



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

IDAHO DEPARTMENT OF  
HEALTH & WELFARE

DEBBY RANSOM, R.N., R.H.I.T. – Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: (208) 334-6626  
FAX: (208) 364-1888  
E-mail: [fsb@dhw.idaho.gov](mailto:fsb@dhw.idaho.gov)

May 23, 2011

Rod Jacobson, Administrator  
Bear Lake Memorial Hospital  
164 South Fifth Street  
Montpelier, Idaho 83254

RE: Bear Lake Memorial Hospital, Provider ID# 131316

Dear Mr. Jacobson:

This is to advise you of the findings of the Medicare/Licensure Fire Life Safety Survey, which was concluded at Bear Lake Memorial Hospital, on May 11, 2011.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicare deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;
2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;
4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Rod Jacobson, Administrator  
May 23, 2011  
Page 2 of 2

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

After you have completed your Plan of Correction, return the original to this office by **June 6, 2011**, and keep a copy for your records.

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

Sincerely,

A handwritten signature in black ink, appearing to read 'TB' followed by a stylized flourish.

TAYLOR BARKLEY  
Health Facility Surveyor  
Facility Fire Safety and Construction Program

TB/lj

Enclosure

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

Printed: 05/20/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>131316</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/11/2011</b>
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NAME OF PROVIDER OR SUPPLIER <b>BEAR LAKE MEMORIAL HOSPITAL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>164 SOUTH FIFTH STREET MONTPELIER, ID 83254</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K-000

INITIAL COMMENTS

K 000

The hospital building is a single story structure with a partial basement. Original construction was 1958 with subsequent additions to include a major addition/renovation completed in 1998. The construction is Type V(111) and is fully sprinklered. The upgraded fire alarm system includes smoke detection throughout the corridors and open areas. The main level of the hospital has 5 exits to grade plus a horizontal exit to the physically attached Skilled nursing Facility. There are two remote exits from the basement which are accessible through Central Stores/Purchasing. The main level of the hospital is sub-divided into three smoke zones.

The following deficiencies were cited during the annual fire/life safety survey conducted on May 11, 2011. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 485.623.

The Survey was conducted by:

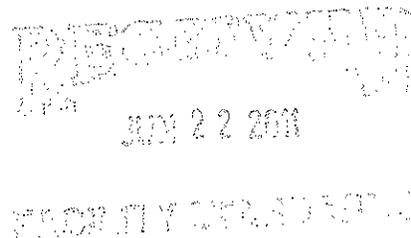
Taylor Barkley  
Health Facility Surveyor  
Facility Fire Safety and Construction

K 017

NFPA 101 LIFE SAFETY CODE STANDARD

K 017

Corridors are separated from use areas by walls constructed with at least 1/2 hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain



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

*God Jacobson*

*Admin*

*6-1-11*

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

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K 017	<p>Continued From page 1</p> <p>conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5</p> <p>This Standard is not met as evidenced by: Based on observation the facility did not ensure that corridor walls were smoke resisting. Openings in corridor walls can allow smoke and fire gasses to enter the corridors. The facility had a census of five patients on the day of survey. This deficiency affected no patients and three staff members in one of five smoke compartments.</p> <p>Findings include:</p> <p>During the tour of the facility on May 11, 2011 at 12:40 PM, observation of the maintenance corridor in the basement revealed twelve holes in the walls that ranged from one inch to five inches in size. This was observed and noted by the Maintenance Supervisor and Surveyor.</p> <p>Actual NFPA Standard:</p> <p>19.3.6.2.1* Corridor walls shall be continuous from the floor to the underside of the floor or roof deck above, through any concealed spaces, such as those above-suspended ceilings, and through interstitial structural and mechanical spaces, and they shall have a fire resistance rating of not less than 1/2 hour.</p>	K 017	<p>All noted holes have been fire caulked. Personnel will be more diligent in follow up after modifications are made.</p>	July 1

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K 017	Continued From page 2	K 017		
K 018	<p>19.3.6.2.2* Corridor walls shall form a barrier to limit the transfer of smoke.</p>	K 018		
	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This Standard is not met as evidenced by: Based on observation the facility did not ensure that corridor doors were smoke resisting and did not have any impediments to closing. Openings in corridor doors or doors left open can allow smoke and fire gasses to enter the corridor. The facility had a census of five patients on the day of survey. These deficiencies affected five patients and twenty seven staff members in four of five smoke compartments.</p>			

