



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

IDAHO DEPARTMENT OF
HEALTH & WELFARE

DEBBY RANSOM, R.N., R.H.I.T – Chief
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August 2, 2012

Sally Jeffcoat, Administrator
St. Alphonsus Regional Medical Center
1055 North Curtis Road
Boise, Idaho 83706

RE: St Alphonsus Regional Medical Center, Provider ID# 130007

Dear Ms. Jeffcoat:

This is to advise you of the findings of the Medicare/Licensure Fire Life Safety Survey, which was concluded at St Alphonsus Regional Medical Center, on July 27, 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.

Sally Jeffcoat, Administrator
August 2, 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 **August 15, 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 'MPG', followed by a long horizontal flourish line 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: 07/31/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130007	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - BEHAVIORAL HEALTH CEN B. WING _____	(X3) DATE SURVEY COMPLETED 07/27/2012
NAME OF PROVIDER OR SUPPLIER ST ALPHONSUS REGIONAL MEDICAL CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 1055 NORTH CURTIS ROAD BOISE, ID 83706	
(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 027	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to maintain smoke barrier doors that would close and resist the passage of smoke. The deficient practice affected two of five smoke compartments, staff and patients.</p> <p>Findings include:</p> <p>Observation on 7/26/12 at 11:53 a.m. revealed that the smoke doors that separated the corridor by room 105 would not fully open. One of the doors auto closure devices would only allow the door to open 50% of the way. Interview with the Engineering Manager on 07/26/12 at 11:53 a.m. revealed that the facility was not aware that the smoke door was not opening properly.</p> <p>Actual NFPA Standard:</p> <p>NFPA 101, 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.</p>	K 027	<p>See attached report</p> <p>RECEIVED AUG 15 2012 FACILITY STANDARDS</p>	

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

TITLE

(X6) DATE

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

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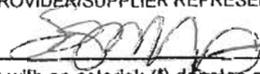
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130007	(X2) MULTIPLE CONSTRUCTION A. BUILDING 05 - ENTIRE HOSPITAL INCLUD B. WING _____	(X3) DATE SURVEY COMPLETED 07/27/2012
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NAME OF PROVIDER OR SUPPLIER ST ALPHONSUS REGIONAL MEDICAL CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 1055 NORTH CURTIS ROAD BOISE, ID 83706
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K 000	<p>INITIAL COMMENTS</p> <p>The Saint Alphonsus Regional Medical Center campus buildings that were surveyed are Type II (222) and Type I (433) structures with completion dates in the late 1960's through to include 2007. The Central Tower and Free Standing Emergency Department (FSED) were surveyed under the 2000 Life Safety Code Chapter 101, New Health Care Occupancies, with other buildings surveyed under the 2000 Life Safety Code Chapter 101, Existing Health Care Occupancies. Buildings surveyed included: Central Tower, Eagle Free Standing Emergency Department, Surgery Center, South Tower, North Tower, Emergency Department, Outpatient Surgery Center, Family Medical Center, Emerald Health Plaza and Behavioral Health. The survey was conducted in accordance with CFR 485.623.</p> <p>The following deficiencies were cited:</p> <p>The surveyors conducting the survey were:</p> <p>Mark Grimes, Supervisor Facility Fire/Life Safety and Construction Program</p> <p>Tom Mroz CFI-II Health Facility Surveyor Facility Fire/Life Safety and Construction Program</p>	K 000	<p style="text-align: center;">RECEIVED AUG 15 2012 FACILITY STANDARDS</p> <p>See attached report</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>See attached report</p>	

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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 the fire and smoke barrier walls. The deficient practice affected all smoke compartments, staff, and patients on the dates of the survey.</p> <p>Findings include:</p> <p>Observation between 07/23/12 and 07/26/12 revealed that the fire/smoke barrier walls in the following locations had various conduits, wire, and pipe penetrations that were not sealed: C4 communication closet, electric closet next to RT clean equipment room; Pharmacy shell/Ultrasound; basement electric room, Oncology Infusion floor electric closet; 2nd floor Environmental Services next to men 's locker; kitchen, above ceiling by C9232 cross corridor doors; above ceiling corridor by 9217; EHP electric closet; and above ceiling 1st floor northeast stairwell. Interview with the Engineering Manager on 07/26/12 . revealed that the facility was not aware of the unsealed penetrations in the fire and smoke barrier walls. These findings are only inclusive of the limited samples taken.</p> <p>Actual NFPA Standards: NFPA 101, 19.3.7.3. Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour.</p>	K 025	See attached report	

