



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

June 1, 2012

Louis Kraml, Administrator
Bingham Memorial Hospital
98 Poplar Street
Blackfoot, Idaho 83221

RE: Bingham Memorial Hospital, Provider ID# 131325

Dear Mr. Kraml:

This is to advise you of the findings of the Medicare/Licensure Fire Life Safety Survey, which was concluded at Bingham Memorial Hospital, on May 23, 2012.

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.

Louis Kraml, Administrator
June 1, 2012
Page 2 of 2

After each deficiency has been answered and dated, the administrator should sign both the CMS Form 2567 and State Form in the spaces provided on the bottom of the first pages of each of the respective forms and return the originals to this office by **June 14, 2012.**

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 'M.P. Grimes', with a long horizontal flourish extending to the right.

MARK P. GRIMES
Supervisor
Facility Fire Safety and Construction Program

MPG/lj

Enclosure

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

Printed: 06/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131325	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 05/23/2012
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NAME OF PROVIDER OR SUPPLIER BINGHAM MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 98 POPLAR STREET BLACKFOOT, ID 83221
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K 000	<p>INITIAL COMMENTS</p> <p>The Hospital consists of two (2) portions both of which are Type II construction. The former "living center" was constructed/completed in 1977 and is single story with a full finished basement. The "main" hospital portion is two story with a full finished basement and was completed in October 1979. There have been numerous small additions and remodels since constructed. The hospital is fully sprinklered per NFPA 13 for light hazard occupancy. Two generator sets provide emergency power through a type 1, Essential Electrical System. A single story long term care facility is attached to, but separated by a two (2) hour fire wall.</p> <p>The following deficiencies were cited at the above facility during a recertification survey conducted on May 23, 2112. The facility was surveyed under the Life Safety Code, 2000 Edition, Existing Health Care Occupancies in accordance with 42 CFR 282.41(b)</p> <p>The fire/life safety survey was conducted by:</p> <p>Tom Mroz CFI-II Facility Fire Safety & Construction Bureau of Facility Standards Idaho Department of Health & Welfare</p>	K 000	<p style="text-align: center;">RECEIVED JUN 14 2012 FACILITY STANDARDS</p>	
K 025	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted</p>	K 025		<p>K 025 Identified Patients: No patients were identified to be effected by this. It had the potential to effect four of four smoke compartments, staff, and 20 patients.</p> <p style="text-align: right;">6/14/12</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE SWRC-Administrator	(X6) DATE 6/13/12
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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 025	<p>Continued From page 1 heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to maintain smoke barriers with at least a one half hour fire resistance rating. The deficient practice affected four of four smoke compartments, staff, and 20 patients. The facility has the capacity for 25 beds with a census of 20 the day of survey.</p> <p>Findings Include:</p> <p>1. Observation on 05-23-12 at 10:18 a.m. revealed unsealed penetrations for data cables in the ceiling of the IT room off of the Pharmacy corridor. The cables penetrated through a three inch circular opening in the ceiling and the space around the four one inch electric conduit pipe going through the ceiling. Two one inch circular penetrations were present between the conduit pipes. Interview with the Maintenance Director on 05-23-12 at 10:18 a.m. revealed that the facility was unaware of the open ceiling penetrations in the ceiling.</p> <p>2. Observation on 05-23-12 at 11:01 a.m. revealed an approximately 10' X 2 ½' section of drop ceiling that was removed in the 1st floor ICU IT room. An open floor penetration around the approximately 4" data piping to the basement was unsealed. Interview with the Maintenance Director on 05-23-12 at 11:01 a.m. revealed that the facility was unaware of the missing section of ceiling, and the through the floor penetration.</p>	K 025	<p>Corrective Action: The identified areas: 1. The penetrations for data cables in the ceiling of the IT room off of the Pharmacy corridor, 2. Missing section of drop ceiling in the 1st floor ICU IT room, 3. Open penetrations around the two 4" pipes that went through the floor to the basement, 4. The open penetration above the ceiling in the wall separating the hospital from the skilled nursing home; were all corrected to close the openings around the cables to meet NFPA 101 standards.</p> <p>Ongoing Compliance: The Engineering Director and/or designee will monitor the smoke compartments to make sure that the facility maintains smoke barriers to NFPA 101.</p> <p>Quality Assurance: The Engineering Director and/or designee will monitor for compliance. Areas of concern will be addressed as needed PRN or at monthly Safety meeting.</p>	6/14/12