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K 018	Continued From page 3 Findings include:  1. During the tour of the facility on May 11, 2011 at 12:35 PM, observation of the door to the purchasing storage room revealed that the door was being held open with a drop down door stop. This was observed and noted by the Maintenance Supervisor and Surveyor.  2. During the tour of the facility on May 11, 2011 at 1:02 PM, observation of the door to the case management office revealed that the door was being held open with a door wedge. This was observed and noted by the Maintenance Supervisor and Surveyor.  3. During the tour of the facility on May 11, 2011 at 1:57 PM, observation of the door to ER #2 revealed that the door was being held open with a door wedge. This was observed and noted by the Maintenance Supervisor and Surveyor.  4. During the tour of the facility on May 11, 2011 at 1:27 PM, observation of the door to patient room #7 revealed that the door was being blocked from closing due to a bed pushed up to the wall. This was observed and noted by the Maintenance Supervisor and Surveyor.  5. During the tour of the facility on May 11, 2011 at 12:42 PM, observation of the door to the basement storage room revealed that the upper half of the door was screened and not solid. This was observed and noted by the Maintenance Supervisor and Surveyor.	K 018	In the short term the kick down will be removed. Long term solution - the door will be controlled by a magnetic latch tied to the fire system.  Employees will be reminded that door stops are not to be used in this facility. An inservice will be given. Maintenance, Admin & Safety personnel will monitor.  Wedge will be removed and during remodel this door too will be placed on fire alarm magnet.  Nurses will be instructed to avoid pushing beds too close to door. Nurse mgmt will check for this issue while doing daily rounds.  Glass has been installed as of May 28, 2011.	July 1st  July 1  July 1  July 1  5-28-11
	6. During the tour of the facility on May 11, 2011 at 1:04 PM, observation of the door to the telephone equipment room revealed a transfer grille in the door. This was observed and noted by		A metal plate will be placed between the inside and outside grills.	July 1

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K 018	Continued From page 4 the Maintenance Supervisor and Surveyor.  7. During the tour of the facility on May 11, 2011 at 1:05 PM, observation of the door to the elevator equipment room revealed two transfer grilles in the door. This was observed and noted by the Maintenance Supervisor and Surveyor.  Actual NFPA Standard:  19.3.6.4 Transfer Grilles. Transfer grilles, regardless of whether they are protected by fusible link-operated dampers, shall not be used in these walls or doors. Exception: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials shall be permitted to have ventilating louvers or to be undercut.	K 018	<del>Both grills will have a</del> metal plate placed between the inside & outside grills.	July 1
K 027	NFPA 101 LIFE SAFETY CODE STANDARD  Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7  This Standard is not met as evidenced by: Based on observation the facility did not ensure that smoke compartment doors are self closing. Smoke compartment doors that do not self close can allow smoke and fire gasses to enter	K 027		

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K 027	Continued From page 5 adjoining smoke compartments. The facility had a census of five patients on the day of survey. This deficiency affected no patients and three staff members in two of five smoke compartments.  Findings include:  During the tour of the facility on May 11, 2011 at 12:47 PM, observation of the maintenance corridor smoke door revealed that it would not self close when released from the open position. This was observed and noted by the Maintenance Supervisor and Surveyor.  Actual NFPA Standard:  19.3.7.6* Doors in smoke barriers shall comply with 8.3.4 and shall be self-closing or automatic-closing in accordance with 19.2.2.2.6. Such doors in smoke barriers shall not be required to swing with egress travel. Positive latching hardware shall not be required.	K 027	Door was adjusted. During monthly fire drills all magnetic fire doors will be checked to assure closing properly.	July 1
K 029	NFPA 101 LIFE SAFETY CODE STANDARD  One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1	K 029		