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K 025	Continued From page 2 NFPA 101, 8.3.6.1 (1) a and b. 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 by filling the space between the penetrating item and the smoke barrier with a material that is capable of maintaining the smoke resistance of the smoke barrier or it shall be protected by an approved device that is designed for the specific purpose.	K 025	See attached report	
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. This deficient practice affected all smoke compartments, staff and patients on the dates of the survey. Findings include: 1. Observation between 07/23/12 and 7/25/12, revealed electric circuit breakers were not labeled as to what they control in the Central Tower and Kitchen Interview with the Engineering Manager on 07/23/12 revealed that the facility was not aware the circuits were not properly labeled. These findings are only inclusive of the sample taken. 2. Observation between 07/23/12 and 7/25/12 revealed relocatable power taps utilized outside of their UL listing in the following locations: RT Office; 2nd floor NICU; Learning Systems office;	K 147	See attached report	

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K 147	<p>Continued From page 3 office behind Endo Reception, and the doctors lounge Interview with the Engineering Manager on 07/23/12, revealed that the facility was not aware of the requirement that prohibits the use of power strips for appliances. These findings are only inclusive of the sample taken.</p> <p>3. Observation on 07/25/12 at 11:15 a.m. revealed exposed wires protruding from an electric raceway disconnected from the junction box underneath the kitchen sink. Interview with the Engineering Manager on 07/25/12, revealed that the facility was not aware of the exposed wires.</p> <p>Actual NFPA Standard(s):</p> <p>Item #1</p> <p>NFPA 70, 110-22. Identification of Disconnecting Means Each disconnecting means required by this Code for motors and appliances, and each service, feeder, or branch circuit at the point where it originates, shall be legibly marked to indicate its purpose unless located and arranged so the purpose is evident. The marking shall be of sufficient durability to withstand the environment involved.</p> <p>Item #2</p> <p>NFPA 70, 110-3. Examination, Identification, Installation, and Use of Equipment (a) Examination. In judging equipment, considerations such as the following shall be evaluated: 1. Suitability for installation and use in conformity</p>	K 147	See attached report	



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K 147	Continued From page 4 with the provisions of this Code FPN: Suitability of equipment use may be identified by a description marked on or provided with a product to identify the suitability of the product for a specific purpose, environment, or application. Suitability of equipment may be evidenced by listing or labeling. 2. Mechanical strength and durability, including, for parts designed to enclose and protect other equipment, the adequacy of the protection thus provided 3. Wire-bending and connection space 4. Electrical insulation 5. Heating effects under normal conditions of use and also under abnormal conditions likely to arise in service 6. Arcing effects 7. Classification by type, size, voltage, current capacity, and specific use 8. Other factors that contribute to the practical safeguarding of persons using or likely to come in contact with the 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 #3 NFPA 70, 300-12. Mechanical Continuity - Raceways and Cables Metal or nonmetallic raceways, cable armors, and cable sheaths shall be continuous between cabinets, boxes, fittings, or other enclosures or outlets.	K 147	See attached report	

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B 000	16.03.14 Initial Comments The Saint Alphonsus Regional Medical Center campus buildings that were surveyed are Type II (222) and Type I (433) structures with completion dates in the late 1960's through to and including 2007. The survey was conducted in reference to New Health Care and Existing Health Care Occupancies NFPA Life Safety Code 2000, and the Rules and Minimum Standards for Hospitals in Idaho-1988. The surveyors conducting the survey were: Mark Grimes, Supervisor Facility Fire/Life Safety and Construction Program Tom Mroz CF1-II Health Facility Surveyor Facility Fire/Life Safety and Construction Program	B 000	See attached report 	
BB161	16.03.14.510 Fire and Life Safety Standards 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. General Requirements. General requirements for the fire and life safety standards for a hospital are that: The hospital shall be structurally sound and shall be maintained and equipped to assure the safety of patients, employees, and the public. 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 the following Federal tags on CMS 2567:	BB161	See attached report	

