tr>
<td></td>
<td>gallons (0.53 gallons in suites) of fluid and 18</td>
</tr>
<tr>
<td></td>
<td>ounces of Level 1 aerosols</td>
</tr>
<tr>
<td></td>
<td>• Dispensers shall have a minimum of 4-foot</td>
</tr>
<tr>
<td></td>
<td>horizontal spacing</td>
</tr>
<tr>
<td></td>
<td>• Not more than an aggregate of 10 gallons of</td>
</tr>
<tr>
<td></td>
<td>fluid or 135 ounces aerosol are used in a single</td>
</tr>
<tr>
<td></td>
<td>smoke compartment outside a storage cabinet,</td>
</tr>
<tr>
<td></td>
<td>excluding one individual dispenser per room</td>
</tr>
<tr>
<td></td>
<td>• Storage in a single smoke compartment greater than</td>
</tr>
<tr>
<td></td>
<td>5 gallons complies with NFPA 30</td>
</tr>
<tr>
<td></td>
<td>• Dispensers are not installed within 1 inch of an</td>
</tr>
<tr>
<td></td>
<td>ignition source</td>
</tr>
<tr>
<td></td>
<td>• Dispensers over carpeted floors are in</td>
</tr>
<tr>
<td></td>
<td>sprinklered smoke compartments</td>
</tr>
<tr>
<td></td>
<td>• ABHR does not exceed 95 percent alcohol</td>
</tr>
<tr>
<td></td>
<td>• Operation of the dispenser shall comply with</td>
</tr>
<tr>
<td></td>
<td>Section 18.3.2.6(11) or 19.3.2.6(11)</td>
</tr>
<tr>
<td></td>
<td>• ABHR is protected against inappropriate access</td>
</tr>
<tr>
<td></td>
<td>18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460,</td>
</tr>
<tr>
<td></td>
<td>482, 483, and 485</td>
</tr>
<tr>
<td></td>
<td>This STANDARD is not met as evidenced by:</td>
</tr>
<tr>
<td></td>
<td>Based on record review, observation and</td>
</tr>
<tr>
<td></td>
<td>interview, the facility failed to ensure</td>
</tr>
<tr>
<td></td>
<td>automatically activated Alcohol Based Hand Rub</td>
</tr>
<tr>
<td></td>
<td>Dispensers (ABHR), were maintained in</td>
</tr>
<tr>
<td></td>
<td>accordance with NFPA 101. Failure to install, test</td>
</tr>
<tr>
<td></td>
<td>and document operation of ABHR dispensers under</td>
</tr>
<tr>
<td></td>
<td>manufacturer's recommendations and in</td>
</tr>
<tr>
<td></td>
<td>accordance with the standard, has the potential of</td>
</tr>
<tr>
<td></td>
<td>increasing the risk of fires from flammable liquids.</td>
</tr>
<tr>
<td></td>
<td>This deficient practice affected all patients, staff</td>
</tr>
<tr>
<td></td>
<td>and visitors on the date(s) of the survey.</td>
</tr>
<tr>
<td></td>
<td>Findings include:</td>
</tr>
<tr>
<td></td>
<td>1) During review of facility maintenance and</td>
</tr>
</tbody>
</table>

**K325**

A log was created on 8/6/18 to document when inspection and testing takes place. On 8/9/18, Environmental Service Techs. were trained on how to test the alcohol based hand rub dispenser. On 8/10/18, the alcohol dispenser in room 2005 and the one in the endoscopy procedure room were moved, so they are not within 1 inch of the light switch.
**DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
**CENTERS FOR MEDICARE & MEDICAID SERVICES**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.</th>
<th>(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 • ENTIRE HOSPITAL</th>
<th>(X3) DATE SURVEY COMPLETED</th>
</tr>
</thead>
<tbody>
<tr>
<td>130025</td>
<td></td>
<td>06/28/2018</td>
</tr>
</tbody>
</table>

