Eastern Idaho Regional Medical Center is an approximately 385,000 square foot Type 1 constructed building completed in 1985. Subsequent additions were completed in 1995 and 2001. The six-story building is fully sprinklered and protected throughout by a complete, supervised, manual fire alarm/smoke detection system which includes smoke detection in patient rooms as well as corridors and open spaces. There are nine (9) smoke compartments on the first floor and seven (7) smoke compartments on the second floor. Floors three (3) through six (6) each have three (3) smoke compartments. Essential Electrical Systems are supplied by two (2) diesel powered, on-site automatic generators. The Behavioral Health Unit has a third diesel powered, on-site automatic generator. All Essential Electrical Systems annunciator panels are constantly monitored on site at the Medical Office Building PBX. The facility is equipped with piped medical gas, vacuum and WAGD systems. Floors one (1) and two (2) have multiple exits to grade. Floors three (3) through six (6) are provided with access to four stairwells. The facility is licensed for 269 beds and had a census of approximately 187 on the dates of the survey.

The buildings surveyed in accordance with 42 CFR 482.15 Emergency Preparedness Rule established by CMS included: Eastern Idaho Regional Medical Center, Cancer Center, Outpatient Physical Therapy, and Behavioral Health Unit.

The following deficiencies were cited during the Validation Emergency Preparedness Survey on [06/13/2019].

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

**E000** Continued From page 1

June 10 - 13, 2019. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 482.15.

The Survey was conducted by:

- Linda Chaney
  - Health Facility Surveyor
  - Facility Fire Safety & Construction Program

- Nate Elkins, Supervisor
  - Facility Fire Safety & Construction Program

**E007**

EP Program Patient Population

CFR(s): 482.15(a)(3)

[(a) 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:

(3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.**

*Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.]

This STANDARD is not met as evidenced by:

**E018**

Procedures for Tracking of Staff and Patients

CFR(s): 482.15(b)(2)

[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness
## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

### Provider/Supplier/CLIA Identification Number:
130018

### Name of Provider or Supplier
EASTERN IDAHO REGIONAL MEDICAL CENTER

### Street Address, City, State, Zip Code
3100 CHANNING WAY
IDAHO FALLS, ID 83404

<table>
<thead>
<tr>
<th>ID</th>
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<th>TAG</th>
<th>Street Address, City, State, Zip Code</th>
<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-referenced to the Appropriate Deficiency)</th>
</tr>
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</table>
| E018 | Continued From page 2 | 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:**

1. 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 Inpatient Hospice at §418.113(b)(6);]

Policies and procedures. (ii) 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

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**Plan of Correction (POC):**

HICS form 252 (Section Personnel Time Sheet) covers the requirement for this staff tracking tool. This form will be utilized in the Emergency Operations Plan (EOP) and will be placed in the EOP as Attachment M.

Process for implementing POC: The above information and process regarding the use of the HICS form 252 was presented to the Emergency Preparedness Committee on June 26, 2019.

Monitoring & tracking procedures ensuring the POC is effective: The HICS form 252 is placed within the EOP which is reviewed on an annual basis. The form will be utilized for all emergency drills, exercises, and actual events.

Process improvement actions incorporated into the QAPI program: The review of these forms will occur with all debriefings that occur for all emergency drills, exercises, and actual events. The review results and any associated action plans that are developed, will be presented to the Emergency Preparedness Committee on an ongoing basis.

Individual responsible: Jim Howard, Director of Emergency Preparedness
**Summary Statement of Deficiencies**

Continued From page 3

- 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. (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 and Interview, it was determined the facility failed to provide a current policy for tracking on-duty staff during an emergency, to include the specific name and location of receiving facility or other location in the event they are relocated with patients during an emergency. This information must be readily available, accurate, and shareable among officials within and across the emergency response systems as needed in the interest of the patient. This deficient practice had the potential to affect all patients and staff on the dates of the
Findings Include:

On June 11, 2019, from approximately 11:00 AM to 3:00 PM, review of the provided records, policies and procedures failed to demonstrate the facility had in place a system to track the location of on-duty staff during an emergency. Interview of the Emergency Preparedness Liaison on June 12, 2019 at approximately 2:30 PM, revealed the facility was unaware of the requirement to track on-duty staff during an emergency.

Reference:

42 CFR 482.15 (b) (2)

(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
E 037 Continued From page 5

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 least annually.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures.

*For Hospices at §418.113(d): (1) Training. The hospice must do all of the following:
(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.
(ii) Demonstrate staff knowledge of emergency procedures.
(iii) Provide emergency preparedness training at least annually.
(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.

*For PRTFs at §441.184(d): (1) Training program. The PRTF 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 roles.
(ii) After initial training, provide emergency preparedness training at least annually.
(iii) Demonstrate staff knowledge of emergency procedures.

Plan of Correction (POC): Organize an Emergency Preparedness Education sub-committee in conjunction with the hospital’s Human Resources and Education departments to develop initial and annual training Emergency Preparedness education and testing for all new and current staff.

Process for implementing POC: The sub-committee will meet and develop the training/testing material. The material that is developed will be submitted to and approved by the Emergency Preparedness Committee. All staff will receive the training at orientation and on an ongoing, annual basis.

Monitoring & tracking procedures ensuring the POC is effective: The education plan will be reviewed on an annual basis to ensure continued compliance with the most current regulatory standards. After completion of the staff education, competency will be verified through testing to ensure staff have retained knowledge of EP procedures.

Process improvement actions incorporated into the QAPI program: Each Director and/or Manager will be responsible for the review of the education completion with individual follow-up as needed. This will occur on an ongoing basis. The Director of Emergency Preparedness will review the results on an annual basis and results will be reported to the Emergency Preparedness Committee on an annual basis.

Individual responsible: Jim Howard, Director of Emergency Preparedness
**Summary Statement of Deficiencies**

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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<th>FORM APPROVED OMB NO. 0938-0391</th>
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**E 037 Continued From page 6**

(iv) Maintain documentation of all emergency preparedness training.

*For PACE at §460.84(d): (1) The PACE organization 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, contractors, participants, and volunteers, consistent with their expected roles.
   (ii) Provide emergency preparedness training at least annually.
   (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.
   (iv) Maintain documentation of all training.

