



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

July 30, 2014

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

RE: Bear Lake Memorial Hospital, Provider ID# 131316

Dear Mr. Jacobson:

This is to advise you of the findings of the Medicare/Licensure Fire Life Safety Survey, which was concluded at Bear Lake Memorial Hospital, on July 22, 2014.

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.

FILE COPY

Rod Jacobson, Administrator

July 30, 2014

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 12, 2014**.

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

Sincerely,



MARK P. GRIMES

Supervisor

Facility Fire Safety and Construction Program

MPG/lj

Enclosure

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

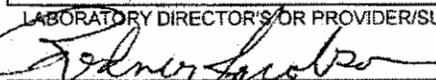
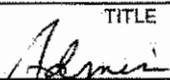
Printed: 07/30/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131316	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE HOSPITAL B. WING _____	(X3) DATE SURVEY COMPLETED 07/22/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83254
--	---

(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	<p>INITIAL COMMENTS</p> <p>The hospital building is a single story structure with a partial basement. The building was originally constructed in 1958 with subsequent additions to include a major addition/renovation completed in 1998, as well as a new addition/renovation currently in progress. The construction is Type V(111) and is fully sprinklered. The upgraded fire alarm system includes smoke detection throughout the corridors and common areas. The main level of the hospital has 5 exits to grade plus a horizontal exit to the physically attached Skilled Nursing Facility. There are two remote exits from the basement which are accessible through the Central Supply office and storage area. The main level of the hospital is sub-divided into three smoke compartments with the partial basement sub-divided into two smoke compartments.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on July 22, 2014. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy and in accordance with 42 CFR 485.623.</p> <p>The survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	K 000	<p style="text-align: center;">RECEIVED SEP 02 2014 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</p>	K 025		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE 	(X6) DATE 8-12-14
---	---	-----------------------------

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131316	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE HOSPITAL B. WING _____	(X3) DATE SURVEY COMPLETED 07/22/2014
NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83254		
(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 025	<p>Continued From page 1</p> <p>floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted 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 ensure that smoke barriers would resist the passage of smoke. Failure to maintain smoke barriers would allow smoke and dangerous gases to pass freely between smoke compartments affecting egress during a fire. This deficient practice affected 8 patients, staff and visitors in 5 of 5 smoke compartments on the date of the survey. The facility is licensed for 21 beds and had a census of 8 on the day of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on July 22, 2014 from 10:15 AM to 11:45 AM, observation of the ceiling in the electrical room located in the partial basement revealed (3) unsealed holes in the ceiling through to the Laboratory. Interview of the Maintenance Director revealed these holes had been drilled to accommodate the construction in progress and had not yet been sealed.</p> <p>2) During the facility tour conducted on July 22, 2014 from 11:45 AM to 12:30 PM, observation of the walls separating the Electrical room, the Dietary Storage room and the Dry Storage room revealed (2) unsealed pipes approximately three inches in diameter penetrating all three walls. When asked, the Maintenance Director stated these unsealed penetrations were done as part of the current construction project and had not yet</p>	K 025	<p>The alleged deficiency K 025 refers to the unsealed holes in the walls and floors. The condition is related to the current remodeling project and is covered in our construction management contract. The cited deficiency had the potential to effect 21 patients, staff and visitors. The plan of correction is addressed below with the items numbered according to the numbered findings.</p> <p>This contract address the conditions stated in #1, #2, #6, and #8.</p> <p>The above mentioned holes will be sealed and corrected under the direction of the maintenance supervisor by 09/10/14.</p> <p>The maintenance supervisor will be responsible to monitor for any gaps or openings not sealed during and after the construction is completed. He will work closely with the contractors to monitor for compliance in the contract until the project is completed.</p>	

