



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

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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September 10, 2012

Wade Johnson, Administrator
St. Luke's McCall
1000 State Street
McCall, ID 83638

RE: St. Luke's McCall, Provider ID# 131312

Dear Mr. Johnson:

This is to advise you of the findings of the Medicare/Licensure Fire Life Safety Survey, which was concluded at St. Luke's McCall, on September 5, 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.

Wade Johnson, Administrator
September 10, 2012
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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 **September 24, 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 'Mark 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: 09/10/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131312	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE HOSPITAL B. WING _____	(X3) DATE SURVEY COMPLETED 09/05/2012
NAME OF PROVIDER OR SUPPLIER ST LUKE'S MCCALL		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 STATE STREET MC CALL, ID 83638		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The hospital is a single story building constructed in 1957. Basic construction type is V(111) except the 1997 addition which is Type II construction. The renovation and addition included a new kitchen, small staff dining, ED, OR, lab, admissions, conference rooms, CS, business, and mechanical. There have been continual upgrades since that time with recent remodeling this year in the OR areas. The buildings life safety features includes automatic fire extinguisher system, fire alarm/smoke detection throughout , emergency power (i.e., diesel generator set), piped in medical gases and vacuum, three exits to the exterior grade, four exits from specific areas, and portable fire extinguishers. The following deficiencies were cited during the fire/life safety survey. The facility was surveyed on September 5, 2012 in accordance the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy and 42 CFR 485.623. The surveyor conducting the survey was: Tom Mroz CFI-II Health Facility Surveyor Facility Fire/Life Safety & Construction Program	K 000	See subsequent Plan of Correction (POC) for specific findings	
K 025	NFPA 101 LIFE SAFETY CODE STANDARD 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 heating, ventilating, and air conditioning systems.	K 025		

RECEIVED
SEP 24 2012
FACILITY STANDARDS

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

TITLE

(X6) DATE

Murray Jendall

CEO

9-20-12

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	Continued From page 1 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 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 three of six smoke compartments, staff, and patients. Findings Include: 1. Observation on 09/05/12 at 10:20 a.m. revealed two 2' x 2' sections of drop ceiling that were removed in the HIM storage room. Interview with the Director of Engineering on 09/05/12 at 10:20 a.m. disclosed that the facility was unaware of the missing sections of ceiling, 2. Observation on 09/05/12 at 10:35 a.m. revealed an approximately 2" x 5" open penetration around the two 2" conduit pipes that went through the wall of the electric room. Interview with the Director of Engineering on 09/05/12 at 10:35 a.m. disclosed that the facility was unaware of the through the wall penetration. 3. Observation on 09/05/12 at 11:10 a.m. revealed two open penetrations around conduit pipe and one penetration around data wires above the cross corridor door ceiling by patient room #1. Interview with the Director of Engineering on 05-23-12 at 11:10 a.m. revealed that the facility was unaware of the through the wall penetration The finding was acknowledged by the VP of Diagnostic Services and the Director of	K 025	<u>K025-NFPA Life Safety Code Standard.</u> 1. Missing Ceiling Tiles: a. The two sections of missing ceiling tile were immediately replaced during the survey process (9/5/12) 9/5/12 b. An inspection of the entire organization was conducted on 9/6/12 to assure no further missing or damaged ceiling tiles. 9/6/12 c. A schedule has been established with the Facilities Department to perform monthly inspections of this aspect of the Environment of Care (EOC). All staff and managers will be educated on the importance of this standard by 9/30/2012, and instructed to report damaged or missing ceiling tiles to the Facilities Department upon discovery. 9/30/12 d. These activities will be monitored by the Director of Facilities, in partnership with the Manager of Patient Care Quality and Safety; reported to the CEO and Sr. Leadership Quarterly; and through Quarterly Summary reports to the Quality Committee of the Board of Directors. 9/21/12 and Ongoing 2. Smoke Penetrations: a. The interim Life Safety Plan was immediately initiated pending repairs to the smoke penetration barriers. 9/5/12 b. An inspection of these locations was conducted on 9/6/12, and all penetrations will be sealed by 9/21/20012. 9/6/12 & 9/21/12 c.	