*For CORFs at §485.68(d): (1) Training. The CORF must do all of the following:
   (i) 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.
   (ii) Provide emergency preparedness training at least annually.
   (iii) Maintain documentation of the training.
   (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.
E 037 Continued From page 7

*For CAHs at §485.625(d): (1) Training program. The CAH must do all of the following:
(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, 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): (1) 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 (EP) training program to include initial and annual training. Failure to implement a training program on the EP plan, has the potential to hinder staff response during a disaster. This deficient practice affected all patients and staff on the dates of the survey.
Findings include:

On June 11, 2019, from approximately 11:00 AM to 3:00 PM, review of the facility EP documentation revealed a written training plan, but there was no documentation that initial/annual training for all new and existing staff, or individuals providing services under arrangement had taken place. Interview of multiple staff members in nursing and support roles during the facility tour on June 12, 2019, from approximately 9:00 AM - 3:30 PM confirmed the facility had not implemented their training program for EP. Staff could not recall training on the Emergency Preparedness plan, nor did they know their role and responsibility during a disaster.

Reference:

42 CFR 482.15 (d) (1)
Eastern Idaho Regional Medical Center is an approximately 385,000 square foot Type 1 constructed building completed in 1985. Subsequent additions were completed in 1995 and 2001. The six-story building is fully sprinklered and protected throughout by a complete, supervised, manual fire alarm/smoke detection system which includes smoke detection in patient rooms as well as corridors and open spaces. There are nine (9) smoke compartments on the first floor and seven (7) smoke compartments on the second floor. Floors three (3) through six (6) each have three (3) smoke compartments. Essential Electrical Systems are supplied by two (2) diesel powered, on-site automatic generators. The Behavioral Health Unit has a third diesel powered, on-site automatic generator. All Essential Electrical Systems annunciator panels are constantly monitored on site.

The facility is equipped with piped medical gas, vacuum and WAGD systems. Floors one (1) and two (2) have multiple exits to grade. Floors three (3) through six (6) are provided with access to four stairwells. The facility is licensed for 289 beds and had a census of approximately 187 on the dates of the survey.

The buildings surveyed in accordance with 42 CFR 482.41, Physical Environment included: Eastern Idaho Regional Medical Center, Cancer Center, Outpatient Physical Therapy, and Behavioral Health Unit.

The following deficiencies were cited during the Fire/Life Safety Validation Survey from June 10 - 13, 2019. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing...
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:  
130018

(X2) MULTIPLE CONSTRUCTION
A. BUILDING 01 - ENTIRE HOSPITAL

B. WING

(X3) DATE SURVEY COMPLETED  
06/13/2019

NAME OF PROVIDER OR SUPPLIER  
EASTERN IDAHO REGIONAL MEDICAL CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE  
3100 CHANNING WAY  
IDAHO FALLS, ID 83404

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE

K 000  
Continued From page 1
Health Care Occupancy, in accordance with 42 CFR 482.41.

The Survey was conducted by:
Linda Chaney  
Health Facility Surveyor  
Facility Fire Safety & Construction Program
Nate Elkins, Supervisor  
Facility Fire Safety & Construction Program

K 161  
Building Construction Type and Height
CFR(s): NFPA 101

Building Construction Type and Height
2012 EXISTING
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), I (332), II (222) Any number of stories non-sprinklered and sprinklered

2  
II (111) One story non-sprinklered Maximum 3 stories sprinklered

3  
II (000) Not allowed non-sprinklered

4  
III (211) Maximum 2 stories sprinklered

5  
IV (2HH)

6  
V (111)
K161  Continued From page 2

7  III (200)  Not allowed  non-sprinklered
8  V (000)  Maximum 1 story sprinklered  

Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5)

Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.

This STANDARD is not met as evidenced by:

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 had the potential to affect staff on the dates of the survey.

Findings include:

During the facility tour on June 12, 2019, from approximately 9:00 AM - 3:30 PM, observation of the main server room on the first floor revealed an approximately 12" x 12" penetration in the wall. Interview of the Director of Facilities at the time of discovery revealed the facility was unaware of the hole in the wall.

Actual NFPA standard:

19.1.6 Minimum Construction Requirements.

Plan of Correction (POC): The penetration in the main server room has been repaired. This was corrected prior to the surveyor's departure.

Process for implementing POC: Repair was assigned to the drywall repair vendor. Verification of completion was completed by the Director of Plant Operations.

Monitoring & tracking procedures ensuring the POC is effective: The main server room has been added to areas for observation for Environment of Care (EOC) Rounds which occur on a biannual basis.

Process improvement actions incorporated into the QAPI program: The EOC rounds results will be reviewed by the Compliance Leader on a biannual basis. Also, a summary report of EOC rounds will be given to the Environment of Care Committee on an ongoing basis.

Individual responsible: Brett Hanson, Director of Facility Management
## Statement of Deficiencies and Plan of Correction

### Eastern Idaho Regional Medical Center

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<thead>
<tr>
<th>ID</th>
<th>Tag</th>
<th>Summary Statement of Deficiencies</th>
<th>ID</th>
<th>Tag</th>
<th>Provider's Plan of Correction</th>
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<tbody>
<tr>
<td>K161</td>
<td>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.) 8.2 Construction and Compartmentation. 8.2.1 Construction. 8.2.1.1 Buildings or structures occupied or used in accordance with the individual occupancy chapters, Chapters 11 through 43, shall meet the minimum construction requirements of those chapters.</td>
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<tr>
<td>K211</td>
<td>Means of Egress - General</td>
<td>Plan of Correction (POC): The pallet and other storage items have been removed from the exit path. This was corrected prior to the surveyor's departure.</td>
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</table>

**Findings include:**

During the facility tour on June 12, 2019, from approximately 9:00 AM - 3:30 PM, observation of the "Catch All" storage area, revealed one of two exits were obstructed by a full pallet and other storage items. Interview of the Director of

| Individual responsible: Brett Hanson, Director of Facility Management |

| Process for implementing POC: The above mentioned items were removed by the facility engineering staff. Re-education will be given to the facility leadership regarding the expectation of leaving exit paths free of obstructions. |

| Process improvement actions incorporated into the QAPI program: The EOC rounds results will be reviewed by the Compliance Leader on a biannual basis. Also, a summary report of EOC rounds will be given to the Environment of Care Committee on an ongoing basis. |

| Monitoring & tracking procedures ensuring the POC is effective: The "Catch All" storage area has been added to areas for observation for Environment of Care (EOC) rounds. |
**K 211** Continued From page 4
Facilities and Interim Director of Facilities at the time of discovery revealed staff had been instructed to keep the exits clear of storage items and the facility was not aware the exit door had been blocked.