**NAME OF PROVIDER OR SUPPLIER**  
MADISON MEMORIAL HOSPITAL

**STREET ADDRESS, CITY, STATE, ZIP CODE**  
450 EAST MAIN STREET  
REXBURG, ID 83440

**ID PREFIX TAG**  
K 325  
K 353

<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (FACILITY DEFICIENCY MUST BE PREPARED BY BOTH REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE EFFICIENCY)</th>
<th>DATE COMPLETION</th>
</tr>
</thead>
<tbody>
<tr>
<td>K 325</td>
<td>Continued From page 11 Inspection records conducted on 6/25/18 from approximately 2:30 - 4:00 PM, no records were available for the documentation of inspection and testing performed during the refill of ABHR dispensers. When interviewed, the Housekeeping supervisor and one (1) housekeeping staff on duty at approximately 3:30 PM revealed Housekeeping was responsible for the refilling of ABHR dispensers and no inspections or testing of the dispensers was being performed or documented. 2) During the facility tour conducted on 6/26/18 from 8:45 AM - 3:30 PM, observation of installed ABHR dispensers revealed automatically activated dispensers had been installed throughout the facility. 3) During the facility tour conducted on 6/26/18 from 8:45 AM - 3:30 PM, observation of Installed ABHR dispensers showed the following dispensers were installed within 1 inch of, or above an ignition source: Room 2005 the ABHR dispenser was within 1 inch of the light switch. The ABHR dispenser in the Endoscopy procedure room of the Surgery Suite was within 1 inch of the light switch.</td>
<td>K 325</td>
<td></td>
<td></td>
</tr>
<tr>
<td>K 353</td>
<td>Continued From page 12</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>a) Date sprinkler system last checked</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>b) Who provided system test</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>c) Water system supply source</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>9.7.5, 9.7.7, 9.7.8, and NFPA 25</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>This STANDARD is not met as evidenced by:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Based on record review and interview, the facility failed to ensure that fire suppression systems were maintained in accordance with NFPA 25.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Failure to maintain the fire suppression system has the potential to hinder performance during a fire event. This deficient practice affected all patients, staff and visitors on the date(s) of the survey.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Findings include:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>During review of provided facility inspection and testing records conducted on 6/25/18 from 2:30 - 4:00 PM, no records were available for weekly inspection of the dry system gauges.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Interview of the Engineering Manager revealed he was not aware of the requirement for weekly dry system inspections.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Actual NFPA standard:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>NFPA 25</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

K 353

On 8/7/18, we modified our fire riser form to prompt for weekly, not just monthly, inspections of the dry fire riser.
### Statement of Deficiencies and Plan of Correction

<table>
<thead>
<tr>
<th>ID Prefix</th>
<th>Provider/Supplier/Plan of Correction Identification Number</th>
<th>Name of Provider or Supplier</th>
<th>Street Address, City, State, Zip Code</th>
<th>Summary Statement of Deficiencies</th>
<th>Provider's Plan of Correction</th>
<th>Cross-Referenced to the Appropriate Efficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>K 353</td>
<td>130025</td>
<td>Madison Memorial Hospital</td>
<td>450 East Main Street, Rexburg, ID 83440</td>
<td>K 353</td>
<td>K 353</td>
<td>K355</td>
</tr>
</tbody>
</table>

#### K 353 Continued From page 13

- 5.2.4 Gauges.
- 5.2.4.2 Gauges on dry, preaction, and deluge systems shall be inspected weekly to ensure that normal air and water pressures are being maintained.

**K 355 Portable Fire Extinguishers**

- CFR(s): NFPA 101
- Fire Extinguishers

  - Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers.
  - 16.3.5.12, 16.3.5.12, NFPA 10

This STANDARD is not met as evidenced by:

Based on observation, the facility failed to ensure fire extinguishers were installed in accordance with NFPA 10. Failure to install fire extinguishers at the correct height has the potential to hinder staff access during a fire. This deficient practice affected patients, staff and visitors on the date(s) of the survey.