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K-029	<p>Continued From page 6</p> <p>This Standard is not met as evidenced by: Based on observation and interview it was determined that the facility did not ensure that hazardous areas were constructed with smoke resisting partitions and self closing doors. Hazardous area doors that do not self close and areas that are not smoke resisting can allow smoke and fire gasses to enter the corridor or other areas of the facility in the event of a fire. The facility had a census of five patients on the day of survey. This deficiency affected two patients and twelve staff members in two of five smoke compartments.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. During the tour of the facility on May 11, 2011 at 12:50 PM, observation of the cold storage room revealed two holes in the wall that were approximately twelve inches by twelve inches in size. This was observed and noted by the Maintenance Supervisor and Surveyor.</li> <li>2. During the tour of the facility on May 11, 2011 at 12:52 PM, observation of the fan room revealed a hole in the wall that was approximately ten inches by twelve inches in size. This was observed and noted by the Maintenance Supervisor and Surveyor.</li> <li>3. During the tour of the facility on May 11, 2011 at 1:46 PM, observation of the storage room by the ultrasound room revealed that the door would not self close when released from the open position. This was observed and noted by the Maintenance Supervisor and Surveyor.</li> </ol> <p>Actual NFPA Standard: 19.3.2.1 Hazardous Areas.</p>	K 029	<p>Fire pillows will be placed in both holes. Maintenance personnel will look for other such problems and insure future breaches do not occur.</p> <p>As above.</p> <p>A door closer will be placed on this door. Other hallway doors will be checked for similar issues.</p>	<p>July 1</p> <p>July 1</p>
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K 029	Continued From page 7 Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		
K 056	NFPA 101 LIFE SAFETY CODE STANDARD	K 056		
	If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the			

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<del>K-056</del>	<del>Continued From page 8</del>	<del>K-056</del>		
	<p>Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>This Standard is not met as evidenced by: Based on observation and interview the facility did not ensure that the sprinkler system was installed and maintained in accordance NFPA 13. A painted sprinkler head has the potential to not operate as designed or may not operate at all in the event of a fire. Unprotected areas can allow a fire to grow, accelerate and spread. The facility had a census of five patients on the day of survey. This deficiency affected five patients and twenty six staff members in three of five smoke compartments.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. During the tour of the facility on May 11, 2011 at 1:52 PM, observation of the x-ray room revealed a painted pendent sprinkler head. This was observed and noted by the Maintenance Supervisor and Surveyor.</li> <li>2. During the tour of the facility on May 11, 2011 at 1:50 PM, observation of the x-ray room revealed a closet that is approximately four feet by five feet in size that does not have any sprinkler protection. When questioned by the Surveyor the Maintenance Supervisor stated that the closet had been added to the room and he did not know that closets are required to have</li> </ol>		<p>The pendent will be changed out. An inspection for pendent with similar issues will be conducted.</p> <p>Sprinkler heads will be installed.</p>	<p>July 1</p> <p>July 31</p>

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K 056	<p>Continued From page 9 sprinkler protection.</p> <p>3. During the tour of the facility on May 11, 2011 at 1:51 PM, observation of the x-ray room revealed a bathroom that does not have any sprinkler protection. This was observed and noted by the Maintenance Supervisor and Surveyor.</p> <p>4. During the tour of the facility on May 11, 2011 at 1:37 PM, observation of the freight elevator shaft revealed that it did not have any sprinkler protection. When questioned by the Surveyor the Maintenance Supervisor stated that he was unaware of the requirement for sprinklers in the shaft.</p> <p>5. During the tour of the facility on May 11, 2011 at 1:12 PM, observation of the south side of the facility revealed a combustibile covered entry that is approximately fifteen feet by forty seven feet in size that does not have any sprinkler protection. This was observed and noted by the Maintenance Supervisor and Surveyor.</p> <p>6. During the tour of the facility on May 11, 2011 at 2:10 PM, observation of the south west side of the facility revealed a combustibile covered entry that is approximately six feet by twelve feet in size that does not have any sprinkler protection. This was observed and noted by the Maintenance Supervisor and Surveyor.</p> <p>7. During the tour of the facility on May 11, 2011 at 1:37 PM, observation of the basement revealed two walk in coolers that do not have any sprinkler protection. When questioned by the Surveyor the Maintenance Supervisor stated that he was unaware of the requirement for sprinklers in the coolers.</p>	K 056	<p>Sprinkler head will be installed.</p> <p>Demolition Plan attached</p> <p>Sprinkler head will be installed.</p> <p>Above</p> <p>Above</p>	<p>July 31</p> <p>July 31</p> <p>July 31</p> <p>July 31</p> <p>July 31</p>
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NAME OF PROVIDER OR SUPPLIER <b>BEAR LAKE MEMORIAL HOSPITAL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>164 SOUTH FIFTH STREET MONTPELIER, ID 83254</b>
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K-056	Continued From page 10 Actual NFPA Standard:	K-056		
	<p>NFPA 13 Standard for the Installation of Sprinkler Systems 1999 Edition reference:</p> <p>5-1.1* The requirements for spacing, location, and position of sprinklers shall be based on the following principles: (1) Sprinklers installed throughout the premises (2) Sprinklers located so as not to exceed maximum protection area per sprinkler (3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution</p> <p>5-13.6 Elevator Hoistways and Machine Rooms. 5-13.6.1* Sidewall spray sprinklers shall be installed at the bottom of each elevator hoistway not more than 2 ft (0.61 m) above the floor of the pit. Exception: For enclosed, noncombustible elevator shafts that do not contain combustible hydraulic fluids, the sprinklers at the bottom of the shaft are not required.</p> <p>5-13.6.3* Upright or pendent spray sprinklers shall be installed at the top of elevator hoistways. Exception: Sprinklers are not required at the tops of noncombustible hoistways of passenger elevators with car enclosure materials that meet the requirements of ASME A17.1, Safety Code for Elevators and Escalators.</p> <p>5-13.8* Exterior Roofs or Canopies. 5-13.8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 ft (1.2 m) in width. Exception: Sprinklers are permitted to be omitted</p>			