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K 025	<p>Continued From page 2</p> <p>3. Observation on 05-23-12 at 11:15 a.m. revealed an approximately 1 " open penetration around the two 4 " pipes that went through the floor to the basement. Interview with the Maintenance Director on 05-23-12 at 11:15 a.m. revealed that the facility was unaware of the through the floor penetrations.</p> <p>4. Observation on 05-23-12 at 2:20 p.m. revealed an approximately 3 " open penetration above the ceiling in the wall separating the hospital from the skilled nursing home Interview with the Maintenance Director on 05-23-12 at 2:20 p.m. revealed that the facility was unaware of the through the wall penetration</p> <p>The census of 20 was verified by the Chief Nursing Officer on 05/23/12. The finding was acknowledged by the Chief Nursing Officer and verified by the Maintenance Supervisor at the exit interview on 05/23/12.</p> <p>Actual NFPA Standard: NFPA 101, 19.3.7.3. Smoke barriers shall provide at least a one half hour fire resistance rating. Actual NFPA Standard: NFPA 101, 8.3.6.1. 8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: (1) The space between the penetrating item and the smoke barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose.</p>	K 025		
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K 025	Continued From page 3 (2) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (3) Where designs take transmission of vibration into consideration, any vibration isolation shall meet one of the following conditions: a. It shall be made on either side of the smoke barrier. b. It shall be made by an approved device that is designed for the specific purpose.	K 025		
K 062	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This Standard is not met as evidenced by: Based on observation, interview, and record review, the facility failed to properly maintain the water based fire protection systems. The deficient practice affected all four smoke compartments, staff and all patients. The facility has the capacity for 25 beds with a census of 20 the day of survey. Findings include: 1.) During record review of the facility's sprinkler testing reports for the last 12 month period on	K 062	K 062 Identified Patients: No patients were identified to be effected by this. It had the potential to effect four of four smoke compartments, staff, and 20 patients. Corrective Action: The facility will: 1. Document quarterly test reports of the automatic sprinkler system's water flow and supervisory devices, 2. Install sprinkler head escutcheons in accordance with their listing in: the 2nd floor corridor opposite room 225, Pharmacy corridor, and surgical corridor, 3. Change the one quick response sprinkler head to a standard response head, to match the 24 other sprinkler heads in the Materials management smoke compartment.	6/14/12

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K 062	<p>Continued From page 4</p> <p>05/23/12 at 9:45 a.m., documentation provided by the facility indicated that the sprinkler system had been tested on 07/18/2012 as annual inspections. The facility was unable to provide any documented quarterly test reports of the automatic sprinkler system's water flow and supervisory devices for the year of 2011 or 2012. Interview with the facility Maintenance Supervisor on 05/23/12 at 4:00 p.m. revealed the facility was not aware of the requirement for quarterly sprinkler testing.</p> <p>2.) During the facility tour on 05/23/12 between 10:00 a.m. and 4:00 p.m., observed that sprinkler head escutcheons were not installed in accordance with the listing in the following locations: 2nd floor corridor opposite room 225; Pharmacy corridor; surgical corridor; Interview with the facility Maintenance Supervisor on 05/23/12 at 4:00 p.m. revealed the facility was not aware of the out of place sprinkler head escutcheons.</p> <p>3.) Observation on 05/23/12 at 2:40 p.m. revealed that sprinkler heads installed in the Materials Management smoke compartment were a mixture of quick-response heads and standard response heads. One of the 25 sprinkler heads in the smoke compartment was a quick response type sprinkler head. Interview with the Maintenance Supervisor on 05/23/12 at 2:40 p.m. revealed that the facility was not aware that a quick-response type head was installed with the standard response heads in the smoke compartment.</p> <p>The census of 20 was verified by the Chief Nursing Officer on 05/23/12. The finding was acknowledged by the Chief Nursing Officer and verified by the Maintenance Supervisor at the exit</p>	K 062	<p>Ongoing Compliance:</p> <p>The Engineering Director and/or designee will monitor the completion of the quarterly test reports of the sprinkler system's water flow and supervisory devices, monitor sprinkler head escutcheons to be install in accordance, and sprinkler heads to be either all quick or standard response heads in each smoke compartment to meet NFPA standards.</p> <p>Quality Assurance:</p> <p>The Engineering Director and/or designee will monitor for compliance. Areas of concern will be addressed as needed PRN or at monthly Safety meeting.</p>	6/14/12