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K 025	Continued From page 2 Engineering at the exit interview on 09/05/12. 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. (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	e. A schedule has been established with the Facilities Department to perform quarterly 'above ceiling' inspections of this aspect of the Environment of Care (EOC). This schedule will assure that all sections of the building will be inspected at least annually. A process will be established to assure contractors and vendors receive 'just in time' instruction on barrier penetration standards prior to initiating their work, followed by an inspection by McCall Facilities staff prior to the work being considered completed. f. These activities will be monitored by the Director of Facilities, in partnership with the Manager of Patient Care Quality and Safety; reported to the CEO and Sr. Leadership Quarterly; and through Quarterly Summary reports to the Quality Committee of the Board of Directors.	9/21/12	
K 050	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under	K 050	See subsequent page		9/21/12 and ongoing

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K 050	<p>Continued From page 3</p> <p>varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>This Standard is not met as evidenced by: Based on observation, record review, and interview, the facility failed to provide fire drills for three of four quarters reviewed. The deficient practice would potentially affect six of six smoke compartments, all patients, and occupants of the building.</p> <p>The findings include:</p> <p>Observation during record review on 09/05/12 at 9:30 a.m. revealed that for 2nd shift of the 4th quarter in 2011 and the 1st and 2nd shifts of the 1st and 2nd quarter of 2012, no fire drills were documented as being held. Interview on 09/05/12 at 9:30 a.m. with the Director of Engineering disclosed that the facility was aware the drills were not performed.</p> <p>The finding was acknowledged by the VP of Diagnostic Services and verified by the Director of Engineering at the exit interview on 09/05/12.</p> <p>Actual NFPA Standard NFPA 101, 19.7.1.2 Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills</p>	K 050	<p><u>K050-NFPA 101 Life Safety Code Standard.</u></p> <p>1. Fire Drills</p> <p>a. A fire drill was conducted for the third quarter (9/21/12). 9/21/12</p> <p>b. An annual fire drill plan has been developed/approved outlining standards for monthly drills that will provide (at minimum) one fire drill on each shift each quarter. The Director of Facilities will be responsible for carrying out this plan. 9/21/12</p> <p>c. A fire drill evaluation tool has been adopted that will be utilized to record staff responses to every fire drill. Fire drills will be monitored and evaluated by the Manager of Patient Care Quality and Safety and reported to the CEO and senior leadership. 9/21/12</p> <p>d. These activities will be monitored by the Director of Facilities, in partnership with the Manager of Patient Care Quality and Safety; reported to the CEO and Sr. Leadership Quarterly; and through Quarterly Summary reports to the Quality Committee of the Board of Directors. 9/21/12 and ongoing</p>		

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K 050	Continued From page 4 shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building.	K 050			
K 052	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to provide a smoke detector above a fire alarm control panel. The deficient practice would affect six of six smoke compartments, all patients, and occupants of the building. Findings include: Observation of the fire alarm control panel	K 052	See Subsequent page		