Actual NFPA standard:

NFPA 101
19.2 Means of Egress Requirements.
19.2.1 General. Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7, unless otherwise modified by 19.2.2 through 19.2.11.
7.1.10 Means of Egress Reliability.
7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.

K 291 Emergency Lighting
CFR(s): NFPA 101
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
This STANDARD is not met as evidenced by:
Based on record review and interview the facility failed to provide monthly and annual emergency lighting test documentation. Failure to test the emergency lighting could inhibit egress of patients during an emergency. This deficient practice affected all patients and staff on the dates of the survey.

Findings include:
During review of provided maintenance

<table>
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<tr>
<th><strong>K 211</strong></th>
<th><strong>K 291</strong></th>
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<tbody>
<tr>
<td><strong>Plan of Correction (POC):</strong> The battery powered and the generator powered emergency lighting were tested. This was corrected prior to the surveyor's departure.</td>
<td><strong>K 291</strong></td>
</tr>
<tr>
<td><strong>Process for implementing POC:</strong> The battery powered and the generator powered emergency lighting was added to the current inventory for monthly and annual inspection with associated documentation.</td>
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<td><strong>Monitoring &amp; tracking procedures ensuring the POC is effective:</strong> Inspections of the lighting, as above mentioned, will occur on a monthly basis to verify the pass/fail status of each light.</td>
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<td><strong>Process improvement actions incorporated into the QAPI program:</strong> The results of the inspections will be reviewed by the Compliance Leader on a monthly basis.</td>
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<tr>
<td><strong>Individual responsible:</strong> Brett Hanson, Director of Facility Management</td>
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K 291 | | | |

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<tr>
<td>K 291</td>
<td>Continued From page 6</td>
<td>lighting system is battery powered. (4) The emergency lighting equipment shall be fully operational for the duration of the tests required by 7.9.3.1.1(1) and (3). (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. 7.9.3.1.2 Testing of required emergency lighting systems shall be permitted to be conducted as follows: (1) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall be provided. (2) Not less than once every 30 days, self-testing/self-diagnostic battery-operated emergency lighting equipment shall automatically perform a test with a duration of a minimum of 30 seconds and a diagnostic routine. (3) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall indicate failures by a status indicator. (4) A visual inspection shall be performed at intervals not exceeding 30 days. (5) Functional testing shall be conducted annually for a minimum of 1-1/2 hours. (6) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall be fully operational for the duration of the 1-1/2-hour test. (7) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. 7.9.3.1.3 Testing of required emergency lighting systems shall be permitted to be conducted as follows: (1) Computer-based, self-testing/self-diagnostic battery-operated emergency lighting equipment shall be provided. (2) Not less than once every 30 days, emergency lighting equipment</td>
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<td>K291</td>
<td>Continued From page 7 shall automatically perform a test with a duration of a minimum of 30 seconds and a diagnostic routine. (3) The emergency lighting equipment shall automatically perform annually a test for a minimum of 1-1/2 hours. (4) The emergency lighting equipment shall be fully operational for the duration of the tests required by 7.9.3.1.3(2) and (3). (5) The computer-based system shall be capable of providing a report of the history of tests and failures at all times.</td>
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<td>K321</td>
<td>Hazardous Areas - Enclosure CFR(s): NFPA 101</td>
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<td>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 resisting 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. 19.3.2.1, 19.3.5.9</td>
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<tr>
<td>Area</td>
<td>Automatic Sprinkler</td>
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<tr>
<td>a. Boiler and Fuel-Fired Heater Rooms</td>
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<td>b. Laundries (larger than 100 square feet)</td>
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<td>c. Repair, Maintenance, and Paint Shops</td>
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<td>d. Soiled Linen Rooms (exceeding 64 gallons)</td>
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**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:** 130018

**STATE NAME OF PROVIDER OR SUPPLIER**

**EASTERN IDAHO REGIONAL MEDICAL CENTER**

**A. PROVIDER'S PLAN OF CORRECTION**

**K321** Continued From page 8

- **e. Trash Collection Rooms** (exceeding 64 gallons)
- **f. Combustible Storage Rooms/Spaces** (over 50 square feet)
- **g. Laboratories (if classified as Severe Hazard - see K322)**

This STANDARD is not met as evidenced by:

Based on observation and interview, the facility failed to ensure hazardous areas were protected with self-closing doors. Failure to provide self-closing doors for hazardous areas could allow smoke and dangerous gases to pass freely into corridors and hinder egress of occupants during a fire event. This deficient practice affected two (2) visitors and one (1) staff in the gift shop on the date of the survey.

Findings include:

During the facility tour on June 12, 2019, from approximately 9:00 AM - 3:30 PM, observation of the gift shop storage room revealed the self-closing door was being chocked open. The room was larger than 50 ft². When asked, the person working in the gift shop stated the door is always chocked open and has been for years.

Actual NFPA standard:

**NFPA 101**

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:

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<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tbody>
<tr>
<td>K321</td>
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<td>K321</td>
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<td></td>
<td>Plan of Correction (POC): The door chock was removed from the gift shop storage room. This was corrected prior to the surveyor's departure.</td>
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<td>Process for implementing POC: Education will be given to all leadership within the facility of the expectation of doors not being chocked open.</td>
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<td>Monitoring &amp; tracking procedures ensuring the POC is effective: The verification of the absence of doors being chocked open has been added to areas for observation for Environment of Care (EOC) rounds.</td>
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<td>Process improvement actions incorporated into the QAPI program: The EOC rounds results will be reviewed by the Compliance Leader on a biannual basis. Also a summary report of EOC rounds will be given to the Environment of Care Committee on an ongoing basis.</td>
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<td>Individual responsible: Brett Hanson, Director of Facility Management.</td>
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**DATE SURVEY COMPLETED:** 06/13/2019