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

Printed: 07/30/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131316	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE HOSPITAL B. WING _____	(X3) DATE SURVEY COMPLETED 07/22/2014
NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83254	
(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 025	Continued From page 2 been sealed. 3) During the facility tour conducted on July 22, 2014 from 11:45 AM to 12:30 PM, observation of the ceiling in the dialysis unit located in the partial basement revealed (3) ceiling tiles with approximately 1/2" gaps around sprinkler pendants. When questioned, the Maintenance Director stated he was not aware of these gaps. 4) During the facility tour conducted on July 22, 2014 from 11:45 AM to 12:30 PM, observation of the storage room next to the elevator equipment room revealed a missing ceiling tile. Interview of the Maintenance Director revealed he was not aware this ceiling tile was missing. 5) During the facility tour conducted on July 22, 2014 from 11:45 AM to 12:30 PM, observation of the Dietary Services office ceiling revealed the sprinkler escutcheon was missing. When asked, the Maintenance Director stated he was unaware this escutcheon was gone. 6) During the facility tour conducted on July 22, 2014 from 11:45 AM to 12:30 PM, an above the ceiling inspection of the 2-hour fire wall separating the maintenance department and central supply from the support services and dialysis corridor revealed (2) pipes approximately three inches in diameter passing through unsealed penetrations in the wall. When asked, the Maintenance Director stated these were plumbing pipes installed during the current construction project and had not yet been sealed. 7) During the facility tour conducted on July 22, 2014 from 1:30 PM to 3:00 PM, observation of the sprinkler escutcheons in the ceilings of patient rooms #1, #2, #3 and the converted CCU area adjacent to the nurses station, revealed (4) of these escutcheons had separated from the ceiling leaving a gap between the ceiling tile and the escutcheon of approximately 1/2". Interview of the Maintenance Director revealed he was not	K 025	The plan of correction for the alleged deficiency L 025 continues: #3: The gaps around sprinkler pendants will be repaired and an inventory of the facility will be conducted to ensure no other similar problems exist. This inventory will be conducted by the maintenance supervisor and will be done no later than 09/15/14. #4: The ceiling tile will be replaced in the storage room next to the elevator equipment. An inventory of the facility will be conducted by the maintenance supervisor to assure no similar conditions exist. This will be completed by 08/27/14. #5: The sprinkler escutcheon will be replaced in the dietary services office. An inventory of the area will also be conducted by the maintenance supervisor to ensure no similar conditions exist. This will be completed by 08/27/14. #6: Addressed on previous page #7: The sprinkler escutcheons in rooms 1, 2, 3 and CCU will be fixed. Please note these areas will be demolished in the current construction plans. The repairs will take place by 08/27/14. The maintenance supervisor will responsible to inspect and inventory all areas with sprinklers to monitor for the same problem. The completion date will be 09/10/14.	

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

Printed: 07/30/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131316	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE HOSPITAL B. WING _____	(X3) DATE SURVEY COMPLETED 07/22/2014	
NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83254		
(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 025	<p>Continued From page 3</p> <p>aware these escutcheons had been dislodged. 8) During the facility tour conducted on July 22, 2014 from 1:30 PM to 3:00 PM, observation of the floor of the Laboratory revealed (5) holes drilled through the floor into the partial basement below. (3) of these holes were those indicated in finding #1. When asked, the Maintenance Director reaffirmed these were due to the construction project and had not yet been sealed.</p> <p>Actual NFPA standard:</p> <p>8.3 SMOKE BARRIERS 8.3.2* Continuity. Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces.</p> <p>Exception: A smoke barrier required for an occupied space below an interstitial space shall not be required to extend through the interstitial space, provided that the construction assembly forming the bottom of the interstitial space provides resistance to the passage of smoke equal to that provided by the smoke barrier.</p>	K 025	#8: Correction plan addressed on page 2.	
K 029	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed</p>	K 029		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131316	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE HOSPITAL B. WING _____	(X3) DATE SURVEY COMPLETED 07/22/2014	
NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83254		
(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 029	<p>Continued From page 4 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This Standard is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure hazardous areas were protected with self-closing doors. Failure to ensure hazardous area protection would allow smoke and dangerous gases to travel freely into corridors and hinder egress. This deficient practice affected all patients accessing the X-ray department, cafeteria, dialysis and physical therapy, staff and visitors in 3 of 5 smoke compartments on the date of the survey. The facility is licensed for 21 beds and had a census of 8 on the day of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on July 22, 2014 from 11:45 AM to 12:30 PM, observation and operational testing of the ground floor storage room door adjacent to the Dietary office revealed it rubbed on the floor and would not self-close. When asked, the Maintenance Director stated he was aware this door would not self-close.</p> <p>2) During the facility tour conducted on July 22, 2014 from 12:30 PM to 2:30 PM, observation and operational testing of the door from the main kitchen to the cafeteria revealed it would not self-close. Testing of the kitchen door leading from the dishwashing area to the corridor demonstrated it would not self close. This finding was acknowledged by Maintenance staff.</p> <p>3) During the facility tour conducted on July 22, 2014 from 12:30 PM to 2:30 PM, investigation of</p>	K 029	<p>The alleged deficiencies K 029: This deficiency has the potential to affect 21 patients, staff and visitors. The plan of correction is listed according to the numbered findings:</p> <p>#1: Refers to a door on the ground floor storage room not closing with the potential for smoke and dangerous gases to travel into the corridors during a fire. This door will be adjusted to correct the problem by the maintenance supervisor. An inventory of the area for similar issues will be conducted by the maintenance supervisor to ensure no similar problems exist. This will be completed by 09/30/14.</p> <p>#2: This citing refers to a door from the main kitchen to the cafeteria not self-closing. The maintenance supervisor will install self-closing devices or adjust the self-closing devices to ensure doors close properly. An inventory of the area will be conducted by the maintenance supervisor to ensure no similar problems are present. This will be completed by 08/14/14.</p>	

