IDAHO DEPARTMENT OF
HEALTH & WELFARE

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March 5, 2015

James Adamson, Administrator
Mountain View Hospital
2325 Coronado Street
Idaho Falls, ID 83404-1389

RE: Mountain View Hospital, Provider ID# 130065

Dear Mr. Adamson:

This is to advise you of the findings of the Medicare/Licensure Fire Life Safety Survey, which was concluded at Mountain View Hospital, on February 24, 2015.

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.

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 **March 18, 2015.**

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130065	A. BUILDING 01 - ENTIRE HOSPITAL B. WING	02/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HOSPITAL	2325 CORONADO STREET IDAHO FALLS, ID 83404

(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 building is Type I fire resistive two (2) story structure with a finished basement. Total square footage within the hospital is 80,000+ (i.e., 11,000+ basement; 44,000+ main level; and 26,000+ second floor). Construction of the hospital was completed in November 2002. The building is fully sprinklered; has a complete fire alarm/smoke detection system throughout; a Type I essential electrical system; multipe exits from each level; and, smoke barrier partitions on each level. Medical office buildings are attached at each end of the hospital building and are separated from the hospital building by four (4) hour rated wall assemblies. The following deficiencies were cited at the above facility during the annual Fire/Life Safety survey conducted on February 24, 2015. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy and in accordance with 42 CFR 482.41. The survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	K 000		
K 012	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure the fire resistive rating of a	K 012		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
NED HILYARD	Executive Compliance Officer	3/18/2015

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 012	Continued From page 1 non-combustible building was properly maintained. Failure to maintain the fire resistive properties of non-combustible structures would increase the opportunity for fire to communicate between floors. This deficient practice affected the transition between the basement and the main floor of the hospital. The facility is licensed for 43 beds and had a census of 18 on the day of the survey. Findings include: During the facility tour conducted on February 24, 2015 from 12:45 PM to 4:00 PM, observation of the underside of the steel framework supporting the main floor, found ten areas in the disposable storage room and four areas in the mechanical room ranging from approximately two inches by two inches to five inches by ten inches, where the cementitious fire resistive coating appeared to have been painted and subsequently fallen off, exposing the bare steel. Interview of the Facility Operations Manager and Chief Compliance Officer found neither were aware that the protective coating was missing from key structural elements. Further examination of lighting installed in the disposable supplies room found the brackets securing the lighting to the steel structural members had removed the cementitious fire resistive coating and what appeared to be rust was forming at those locations. Due to the application of a secondary, unlisted product such as paint to the cementitious fire resistive coating, it would be prudent to fully evaluate the system to ensure that the fire resistive rating of the facility has not been further compromised.	K 012	K012 PLAN: 1) MVH has requested a waiver and an extension for our Plan of Correction implementation date. This will be completed on or before 6/30/2015. Please refer to Wavier Request letter. See Tab 1. 2) MVH will obtain bids to have fire resistance coating applied to exposed areas. RESPONSE: To date, MVH has been unable to locate a local contractor who is able to apply the appropriate fire resistance coating. MVH will submit documentation as soon as a contractor has been secured to complete the work.	

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K 012	Continued From page 2 Based on the numerous locations found, further documentation was deemed unnecessary. Actual NFPA standard: 19.1.6.2 Health care occupancies shall be limited to the types of building construction shown in Table 19.1.6.2. (See 8.2.1.) Exception*: Any building of Type I(443), Type I(332), Type II(222), or Type II(111) construction shall be permitted to include roofing systems involving combustible supports, decking, or roofing, provided that the following criteria are met: (a) The roof covering meets Class C requirements in accordance with NFPA 256, Standard Methods of Fire Tests of Roof Coverings. (b) The roof is separated from all occupied portions of the building by a noncombustible floor assembly that includes not less than 21/2 in. (6.4 cm) of concrete or gypsum fill. (c) The attic or other space is either unoccupied or protected throughout by an approved automatic sprinkler system.	K 012		
K 038	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This Standard is not met as evidenced by: Based on observation and operational testing the facility failed to ensure that egress was maintained free from obstructions. Failure to keep	K 038		

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	130085	A. BUILDING 01 - ENTIRE HOSPITAL B. WING	02/24/2015