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K 062	<p>Continued From page 5 interview on 05/23/12.</p> <p>Actual NFPA Standards:</p> <p>Item 1.) NFPA 101, 4.6.12.1 Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be continuously maintained in accordance with applicable NFPA requirements or as directed by the authority having jurisdiction.</p> <p>NFPA 25, 1-8*. Records of inspections, tests, and maintenance of the system and its components shall be made available to the authority having jurisdiction upon request. Typical records include, but are not limited to, valve inspections; flow, drain, and pump tests; and trip tests of dry pipe, deluge, and pre-action valves.</p> <p>NFPA 25, 2-3.3. 2-3.3* Alarm Devices. Waterflow alarm devices including, but not limited to, mechanical water motor gongs, vane-type waterflow devices, and pressure switches that provide audible or visual signals shall be tested quarterly.</p> <p>Item 2.) NFPA 13, 3-2.7.2* Escutcheon plates used with a recessed or flush-type sprinkler shall be part of a listed sprinkler assembly.</p> <p>Item 3.) NFPA 101, 4.6.12.1. Every required sprinkler system shall be continuously maintained in proper operating condition.</p> <p>NFPA 13, 5-3.1.5.2. When existing light hazard</p>	K 062		
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K 062	Continued From page 6 systems are converted to use quick-response or residential sprinklers, all sprinklers in a compartment space shall be changed.	K 062		
K 132	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Continuing safety education and supervision is provided, incidents are reviewed monthly, and procedures are reviewed annually in accordance with NFPA 99. 10.2.1.4.2</p> <p>This Standard is not met as evidenced by: Based on interview and record review, it was determined the facility failed to provide continuing safety education for laboratories. This resulted in the potential for the facility's inability to effectively deal with the care, health and safety of staff and other individuals when a laboratory emergency occurs. Findings include:</p> <p>The facility failed to provide continuing safety education for the hospital laboratory and the pathology laboratory. There was no documented orientation and training of new laboratory personnel.</p> <p>The finding was acknowledged by the Chief Nursing Officer and verified by the Maintenance Supervisor at the exit interview on 05/23/12.</p> <p>Actual NFPA Standard: NFPA 99, 10-2.1.4 Orientation and Training. 10-2.1.4.1 New laboratory personnel shall be taught general safety practices for the laboratory and specific safety practices for the equipment and procedures they will use. 10-2.1.4.2 Continuing safety education and supervision shall be provided, incidents shall be</p>	K 132	<p>K 132 Identified Patients: No patients were identified to be effected by this. It had the potential to effect the Hospital Laboratory and Pathology Laboratory, and staff.</p> <p>Corrective Action: The facility will provide continuing safety education for laboratories, including documenting orientation and training of new laboratory personnel.</p> <p>Ongoing Compliance: The Laboratory Director and/or designee will monitor the documentation and continued safety education including orientation and training of new laboratory personnel in accordance with NFPA 99.</p> <p>Quality Assurance: The Laboratory Director and/or designee will monitor for compliance. Areas of concern will be addressed as needed PRN or at monthly Safety meeting.</p>	6/14/12

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K 132	Continued From page 7 reviewed monthly, and procedures shall be reviewed annually.	K 132		
K 135	NFPA 101 LIFE SAFETY CODE STANDARD Flammable and combustible liquids are used from and stored in approved containers in accordance with NFPA 30, Flammable and Combustible Liquids Code, and NFPA 45, Standard on Fire Protection for Laboratories Using Chemicals. Storage cabinets for flammable and combustible liquids are constructed in accordance with NFPA 30, Flammable and Combustible Liquids Code, NFPA 99. 4.3, 10.7.2.1. This Standard is not met as evidenced by: Based on observation and interview, the facility failed to properly store flammable liquids. The deficient practice affected one of four smoke compartments, laboratory staff, and no patients. The facility has the capacity for 25 beds with a census of 20 the day of survey. Findings include: 1. Observation during the tour of the facility on 05-23-12 at 11:50 a.m. revealed storage of flammable liquids outside of the cabinet designed for flammable and combustible storage occurring in the pathology laboratory. Approximately 5 gallons of xylene and 5 gallons of alcohol waste were stored under the counter next to the approved storage cabinet. Interview with the Maintenance Engineer on 05-23-12 at 11:50 a.m. revealed the facility was unaware that the flammable liquids were required to be stored in	K 135	K 135 Identified Patients: No patients were identified to be effected by this. It had the potential to effect one of four smoke compartments, laboratory staff, and no patients. Corrective Action: The facility has ordered cabinets designed for storage of flammable and combustible storage. These cabinets should be shipped June 19th. They should arrive by June 29th and will be installed upon arrival. These will be for the storage of: 1.The xylene and alcohol waste that was identified under the counter in the pathology laboratory 2.The containers of the xylene that was identified in the non-rated cabinet in the hospital laboratory. Ongoing Compliance: The Laboratory Director and/or designee will monitor the proper storage of flammable liquids to make sure it is in accordance with NFPA 30, 45, and 99. Quality Assurance: The Laboratory Director and/or designee will monitor for compliance. Areas of concern will be addressed as needed PRN or at monthly Safety meeting.	6/29/12