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K 056	Continued From page 11 where the canopy or roof is of noncombustible or limited combustible construction.	K 056		
K 072	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10</p> <p>This Standard is not met as evidenced by: Based on observation and interview the facility did not ensure that means of egress were continuously maintained free of all obstructions or impediments. In the event of an emergency requiring evacuation, obstructions or impediments in the means of egress can create a time delay, create an unsafe egress path or completely make the required exit unusable. The facility had a census of five patients on the day of survey. This deficiency affected five patients and five staff members in one of five smoke compartments.</p> <p>Findings include:</p> <p>1. During the tour of the facility on May 11, 2011 at 1:15 PM, observation of the corridor by the nurses station revealed a large copy machine being used in the corridor. The copy machine protrudes approximately two feet into the corridor. When questioned by the Surveyor the Maintenance Supervisor stated that they did not have anywhere else to keep the machine.</p> <p>2. During the tour of the facility on May 11, 2011</p>	K 072	<p>Copier will be moved to the Nurses Station.</p>	<p>July 1</p>

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K-072	Continued From page 12 between the hours of 1:00 PM to 1:50 PM, observation of the main hospital corridor revealed four electronic charting stations that were not moved or used during this time. When questioned by the Surveyor the Maintenance Supervisor stated that the nursing staff kept the machines in the corridor.  Actual NFPA Standard:  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-072	Computers on wheels that are not being used will not be stored in the hallway. Administrator will monitor for compliance. Other forms of electronic medical record entry modes are being investigated.	July 1
K 076	NFPA 101 LIFE SAFETY CODE STANDARD  Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.  (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.  (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4  This Standard is not met as evidenced by: Based on observation the facility did not ensure that medical gas cylinders were secured in accordance with NFPA 99. Unsecured cylinders can result in a cylinder falling over and being ruptured. The facility had a census of five patients	K 076		

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K 076	<p>Continued From page 13 on the day of survey. This deficiency affected all patients, staff and visitors present on the day of the survey.</p> <p>Findings include:</p> <p>During the tour of the facility on May 11, 2011 at 2:10 PM, observation of the medical gas storage area revealed ten K size oxygen cylinders, two K size nitrous oxide cylinders, and two K size nitrogen cylinders that were not individually secured or in a rack. This was observed and noted by the Maintenance Supervisor and Surveyor.</p> <p>Actual NFPA Standard:</p> <p>NFPA 99 Standard for Health Care Facilities 1999 Edition 4-5.1.1.1 Cylinders in service and in storage shall be individually secured and located to prevent falling or being knocked over. (a) Cylinders or supply containers shall be constructed, tested, and maintained in accordance with the U.S. Department of Transportation specifications and regulations. (b) Cylinder contents shall be identified by attached labels or stencils naming the components and giving their proportions. Labels and stencils shall be lettered in accordance with CGA Pamphlet C-4, Standard Method of Marking Portable Compressed Gas Containers to Identify the Material Contained. (c) Contents of cylinders and containers shall be identified by reading the labels prior to use. Labels shall not be defaced, altered, or removed.</p>	K 076	Individual chains will be installed.	July 1
K 130	NFPA 101 MISCELLANEOUS  OTHER LSC DEFICIENCY NOT ON 2786	K 130		