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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	<ol style="list-style-type: none"> 1. K025 Fire and smoke barriers 2. K027 Smoke Barrier Doors 3. K038 Exit Access 4. K077 Medical Gas Shutoff 5. K144 Generator Annunciator 6. K147 Electrical wiring 		<p>See attached report <i>Refer to Federal 2567</i></p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130007	(X2) MULTIPLE CONSTRUCTION A. BUILDING 07 - FSED ST. AL S B. WING _____	(X3) DATE SURVEY COMPLETED 07/27/2012
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NAME OF PROVIDER OR SUPPLIER ST ALPHONSUS REGIONAL MEDICAL CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 1055 NORTH CURTIS ROAD BOISE, ID 83706
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K 077	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Piped in medical gas systems comply with NFPA 99, Chapter 4.</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to post the required precautionary signage at an oxygen shutoff valve location. This deficient practice affected all staff and patients in the facility.</p> <p>The findings include:</p> <p>Observation on 07/26/12 at 10:15 a.m. revealed that the oxygen shutoff panel located in the decontamination room was not secure or posted with a caution to not close or open the valve except in an emergency sign. Interview with the Engineering Manager on 07/26/12 at 10:15 a.m. revealed that the facility was not aware that oxygen shutoff valve was not secured and not labeled.</p> <p>Actual NFPA Standard: NFPA 99, 4-3.1.2.3 Gas Shutoff Valves. Shutoff valves accessible to other than authorized personnel shall be installed in valve boxes with frangible or removable windows large enough to permit manual operation of valves.</p> <p>(b) Main Valve. The main supply line shall be provided with a shutoff valve. The valve shall be located to permit access by authorized personnel only (e.g., by locating in a ceiling or behind a locked access door). The main supply line valve shall be located downstream of the source valve and outside of the source room, enclosure, or where the main line first enters the building. This</p>	K 077	See attached report	

RECEIVED
AUG 15 2012
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X8) DATE _____

[Handwritten Signature]

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K 077	Continued From page 1 valve shall be identified. A main line valve shall not be required where the source shutoff valve is accessible from within the building.	K 077	See attached report	
K 106	NFPA 101 LIFE SAFETY CODE STANDARD Hospitals, and nursing homes and hospices with life support equipment, have a Type I Essential Electrical System powered by a generator with a transfer switch and separate power supply. The EES is in accordance with NFPA 99, 3.4.2.2, 3.4.2.1.4. This Standard is not met as evidenced by: Based on observation and interview, the facility failed to provide for the generator annunciator panel to be located at a constantly attended location. This deficient practice affected all staff and patients in the facility. Findings include: During the facility tour on 07/26/12 at 10:30 a.m., it was observed that the generator annunciator panel was located at an unoccupied location on the vacant 2nd floor nurses ' station. Interview with the Engineering Manager revealed the facility was unaware the generator annunciator panel; was located in an unattended area. . NFPA 99 §3-4.1.1.15 Alarm Annunciator. A remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station (see NFPA 70, National Electrical Code, Section 700-12.) The annunciator shall indicate alarm conditions of	K 106	See attached report	



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K 106	<p>Continued From page 2</p> <p>the emergency or auxiliary power source as follows:</p> <p>(a) Individual visual signals shall indicate the following:</p> <ol style="list-style-type: none"> 1. When the emergency or auxiliary power source is operating to supply power to load 2. When the battery charger is malfunctioning <p>(b) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate the following:</p> <ol style="list-style-type: none"> 1. Low lubricating oil pressure 2. Low water temperature (below those required in 3-4.1.1.9) 3. Excessive water temperature 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply 5. Overcrank (failed to start) 6. Overspeed <p>Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur, but need not display these conditions individually. [110: 3-5.5.2].</p>	K 106	See attached report	



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

Printed: 07/31/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130007	(X2) MULTIPLE CONSTRUCTION A. BUILDING 08 - EMERALD HEALTH PLAZA B. WING _____	(X3) DATE SURVEY COMPLETED 07/27/2012
NAME OF PROVIDER OR SUPPLIER ST ALPHONSUS REGIONAL MEDICAL CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE 1055 NORTH CURTIS ROAD BOISE, ID 83706		
(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 038	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to assure that exit accesses are readily accessible to evacuate the facility at all times. This deficient practice affected visitors, facility personnel, and patients Based on observations and staff interview, the findings are as follows: During the facility tour on 07/26/12 at 12:25 p.m., observed that the facility failed to provide a continuous egress pathway to a public way from the designated exit, at the northwest exit . This exit discharged on to a small landing blocked by landscaping, there was no walking surface beyond the landing. Interview with the Engineering Manager revealed that the facility was not aware the exit did not terminate at a public way.. Actual NFPA 101 reference: 7.7 DISCHARGE FROM EXITS 7.7.1 Exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way. Exception No. 1: This requirement shall not apply to interior exit discharge as otherwise provided in 7.7.2. Exception No. 2: This requirement shall not apply to rooftop exit discharge as otherwise provided in 7.7.6.</p>	K 038	See attached report	