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K 135	<p>Continued From page 8 the designated cabinet.</p> <p>2. Observation during the tour of the facility on 05-23-12 at 11:55 a.m. revealed that the storage of flammable liquids in an unrated cabinet was occurring in the hospital laboratory. Approximately 3 one gallon containers of xylene were stored in a non rated cabinet. Interview with the Maintenance Engineer on 05-23-12 at 11:55 a.m. revealed the facility was unaware that the flammable liquids were stored in a non-rated cabinet</p> <p>The finding was acknowledged by the Administrator and verified by the Maintenance Engineer during the exit interview on 05-23-12.</p> <p>Actual NFPA Standard: NFPA 30, 4.3 Design, Construction, and Capacity of Storage Cabinets. 4.3.3 Storage cabinets that meet at least one of the following sets of requirements shall be acceptable for storage of liquids: (a) Storage cabinets that are designed and constructed to limit the internal temperature at the center of the cabinet and 1 in. (25 mm) from the top of the cabinet to not more than 325°F (162.8°C), when subjected to a 10-minute fire test that simulates the fire exposure of the standard time-temperature curve specified in NFPA 251, Standard Methods of Tests of Fire Endurance of Building Construction and Materials, shall be acceptable. All joints and seams shall remain tight and the door shall remain securely closed during the test. (b) Metal storage cabinets that are constructed in the following manner shall be acceptable. The bottom, top, door, and sides of the cabinet shall be at least No. 18 gauge sheet steel and shall be double-walled, with 1 1/2 in. (38 mm) air space. Joints shall be riveted, welded, or made tight by</p>	K 135		

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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 135	Continued From page 9 some equally effective means. The door shall be provided with a three-point latch arrangement, and the door sill shall be raised at least 2 in. (50 mm) above the bottom of the cabinet to retain spilled liquid within the cabinet. (c) Wooden cabinets constructed in the following manner shall be acceptable. The bottom, sides, and top shall be constructed of exterior grade plywood that is at least 1 in. (25 mm) thick and of a type that will not break down or delaminate under fire conditions. All joints shall be rabbetted and shall be fastened in two directions with wood screws. Where more than one door is used, there shall be a rabbetted overlap of not less than 1 in. (25 mm). Doors shall be equipped with a means of latching and hinges shall be constructed and mounted in such a manner as to not lose their holding capacity when subjected to fire exposure. A raised sill or pan capable of containing a 2 in. (50 mm) depth of liquid shall be provided at the bottom of the cabinet to retain spilled liquid within the cabinet. (d) Listed storage cabinets that have been constructed and tested in accordance with 4.3.3(a) shall be acceptable.	K 135		
K 136	NFPA 101 LIFE SAFETY CODE STANDARD Procedures for laboratory emergencies are developed. Such procedures include alarm actuation, evacuation, and equipment shutdown procedures, and provisions for control of emergencies that could occur in the laboratory, including specific detailed plans for control operations by an emergency control group within the organization or a public fire department in accordance with NFPA 99, 10.2.1.3.1, 19.3.2.1	K 136	K 136 Identified Patients: No patients were identified to be effected by this. It had the potential to effect four of four smoke compartments, staff, and 20 patients.	6/14/12