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K 052	Continued From page 5 located in the unoccupied surgery equipment storage room on 09/05/12 at 10:25 a.m., the facility failed to provide automatic smoke detection at the fire alarm control panel. Lack of smoke detection may cause the fire alarm control panel to be incapacitated by fire before a detection device responded. Interview with the facility Director of Engineering on 09/05/12 at 10:25 a.m., indicated the facility was not aware that smoke detection was required at this location. The finding was acknowledged by the VP of Diagnostic Services and verified by the Director of Engineering at the exit interview on 09/05/12. Actual NFPA standard: NFPA 72, 1-5.6 Protection of Fire Alarm Control Unit(s). In areas that are not continuously occupied, automatic smoke detection shall be provided at the location of each fire alarm control unit(s) to provide notification of fire at that location. Exception: Where ambient conditions prohibit installation of automatic smoke detection, automatic heat detection shall be permitted.	K 052	<u>K052-NFPA 101 Life Safety Code Standard.</u> 1. Smoke Detection a. The Interim Life Safety Plan was placed into effect during the survey process until appropriate repairs were made to the fire panel to provide for automatic smoke detection. 9/5/12 b. An automatic smoke detector has been ordered to meet the requirement for an automatic smoke detection at a fire alarm control panel. This automatic smoke alarm will be installed by 10/30/2012. 9/11/12 & 9/30/12 c. The Director of Facilities Services is responsible for ensuring that the automatic smoke detector is installed and functioning as expected. Functionality of Smoke Detection devices will be evaluated periodically incorporated into the facility inspection and drill processes. 9/21/12 d. Completion of installation will be reported to the Chief Executive Officer and to the Quality Board Committee at the next scheduled meeting following completion. Related activities will be monitored through previously described processes. 9/30/12 and ongoing	
K 056	NFPA 101 LIFE SAFETY CODE STANDARD 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 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	K 056		

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K 056	Continued From page 6 switches, which are electrically connected to the building fire alarm system. 19.3.5 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to provide complete coverage by the automatic sprinkler system as required for a Type V (111) protected, ordinary construction. The deficient practice affected one of six smoke compartments, staff, and patients. Findings include: Observation on 09/05/12 at 10:08 a.m. revealed that sprinkler coverage was not provided for the closet in patient room #3. The closet was approximately two feet by four feet in dimension. Interview with the Director of Engineering on 09/05/12 at 10:08 a.m., disclosed that the facility constructed the new closet and was not aware that the closet is required to be provided with sprinkler protection. The finding was acknowledged by the VP of Diagnostic Services and verified by the Director of Engineering at the exit interview on 09/05/12. Actual NFPA Standard: NFPA 101, 19.3.5.1. Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7.	K 056	<u>K056-NFPA 101 Life Safety Code Standard.</u> 1. Automatic Sprinkler System a. The interim Life Safety Plan was placed in effect until appropriate repairs were made to the sprinkler system in patient care room 3. 9/5/12 b. The required sprinkler head has been contracted to be installed on 9/20/2012. 9/20/12 c. The Director of Facilities Services is responsible for ensuring that the sprinkler is correctly installed. 9/20/12 Completion of installation will be reported to the Chief Executive Officer and to the Quality Board Committee at the next scheduled meeting following completion.		
K 062	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating	K 062	See subsequent page		

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K 062	<p>Continued From page 7</p> <p>condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This Standard is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure quarterly automatic fire sprinkler system inspections had been completed. The deficient practice would potentially affect six of six smoke compartments, all patients, and occupants of the building.</p> <p>The findings include:</p> <p>Observation during record review of fire sprinkler inspection reports on 09/05/12 at 8:30 a.m. disclosed that the facility had no documentation for a completed quarterly automatic fire sprinkler system inspection as required for the 3rd and 4th quarter of 2011 and the 1st quarter of 2012.</p> <p>The Director of Facilities stated during interview on 09/05/12 at 8:30 a.m. that, to his knowledge, a quarterly inspection of the sprinkler system had not been completed for the 3rd and 4th quarter of 2011 and the 1st quarter of 2012.</p> <p>The finding was acknowledged by the VP of Diagnostic Services and verified by the Director of Engineering at the exit interview on 09/05/12.</p> <p>Actual NFPA Standard: NFPA 25 2-2 Inspection. 2-2.1 Sprinklers. Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance: Alarm devices Test Quarterly</p>	K 062	<p><u>K062-NFPA 101 Life Safety Code Standard.</u></p> <p>1. Fire Sprinkler System Inspection and Testing</p> <p>a. An inspection and testing of the fire sprinkler system has been conducted by Facilities personnel.</p> <p>b. A routine fire sprinkler system inspection schedule has been re-established. Quarterly Water-based Fire Protection System inspections will be performed by on-site trained facilities personal. Annual fire sprinkler inspection is conducted by an outside vendor.</p> <p>c. The accountability for conduction of fire sprinkler testing and inspections is with the Facilities Director, who reports to the CEO.</p> <p>d. These activities will be monitored by the Director of Facilities, in partnership with the Manager of Patient Care Quality and Safety; reported to the CEO and Sr. Leadership quarterly; and through Quarterly Summary reports to the Quality Committee of the Board of Directors.</p>	9/21/12	