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FACILITY STANDARDS

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

TITLE

(X6) DATE

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

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K 038	Continued From page 1 Exception No. 3: Means of egress shall be permitted to terminate in an exterior area of refuge as provided in Chapters 22 and 23.	K 038	See attached report	



CMS Survey Plan of Correction
 Saint Alphonsus Regional Medical Center
 Date of Survey

Tag	Plan of Correction	Completion Date
Behavioral Health Center K-027 Smoke Barrier Doors	<ol style="list-style-type: none"> 1. Corrective Action was taken to replace the door closer on the smoke door near room 105, allowing the door to open to full open position. All individuals in this space are now capable of full exit egress in the event of an emergency. 2. Corrective action identified in #5 has been completed. No other individuals having the potential to be affected by the incorrectly mounted door closer were identified. 3. To ensure the deficient practice does not reoccur the assigned mechanic will inspect all doors in this facility on a quarterly basis. The inspection will be done on a door inspection checklist to ensure all doors are inspected and that all meet codes. 4. Ongoing corrective action will be monitored by using the semi-annual environment of care committee surveys of this building to ensure doors are safe and meet code requirements. 5. The faulty door closer was replaced on 5 August 2012. A copy of the work order is attached. 	8/5/2012 
Entire Hospital K-025 Fire and Smoke Barriers	<ol style="list-style-type: none"> 1. Corrective Action was taken to repair fire, smoke, and fire/smoke barriers identified in the survey. All individuals in these spaces are now protected by proper barriers. 2. Corrective action identified in #5 has been completed. No other individuals having the potential to be affected by the missing barriers were identified. 3. To ensure the deficient practice does not reoccur a team will conduct inspections of all fire and fire/smoke walls in our main hospital. Any penetrations will be listed and repairs made within 30 days of any new findings during this survey. 4. Ongoing corrective action will be monitored by reestablishing the building maintenance plan penetration inspection requirements and quarterly spot checking for completion and accuracy. 	9/28/2012

FACILITY STANDARDS

CMS Survey Plan of Correction
 Saint Alphonsus Regional Medical Center
 Date of Survey

Tag	Plan of Correction	Completion Date
K-025 (continued)	<p>5. Penetrations have been addressed as follows:</p> <ul style="list-style-type: none"> • The Penetration in the C4 communication closet was completed on 14 August 2012 and a copy of the completed work order is included. • The penetration in the electric closet next to the RT clean equipment room was completed on 14 August 2012 and a copy of the completed work order is included. • The penetration in the pharmacy shell/Ultrasound was completed on 14 August 2012 and a copy of the completed work order is included. • The penetration in the basement electrical room was completed on 4 August 2012 and a copy of the completed work order is included. • The penetration in Oncology infusion floor electric closet was completed on 4 August 2012 and a copy of the completed work order is included. • The penetration in the 2nd floor environmental services closet next to men's locker in the kitchen was repaired on 31 July 2012 and a copy of the completed work order is included. • The penetration in the ceiling by room C9232 was repaired on 31 July 2012 and a copy of the completed work order is included. • The penetration above the ceiling by C9217 was repaired on 30 July 2012 and a copy of the completed work order is included. • The penetration in the electrical closet of EHP was repaired on 8 August 2012 and a copy of the completed work order is included. • The penetration in the ceiling at the 1st floor east stairwell of the central tower was repaired on 14 August 2012 and a copy of the completed work order is included. 	

CMS Survey Plan of Correction
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Entire Hospital K-147 Electrical Wiring	<ol style="list-style-type: none"> 1. Corrective action was taken to: remove all relocatable power strips identified during the inspection; repair the electrical connection to the dishwasher in the South Tower Kitchen; make schedules to add "spare" to unused breakers in the Central Tower; and to properly identify all breakers in the South Tower kitchen. 2. Corrective action identified in #5 has been completed or is scheduled to be completed. No other individuals having the potential to be affected by the incorrectly mounted door closer were identified. 3. The following actions will take place to ensure deficient practice does not reoccur: <ul style="list-style-type: none"> #1 observation: To ensure all breakers are properly labeled our staff will inspect and correct all deficiencies using a line diagram of our electrical distribution system. #2 observation: To ensure all relocatable power taps utilized in our facility are being used within their UL listing a complete inspection of all our facilities will be conducted and deficiencies corrected. #3 observation: To ensure all kitchen equipment is inspected for safety and compliance a full inspection will be made by our plant electrician. 4. We are in the process of building electronic electrical panel breaker identification schedules for all our panels in the hospital and will review with our annual panel inspections to ensure correct breaker identification now and in future projects. Ongoing corrective action will be monitored by using the semi-annual environment of care committee surveys of all buildings to ensure relocatable power strips are utilized properly in our facility. An inspection tag will be attached and a standard developed with both the Purchasing and the Information Management departments to control the purchase and use of power strips in our facility. Increased inspections of all kitchen equipment will be done semi-annually to ensure safe power use in this location. 	9/28/2012