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

Printed: 07/30/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131316	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE HOSPITAL B. WING _____	(X3) DATE SURVEY COMPLETED 07/22/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83254
--	---

(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 029	<p>Continued From page 5</p> <p>the roll-down pass-through door from the kitchen into the cafeteria revealed that if activated, the door would be obstructed from closing by a silverware dispenser and a toaster. Interview of the Maintenance Director indicated he was aware that all doors from the kitchen are required to self-close.</p> <p>4) During the facility tour conducted on July 22, 2014 from 11:45 AM to 12:30 PM, observation and operational testing of the corridor doors into the laundry demonstrated that 1 of 2 doors was not equipped with a self-closing device and was blocked from closing by a clean laundry cart. When asked, the Maintenance Director stated this doorway is used as a pass-through for staging laundry.</p> <p>5) During the facility tour conducted on July 22, 2014 from 1:30 PM to 2:00 PM, observation and operational testing of the door from the corridor into the housekeeping storage room adjacent to the laboratory revealed it would not self-close. Further investigation revealed this room was larger than 50 ft2 with storage of combustible supplies and equipment. When interviewed the Maintenance Director stated he was not aware this door was required to self-close.</p> <p>6) During the facility tour conducted on July 22, 2014 from 2:00 PM to 3:00 PM, observation and operational testing of the door to Soiled Linen in the Operating egress corridor revealed it was not equipped with a self-closing device. When asked, the Maintenance Director stated he was not aware this door was required to self-close.</p> <p>7) During the facility tour conducted on July 22, 2014 from 2:00 PM to 3:00 PM, observation and operational testing of the corridor door into the soiled linen directly across from patient room #4 revealed the latch for the door had been removed. When asked, the Maintenance Director stated he had removed this latch for the current</p>	K 029	<p>The alleged deficiencies K 029: #3 refers to the roll-down pass-through door from the kitchen into the cafeteria being obstructed from closing. An in-service will be conducted by the maintenance supervisor to the dietary staff. This in-service will include education on the need to keep the area clean and clear so the door will close freely. A line will be placed on the Formica to help staff recognize where the door comes in contact with the counter. The corrections will be completed by 08/29/14.</p> <p>#4 refers to a door into the laundry area not equipped with a self-closing device. The correction will be to install a self-closing device. This will be done by the maintenance supervisor by 08/19/14.</p> <p>#5 A self-closing device will be installed on the door from the corridor into the housekeeping storage room by 09/15/14. This will be completed by the maintenance supervisor.</p> <p>#6: Same plan as #5.</p> <p>#7: A latch will be installed by the maintenance supervisor by 08/30/14. This latch will remain in place until the demolition of the area occurs.</p>	
-------	--	-------	--	--

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

Printed: 07/30/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131316	(X2) MULTIPLE CONSTRUCTION A- BUILDING 01 - ENTIRE HOSPITAL B. WING _____	(X3) DATE SURVEY COMPLETED 07/22/2014	
NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83254		
(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 029	<p>Continued From page 6</p> <p>phase of the construction project.</p> <p>8) During the facility tour conducted on July 22, 2014 from 1:30 PM to 2:30 PM, observation and operational testing of the door from the corridor into the Laboratory revealed it would not self-close. Further observation revealed it was equipped with a throw bolt on the Laboratory side which would impede exiting. Interview of the Laboratory staff revealed the throw bolt was installed to keep building occupants from entering. When asked, the Maintenance Director stated he was having problems with this door self-closing.</p> <p>Actual NFPA standard:</p> <p>3.3.13.2 Area, Hazardous. An area of a structure or building that poses a degree of hazard greater than that normal to the general occupancy of the building or structure, such as areas used for the storage or use of combustibles or flammables; toxic, noxious, or corrosive materials; or heat-producing appliances.</p> <p>19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:</p> <p>(1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft² (9.3 m²)</p>	K 029	<p>#8. The self-closing device on the door will be repaired or replaced so the door closes appropriately by 09/15/14.</p> <p>The maintenance supervisor will monitor and check all doors with self-closing devices for the next 6 months. He will document his findings and correct the problems found. He will do a yearly check on all self-closing doors for proper functioning.</p>	

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

Printed: 07/30/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131316	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE HOSPITAL B. WING _____	(X3) DATE SURVEY COMPLETED 07/22/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83254
--	---