Findings include:

- During the facility tour conducted on 6/26/18 from 10:00 AM - 3:30 PM, observation of installed portable fire extinguishers revealed the following:
  - Fire Extinguisher resting on the floor in the MRI observation area.
  - Fire extinguisher in the corridor on the south side of Physical Therapy was mounted at 68 inches, when measured from the floor to the top of the extinguisher.

Actual NFPA standard:

- NFPA 10

---

The MRI fire extinguisher was properly mounted on 8/14/18. The fire extinguisher near physical therapy was lowered to the appropriate height on 6/29/18.
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD REF CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>K 355</td>
<td>Continued From page 14</td>
<td>6.1.3.8 Installation Height. 6.1.3.8.1 Fire extinguishers having a gross weight not exceeding 40 l (18.14 kg) shall be installed so that the top of the fire extinguisher is not more than 5 ft (1.53 m) above the floor. 6.1.3.8.3 In no case shall the clearance between the bottom of the hand portable fire extinguisher and the floor be less than 4 in. (102 mm).</td>
<td>K 355</td>
<td></td>
</tr>
<tr>
<td>K 364</td>
<td>Corridor - Openings CFR(s): NFPA 101</td>
<td>Corridor - Openings Transfer grilles are not used in corridor walls or doors. Auxiliary spaces that do not contain flammable or combustible materials are permitted to have louvers or be undercut. In other than smoke compartments containing patient sleeping rooms, miscellaneous openings are permitted in vision panels or doors, provided the openings per room do not exceed 20 square inches and are 2' or below half the distance from floor to ceiling. In sprinklered rooms, the openings per room do not exceed 80 square inches. Vision panels in corridor walls or doors shall be fixed window assemblies in approved frames. (In fully sprinklered smoke compartments, there are no restrictions in the area and fire resistance of glass and frames.) 18.3.6.5.1, 19.3.6.5.2, 8.3 This STANDARD is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure corridor openings were protected in accordance with NFPA 101. Failure to ensure protection of corridor openings are maintained, has the potential to allow fires to pass into corridors, hindering the</td>
<td>K 364</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (FACH DEFICIENCY MUST BE REFERENCED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>COMPLETION DATE</th>
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</thead>
<tbody>
<tr>
<td>K 355</td>
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<td></td>
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<td></td>
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</tbody>
</table>
### K 364

**Continued From page 15**

Safe egress of patients during a fire. This deficient practice affected patients, staff and visitors on the date(s) of the survey.

Findings include:

1) During review of the annual fire alarm inspection report conducted on 6/25/18 from 2:30 - 4:00 PM, records indicated 1 of 2 roll-up doors at the pass thru windows of the Pharmacy, failed to activate and close with the fire alarm and was currently stuck in the open position.

   Interview of the Bio Med tech working with the vendor on the remedy, substantiated this door and finding from the report had not been repaired as of the date(s) of the survey.

2) During the facility tour conducted on 6/26/18 from 11:00 AM to 12:00 PM, observation of the Pharmacy area revealed the roll-up doors measured approximately 32 inches by 32 inches. Further observation of the roll-up door on the west side of the Pharmacy, verified the roll-up door was stuck open with an approximately 32 inch by 24 inch opening remaining.

**Actual NFPA standard:**

19.3.6.5 Openings.
19.3.6.5.1% Miscellaneous openings, such as mail slots, pharmacy pass-through windows, laboratory pass-through windows, and cashier pass-through windows, shall be permitted to be installed in vision panels or doors without special protection, provided that both of the following criteria are met:

- (1) The aggregate area of openings per room does not exceed 20 in.² (0.015 m²).