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K 062	Continued From page 8 Main drain Test Quarterly Alarm devices Inspection Quarterly Gauges Test 5 years Obstruction- Maintenance- 5 years	K 062	<p><u>K069-NFPA 101 Life Safety Code Standard.</u></p> <p>1. Kitchen Suppression and Exhaust System</p> <p>a. Semi-annual inspection of the kitchen hood suppression system was completed on 9/6/2012.</p> <p>b. A subsequent semi-annual schedule for inspection of the kitchen hood suppression system will be conducted by an approved certified inspection company. The accountability for assuring the inspection of the kitchen fire suppression system is with the Facilities Director (who reports to the CEO) in partnership with the Food Service Contractor.</p> <p>c. These activities will be monitored by the Director of Facilities, in partnership with the Manager of Patient Care Quality and Safety; reported to the CEO and Sr. Leadership Quarterly; and through Quarterly Summary reports to the Quality Committee of the Board of Directors.</p>	9/6/2012
K 069	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96</p> <p>This Standard is not met as evidenced by: Based on observation, record review, and interview, the facility failed to provide semiannual inspection and maintenance of the kitchen suppression and exhaust system at a minimum interval of at least every six months The deficient practice affected one of six smoke compartments, staff and no patients.</p> <p>Findings include:</p> <p>Observation during record review on 09/05/12 at 8:30 a.m. revealed that the kitchen hood fire suppression system 's last inspection and maintenance was accomplished on 01/30/12. The facility was unable to provide a documented inspection and maintenance for the seven month interval between the 01/30/12 and the date of the survey on 09/05/12. Interview on 09/05/12 at 8:30 a.m. with the Director of Engineering revealed that the facility was aware of the requirement for the inspection and servicing of the kitchen hood fire suppression system within a minimum of at least every six months but was not aware of the missing documented inspection and maintenance for the suppression system.</p> <p>The finding was acknowledged by the VP of Diagnostic Services and verified by the Director of Engineering at the exit interview on 09/05/12.</p>	K 069		9/21/12