(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 029	Continued From page 7 (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft ² (4.6 m ²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		
K 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, operational testing and interview, the facility failed to ensure exit enclosures remained free of obstacles. Failure to ensure exit enclosures have a continuous path of egress would prevent the evacuation of occupants during an emergency. This deficient practice affected 8 patients, staff and visitors in 3 of 5 smoke compartments on the date of the survey. The survey is licensed for 21 beds and had a census of 8 on the day of the survey.</p> <p>Findings include:</p>	K 038	<p>The alleged deficiencies cited in K 038 has the potential to affect 21 patients, staff and visitors. The failure to ensure exit enclosures are free from obstacles could prevent evacuation of occupants during an emergency. The plan of correction is listed according to the numbered findings below.</p> <p>#1: Refers to a stairway exit closure at the rear of Central Supply blocked with boxes and chairs. The plan of correction includes an in-service to educate the personnel on the need to keep this area clean and unobstructed. Signs will be hung to remind staff to keep stair free of obstructing items. The maintenance supervisor will be responsible for the in-service and for monitoring the area for compliance. The signs will also be the responsibility of the maintenance department. The date of completion will be 08/25/14.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131316	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE HOSPITAL B. WING _____	(X3) DATE SURVEY COMPLETED 07/22/2014
NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83254		
(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	Continued From page 8 1) During the facility tour conducted on July 22, 2014 from 10:30 AM to 11:30 AM, observation of the stairway exit enclosure at the rear of Central Supply revealed it was blocked with haphazard trash including a chair and stack of empty boxes. This finding was acknowledged by the Maintenance staff. 2) During the facility tour conducted on July 22, 2014 from 2:00 PM to 3:00 PM, observation and operational testing of the exit doors to the loading dock revealed storage of supplies inside the exit vestibule. Further investigation revealed this exit was signed as a primary path of egress. Interview of the Maintenance Director revealed the supplies were recently delivered and the exit was normally kept clear. 3) During the facility tour conducted on July 22, 2014 from 2:00 PM to 3:00 PM, observation and operational testing of the exit doors located next to the Pharmacy revealed that the exit was obstructed by the storage of wheelchairs not in use. Interview of the Maintenance Director indicated these wheelchairs were stored in this location due to inadequate space. This finding was further acknowledged by the CFO during the exit conference conducted on July 22, 2014 at 4:30 PM. Actual NFPA standard: 19.2 MEANS OF EGRESS REQUIREMENTS 19.2.1 General. Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7. Exception: As modified by 19.2.2 through 19.2.11. 7.1.3.2.2 An exit enclosure shall provide a continuous	K 038	#2: The dock area has been cleared of supplies. A conscious effort will be made to keep this area clear, however, there will be times when freight arrives and items will be placed here for short periods of time. This area will be monitored for supplies on a daily basis by the maintenance department. This is completed by the writing of this plan. #3: The citing states wheelchairs not in use were being stored in the exit by pharmacy causing an obstruction. The wheelchairs have been removed from this area. In the new construction a storage area designed for such items is being built. The maintenance department will monitor the area daily for no obstructions in the doorway. This is completed on 07/22/14. The exits will be monitored on a daily basis by the maintenance department to ensure the exits are not obstructed. A record will be kept for 3 months on the findings of his inspection.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131316	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE HOSPITAL B. WING _____	(X3) DATE SURVEY COMPLETED 07/22/2014	
NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83254		
(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 K 054	<p>Continued From page 9 protected path of travel to an exit discharge.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3</p> <p>This Standard is not met as evidenced by: Based on observation and interview the facility failed to ensure that fire alarm systems were properly maintained. Failure to ensure fire alarm systems are properly maintained would result in the systems failure to provide protection during a fire event. This deficient practice affected 8 patients in 1 of 5 smoke compartments on the date of the survey. The facility is licensed for 21 beds and had a census of 8 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on July 22, 2014 from 2:00 PM to 3:00 PM, observation of the smoke detector in the recently renovated CCU area directly adjacent to the nurses station revealed the smoke detector was covered with masking tape. When questioned, the Maintenance Director stated that the smoke detector had been taped during construction.</p> <p>Actual NFPA standard:</p> <p>9.6.1.4 A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72,</p>	K 038 K 054	<p>The alleged deficiency K 054 refers to a smoke detector covered with masking tape. The tape over the smoke detector had the potential to prevent the device from working properly. The deficiency has the potential to affect 21 patients, staff and visitors. The tape was removed from the smoke detector on 07/22/14. This is an area that gets demolished in the construction plan. An inventory of the area will be conducted by the maintenance department to ensure no similar conditions exist. He will also continue to monitor and maintain a record during the construction period of 6 months to be certain the fire alarm systems are not compromised.</p>	

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

Printed: 07/30/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131316	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE HOSPITAL B. WING _____	(X3) DATE SURVEY COMPLETED 07/22/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83254
--	---