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**K 364**

A Vendor Discrepancy Report has been created to track any fire system inspection non-conformance items. This report is reviewed during the morning Engineering meeting in order to track progress and accountability to get items fixed, as needed. We contracted with Johnson Controls/Simplex Grinnell and Valley Overhead Doors to fix the pharmacy roll-up door, which was completed on 8/16/18.
<table>
<thead>
<tr>
<th>K 364</th>
<th>Continued From page 16</th>
</tr>
</thead>
<tbody>
<tr>
<td>(2) The openings are installed at or below half the distance from the floor to the room ceiling.</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>K 511</th>
<th>Utilities - Gas and Electric</th>
</tr>
</thead>
<tbody>
<tr>
<td>CFR(s): NFPA 101</td>
<td></td>
</tr>
<tr>
<td>Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2</td>
<td></td>
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</tbody>
</table>

This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure electrical installations were provided in accordance with NFPA 70. Failure to maintain electrical panels free of obstructions and utilize power strips in compliance with the applicable standard, has the potential to limit staff capabilities and increase the potential of arc fires in the facility. This deficient practice affected patients, staff and visitors on the date(s) of the survey. Findings include: 1) During the facility tour conducted on 6/26/18 from 8:45 AM to 3:30 PM, observation of the south corridor outside Radiology revealed two of three electrical panels were blocked by a portable imaging machine. 2) The blocked electrical panels in radiology and CSP, were unblocked on 7/29/18. The "relocatable power tap" or power strip outlets were removed on 8/7/18 from the Medical Information office and the Surgery Center. Each month our Safety Committee conducts a safety walk around in 3-4 different departments. We added to check for blocked electrical panels and to look for "power strips" to our checklist in July 2018. A walk through of the facility on 8/7/18 by the Risk Manager found no blocked electrical panels and no "power strips" that had higher voltage items, such as microwaves, toaster ovens, and coffee pots in use.
Continued from page 17

2) During the facility tour conducted on 6/26/18 from 8:45 AM to 3:30 PM, observation of the passage way from CSP to the main Surgery section, revealed a trash can was placed in front of the electrical panel, inside the designated demarcation area.

3) During the facility tour conducted on 6/26/18 from 8:45 AM to 3:30 PM, observation of the staff break area in the Medical Information office revealed a relocatable power tap (RPT) was being utilized to supply power to a microwave, toaster and coffee machine.

4) During the tour of the facility Surgery Center conducted on 6/26/18 from 8:45 AM to 3:30 PM, observation of the staff break area revealed a RPT was being utilized to supply power to a microwave, toaster oven, toaster and coffee machine.

Actual NFPA standard:

NFPA 70

Finding(s) 1 and 2

110.32 Work Space About Equipment. Sufficient space shall be provided and maintained about electrical equipment to permit ready and safe operation and maintenance of such equipment. Where energized parts are exposed, the minimum clear work space shall be not less than 2.0 m (61.2 ft) high (measured
### K 712

**Fire Drills**

Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.

19.7.1.4 through 19.7.1.7

This STANDARD is not met as evidenced by:

Based on record review and interview, the facility failed to provide documentation of required fire drills meeting the NFPA 101 standard. Failure to perform audible drills during shift hours conducted prior to 9:00 PM and after to 6:00 AM, has the potential of hindering the safe evacuation of patients during a fire. This deficient practice affected all patients, staff and visitors on the date(s) of the survey.

**Findings include:**

During review of provided facility fire drills conducted on 6/25/18 from approximately 2:30 - 3:30 PM, fire drill documentation revealed the facility failed to conduct audible fire drills on shifts documented prior to 9 o'clock PM as follows:

- On 3/29/18, fire drill conducted at 6:15 PM was noted as "Verbal".
- On 7/7/17, fire drill conducted at 6:00 PM was noted as "Verbal".
- On 12/20/17, fire drill conducted at 7:00 PM was noted as "Verbal".