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K 069	Continued From page 9 Actual NFPA Standard: NFPA 17A, 5-3.1.1. At least semiannually, maintenance shall be conducted in accordance with the manufacturer's listed installation and maintenance manual. NFPA 17A, 5-3.1.1 (g). The maintenance report, with recommendations, if any, shall be filed with the owner or with the designated party responsible for the system. NFPA 17A, 5-3.1.1 (h). Each wet chemical system shall have a tag or label securely attached, indicating the month and year the maintenance is performed and identifying the person performing the service. Only the current tag or label shall remain in place. NFPA 17A, 5-5. The following parts of wet chemical extinguishing systems shall be subjected to a hydrostatic pressure test at intervals not exceeding 12 years: (a) Wet chemical containers (b) Auxiliary pressure containers (c) Hose assemblies	K 069	See previous page		
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	K 076			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131312	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE HOSPITAL B. WING _____		(X3) DATE SURVEY COMPLETED 09/05/2012
NAME OF PROVIDER OR SUPPLIER ST LUKE'S MCCALL			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 STATE STREET MC CALL, ID 83638		
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K 076	Continued From page 10 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to protect freestanding "E" size oxygen cylinder from accidental damage. The deficient practice affected one of six smoke compartments, staff, and no patients. Findings include: Observation on 09/05/12 at 9:55 a.m., revealed that one freestanding "E" size oxygen cylinder located in the cardiopulmonary storage closet was not protected by individual chaining, placement in a rack or use of a cylinder stand/cart. Interview with the Director of Engineering on 09/05/12 at 9:55 a.m., disclosed that the facility was not aware the "E" cylinder was stored lying on the floor without being properly supported or secured. The finding was acknowledged by the VP of Diagnostic Services and verified by the Director of Engineering at the exit interview on 09/05/12. Actual NFPA Standard: NFPA 99, 4-3.5.2.1 (b) 27. Freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart.	K 076	<u>K076-NFPA 101 Life Safety Code Standard.</u> 1. Medical Gas Storage a. An immediate inspection of medical gas storage within all areas of the facility was conducted and any improperly stored canisters were removed and/or stored properly Immediate education on appropriate oxygen storage was provided to all staff of the organization. b. A schedule for a regularly repeating, but no less often than monthly, environment of care inspection, (which includes surveying for inappropriately stored oxygen cylinders) has been implemented. c. All patient-care staff and facilities staff are accountable to note and correct improperly stored medical gases. The Director of Facilities and the Chief Nursing Officer (CNO) shall partner in assuring this standard is met. d. These activities will be monitored by the Director of Facilities, in partnership with the CNO; reported to the CEO and Sr. Leadership Quarterly; and through Quarterly Summary reports to the Quality Committee of the Board of Directors.	9/5/12 9/5/12 9/21/12 9/21/12 and ongoing	
K 132	NFPA 101 LIFE SAFETY CODE STANDARD 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 This Standard is not met as evidenced by:	K 132		9/21/12 and ongoing	

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K 132	Continued From page 11 Based on observation, record review and interview, 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: Observation during record review on 09/05/12 at 11:30 a.m. revealed that the facility failed to provide continuing safety education for the hospital laboratory. There was no documented orientation and training of new laboratory personnel, and no documented continuing safety education. Interview with the VP of Diagnostic Services on 09/05/12 at 11:30 a.m., disclosed that the facility was not aware of the documentation requirements. The finding was acknowledged by the VP of Diagnostic Services and the Director of Engineering at the exit interview on 09/05/12. 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 reviewed monthly, and procedures shall be reviewed annually.	K 132	<u>K132-NFPA 101 Life Safety Code Standard.</u> 1. Safety Education: Laboratory a. Department-specific safety education has been provided to all laboratory staff. 9/21/12 b. All new laboratory staff will receive training on general safety practices for the laboratory and specific safety practices for the equipment and procedures they will use during orientation. This education will be documented on their new hire competency forms. Ongoing laboratory safety education and a review of safety incidents from the previous month will occur monthly during the laboratory staff meeting. 9/21/12 c. The accountability for ensuring laboratory specific safety education & incident review occurs and is documented appropriately falls is with the Laboratory Manager who reports to the VP of Support Services. 9/21/12 and ongoing d. These activities will be monitored by the VP of Support Services; reported to the CEO and Sr. Leadership Quarterly. 9/21/12 and ongoing	9/21/12 9/21/12 9/21/12 and ongoing 9/21/12 and ongoing
K 134	NFPA 101 LIFE SAFETY CODE STANDARD Where the eyes or body of any person can be exposed to injurious corrosive materials, suitable fixed facilities for quick drenching or flushing of	K 134		