(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 054	Continued From page 10 National Fire Alarm Code, unless an existing installation, which shall be permitted to be continued in use, subject to the approval of the authority having jurisdiction.	K 054		
K 062	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that sprinkler controls were maintained free of obstructions. Failure to keep controls for automatic sprinkler systems clear and accessible would result in the inability to provide adequate suppression during a fire. This deficient practice affected no patients, staff and visitors to the main kitchen in 1 of 5 smoke compartments on the date of the survey. The facility is licensed for 21 beds and had a census of 8 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on July 22, 2014 from 2:30 PM to 3:00 PM, observation of the pull station for the kitchen hood suppression system revealed it was blocked by the office door and a serving cart. When asked, the kitchen staff was not aware this pull station controlled the hood suppression system and was the secondary means of operating the system during a fire incident. Further interview of the Maintenance Director indicated he was aware that this pull station was to remain clear.</p>	K 062	<p>The alleged deficiency K 062 refers to blocking of the pull station for the hood suppression system. This deficiency had the potential to affect 21 patients, visitors and staff by a failure to ensure that the sprinkler controls were accessible. A door closure system was placed on this door on 08/06/14 to eliminate the potential of blocking. An in-service was conducted with the dietary staff on 08-06-14 to instruct them on use of the fire suppression system.</p> <p>The maintenance department will monitor all automatic sprinkler controls for any obstructions during the next 3 months and provide education and training to the involved staff. They will maintain a record of any training and problems noted during this time.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131316	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE HOSPITAL B. WING _____	(X3) DATE SURVEY COMPLETED 07/22/2014
NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83254	
(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)
K 062	Continued From page 11 Actual NFPA standard: 4.6.12 Maintenance and Testing. 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. K 067 NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This Standard is not met as evidenced by: Based on record review and interview, the facility failed to complete 4 year interval testing on its dampers as required under NFPA 90A. Failure to ensure dampers will operate to manufacturer's specifications would allow smoke and dangerous gases to pass freely throughout the facility during a fire. This deficient practice affected 8 patients, staff and visitors in 5 of 5 smoke compartments on the date of the survey. The facility is licensed for 21 beds and had a census of 8 on the day of the survey. Findings include:	K 062	The alleged deficiency K067 refers to a failure to perform a 4 year interval testing of dampers. This deficiency has the potential to affect 21 patients, visitors and staff. The failure of the dampers to operate would allow smoke and dangerous gases to pass throughout the facility. To correct this deficiency the facility will contract with a licensed inspection contractor to perform the damper testing. BLMH will contract with this company to do this inspection on a preventative basis every 4 years. The testing of the dampers will be completed by 09/10/14. The Maintenance Supervisor will be responsible to initiate and follow through with the contract agreements and completion of the testing. The MS will also monitor and document the testing and results every 4 years.