Interview of 3 of 3 staff substantiated the "Verbal"
### DEPARTMENT OF HEALTH AND HUMAN SERVICES
**CENTERS FOR MEDICARE & MEDICAID SERVICES**

<table>
<thead>
<tr>
<th>ACTIVITY</th>
<th>PROVIDER/SUPPLIER IDENTIFICATION NUMBER</th>
<th>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION</th>
<th>DATE SURVEY COMPLETED</th>
</tr>
</thead>
<tbody>
<tr>
<td>A) BUILDING 02 • ENTIRE HOSPITAL</td>
<td>130025</td>
<td>K 712 Continued From page 19</td>
<td>06/28/2018</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NAME OF PROVIDER OR SUPPLIER</th>
<th>STREET ADDRESS, CITY, STATE, ZIP CODE</th>
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<tbody>
<tr>
<td>MADISON MEMORIAL HOSPITAL</td>
<td>450 EAST MAIN STREET</td>
</tr>
<tr>
<td></td>
<td>REXBURG, ID 83440</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>ACTIVITY</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>STATEMENT OF DEFICIENCIES</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>K 712</td>
<td>continued from page 19 fire drill indicated the facility was not activating the alarm and the policy of the facility was to conduct non-audible fire drills from 7 o'clock PM to 7 o'clock AM.</td>
<td>Actual NFPA standard:</td>
<td>K 712</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NFPA 101</td>
<td></td>
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<tr>
<td></td>
<td>19.7.1.4% fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions.</td>
<td></td>
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<tr>
<td></td>
<td>19.7.1.6 Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions.</td>
<td></td>
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</tr>
<tr>
<td>K 913</td>
<td>Electrical Systems - Essential Electric System</td>
<td></td>
<td>K 913</td>
</tr>
<tr>
<td></td>
<td>CFR(s): NFPA 101</td>
<td>Electrical Systems - Essential Electric System Maintenance and Testing</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.</td>
<td></td>
</tr>
</tbody>
</table>
### K 918

**Continued From page 20**

Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulation of start and automatic transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.

6.4.4, 6.5.4, 6.6.4 (NFPA 90), NFPA 110, NFPA 111, 700.10 (NFPA 70)

This STANDARD is not met as evidenced by:

Based on record review and interview, the facility failed to ensure the EPSS generator was maintained in accordance with NFPA 110. Failure to conduct weekly generator inspections has the potential to miss issues that might result in incipient failures and a lack of emergency power. This deficient practice affected all patients, staff and visitors on the date of the survey.

Findings include:

During review of the facility inspection and maintenance records conducted on 6/25/18 from 2:30 PM, records indicated that weekly inspections of the emergency generator had not been conducted. On 7/6/18, a weekly generator testing form was created and has been used to document these weekly inspections. On 8/6/18, the risk manager did a spot audit and found that it is being consistently documented.

On 8/9/18, this requirement and compliance to it was discussed as part of our monthly facility safety committee meeting.

### K 919

On 7/6/18, a weekly generator testing form was created and has been used to document these weekly inspections. On 8/6/18, the risk manager did a spot audit and found that it is being consistently documented. We created a "Safety Committee Planning Calendar" that outlines each month what piece(s) of the seven facility management plan will be discussed. On 8/9/18, this requirement and compliance to it was discussed as part of our monthly facility safety committee meeting.
### Summary Statement of Deficiencies

**K 918**

Continued From page 21

been completed prior to June, 2018. When asked about the missing documentation, the Engineering Manager explained the facility had not been conducting weekly inspections prior to that time.

Actual NFPA standard:

- **NFPA 110**
  - 8.4 Operational Inspection and Testing.
  - 8.4.1 EPSS, including all appurtenant components, shall be inspected weekly and exercised under load at least monthly

**K 923**

Gas Equipment - Cylinder and Container Storage

CFR(s): NFPA 101

- Gas Equipment - Cylinder and Container Storage
- Greater than or equal to 3,000 cubic feet
- Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3.
- >300 but <3,000 cubic feet
- Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gate) outdoors that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating.
- Less than or equal to 300 cubic feet
- In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be
K 923 Continued From page 22
handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(Es) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure medical gases were stored in accordance with NFPA 99. Failure to segregate medical gases has the potential to result in the improper gas being administered, or using incorrect cylinders during an emergency requiring supplemental oxygen.