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

Printed: 06/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131325	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 05/23/2012
NAME OF PROVIDER OR SUPPLIER BINGHAM MEMORIAL HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 98 POPLAR STREET BLACKFOOT, ID 83221		
(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 136	<p>Continued From page 10</p> <p>This Standard is not met as evidenced by: Based on interview and record review, it was determined the facility failed to provide documentation of procedures for laboratory emergencies. This resulted in the potential for the facility ' s inability to effectively deal with the care, health and safety of patients, staff and other individuals when a laboratory emergency occurred. Findings include:</p> <p>The facility did not develop procedures for laboratory emergencies within the hospital laboratory and the pathology laboratory. There were no plans available detailing procedures for alarm actuation, evacuation and equipment shutdown procedures, and provisions for control of emergencies that could occur in the laboratory, including specific detailed plans for control operations by an emergency control group within the organization or a public fire department. There were no procedures established for extinguishing clothing fires. When asked about the plan, on 05/23/12 at 4:45 p.m. the facility ' s Chief Nursing Officer stated the hospitals emergency operations plan was all encompassing for all departments within the hospital including the laboratories.</p> <p>The census of 20 was verified by the Chief Nursing Officer on 05/23/12. The finding was acknowledged by the Chief Nursing Officer and verified by the Maintenance Supervisor at the exit interview on 05/23/12.</p> <p>Actual NFPA Standard: NFPA 99, 10-2.1.3 Emergency Procedures. 10-2.1.3.1 Procedures for laboratory emergencies shall be developed. Such procedures shall include alarm actuation, evacuation, and equipment shutdown procedures, and provisions</p>	K 136	<p>Corrective Action: The facility developed procedures for laboratory emergencies within the hospital laboratory and the pathology laboratory detailing procedures for alarm actuation, evacuation and equipment shutdown procedures, and provisions for control of emergency that could occur in the laboratory, including specific detailed plans for control operations by an emergency control group within the organization or a public fire department. There will also be procedures for extinguishing clothing fires. This will be done in accordance with NFPA 99</p> <p>Ongoing Compliance: The Laboratory Director and/or designee will monitor facilities procedures for laboratory emergencies within the hospital laboratory and pathology laboratory to make sure it is in accordance with NFPA 99.</p> <p>Quality Assurance: The Laboratory Director and/or designee will monitor for compliance. Areas of concern will be addressed as needed PRN or at monthly Safety meeting.</p>	6/14/12

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K 136	Continued From page 11 for control of emergencies that could occur in the laboratory, including specific detailed plans for control operations by an emergency control group within the organization or a public fire department. 10-2.1.3.3* Emergency procedures shall be established for extinguishing clothing fires.	K 136		
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 and interview, the facility failed to ensure electrical wiring was in accordance with the National Electrical Code. The deficient practice affected four of four smoke compartments, staff, and patients. The facility has the capacity for 25 beds with a census of 20 the day of survey. Findings include: 1. Observation on 05/23/12 at 10:10 a.m. revealed an unsecured power strip in the dictation room. The power strip was suspended in the air resulting in strain on the wires plugged into it. Interview with the Maintenance Supervisor on 05/23/12 at 10:10 a.m. revealed that the facility was not aware of the improperly secured power strip. 2. Observation on 05/23/12 at 10:19 a.m. revealed an open electric light switch box in the IT room off of the Pharmacy corridor. Interview with the Maintenance Supervisor on 05/23/12 at 10:19 a.m. revealed that the facility was not aware of the missing light switch box cover.	K 147	K 147 Identified Patients: No patients were identified to be effected by this. It had the potential to effect four of four smoke compartments, staff, and 20 patients. Corrective Action: The electrical wiring and equipment were: 1. The power strip in the dictation room that was suspended in air was moved to the correct position alleviating the strain on the wires plugged into it, 2. The open electrical light switch box in the IT room off the Pharmacy corridor was covered with a light switch box cover, 3. The open electrical receptacle box in the ICU IT room was covered with a electric receptacle box cover, 4. The freezer and deli case that were plugged into a power strip were removed from the power strip and plugged into a wall outlet in the Cafe kitchen, 5. The coffee bar in the Cafe was moved so that the extension cord running underneath the carpet would no longer be in the walking path.	6/14/12