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K-130	Continued From page 14	K-130	<p>Holes will be filled. Maintenance will monitor for similar problems. During remodel attention will be paid to avoid similar incidents.</p>	July 1
	<p>This Standard is not met as evidenced by: Based on observation and interview the facility did not ensure that floor/ceiling fire ratings were maintained. This deficiency can allow fire and smoke to spread from the basement to the upper level. The facility had a census of five patients on the day of survey. This deficiency affected two patients and fifteen staff members in two of five smoke compartments.</p> <p>Findings include:</p> <p>During the tour of the facility on May 11, 2011 at 12:45 PM, observation of the dry storage room in the basement revealed two holes that are approximately four inches by ten inches in size in the ceiling that opened into the x-ray room above. When questioned by the Surveyor the Maintenance Supervisor stated that he made the two openings in the concrete floor/ceiling for ventilation to the x-ray room.</p> <p>Actual NFPA Standard:</p> <p>8.2.3.1 Fire Resistance-Rated Assemblies. 8.2.3.1.1 Floor-ceiling assemblies and walls used as fire barriers, including supporting construction, shall be of a design that has been tested to meet the conditions of acceptance of NFPA 251, Standard Methods of Tests of Fire Endurance of Building Construction and Materials. Fire barriers shall be continuous in accordance with 8.2.2.2.</p> <p>8.2.2 Compartmentation. 8.2.2.1</p>			

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K 130	Continued From page 15 Where required by Chapters 12 through 42, every building shall be divided into compartments to limit the spread of fire and restrict the movement of smoke.	K 130		
K 144	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>This Standard is not met as evidenced by: Based on record review, interview and observation the facility did not ensure that the emergency generator and the battery were being inspected on a weekly basis in accordance with NFPA 99 and NFPA 110. Failure to inspect the generator and its battery on a weekly basis could result in the generator not starting or functioning properly in the event of a power outage. The facility had a census of five patients on the day of survey. This deficiency affected all patients, staff and visitors present on the day of the survey.</p> <p>Findings include:</p> <p>During record review on May 11, 2011 at 9:54 AM, the facility was unable to provide documented weekly inspections for the generator or the battery electrolyte levels. When questioned about the weekly generator and battery inspections the Maintenance Supervisor stated that he was unaware of the requirement for</p>	K 144	<p>Generators are inspected weekly and exercised. A form will be drafted to report the testing.</p> <p>As a part of the generator check, the battery electrolyte levels will be checked and documented.</p>	<p>July 1</p> <p>July 1</p>

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K-144	Continued From page 16 weekly-inspections.	K-144		
	<p>Actual NFPA Standard:</p> <p>NFPA 110 Standard for Emergency and Standby Power Systems 1999 Edition 6-4.1* Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly.</p> <p>6-3.4 A written record of the EPSS inspections, tests, exercising, operation, and repairs shall be maintained on the premises. The written record shall include the following:</p> <ul style="list-style-type: none"> <li>(a) The date of the maintenance report</li> <li>(b) Identification of the servicing personnel</li> <li>(c) Notation of any unsatisfactory condition and the corrective action taken, including parts replaced</li> <li>(d) Testing of any repair for the appropriate time as recommended by the manufacturer</li> </ul> <p>NFPA 99 Standard for Health Care Facilities 1999 Edition Chapter 3 Electrical Systems 3-4.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches.</p> <ul style="list-style-type: none"> <li>(a) Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-4.3.1. Maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6.</li> </ul> <p>NFPA 110 Standard for Emergency and Standby</p>			

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K 144	Continued From page 17 Power Systems 1999 Edition 6-3 Maintenance and Operational Testing. 6-3.6* Storage batteries, including electrolyte levels, used in connection with Level 1 and Level 2 systems shall be inspected at intervals of not more than 7 days and shall be maintained in full compliance with manufacturer ' s specifications. Defective batteries shall be repaired or replaced immediately upon discovery of defects.	K 144		
K 147	NFPA 101 LIFE SAFETY CODE STANDARD  Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2  This Standard is not met as evidenced by: Based on observation the facility did not ensure that electrical wiring and equipment were in accordance with NFPA 70, National Electrical Code. This deficiency could overload electrical wiring and possibly start a fire. The facility had a census of five patients on the day of survey. This deficiency affected two patients and twelve staff members in one of five smoke compartments.  Findings include:  1. During the tour of the facility on May 11, 2011 at 1:40 PM, observation of the Administrator's assistants office revealed an extension cord powering a paper shredder. This was observed and noted by the Maintenance Supervisor and Surveyor.	K 147	Employees will be in-serviced on use of extension cords. Maintenance & Admin will monitor for compliance.	July 1
	2. During the tour of the facility on May 11, 2011 at 1:42 PM, observation of the receptionist desk revealed an extension cord powering an adding machine. This was observed and noted by the		Above	