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

3100 CHANNING WAY
IDAHO FALLS, ID 83404

**COMPLETION DATE:** 08/15/19
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>K 321</td>
<td>Continued From page 9 (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 deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard.</td>
<td>K 321</td>
<td></td>
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<tr>
<td>K 325</td>
<td>Alcohol Based Hand Rub Dispenser (ABHR) CFR(s): NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in</td>
<td>K 325</td>
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</table>
**DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
**CENTERS FOR MEDICARE & MEDICAID SERVICES**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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</table>
| K325 | Continued From page 10

sprinklered smoke compartments

* ABHR does not exceed 95 percent alcohol
* Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11)
* ABHR is protected against inappropriate access

18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485

This STANDARD is not met as evidenced by:

Based on record review, observation and interview, the facility failed to ensure alcohol-based hand rub (ABHR) dispensers were maintained properly. Failure to ensure ABHR dispensers are clear of ignition sources and tested during refilling procedures, has the potential of increasing the risk of fires from flammable liquids. This deficient practice affected all patients and staff on the dates of the survey.

**Findings include:**

1.) During review of provided maintenance inspection/testing records on June 11, 2019, from approximately 8:00 AM to 11:00 AM, no documentation could be produced for the testing of ABHR dispensers each time they are refilled. At approximately 9:00 AM, on June 11, 2019, interview of the Safety Coordinator and Environment of Care Coordinator revealed the facility was unaware of this requirement. The Safety Coordinator stated housekeeping staff check to ensure proper operation of the dispenser but was unaware of any documentation to support this claim.

2.) During the facility tour on June 11, 2019, from approximately 3:00 PM - 5:10 PM, and on June 12, 2019, from approximately 8:00 AM - 3:30 PM, both automatic and manual ABHR dispensers were identified throughout the facility. Further

**Plan of Correction (POC):**

1. Will create documentation that will be affixed to the alcohol-based hand rub (ABHR) dispensers upon them being refilled.
2. Will relocate the alcohol-based hand rub (ABHR) dispensers away from electrical outlets.

**Process for implementing POC:**

1. Education will occur to those applicable staff that will be responsible for the documentation. Training will include the process of testing the dispensers and documenting on the label to affix to the refill containers.
2. Verification of completion will be completed by the Director of Plant Operations.

**Monitoring & tracking procedures ensuring the POC is effective:**

Checks of the alcohol-based hand rub (ABHR) dispensers has been added to areas for observation for Environment of Care (EOC) rounds. With any new installation, the location will be verified by Engineering to ensure that it is not over an electrical outlet.

**Process improvement actions incorporated into the QAPI program:**

The EOC rounds results will be reviewed by the Compliance Leader on a biannual basis. Also, a summary report of EOC rounds will be given to the Environment of Care Committee on an ongoing basis.

**Individual responsible:** Brett Hanson, Director of Facility Management
Continued From page 11

observation revealed the following areas had ABHR dispensers installed over an electrical outlet:

a.) First Floor corridor outside of the Emergency Room Par Room.

b.) Kitchen Dietary Office

c.) Nuclear Medicine Suite Dressing Room

Interview of the Director of Facilities, the Safety Coordinator, and Chief Engineer on June 12, 2019, at approximately 11:00 AM, revealed the facility was unaware ABHR dispensers had been installed above electrical outlets.

Actual NFPA standard:

NFPA 101
19.3.2.6* Alcohol-Based Hand-Rub Dispensers.

Alcohol-based hand-rub dispensers shall be protected in accordance with 8.7.3.1, unless all of the following conditions are met:

(1) Where dispensers are installed in a corridor, the corridor shall have a minimum width of 6 ft (1830 mm).

(2) The maximum individual dispenser fluid capacity shall be as follows: (a) 0.32 gal (1.2 L) for dispensers in rooms, corridors, and areas open to corridors

(b) 0.53 gal (2.0 L) for dispensers in suites of rooms

(3) Where aerosol containers are used, the maximum capacity of the aerosol dispenser shall be 18 oz. (0.51 kg) and shall be limited to Level 1 aerosols as defined in NFPA30B, Code for the Manufacture and Storage of Aerosol Products.

(4) Dispensers shall be separated from each other by horizontal spacing of not less than 48 in. (1220 mm).

(5) Not more than an aggregate 10 gal (37.8 L) of alcohol based hand-rub solution or 1135 oz (32.2
K 325 Continued From page 12

kg) of Level 1 aerosols, or a combination of
liquids and Level 1 aerosols not to exceed, in
total, the equivalent of 10 gal (37.8 L) or 1135 oz
(32.2 kg), shall be in use outside of a
storage cabinet in a single smoke compartment,
except as otherwise provided in 19.3.2.6(6).
(6) One dispenser complying with 19.3.2.6(2) or
(3) per room and located in that room shall not be
included in the aggregated quantity addressed in
19.3.2.6(5).
(7) Storage of quantities greater than 5 gal (18.9
L) in a single smoke compartment shall meet the
requirements of NFPA 30, Flammable and
Combustible Liquids Code.
(8) Dispensers shall not be installed in the
following locations:
(a) Above an ignition source within a 1 in. (25
mm) horizontal distance from each side of the
ignition source
(b) To the side of an ignition source within a 1 in.
(25mm) horizontal distance from the ignition
source
(c) Beneath an ignition source within a 1 in. (25
mm) vertical distance from the ignition source
(9) Dispensers installed directly over carpeted
floors shall be permitted only in sprinklered
smoke compartments.
(10) The alcohol-based hand-rub solution shall
not exceed 95 percent alcohol content by volume.
(11) Operation of the dispenser shall comply with
the following
criteria:
(a) The dispenser shall not release its contents
except when the dispenser is activated, either
manually or automatically by touch-free
activation.
(b) Any activation of the dispenser shall occur
only when an object is placed within 4 in. (100
mm) of the sensing device.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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<td>K 325</td>
<td>Continued From page 13</td>
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<td>(c) An object placed within the activation zone and left in place shall not cause more than one activation.</td>
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<td>(d) The dispenser shall not dispense more solution than the amount required for hand hygiene consistent with label instructions.</td>
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<td>(e) The dispenser shall be designed, constructed, and operated in a manner that ensures that accidental or malicious activation of the dispensing device is minimized.</td>
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<td>(f) The dispenser shall be tested in accordance with the manufacturer's care and use instructions each time a new refill is installed.</td>
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<tr>
<td>K 353</td>
<td>Sprinkler System - Maintenance and Testing</td>
<td>CFR(s): NFPA 101</td>
<td>Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.</td>
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<td>a) Date sprinkler system last checked</td>
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<td>b) Who provided system test</td>
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<td>c) Water system supply source</td>
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<td>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25</td>
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<td>This STANDARD is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure fire</td>
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION
(X1) PROVIDER/SUPPLIER/CUSTODIAN IDENTIFICATION NUMBER:
130018
B. WING