Findings include:

During the facility tour conducted on 6/26/18 from 8:30 - 11:45 AM, observation of the oxygen storage area outside the Therapy department revealed the stored cylinders did not have any identifying segregation between empty or full.

Further observation of the Surgery Center from 2:30 - 3:00 PM revealed the cylinders stored in the oxygen storage location on the northwest side of the building, intermixed gases such as oxygen, carbon dioxide, and medical air and did not have segregation of full or empty cylinders in storage.
<table>
<thead>
<tr>
<th>K 923</th>
<th>Continued From page 23</th>
</tr>
</thead>
<tbody>
<tr>
<td>NFPA 99</td>
<td></td>
</tr>
<tr>
<td>11.6.5 Special Precautions - Storage of Cylinders and Containers.</td>
<td></td>
</tr>
<tr>
<td>11.6.5.1 Storage shall be planned so that cylinders can be used in the order in which they are received from the supplier.</td>
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<tr>
<td>11.6.5.2 If empty and full cylinders are stored within the same enclosure, empty cylinders shall be segregated from full cylinders.</td>
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<tr>
<td>11.6.5.3 Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed in a rapid manner.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>K 927</th>
<th>Gas Equipment - Transfilling Cylinders</th>
</tr>
</thead>
<tbody>
<tr>
<td>CFR(5): NFPA 101</td>
<td></td>
</tr>
<tr>
<td>Gas Equipment - Transfilling Cylinders</td>
<td></td>
</tr>
<tr>
<td>Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99).</td>
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</tr>
<tr>
<td>11.5.2.2 (NFPA 99)</td>
<td></td>
</tr>
<tr>
<td>This STANDARD is not met as evidenced by:</td>
<td></td>
</tr>
<tr>
<td>Based on observation and interview, the facility failed to ensure oxygen transfilling was performed in accordance with NFPA 99. Failure to sign oxygen transfill areas and provide mechanical ventilation to those spaces, has the potential for creating an oxygen rich environment and increase the potential for fires and explosions.</td>
<td></td>
</tr>
</tbody>
</table>
**Findings Include:**

During the facility tour conducted on 6/26/18 from 8:30 AM to 3:30 PM, observation of the storage room in the Med Surge, north of the nurse’s station, revealed the space was being used for the storage of combustibles and transfilling of oxygen. Further observation demonstrated the space was not mechanically ventilated, signed for the transfilling process and the cryogenic oxygen cylinder was placed directly on the vinyl composite floor.

In addition, the oxygen storage outside of the Therapy department was also being utilized as a transfilling location and was not signed for that purpose or mechanically ventilated.

When asked about the absence of the signs and mechanical ventilation in these two spaces, the Engineering Manager stated he was not aware of that requirement, but was aware that the transfilling could not take place directly on the vinyl composite floor.

**Actual NFPA standard:**

**NFPA 99**

8.3.7.5.3.2 Mechanical exhaust shall be at a rate of 1 L/sec of airflow for each 300 L (1 cfm per 5 ft³ of fluid) designed to be stored in the space and not less than 24 L/sec (50 cfm) nor more than 235 L/sec (500 cfm).

11.5.2.3 Transfiling Liquid Oxygen. Transfiling of liquid oxygen shall comply with 11.5.2.3.1 or 11.5.2.3.2, as applicable.

11.5.2.3.1 Transfiling to liquid oxygen base
<table>
<thead>
<tr>
<th>Provider/Supplier Identification Number</th>
<th>Multiple Construction</th>
<th>Date Survey Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>130025</td>
<td>A, Building 2 - Entire Hospital</td>
<td>06/28/2018</td>
</tr>
</tbody>
</table>

**Name of Provider or Supplier:**

**Madison Memorial Hospital**

**Street Address, City, State, Zip Code:**

450 East Main Street
REXBURG, ID 83440

**Summary Statement of Deficiencies**

(K 927) Continued From page 25

Reservoir containers or liquid oxygen portable containers over 344.74 kPa (50 psi) shall

**Provider's Plan of Correction**

(K 927)