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

Printed: 07/30/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131316	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE HOSPITAL B. WING _____	(X3) DATE SURVEY COMPLETED 07/22/2014	
NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83254		
(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 067	<p>Continued From page 12</p> <p>During record review conducted at the facility on July 22, 2014 from 9:15 AM to 11:00 AM, the facility failed to provide a 4-year interval testing report of its dampers. When interviewed, the Maintenance Director stated this testing had not been completed.</p> <p>Actual NFPA standard:</p> <p>NFPA 90A 3-4.7 Maintenance. At least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify that they fully close; the latch, if provided, shall be checked; and moving parts shall be lubricated as necessary.</p> <p>K 130 NFPA 101 MISCELLANEOUS</p> <p>OTHER LSC DEFICIENCY NOT ON 2786</p> <p>This Standard is not met as evidenced by: Based on record review and interview, the facility failed to ensure interim life safety measures were initiated, monitored, and training was completed by staff during the course of construction. Failure to train staff on interim life safety measures required would result in the inability of staff to be prepared for an emergency should normal systems be disabled due to construction. This deficient practice affected 8 patients, staff and visitors in 5 of 5 smoke compartments on the date of the survey. The facility is licensed for 21 beds and had a census of 8 on the day of the survey.</p> <p>Findings include:</p>	K 067	<p>In reference to the alleged deficiency K 130 citing that staff were not trained with interim life safety measures. This deficiency had the potential to affect 21 patients, visitors and staff. Failure to train staff could result in the lack of preparation during an emergency. The maintenance supervisor will meet with the Safety Committee to inform them of the interim life safety measures. The affected staff and construction workers will be trained and the area will be monitored for compliance by the maintenance supervisor. This will be completed by 08/19/14.</p> <p>The plan of correction is stated below with reference to the numbered findings.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131316	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE HOSPITAL B. WING _____	(X3) DATE SURVEY COMPLETED 07/22/2014	
NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83254		
(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 130	<p>Continued From page 13</p> <p>1) During record review conducted on July 22, 2014 from 10:00 AM to 10:30 AM, interview of the Maintenance Director revealed he was not aware of any interim life safety measures being documented or training having been performed with staff.</p> <p>2) During the facility tour conducted on July 22, 2014 from 10:30 AM to 12:30 PM, interview of the Maintenance Director revealed that the contractor for the construction project could not provide documentation of staff training regarding interim life safety measures in place.</p> <p>3) During the facility tour conducted on July 22, 2014 from 1:30 PM to 2:30 PM, observation of patient room #9 revealed that the door to the room was open to the hallway. Further investigation of the room showed the window of the room abutted the area of construction and was left open and unsealed to the construction project.</p> <p>4) During the facility tour conducted on July 22, 2014 from 1:30 PM to 2:30 PM, observation of the exit adjacent to resident room #9 demonstrated that it was blocked off with construction tape. Interview of the Maintenance Director revealed that this exit was for construction personnel to enter the building during the course of the project. He further indicated that this exit was eliminated from the posted evacuation plan. When asked if staff had training on evacuation for this area, the Maintenance Director stated he was not aware of any training.</p> <p>5) During the exit conference conducted on July 22, 2014 from 4:30 PM to 5:00 PM, the surveyor again requested all interim life safety measures documentation and training. The Maintenance Director stated no documented training was available.</p> <p>6) During record review and facility tour</p>	K 130	<p>Continued K 130:</p> <p>#1, #2: The nursing staff was trained during an in-service on 08/19/14 regarding the exit that has been blocked during construction and the emergency exits that will be used. This information was also included in the weekly email on 08/18/14 to all nursing staff from the nursing supervisor with a required response to verify understanding. The staff had been previously trained but documentation was not provided for the training. The maintenance supervisor will receive a copy of the email and the minutes from nurses meeting to validate the training. All staff who work in this area will be informed and trained of the new temporary evacuation plan by 08/19/14.</p> <p>#3: All windows have been disabled so that they cannot be opened during the construction process. This was completed on 08/01/14.</p> <p>#4: POC above see #1 and #2.</p> <p>#5: POC above see #1 and #2.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131316	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE HOSPITAL B. WING _____	(X3) DATE SURVEY COMPLETED 07/22/2014
NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83254		
(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 130	<p>Continued From page 14 conducted on July 22, 2014 from 10:00 AM to 5:00 PM, the facility failed to ensure interim life safety measures were conducted. Refer to K tag citing's K025; K054; K141; K147.</p> <p>Actual NFPA standard:</p> <p>19.1.1.4.6 Construction, Repair, and Improvement Operations. (See 4.6.10.) 4.6.10 Construction, Repair, and Improvement Operations. 4.6.10.1* Buildings or portions of buildings shall be permitted to be occupied during construction, repair, alterations, or additions only where required means of egress and required fire protection features are in place and continuously maintained for the portion occupied or where alternative life safety measures acceptable to the authority having jurisdiction are in place.</p> <p>NFPA 241 7.1 Fire Safety Program. An overall construction or demolition fire safety program shall be developed; essential items to be emphasized include the following:</p> <ol style="list-style-type: none"> (1) Good housekeeping (2) On-site security (3) Installation of new fire protection systems as construction progresses (4) Preservation of existing systems during demolition (5) Organization and training of an on-site fire brigade (6) Development of a prefire plan with the local fire department (7) Rapid communication (8) Consideration of special hazards resulting from previous occupancies 	K 130	<p>The maintenance department will monitor any changes that have the potential to affect the life safety measures during the time of the construction and remodeling project. They will ensure that staff have been notified and training and documentation is completed.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131316	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE HOSPITAL B. WING _____	(X3) DATE SURVEY COMPLETED 07/22/2014
NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83254		
(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 130	<p>Continued From page 15</p> <p>(9) Protection of existing structures and equipment from exposure fires resulting from construction, alteration, and demolition operations</p> <p>7.2 Owner ' s Responsibility for Fire Protection.</p> <p>7.2.1*</p> <p>The owner shall designate a person who shall be responsible for the fire prevention program and who shall ensure that it is carried out to completion.</p> <p>7.2.1.1</p> <p>This fire prevention program manager shall have the authority to enforce the provisions of this and other applicable fire protection standards.</p> <p>7.2.1.2</p> <p>The fire prevention program manager shall have knowledge of the applicable fire protection standards, available fire protection systems, and fire inspection procedures.</p> <p>7.2.1.3</p> <p>Inspection records shall be available for review by the authority having jurisdiction.</p> <p>7.2.2</p> <p>Where guard service is provided, the manager shall be responsible for the guard service.</p> <p>7.2.3* Prefire Plans.</p> <p>7.2.3.1</p> <p>Where there is public fire protection or a private fire brigade, the manager shall be responsible for the development of prefire plans in conjunction with the fire agencies.</p> <p>7.2.3.2</p> <p>Prefire plans shall be updated as necessary.</p> <p>7.2.3.3</p> <p>The prefire plan shall include provisions for on-site visits by the fire agency.</p> <p>7.2.4 Program Manager Responsibilities.</p> <p>7.2.4.1</p> <p>The manager shall be responsible for ensuring that proper training in the use of protection equipment has been provided.</p>	K 130		