(C2) MULTIPLE CONSTRUCTION
A. BUILDING 01 - ENTIRE HOSPITAL

(X3) DATE SURVEY COMPLETED
06/13/2019

NAME OF PROVIDER OR SUPPLIER
EASTERN IDAHO REGIONAL MEDICAL CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
3100 CHANNING WAY
IDAHO FALLS, ID 83404

(X4) ID PREFIX
TAG

SERIES STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

K353

PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE
APPROPRIATE DEFICIENCY)

Plan of Correction (POC):
1. The facility will remove the paint from Fire Sprinklers in Room 14 at BHC and the SANE room. Will install the Fire Sprinkler escutcheon rings on the 8 sprinklers in the BHC gym, the sprinkler in Gift Shop storage room and the sprinkler in the Labor & Delivery Dressing Room.
2. The dry system gauge inspection was completed.

Process for implementing POC:
1. Verification of completion will be completed by the Director of Plant Operations.
2. The dry system gauge inspection will occur on a weekly basis going forward.

Monitoring & tracking procedures ensuring the POC is effective:
1. Checks for the fire sprinklers will be added to the annual Fire Sprinkler Inspection. Also, the visual observation of fire sprinklers has been added to areas for observation for Environment of Care (EOC) rounds.
2. The dry system gauge inspection will be added to the current Building Systems inspection checklist to occur on a weekly basis.

Process improvement actions incorporated into the QAPI program:
1. The Fire Sprinkler Inspection report will be reviewed on an annual basis. EOC rounds results will be reviewed by the Compliance Leader on a biannual basis. Also, a summary report of EOC rounds will be given to the Environment of Care Committee on an ongoing basis.
2. The Compliance Leader will review the results of the inspection checklist on a monthly basis.

Individual responsible: Brett Hanson, Director of Facility Management

Form CMS-2587(02-99) Previous Versions Obsolete

PRINTED: 06/21/2019
FORM APPROVED
OMB NO. 0938-0391

K353

Continued From page 14
suppression systems were maintained properly. Failure to inspect system components and ensure fire suppression system pendants were maintained free of obstructions such as paint or corrosion could hinder system performance during a fire event. This deficient practice affected all patients and staff on the dates of the survey.

Findings include:

1.) During the facility tour on June 11, 2019, from approximately 3:00 PM - 5:10 PM, and June 12, 2019, from approximately 9:00 AM - 3:30 PM, observation of the bath in room #14 at the Behavioral Health Center (BHC) revealed a corroded sprinkler head, and the SANE room bath in Radiology had a painted sprinkler head. The Behavioral Health Clinic (BHC) Gym was missing eight (8) escutcheon rings, the Gift Shop storage room was missing one (1) escutcheon ring and the Labor & Delivery dressing room was missing one (1) escutcheon ring.
2.) During record review on June 11, 2019, from approximately 8:00 AM to 11:00 AM, no documentation for weekly dry system gauge inspections could be produced.

Actual NFPA standard:
NFPA 25
1.) 5.2.1 Sprinklers.
   5.2.1.1* Sprinklers shall be inspected from the floor level annually.
   5.2.1.1.1* Sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and
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<tr>
<td>K 353</td>
<td>Continued From page 15 physical damage; and shall be installed in the correct orientation (e.g., upright, pendent, or sidewall). 5.2.1.1.2 Any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical damage (4) Loss of fluid in the glass bulb heat responsive element (5) *Loading (6) Painting unless painted by the sprinkler manufacturer. 8.3.5.6.2 (3) The annular space created by the membrane penetration of a fire sprinkler shall be permitted, provided that the space is covered by a metal escutcheon plate. 2.) 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.</td>
<td>K 353</td>
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<td>K 363</td>
<td>Corridor - Doors CFR(s): NFPA 101</td>
<td>K 363</td>
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|               | Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors

*Loading
K 363 Continued From page 16

To rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.

19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485

Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.

This STANDARD is not met as evidenced by:

Based on observation and operational testing, the facility failed to maintain doors that protect corridor openings. Failure to maintain corridor doors could allow smoke and dangerous gases to pass freely and hinder protection in place.

During the facility tour on June 12, 2019 at approximately 11:00 AM, observation and operational testing of the corridor door leading to the Burn Trauma waiting room was chocked open.

Plan of Correction (POC): The door chock was removed from the Burn Trauma waiting room. This was corrected prior to the surveyor's departure.

Process for implementing POC: Education will be given to all leadership within the facility of the expectation of doors not being chocked open.

Monitoring & tracking procedures ensuring the POC is effective: The verification of the absence of doors being chocked open has been added to areas for observation for Environment of Care (EOC) rounds.

Process improvement actions incorporated into the QAPI program: The EOC rounds results will be reviewed by the Compliance Leader on a biannual basis. Also, a summary report of EOC rounds will be given to the Environment of Care Committee on an ongoing basis.