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K 134	<p>Continued From page 12</p> <p>the eyes and body are provided within the work area for immediate emergency use. Fixed eye baths are designed and installed to avoid injurious water pressure in accordance with NFPA 99. 10.6</p> <p>This Standard is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide an suitable emergency shower 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.</p> <p>Findings include:</p> <p>Observation 09/05/12 at 11:25 a.m., revealed that the facility failed to provide a suitable emergency shower within the laboratory work area for immediate emergency use. The area beneath the fixed shower was obstructed by a document shredder receptacle and wall mounted coat rack. Interview with the Director of Engineering on 09/05/12 at 11:25 a.m., disclosed that the facility was not aware the obstructions would prevent immediate emergency shower use.</p> <p>The finding was acknowledged by the VP of Diagnostic Services and the Director of Engineering at the exit interview on 09/05/12.</p> <p>Actual NFPA Standard: NFPA 99, 10-6 Emergency Shower. Where the eyes or body of any person can be exposed to injurious corrosive materials, suitable fixed facilities for quick drenching or flushing of the eyes and body shall be provided within the</p>	K 134	<p><u>K134-NFPA 101 Life Safety Code Standard.</u></p> <p>1. Shower and Eyewash Station: Laboratory</p> <p>a. The laboratory shower was immediately made operational by removing all obstructions that would prevent immediate emergency shower use. 9/5/12</p> <p>b. A plan is developed and implemented for a monthly EOC inspection of the laboratory to include the shower area, to assure a safe environment and compliance with all environmental regulatory requirements. 9/21/12</p> <p>c. The accountability for both ensuring that emergency shower facilities meet standards and that routine inspections occur and are appropriately documented is with the Laboratory Manager who reports to the VP of Support Services. 9/21/12 and ongoing</p> <p>d. Weekly inspections of the shower area will be performed to assure standards are met, until three months with no deficiencies have occurred, when these will be incorporated into the monthly laboratory EOC rounds. (continued) 9/21/12 and ongoing</p>		

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

Printed: 09/10/2012
FORM APPROVED
OMB NO. 0938-0391

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K 134	Continued From page 13 work area for immediate emergency use. Fixed eye baths shall be designed and installed to avoid injurious water pressure.	K 134	d. (continued) These activities will be monitored by the VP of Support Services; reported to the CEO and Sr. Leadership Quarterly, and to the Quality Committee of the Board of Directors with routine report summaries on EOC activities.	Continued 9/21/12 and ongoing	

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B 000	16.03.14 Initial Comments The hospital is a single story building constructed in 1957. Basic construction type is V(111) except the 1997 addition which is Type II construction. The renovation and addition included a new kitchen, small staff dining, ED, OR, lab, admissions, conference rooms, CS, business, and mechanical. There have been continual upgrades since that time with recent remodeling this year in the OR areas. The buildings life safety features includes automatic fire extinguisher system, fire alarm/smoke detection throughout, emergency power (i.e., diesel generator set), piped in medical gases and vacuum, three exits to the exterior grade, four exits from specific areas, and portable fire extinguishers. The following deficiencies were cited during the fire/life safety survey. The facility was surveyed on September 5, 2012 in accordance the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy and IDAPA 16.03.14 Rules and Minimum Standards for Hospitals in Idaho. The surveyor conducting the survey was: Tom Mroz CFI-II Health Facility Surveyor Facility Fire/Life Safety & Construction Program	B 000	No plan needed for this section	
BB499	16.03.14.510.01 Fire & Life Safety Standards, General Require 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. (10-14-88) 01. General Requirements. General	BB499		

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FACILITY STANDARDS

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

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

Michael Fenwick

TITLE

CEO

(X6) DATE

9-20-12

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BB499	Continued From Page 1 requirements for the fire and life safety standards for a hospital are that: (10-14-88) a. The hospital shall be structurally sound and shall be maintained and equipped to assure the safety of patients, employees, and the public. (10-14-88) b. 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. (10-14-88) This RULE: is not met as evidenced by: Refer to federal CMS form 2567 and K tags: 1.) K025 Penetrations 2.) K050 Fire Drills 3.) K052 Fire Alarm System 4.) K056 Fire Sprinklers 5.) K062 Quarterly Sprinkler Inspection 6.) K069 Kitchen Hood Inspection 7.) K076 Compressed Gas Cylinder 8.) K132 Laboratory Training Documentation 9.) K134 Laboratory Shower	BB499		

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