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K 147	Continued From page 12 3. Observation on 05/23/12 at 10:30 a.m. revealed an open electric receptacle box in the ICU IT room. Interview with the Maintenance Supervisor on 05/23/12 at 10:30 a.m. revealed that the facility was not aware of the missing electric receptacle box cover. 4. Observation on 05/23/12 at 2:00 p.m. revealed a freezer and a deli case plugged into a power strip that was plugged into a wall outlet in the Café kitchen. Interview with the Maintenance Supervisor on 05/23/12 at 2:00 p.m. revealed that the facility was not aware of the requirement that prohibits the use of power strips for appliances. 5. Observation on 05/23/12 at 2:05 p.m. revealed an extension cord run underneath a carpet powering the coffee bar in the Café. Interview with the Maintenance Supervisor on 05/23/12 at 2:05 p.m. revealed that the facility was not aware the cord could not be underneath the carpet. The census of 20 was verified by the Chief Nursing Officer on 05/23/12. The finding was acknowledged by the Chief Nursing Officer and verified by the Maintenance Supervisor at the exit interview on 05/23/12. Actual NFPA Standard(s): Item #1 NFPA 70,110-3. Examination, Identification, Installation, and Use of Equipment. (b) Installation and Use. Listed or labeled equipment shall be installed and used in accordance with any instructions included in the listing or labeling. Item #2 NFPA 70, Article 370-25. Covers and Canopies. In completed installations, each box shall have a cover, faceplate, or fixture canopy	K 147	Ongoing Compliance: The Engineering Director and/or designee will monitor the electrical wiring and equipment to make sure it is in accordance with NFPA 70, national electrical code 9.1.2. Quality Assurance: The Engineering Director and/or designee will monitor for compliance. Areas of concern will be addressed as needed PRN or at monthly Safety meeting.	6/14/12
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K 147	Continued From page 13 Item#3 NFPA 70, Article 370-25. Covers and Canopies. In completed installations, each box shall have a cover, faceplate, or fixture canopy Item#4 NFPA 70, 110-3. Examination, Identification, Installation, and Use of Equipment. (b) Installation and Use. Listed or labeled equipment shall be installed and used in accordance with any instructions included in the listing or labeling. Item #5 NFPA 70, 400-8. Uses Not Permitted Unless specifically permitted in Section 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 Section 364-8. 5. Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors 6. Where installed in raceways, except as otherwise permitted in this Code	K 147		

Bureau of Facility Standards

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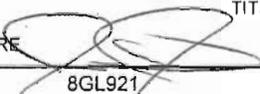
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B 000	16.03.14 Initial Comments The Hospital consists of two (2) portions both of which are Type II construction. The former "living center" was constructed/completed in 1977 and is single story with a full finished basement. The "main" hospital portion is two story with a full finished basement and was completed in October 1979. There have been numerous small additions and remodels since constructed. The hospital is fully sprinklered per NFPA 13 for light hazard occupancy. Two generator sets provide emergency power through a type 1, Essential Electrical System. A single story long term care facility is attached to, but separated by a two (2) hour fire wall. The following deficiencies were cited at the above facility during a recertification survey conducted on May 23, 2012. The facility was surveyed under IDAPA 16.03.14 Rules and Minimum Standards for Hospitals in Idaho The fire/life safety survey was conducted by: Tom Mroz CFI-II Facility Fire Safety & Construction and continuation by Mark P. Grimes, Supervisor Facility Fire Safety & Construction Program Bureau of Facility Standards Idaho Department of Health & Welfare	B 000		
BB162	16.03.14.510.02 Life Safety Code Requirements Life Safety Code Requirements. The hospital shall meet such provisions of the "Life Safety Code", 1985 Edition, of the National Fire	BB162	BB162 Please refer to K025, K062, K132, K135, K136, and K148	



Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE *SURC Administrator* (X6) DATE *6/13/12*

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BB162	<p>Continued From page 1</p> <p>Protection Association as are applicable to Health Care Occupancies which is incorporated by reference.</p> <p>Any hospital in compliance with either the 1967 Edition of the "Life Safety Code" or the 1981 Edition of the "Life Safety Code" prior to the effective date of these rules is considered to be in compliance with this section so long as the hospital continues to remain in compliance with that Edition of the "Life Safety Code." Life Safety Codes are available in the licensing agency of the Department.</p> <p>Remodelings, additions, and/or upgrading of building systems in existing hospitals shall meet the minimum standards set forth in the 1985 Edition of the "Life Safety Code" for new construction.</p> <p>In the event of a conflict between the applicable edition of the Life Safety Code and applicable state or local building, fire, electrical, plumbing, zoning, heating, sanitation or other applicable codes, the most restrictive shall govern.</p> <p>This Rule is not met as evidenced by: This rule is not met as evidenced by:</p> <p>Based upon surveyor observation made on May 23, 2012 the facility failed to ensure compliance with the Life Safety Code as adopted by CMS, a more restrictive code, as required under state licensing regulation.</p> <p>Findings included:</p> <p>See findings noted under the federal K tags K025, K062, K132, K135, K136 and K148 on the federal form 2567.</p>	BB162		