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K-147	Continued From page 18 Maintenance Supervisor and Surveyor  Actual NFPA Standard:  NFPA 70 National Electrical Code © 2002 Edition  400.8 Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of 368.8. (5) Where concealed by walls, floors, or ceilings or located above suspended or dropped ceilings (6) Where installed in raceways, except as otherwise permitted in this Code	K-147		
K 211	NFPA 101 LIFE SAFETY CODE STANDARD  Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully	K 211		

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K 211	Continued From page 19 sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623  This Standard is not met as evidenced by: Based on observation the facility did not ensure that alcohol based hand rub dispensers were not installed above or adjacent to an ignition source. An alcohol based hand rub dispenser installed above an ignition source could start a fire in case of dispenser leakage. The facility had a census of five patients on the day of survey. This deficiency affected five patients and twenty eight staff members in three of five smoke compartments.  Findings include:  During the tour of the facility on May 11, 2011 between the hours of 1:00 PM and 2:00 PM, observation of the following areas revealed alcohol based hand rub dispensers that are within approximately six inches above light switches. The areas observed are as follows; Patient rooms #1, 3, 4, 5, 6, 8, 10, 11, and in the physical therapy office, exercise area, rooms #1, 2, 3, 4, 5, and in the lab. This was observed and noted by the Maintenance Supervisor and Surveyor.	K 211	All alcohol based disinfecting dispensers will be moved at least 18 inches from ignition source.	July 1

Bureau of Facility Standards

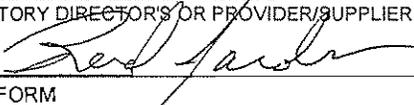
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B 000	16.03.14 Initial Comments	B 000		
	<p>The hospital building is a single story structure with a partial basement. Original construction was 1958 with subsequent additions to include a major addition/renovation completed in 1998. The construction is Type V(111) and is fully sprinklered. The upgraded fire alarm system includes smoke detection throughout the corridors and open areas. The main level of the hospital has 5 exits to grade plus a horizontal exit to the physically attached Skilled nursing Facility. There are two remote exits from the basement which are accessible through Central Stores/Purchasing. The main level of the hospital is sub-divided into three smoke zones.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on May 11, 2011. The facility was surveyed in accordance with IDAPA 16.03.14 and the 1985 Edition of the Life Safety Code.</p> <p>The survey was conducted by:</p> <p>Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction</p>			
BB161	16.03.14.510 Fire and Life Safety Standards	BB161		
	<p>Buildings on the premises used as a hospital shall meet all the requirements of local, state, and national codes concerning fire and life safety that are applicable to hospitals.</p> <p>General Requirements. General requirements for the fire and life safety standards for a hospital are that:</p> <p>The hospital shall be structurally sound and shall be maintained and equipped to assure the safety of patients, employees, and the public.</p>			

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MAY 22 2011  
BUREAU OF FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>Admin</b>	(X6) DATE <b>6-11-11</b>
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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>131316</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - ENTIRE HOSPITAL</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/11/2011</b>
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NAME OF PROVIDER OR SUPPLIER <b>BEAR LAKE MEMORIAL HOSPITAL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>164 SOUTH FIFTH STREET MONTPELIER, ID 83254</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
BB161	<p>Continued From Page 1</p> <p>On the premises of all hospitals where natural or man-made hazards are present, suitable fences, guards, and railings shall be provided to protect patients, employees, and the public. This Rule is not met as evidenced by: Refer to Federal K tags on the CMS 2567;</p> <ol style="list-style-type: none"> <li>1. K017 Smoke resisting corridors.</li> <li>2. K018 Corridor doors.</li> <li>3. K027 Smoke doors.</li> <li>4. K029 Hazardous areas.</li> <li>5. K211 Alcohol based hand rub dispensers.</li> <li>6. K056 Sprinkler system installation.</li> <li>7. K072 Means of egress.</li> <li>8. K076 Medical gas storage.</li> <li>9. K144 Generator weekly inspections.</li> <li>10. K147 Extension cords.</li> <li>11. K130 Floor/ceiling rated assemblies.</li> </ol>	BB161	<p>Refer to Fed POC.</p>	<p>6-11-11 <sup>13</sup></p>