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

Printed: 07/30/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131316	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE HOSPITAL B. WING _____	(X3) DATE SURVEY COMPLETED 07/22/2014
NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83254		
(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 130	Continued From page 16 7.2.4.2 The manager shall be responsible for the presence of adequate numbers and types of fire protection devices and appliances and for their proper maintenance. 7.2.4.3 The manager shall be responsible for supervising the permit system for hot work operations. (See Section 5.1.) 7.2.4.4 A weekly self-inspection program shall be implemented with records maintained and made available. 7.2.4.5* Impairments to the fire protection systems or fire alarm, detection, or communications systems shall be authorized only by the fire prevention program manager. 7.2.4.6 Temporary protective coverings used on fire protection devices during renovations, such as painting, shall be removed promptly when work has been completed in the area.	K 130		
K 141	NFPA 101 LIFE SAFETY CODE STANDARD Non-smoking and no smoking signs in areas where oxygen is used or stored are in accordance with 19.3.2.4, NFPA 99, 8.6.4.2. This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that medical gases were stored with proper signage. Failure to ensure that signs are posted indicating oxygen is being stored or in use would expose occupants to fire or explosions. This deficient practice affected 8 patients, staff and visitors on the date of the survey. The facility is licensed for 21 beds and had a census of 8 on	K 141		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131316	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE HOSPITAL B. WING _____	(X3) DATE SURVEY COMPLETED 07/22/2014
--	---	---	---

NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83254
--	---

(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 141	<p>Continued From page 17 the day of the survey</p> <p>Findings include:</p> <p>During the facility tour conducted on July 22, 2014 from 1:45 PM to 2:30 PM, observation of patient room #9 revealed this room was being used to keep materials and supplies moved during the construction project from the renovated CCU area. Further investigation revealed (3) "E" size oxygen containers were stored in this room without proper signage. When asked, the Maintenance Director stated he was not aware that oxygen was being stored at this location.</p> <p>Actual NFPA standard:</p> <p>NFPA 99 8-3.1.11.3 Signs. A precautionary sign, readable from a distance of 5 ft (1.5 m), shall be conspicuously displayed on each door or gate of the storage room or enclosure. The sign shall include the following wording as a minimum: CAUTION OXIDIZING GAS(ES) STORED WITHIN NO SMOKING</p>	K 141	<p>The alleged deficiency K 141 is regarding the storage of "E" size oxygen containers in a room without proper signage. This deficiency had the potential to affect 21 patients, visitors and staff. The containers should not have been stored in this area. The cylinder was removed on 07/28/14. Staff was educated where oxygen can be stored during an in-service on 08/19/14 and also in an email on 08/18/14. All nursing staff will be required to respond to the email to verify they have been trained in the proper storage of oxygen containers. A sign was placed on the door and the dock area where the containers will be stored on 08/14/14.</p>	
K 147	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure electrical installations were in accordance with NFPA 70. Failure to ensure proper electrical installations would result in</p>	K 147	<p>The maintenance department staff will do a weekly walk through to assure that O2 cylinders are being stored in the appropriate marked areas. A log will be kept for 3 months addressing the inappropriate storage or staff teaching reinforcement done.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131316	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE HOSPITAL B. WING _____	(X3) DATE SURVEY COMPLETED 07/22/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83254
--	---