CMS Survey Plan of Correction
 Saint Alphonsus Regional Medical Center
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Tag	Plan of Correction	Completion Date
K-147 (continued)	<p>5. Electrical wiring issues will be addressed as follows:</p> <ul style="list-style-type: none"> • Labeling of electrical panels in the Central Tower and Kitchen will be completed within 60 days and a completed work order will be forwarded. • The power strip located in the RT office was removed and the completed work order is included. • The relocatable power strip located in the NICU equipment room was removed on 14 August 2012 and a copy of the completed work order is attached to this report. • A work order has been written to remove the relocatable power strip located in the learning systems office and a copy of the completed work order will be forwarded when this work is completed. • A work order has been written to remove the relocatable power strip located in the office behind the Endoscopy reception area and the completed work order will be forwarded when the work is completed. • The relocatable power strip located in the doctor's lounge was removed on 2 August 2012 and a copy of the completed work order is included. • The repair to the junction box in the kitchen was completed on 29 July 2012 and a copy of the completed work order is included. 	

CMS Survey Plan of Correction
 Saint Alphonsus Regional Medical Center
 Date of Survey

Tag	Plan of Correction	Completion Date
Free Standing Emergency Department, Eagle Health Plaza K-077 Medical Gas Shut off	<ol style="list-style-type: none"> 1. Corrective Action has been scheduled to secure the valve box and identify the location of the medical gas main shut off valves. All individuals will be protected by a main gas shut off valve that is locked and the valve is identified by a sign. 2. Corrective action identified in #5 has been scheduled. No other individuals having the potential to be affected by the location and access to the main gas shut off were identified. 3. To ensure the deficient practice does not reoccur all buildings using piped medical gas systems will be inspected for code compliance. Location of valves and signage will be included in the annual medical gas inspection items identified in our current inspection process. 4. Ongoing corrective action will be monitored by using the semi-annual environment of care committee surveys of all buildings to ensure medical gas system code compliance. 5. A work order to secure and place a proper sign at this location has been written and work will be completed before the end of August. A completed work order will be forwarded when the work is completed. 	8/31/2012
Free Standing Emergency Department, Eagle Health Plaza K-106 Generator Annunciator	<ol style="list-style-type: none"> 1. Corrective Action has been scheduled to relocate the generator monitoring station from the unoccupied space to the occupied emergency department on the first floor. All individuals working in this building will be protected by a monitoring station that identifies code required points on the building generator. 2. Corrective action identified in #5 has been scheduled. No other individuals having the potential to be affected by the location of the generator monitoring station were identified. 3. To ensure the deficient practice does not reoccur all buildings using an emergency generator the location of the monitoring panel will be inspected for code compliance. 4. Ongoing corrective action will be monitored by using the semi-annual environment of care 	9/28/2012

CMS Survey Plan of Correction
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Tag	Plan of Correction	Completion Date
K-106 (continued)	<p>committee surveys of all buildings to ensure emergency generator monitoring is being done in compliance with codes.</p> <p>5. The emergency generator monitoring station is scheduled to be moved to the occupied section of the building in the emergency department nurse's station this month. As soon as this work is done a completed work order will be forwarded.</p>	
Emerald Health Plaza K-038 Exit Access	<ol style="list-style-type: none"> 1. Corrective Action has been scheduled to replace the access to the public way. All individuals in this space will be capable of full exit egress in the event of an emergency upon completion. 2. Corrective action identified in #5 has been scheduled. No other individuals having the potential to be affected by the exit egress path to the public way were identified. 3. To ensure the deficient practice does not reoccur the mechanics at all our outbuildings will be given training on the requirement for exit discharge requirements. This training will be conducted at our next department meeting in August. All buildings will be inspected for code compliance. 4. Ongoing corrective action will be monitored by using the semi-annual environment of care committee surveys of all buildings to ensure compliance with exiting requirements. 5. The step and sidewalk replacement has been bid and this work is scheduled for completion by the 28 September 2012. A copy of the completed work order will be forwarded as soon as this work is completed. 	9/28/2012