Bureau of Facility Standards

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BB592	Continued From page 2	BB592		
BB592	<p>16.03.14.600.03 Plans, Specificaitons, and Inspections</p> <p>03. Plans, Specifications, and Inspections. Plans, specifications, and inspections of any new facility construction or any addition, conversion, or remodeling of an existing structure shall be governed by the following: (10-14-88)</p> <p>a. Plans for new construction, additions, conversions, and/or remodels shall be prepared by or executed under the supervision of an architect or engineer licensed in the state of Idaho. This requirement can be waived by the Department in connection with minor alterations provided the alterations comply with all construction requirements. (10-14-88)</p> <p>b. Prior to commencing work pertaining to construction of a new building, any addition or structural changes to existing facilities, or conversion of existing buildings to be used as a hospital, plans and specifications shall be submitted to, and approved by, the Department. (10-14-88)</p> <p>c. Preliminary plans shall be submitted and shall include at least the following: (10-14-88)</p> <p>i. The assignment of all spaces, size of areas and rooms, and indicate in out line the fixed equipment; and (10-14-88)</p> <p>ii. Drawings of each floor including, but not limited to, the basement, approach or site plan, roads, parking areas, and sidewalks; and (10-14-88)</p> <p>iii. The total floor area and number of beds; and (10-14-88)</p>	BB592	<p>BB592</p> <p>Identified Patients: No patients were identified to be effected by this. It had the potential to effect one of four smoke compartments, staff, visitors, and 20 patients.</p> <p>Corrective Action: The project in the area off the Emergency Department was put on hold. The plans for the project were sent in for retroactive review and approval to the FFS&C Supervisor/Surveyor.</p> <p>Ongoing Compliance: The Engineering Director and/or designee will submit plans and specifications for modifications to the exiting system and remodeling prior to commencing work.</p> <p>Quality Assurance: The Engineering Director and/or designee will monitor for compliance. Areas of concern will be addressed as needed PRN or at monthly Safety meeting.</p>	6/14/12

Bureau of Facility Standards

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BB592	Continued From page 3 iv. Outline specifications describing the general construction, including interior finishes, acoustical materials, and HVAC; and (10-14-88) v. The plans shall be drawn to scale of sufficient size to clearly present the proposed design, but not less than a scale of one-eighth (1/8) inch to one (1) foot. (10-14-88) d. Before commencement of construction, working drawings shall be developed in close cooperation and with approval of the Department and other appropriate agencies, and: (10-14-88) i. The drawings and specifications shall be well prepared and of accurate dimensions and shall include all necessary explanatory notes, schedules, and legends. They shall be stamped with the architect's or engineer's seal; and (10-14-88) ii. The drawings shall be complete and adequate for contract purposes. (10-14-88) e. Prior to occupancy, the construction shall be inspected and approved by the Department. The Department shall be notified at least two (2) weeks prior to completion in order to schedule a final inspection. (10-14-88) This Rule is not met as evidenced by: Based on observation and interview the facility failed to submit plans and specifications for modifications to the exiting system and remodeling of the ER reception area prior to commencing work, thereby potentially endangering all patients, visitors and staff. This deficient practice affects one of four compartments, staff, patients and visitor who may	BB592		

Bureau of Facility Standards

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BB592	<p>Continued From page 4</p> <p>use the building. The facility has 25 beds and at the time of the survey the census was 20.</p> <p>Findings include:</p> <p>1.) Observation on 05/23/12 at 11:45 a.m. revealed the facility had commenced work on a remodel of the ER reception area. The facility relocated the existing means of egress to the stair landing, and changed the exit discharge from double doors to a single door. The facility sealed off the former exit with sheetrock and framed out a storage closet in its place. An approximately 4' high "L" shape steel partition with electric conduit and boxes was constructed in what was the patient waiting area. Interview on 05/23/12 at 11:45 a.m. with facility BMH Engineering Personnel 1 revealed no construction plans were prepared for the project. The facility acknowledged that a building permit from the city of Blackfoot was required and stated it was on file in his office. Interview also revealed that BMH Engineering Personnel 1 decided notification to the Department was not required as the construction wasn't in a patient care area.</p> <p>The census of 20 was verified by the Chief Nursing Officer. The finding was acknowledged by the Chief Nursing Officer and verified by the Maintenance Supervisor at the exit interview on 05/23/12. (Administrator was not available during the survey)</p> <p>2.) During a continued investigation of this deficient practice on May 30, 2012, the Facility Fire Safety & Construction Program Supervisor interviewed the City of Blackfoot Building Official. During the Interview with Building Official #1, on May 30, 2012 at approximately 9:30 AM, the</p>	BB592		