Individual responsible: Brett Hanson,
Director of Facility Management
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<tr>
<td>K 363</td>
<td>Continued From page 17 After removing the chalk, it was determined the door was self-closing. Observation of the size of the waiting room revealed it was greater than 600 ft². Actual NFPA Standard 19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be doors constructed to resist the passage of smoke and shall be constructed of materials such as the following: (1) 13.4 in. (44 mm) thick, solid-bonded core wood (2) Material that resists fire for a minimum of 20 minutes</td>
<td>K 363</td>
<td>Plan of Correction (POC): As the wall identified in the findings is not a fire rated partition, the Fire Rating label on said wall will be removed.</td>
<td>08/15/19</td>
</tr>
<tr>
<td>K 372</td>
<td>Subdivision of Building Spaces - Smoke Barrier CFR(6): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure the fire and smoke resistive properties of the structure were maintained. Failure to maintain rated barriers could allow fire, smoke and</td>
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CILA IDENTIFICATION NUMBER:
130018

(X2) MULTIPLE CONSTRUCTION
A. BUILDING 01 - ENTIRE HOSPITAL
B. WING

(X3) DATE SURVEY COMPLETED
06/13/2019

NAME OF PROVIDER OR SUPPLIER
EASTERN IDAHO REGIONAL MEDICAL CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
3100 CHANNING WAY
IDAHO FALLS, ID 83404

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<td>K372</td>
<td>Continued From page 18</td>
<td>dangerous gases to pass between compartments during a fire. This deficient practice affected patients and staff on the second floor, in 1 of 7 smoke compartments on the dates of the survey. Findings include: During the facility tour on June 12, 2019, at 9:45 AM, inspection of the rated barrier above the drop ceiling located in the central supply surgery center near the entrance door, revealed approximately one-fourth of the wall had been cut away. Actual NFPA standard: 8.5.6 Penetrations. 8.5.6.3 Where a smoke barrier is also constructed as a fire barrier, the penetrations shall be protected in accordance with the requirements of 8.3.5 to limit the spread of fire for a time period equal to the fire resistance rating of the assembly and 8.5.6 to restrict the transfer of smoke, unless the requirements of 8.5.6.4 are met.</td>
<td>K374</td>
<td>Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and</td>
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</tbody>
</table>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER: 130018

(X2) MULTIPLE CONSTRUCTION
A. BUILDING 01 - ENTIRE HOSPITAL

B. WING__

(X3) DATE SURVEY COMPLETED: 06/13/2019

NAME OF PROVIDER OR SUPPLIER: EASTERN IDAHO REGIONAL MEDICAL CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 3100 CHANNING WAY, IDAHO FALLS, ID 83404

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL 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 DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>K 374</td>
<td>Continued From page 19 are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This STANDARD is not met as evidenced by: Based on observation and operational testing, the facility failed to ensure cross corridor doors were maintained to limit the transfer of smoke, fire and dangerous gases between compartments. Failure to ensure rated doors limit the transfer of smoke, has the potential to hinder egress and the ability to shelter in place. This deficient practice affected patients and staff in the burn trauma and medical imaging areas of the facility on the dates of the survey. Findings include: During the facility tour on June 12, 2019, from approximately 9:00 AM - 3:30 PM, observation and operational testing of the cross-corridor smoke barrier doors located on the second floor near the CT-1 room and at the front hall of Medical Imaging, revealed both sets of cross-corridor doors would not self-close and latch when released from the magnetic hold open device. Actual NFPA standard: 19.3.7.8* Doors in smoke barriers shall comply with 8.5.4 and all of the following: (1) The doors shall be self-closing or automatic-closing in accordance with 19.2.2.2.7. (2) Latching hardware shall not be required (3) The doors shall not be required to swing in the direction of egress travel. 8.5.4.1* Doors in smoke barriers shall close the</td>
<td>K 374 Plan of Correction (POC): Vendors have been contracted and tasked with inspection and repairs to all noted doors. This was corrected prior to the surveyor’s departure. Process for implementing POC: Doors are inspected and repairs are completed per NFPA standards. Verification of completion was completed by the Director of Plant Operations. Monitoring &amp; tracking procedures ensuring the POC is effective: The visual observation of doors latching has been added to areas for observation for Environment of Care (EOC) rounds. Process improvement actions incorporated into the QAPI program: The EOC rounds results will be reviewed by the Compliance Leader on a biannual basis. Also a summary report of EOC rounds will be given to the Environment of Care Committee on an ongoing basis. Individual responsible: Brett Hansen, Director of Facility Management</td>
<td>06/14/19</td>
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</tbody>
</table>

FORM CMS-2587(02·99) Previous Versions Obsolete
Event ID: 81WC21 Facility ID: IDLFQV

If continuation sheet Page 20 of 30
### Summary Statement of Deficiencies

<table>
<thead>
<tr>
<th>Deficiency</th>
<th>ID</th>
<th>Prefix</th>
<th>TAG</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>K 374</td>
<td>130018</td>
<td>B. WING</td>
<td>06/13/2019</td>
<td>Continued From page 20, opening, leaving only the minimum clearance necessary for proper operation, and shall be without louvers or grilles. The clearance under the bottom of a new door shall be a maximum of 3.4 in. (19 mm). 8.5.4.4* Doors in smoke barriers shall be self-closing or automatic-closing in accordance with 7.2.1.8 and shall comply with the provisions of 7.2.1.</td>
</tr>
<tr>
<td>K 907</td>
<td>130018</td>
<td>B. WING</td>
<td>06/13/2019</td>
<td>Plan of Correction (POC): Will develop a written maintenance program for positive pressure medical gas central piping, medical-surgical vacuum, and WAGD systems that will match the process we currently already had in place.</td>
</tr>
</tbody>
</table>

**Plan of Correction (POC):**

- Develop a written maintenance program for positive pressure medical gas central piping, medical-surgical vacuum, and WAGD systems that will match the process we currently already had in place.

**Process for implementing POC:**

- The written maintenance program will be placed in the Building Maintenance software system.

**Monitoring & tracking procedures ensuring the POC is effective:**

- The written maintenance program will be reviewed on an annual basis to ensure continued compliance.

**Process improvement actions incorporated into the QAPI program:**

- The annual review of the program will be approved by the Director of Plant Operations.