(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 147	<p>Continued From page 18</p> <p>electrocution or fire. This deficient practice affected 8 patients, staff and visitors in 5 of 5 smoke compartments on the date of the survey. The facility is licensed for 21 beds and had a census of 8 on the day of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on July 22, 2014 from 10:15 AM to 11:00 AM, observation of the Central supply storage room revealed (3) four inch square electrical conduit boxes without covers. Interview of the Maintenance Director indicated that the electrician had been relocating wiring and he was not aware of these being open.</p> <p>2) During the facility tour conducted on July 22, 2014 from 10:15 AM to 11:00 AM, observation of the staircase enclosure at the rear of the Central supply storage area revealed a four inch square electrical conduit box which was missing the protective cover. This finding was acknowledged by the Assistant Maintenance staff member.</p> <p>3) During the facility tour conducted on July 22, 2014 from 11:00 AM to 12:30 PM, observation of the storage area adjacent to the Dietary Services office revealed an extension cord in use supplying a battery charger to a demisting unit. When asked, the Maintenance Director stated he was unaware this extension cord was here.</p> <p>Actual NFPA standard:</p> <p>NFPA 70 110.12 Mechanical Execution of Work. Electrical equipment shall be installed in a neat and workmanlike manner. (A) Unused Openings. Unused cable or raceway openings in boxes, raceways, auxiliary gutters, cabinets, cutout boxes, meter socket enclosures, equipment cases, or housings shall be effectively</p>	K 147	<p>The alleged deficiency K 147 referring to improper electrical installations had the potential to affect 21 patients, visitors and staff. The POC is below and addressed the numbered findings.</p> <p>#1 and #2: The electrical conduit boxes in the Central supply storage area will have covers placed over them. The electrician has been working in this area during the construction. The maintenance supervisor will replace these covers and do a survey of the area to monitor for any other issues. This will be completed by 08/20/14.</p> <p>#3: An extension cord in the storage area adjacent to the Dietary Services office has been removed and the electrical device has been plugged directly into a wall outlet. The Maintenance Supervisor will do an inventory of the area to assure there are not any other issues. This was done on 08/18/14.</p> <p>The maintenance supervisor will be responsible to monitor the electrical work during the construction phases. He will work closely with the electrician to ensure compliance with laws are met.</p>	
-------	---	-------	---	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131316	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE HOSPITAL B. WING _____	(X3) DATE SURVEY COMPLETED 07/22/2014	
NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83254		
(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 147	<p>Continued From page 19</p> <p>closed to afford protection substantially equivalent to the wall of the equipment. Where metallic plugs or plates are used with nonmetallic enclosures, they shall be recessed at least 6 mm (¼ in.) from the outer surface of the enclosure.</p> <p>(B) Subsurface Enclosures. Conductors shall be racked to provide ready and safe access in underground and subsurface enclosures into which persons enter for installation and maintenance.</p> <p>(C) Integrity of Electrical Equipment and Connections. Internal parts of electrical equipment, including busbars, wiring terminals, insulators, and other surfaces, shall not be damaged or contaminated by foreign materials such as paint, plaster, cleaners, abrasives, or corrosive residues. There shall be no damaged parts that may adversely affect safe operation or mechanical strength of the equipment such as parts that are broken; bent; cut; or deteriorated by corrosion, chemical action, or overheating.</p> <p>314.17 Conductors Entering Boxes, Conduit Bodies, or Fittings. Conductors entering boxes, conduit bodies, or fittings shall be protected from abrasion and shall comply with 314.17(A) through (D).</p> <p>(A) Openings to Be Closed. Openings through which conductors enter shall be adequately closed.</p> <p>...</p> <p>400.8 Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following:</p> <p>(1) As a substitute for the fixed wiring of a structure</p> <p>(2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or</p>	K 147		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131316	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE HOSPITAL B. WING _____	(X3) DATE SURVEY COMPLETED 07/22/2014	
NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83254		
(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 147	Continued From page 20 floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of 368.8. (5) Where concealed by walls, floors, or ceilings or located above suspended or dropped ceilings (6) Where installed in raceways, except as otherwise permitted in this Code	K 147		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131316	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/22/2014
NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83254		
(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
B 000	<p>16.03.14 Initial Comments</p> <p>The hospital building is a single story structure with a partial basement. The building was originally constructed in 1958 with subsequent additions to include a major addition/renovation completed in 1998, as well as an addition/renovation currently in progress. The construction is Type V(111) and is fully sprinklered. The upgraded fire alarm system includes smoke detection throughout the corridors and common areas. The main level of the hospital has 5 exits to grade plus a horizontal exit to the physically attached Skilled Nursing Facility. There are two remote exits from the basement which are accessible through the Central Supply office and storage area. The main level of the hospital is sub-divided into three smoke compartments with the partial basement sub-divided into two smoke compartments.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on July 22, 2014. The facility was surveyed in accordance with IDAPA 16.03.14 and under the 1985 Edition of the Life Safety Code.</p> <p>The survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	B 000	<p>REVISED PLAN OF CORRECTION 08/27/14</p> <p style="text-align: center;">RECEIVED SEP 02 2014 FACILITY STANDARDS</p>	
BB161	<p>16.03.14.510 Fire and Life Safety Standards</p> <p>Buildings on the premises used as a hospital shall meet all the requirements of local, state, and national codes concerning fire and life safety that are applicable to hospitals. General Requirements. General requirements for the fire and life safety standards for a hospital are that:</p>	BB161	Refer to Federal Form K Tag	

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

Radney Jacobsen

TITLE

Admin

(X6) DATE

8-12-14

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131316	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/22/2014
NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83254		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
BB161	Continued From Page 1 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 federal "K" tags on CMS 2567 K 025 Smoke barriers K 029 Hazardous Area K 038 Egress access K 054 Smoke Detection K 062 Sprinkler controls K 067 Fire Dampers K 130 Interim Life Safety Measures K 141 Medical Gas storage K 147 Electrical	BB161		