Bureau of Facility Standards

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BB592	<p>Continued From page 5</p> <p>Official was asked if there had been any building permits issued to Bingham Memorial Hospital (BMH) during the last 12 months, the Official answered "no". A second question asked "how about going back 24 months?" the Official indicated yes, several, but he would have to look them up. The Official conducted research into City Building permit records and provided two permits for BMH: Permit #3521 for the pathology lab issued in August of 2010, and Permit # 3601 for a Lab Expansion project issued in February of 2011.</p> <p>The Building Official was asked if there were any active permits on a project involving an exit access corridor or exit doors? He indicated he was not aware of any, and took special interest in the question. Stating he would also be interested in changes to the egress system.</p> <p>At approximately 10:00 AM on May 30, 2012, the FFS&C Supervisor entered BMH and advised the Hospital Administrator of the continued investigation of the previous weeks survey finding. The Administrator assigned the Maintenance Supervisor to accompany the surveyor to the construction area. At the construction area off the Emergency Department a modified exit door was observed. The BMH Engineering Personnel 1 joined us and advised that the project was currently on hold, until plans could be completed and sent in for retroactive review and approval before the construction continued. Observation revealed the exit access was still available, and no immediate danger was identified. The FFS&C Supervisor/Surveyor exited the facility.</p>	BB592		

Bureau of Facility Standards

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BB592	Continued From page 6 Actual IDAPA Regulation: 592. NEW CONSTRUCTION AND NEW HOSPITAL STANDARDS. The standards set forth in this section together with the standards set out in the Section 510 (entitled Fire and Life Safety Standards), shall apply to all new construction or new hospitals begun after the effective date of these rules (see Subsection 002.26). These standards are intended to specify the minimum essential facilities that shall be included in a hospital. (12-31-91) 01. Additions, Conversions, Remodelings, Etc. Additions to existing hospitals, conversions of existing buildings or portions thereof for use as a hospital, and portions of a hospital undergoing remodeling, alteration, addition or upgrading of a hospital or hospital building system that affects the structural integrity of the building, that changes functional operation, that affects fire safety or that adds beds, departments or services over those for which the hospital is currently licensed (herein simply " remodeling or remodels ") shall be required to meet these standards. (10-14-88) 02. General Requirements of Constructions. General requirements for construction of a hospital are that: (10-14-88) a. All new construction or new hospitals (see Subsection 002.26) shall comply with any and all state and local building, fire, electrical, plumbing, zoning, heating, or other applicable codes adopted by the jurisdiction in which the hospital is located and which are in effect when construction is begun. Where a conflict in code requirements occurs, the most restrictive shall govern. (12-31-91) b. Minimum construction standards shall be in accordance with the DHHS Publication No. (HRS-M-HF)84-1, " Construction and Equipment	BB592		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IDVRYD	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	(X3) DATE SURVEY COMPLETED 05/23/2012
NAME OF PROVIDER OR SUPPLIER BINGHAM MEMORIAL HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 98 POPLAR STREET BLACKFOOT, ID 83221		
(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
BB592	Continued From page 7 of Hospitals and Medical Facilities " as are applicable to a hospital and is incorporated herein by reference, available in the licensing agency of the Department. (10-14-88) 03. Plans, Specifications, and Inspections. Plans, specifications, and inspections of any new facility construction or any addition, conversion, or remodeling of an existing structure shall be governed by the following: (10-14-88) a. Plans for new construction, additions, conversions, and/or remodels shall be prepared by or executed under the supervision of an architect or engineer licensed in the state of Idaho. This requirement can be waived by the Department in connection with minor alterations provided the alterations comply with all construction requirements. (10-14-88) b. Prior to commencing work pertaining to construction of a new building, any addition or structural changes to existing facilities, or conversion of existing buildings to be used as a hospital, plans and specifications shall be submitted to, and approved by, the Department. (10-14-88) c. Preliminary plans shall be submitted and shall include at least the following: (10-14-88) i. The assignment of all spaces, size of areas and rooms, and indicate in out line the fixed equipment; and (10-14-88) ii. Drawings of each floor including, but not limited to, the basement, approach or site plan, roads, parking areas,	BB592		