**Individual responsible:** Brett Hanson, Director of Facility Management.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**IDentiFICATION NUMBER:** 130018

**NAME OF PROVIDER OR SUPPLIER:** EASTERN IDAHO REGIONAL MEDICAL CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE:** 3100 CHANNING WAY, IDAHO FALLS, ID 83404

**SUMMARY STATEMENT OF DEFICIENCIES**

*Each deficiency must be preceded by full regulatory or LSC identifying information*

<table>
<thead>
<tr>
<th>ID</th>
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<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>(X6) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>K907</td>
<td>Continued From page 21 maintenance program based on a facility risk assessment and manufacturer's recommendations, could result in fire, explosion, or a lack of system performance as designed. This deficient practice affected all patients and staff on the dates of the survey. Findings include: During record review on June 11, 2019, from approximately 8:00 AM to 11:00 AM, no documentation of a written maintenance program for the positive pressure gas central piping, medical-surgical vacuum, and WAGD systems could be produced. Interview of the Safety Coordinator and Environment of Care Coordinator at the time of record review, and the Director of Facilities and Chief Engineer on June 12, 2019 at approximately 8:15 AM, confirmed the facility did not have a written maintenance program. All staff interviewed were unaware of the requirement for a written maintenance program based on a facility risk assessment and manufacturer's recommendations. Actual NFPA standard: NFPA 99 5.1.14.2.1* General. Health care facilities with installed medical gas, vacuum, WAGD, or medical support gas systems, or combinations thereof, shall develop and document periodic maintenance programs for these systems and their subcomponents as appropriate to the equipment installed. 5.1.14.2.2 Maintenance Programs. 5.1.14.2.2.1 Inventories. Inventories of medical gas, vacuum, WAGD, and medical support gas systems shall include at least all source...</td>
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</table>

**Actual NFPA standard:**

1. NFPA 99
2. 5.1.14.2.1* General. Health care facilities with installed medical gas, vacuum, WAGD, or medical support gas systems, or combinations thereof, shall develop and document periodic maintenance programs for these systems and their subcomponents as appropriate to the equipment installed.
3. 5.1.14.2.2 Maintenance Programs.
4. 5.1.14.2.2.1 Inventories. Inventories of medical gas, vacuum, WAGD, and medical support gas systems shall include at least all source...
<table>
<thead>
<tr>
<th>K907</th>
<th>Continued From page 22</th>
<th>K907</th>
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<tbody>
<tr>
<td>subsystems, control valves, alarms, manufactured assemblies containing patient gases, and outlets. 5.1.14.2.2.2* Inspection Schedules. Scheduled inspections for equipment and procedures shall be established through the risk assessment of the facility and developed with consideration of the original equipment manufacturer recommendations and other recommendations as required by the authority having jurisdiction. 5.1.14.2.2.3 Inspection Procedures. The facility shall be permitted to use any inspection procedure(s) or testing methods established through its own risk assessment. 5.1.14.2.2.4 Maintenance Schedules. Scheduled maintenance for equipment and procedures shall be established through the risk assessment of the facility and developed with consideration of the original equipment manufacturer recommendations and other recommendations as required by the authority having jurisdiction. 5.1.14.2.2.5 Qualifications. Persons maintaining these systems shall be qualified to perform these operations. Appropriate qualification shall be demonstrated by any of the following: (1) Training and certification through the health care facility by which such persons are employed to work with specific equipment as installed in that facility (2) Credentialing to the requirements of ASSE 6040, Professional Qualification Standard for Medical Gas Maintenance Personnel (3) Credentialing to the requirements of ASSE 6030, Professional Qualification Standard for Medical Gas Systems Verifiers 5.1.14.2.3 Inspection and Testing Operations. 5.1.14.2.3.1 General. The elements in 5.1.14.2.2.2 through 5.1.15 shall be inspected or tested as part of the maintenance program as</td>
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**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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</thead>
</table>
| K 907 | Continued From page 23 | K 907 | (1)*Medical air source, as follows:  
(a) Room temperature  
(b) Shaft seal condition  
(c) Filter condition  
(d) Presence of hydrocarbons  
(e) Room ventilation  
(f) Water quality, if so equipped  
(g) Intake location  
(h) Carbon monoxide monitor calibration  
(i) Air purity  
(j) Dew point  
(2)*Medical vacuum source - exhaust location  
(3) WAGD source - exhaust location  
(4)*Instrument air source - filter condition  
(5)*Manifold sources (including systems complying with 5.1.3.5.10, 5.1.3.5.11, 5.1.3.5.12, and 5.1.3.5.13), as follows:  
(a) Ventilation  
(b) Enclosure labeling  
(6) Bulk cryogenic liquid source inspected in accordance with NFPA 55, Compressed Gases and Cryogenic Fluids Code  
(7) Final line regulation for all positive pressure systems - delivery pressure  
(8)*Valves - labeling  
(9)*Alarms and warning systems-lamp and audio operation  
(10) Alarms and warning systems, as follows:  
(a) Master alarm signal operation  
(b) Area alarm signal operation  
(c) Local alarm signal operation  
(11)*Station outlets/inlets, as follows:  
(a) Flow  
(b) Labeling  
(c) Latching/delatching  
(d) Leaks  
5.1.14.2.3.2 Manufactured Assemblies Employing Flexible Connection(s) Between the User |
### Terminal and the Piping System.

(A) Non-stationary booms and articulating assemblies, other than head walls utilizing flexible connectors, shall be tested for leaks, per manufacturer’s recommendations, every 18 months or at a duration as determined by a risk assessment.

(B) The system pressure to non-stationary booms and articulating arms shall be maintained at operating pressure until each joint has been examined for leakage by effective means of leak detection that is safe for use with oxygen.

(C) Safe working condition of the flexible assemblies shall be confirmed.

(D) D.I.S.S. connectors internal to the boom and assemblies shall be checked for leakage.

(E) Leaks, if any, shall be repaired (if permitted), or the components replaced (if required), and the equipment retested prior to placing the equipment back into service.

(F) Additional testing of non-stationary booms or articulating arms shall be performed at intervals defined by documented performance data.

5.1.14.3 Medical Gas and Vacuum Systems Information and Warning Signs.

5.1.14.3.1 The gas content of medical gas and vacuum piping systems shall be labeled in accordance with 5.1.11.1.

5.1.14.3.2 Labels for shutoff valves shall be in accordance with 5.1.11.2 and updated when modifications are made changing the areas served.

5.1.14.4 Medical Gas and Vacuum Systems Maintenance and Record Keeping. See B.5.2.

5.1.14.4.1 Permanent records of all tests required by 5.1.12.3.1 through 5.1.12.3.14 shall be maintained in the organization’s files.

5.1.14.4.2 The supplier of the bulk cryogenic liquid system shall, upon request, provide...
### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CUA Identification Number:** 130018

**Name of Provider or Supplier:** Eastern Idaho Regional Medical Center

**Street Address, City, State, Zip Code:** 3100 Channing Way, Idaho Falls, ID 83404

<table>
<thead>
<tr>
<th>ID</th>
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<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</th>
<th>K 907</th>
<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency)</th>
<th>Completion Date</th>
</tr>
</thead>
</table>
| K 907 | Continued From page 25 | documentation of vaporizer(s) sizing criteria to the facility.  
5.1.14.4.3 An annual review of bulk system capacity shall be conducted to ensure the source system has sufficient capacity.  
5.1.14.4.4 Central supply systems for nonflammable medical gases shall conform to the following:  
(1) They shall be inspected annually.  
(2) They shall be maintained by a qualified representative of the equipment owner.  
(3) A record of the annual inspection shall be available for review by the authority having jurisdiction.  
5.1.14.4.5 A periodic testing procedure for nonflammable medical gas and vacuum and related alarm systems shall be implemented.  
5.1.14.4.6 Whenever modifications are made that breach the pipeline, any necessary installer and verification test specified in 5.1.12 shall be conducted on the downstream portions of the medical gas piping system.  
5.1.14.4.7 Procedures, as specified, shall be established for the following:  
(1) Maintenance program for the medical air compressor supply system in accordance with the manufacturer’s recommendations  
(2) Facility testing and calibration procedure that ensures carbon monoxide monitors are calibrated at least annually or more often if recommended by the manufacturer  
(3) Maintenance program for both the medical-surgical vacuum piping system and the secondary equipment attached to medical-surgical vacuum station inlets to ensure the continued good performance of the entire medical-surgical vacuum system  
(4) Maintenance program for the WAGD system to ensure performance | | | |

**Form CMS-2587(02-99) Previous Versions Obsolete**  
**Event ID:** 61WGC1  
**Facility ID:** IDLFQV  
**If continuation sheet Page 26 of 30**
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</thead>
<tbody>
<tr>
<td>K907</td>
<td>Continued From page 26 5.1.14.4.8 Audible and visual alarm indicators shall meet the following requirements: (1) They shall be periodically tested to determine that they are functioning properly. (2) Records of the test shall be maintained until the next test is performed. 5.1.14.4.9 Medical-surgical vacuum station inlet terminal performance, as required in 5.1.12.3.10.4, shall be tested as follows: (1) On a regular preventive maintenance schedule as determined by the facility maintenance staff (2) Based on flow of free air (NI/min or SCFM) into a station inlet while simultaneously checking the vacuum level. 5.1.15* Category 1 Maintenance. Facilities shall have a routine maintenance program for their piped medical gas and vacuum systems. 5.2 Category 2 Piped Gas and Vacuum Systems. 5.2.1* Applicability. These requirements shall apply to health care facilities that qualify for Category 2 systems as referenced in Chapter 4. 5.2.1.1 Section 5.2 through 5.2.12 shall apply to new health care facilities or facilities making changes that alter the piping. 5.2.1.2 Subsection 5.2.13 5.2.14* Category 2 Maintenance. Facilities shall have a routine maintenance program for their piped medical gas and vacuum systems. 5.3.13.4.2 A periodic testing procedure for Category 3 gas and vacuum systems and related alarm systems shall be implemented.</td>
<td>K907</td>
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<tr>
<td>K923</td>
<td>Gas Equipment - Cylinder and Container Storage CFR(s): NFPA 101</td>
<td>K923</td>
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Facility ID: IOLFQV
Event ID: 61WC21
Facility ID: IDLFQV

If continuation sheet Page 27 of 30
K923 Continued From page 27

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 gates 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 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, 11.8.5 (NFPA 99)

This STANDARD is not met as evidenced by:

Based on observation and interview, the facility failed to ensure medical gas cylinders and oxygen storage areas were maintained in accordance with NFPA 99. Failure to properly sign oxygen storage areas and separate full cylinders from
I, DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:
130018
(X2) MULTIPLE CONSTRUCTION
A. BUILDING 01 - ENTIRE HOSPITAL
B. WING

NAME OF PROVIDER OR SUPPLIER
EASTERN IDAHO REGIONAL MEDICAL CENTER

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<tr>
<td>K923</td>
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<td>Continued From page 28</td>
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</table>

Findings include:

1.) During the facility tour on June 11, 2019 at 8:50 AM, observation of the oxygen storage room on the sixth floor, in the Physical Therapy Gym, revealed the oxygen storage room was not identified as an oxygen storage area with the required signage.

2.) On June 12, 2019, during the facility tour of the second floor at approximately 9:00 AM - 11:30 AM, observation of both the Surgical Holding area and the Cath Lab storage, revealed full and empty oxygen cylinders were being stored together. There was no segregation or signage to indicate where full and empty oxygen cylinders should be stored. On the facility tour, at the time of discovery, interview of the Director of Facilities and Safety Coordinator revealed, staff were aware of the requirement to segregate full and empty oxygen cylinders but had not stored them properly.

Actual NFPA standard:

NFPA 99
1.) 11.3.4 Signs.
1.3.4.1 A precautionary sign, readable from a distance of 1.5 m (5 ft), shall be displayed on each door or gate of the storage room or

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</table>
| K923   |        |     | Plan of Correction (POC):
1. The oxygen storage room on 6th floor in the PT gym has been labeled appropriately. This was corrected prior to the surveyor's departure.
2. Have segregated full and empty oxygen cylinders within the Surgical Holding area. This was corrected prior to the surveyor's departure.

Process for implementing POC: Verification of completion was completed by the Director of Plant Operations.

Monitoring & tracking procedures ensuring the POC is effective: The visual observation of proper oxygen storage signs, and the presence of full and empty oxygen cylinders being stored separately, has been added to areas for observation for Environment of Care (EOC) rounds.

Process improvement actions incorporated into the QAPI program: The EOC rounds results will be reviewed by the Compliance Leader on a biannual basis. Also, a summary report of EOC rounds will be given to the Environment of Care Committee on an ongoing basis.

Individual responsible: Brett Hanson, Director of Facility Management
K 923 Continued From page 29 enclosure.

2.) 11.6.5 Special Precautions - Storage of Cylinders and Containers.
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.
11.6.5.2 If empty and full cylinders are stored within the same enclosure, empty cylinders shall be segregated from full cylinders.
11.6.5.3 Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed in a rapid manner.