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K 038	Continued From page 3 means of egress free from obstacles could hinder the safe evacuation of occupants during an emergency. This deficient practice affected patients, staff and visitors utilizing the Pain Clinic on the date of the survey. The facility is licensed for 43 beds and had a census of 18 on the day of the survey. Findings include: During the facility tour conducted on February 24, 2015 from 12:45 PM to 4:00 PM, observation of the soiled utility door in the Pain Clinic found it was equipped with a slide bolt lock at the top of the door on the egress side in addition to the passage lock. When tested, the door would not open from the egress side with the slide lock engaged. 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. 7.1.10 Means of Egress Reliability. 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. 7.2.1.5 Locks, Latches, and Alarm Devices. 7.2.1.5.1 Doors shall be arranged to be opened readily from the egress side whenever the building is	K 038	K038 PLAN: Remove slide bolt from soiled utility door located in Pain Clinic. RESPONSE: Removed slide bolt from soiled utility door. A second door was found to not open from the egress side while locked. Both locks were removed. Section 13 (Fire Safety) c and g of MVH Safety Policy # 1275 was updated to include prohibiting the installation of locking devices on the egress side of any door. EVIDENCE: 1) Tab 1 Section 1 - Work Order 5117 and 5123 2) Tab 1 Section 2 - Pictures of completed work. 3) Tab 3 Section 1 - Safety Policy # 1275 refer to Section 13 c and g.	3/13/15

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K 038	Continued From page 4 occupied. Locks, if provided, shall not require the use of a key, a tool, or special knowledge or effort for operation from the egress side. Exception No. 1: This requirement shall not apply where otherwise provided in Chapters 18 through 23. Exception No. 2: Exterior doors shall be permitted to have key-operated locks from the egress side, provided that the following criteria are met: (a) Permission to use this exception is provided in Chapters 12 through 42 for the specific occupancy. (b) On or adjacent to the door, there is a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high on a contrasting background that reads as follows: THIS DOOR TO REMAIN UNLOCKED WHEN THE BUILDING IS OCCUPIED (c) The locking device is of a type that is readily distinguishable as locked. (d) A key is immediately available to any occupant inside the building when it is locked. Exception No. 2 shall be permitted to be revoked by the authority having jurisdiction for cause. Exception No. 3: Where permitted in Chapters 12 through 42, key operation shall be permitted, provided that the key cannot be removed when the door is locked from the side from which egress is to be made.	K 038		
K 054	NFPA 101 LIFE SAFETY CODE STANDARD 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 This Standard is not met as evidenced by:	K 054		

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K 054	Continued From page 5 Based on observation, the facility failed to ensure that smoke detectors were maintained. Failure to properly maintain smoke detection could result in the failure of the system to adequately respond during a fire. This deficient practice affected the basement level of the facility operations. The facility is licensed for 43 beds and had a census of 18 on the day of the survey. Findings include: During the facility tour conducted on February 24, 2015 from 12:45 PM to 4:00 PM, observation of smoke detectors in the Surgical Short Stay and Maintenance shop found two in the Surgical Short Stay covered by blue masking tape and one in the Maintenance area abutting the Maintenance office covered with a plastic bag resulting in detectors incapable of sensing smoke. Actual NFPA standard: 9.6.1.3* The provisions of Section 9.6 cover the basic functions of a complete fire alarm system, including fire detection, alarm, and communications. These systems are primarily intended to provide the indication and warning of abnormal conditions, the summoning of appropriate aid, and the control of occupancy facilities to enhance protection of life. 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, National Fire Alarm Code, unless an existing installation, which shall be permitted to be continued in use, subject to the approval of the	K 054	K054 PLAN: 1) Update MVH Policy #1276 Contractors and Outside Service Companies to include a Construction Rounds and Compliance Checklist. 2) Update MVH Policy #1275 Safety Policy to include Contractor and Outside Service Safety. RESPONSE: The blue masking tape was removed during the State Inspection MVH Policy #1276 and #1275 have been updated. EVIDENCE: 1)Tab 3 Section 1 - MVH Policy #1275 Safety Policy refer to Section 16 2) Tab 3 Section 2 - MVH.Policy #1276 Contractors and Outside Service Companies including Construction Rounds and Compliance Checklist 3)Tab 3 Section 3 - Policy Orientation Sign Off Sheet +	3/13/15

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K 054	Continued From page 6 authority having jurisdiction.	K 054		
K 130	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This Standard is not met as evidenced by: Based on record review and interview, the facility failed to ensure that smoke dampers were operational. Failure to ensure that smoke/fire dampers were operational could allow smoke and dangerous gases to pass freely between smoke compartments. This deficient practice affected patients staff and visitors of the operation suite on the date of the survey. The facility is licensed for 43 beds and had a census of 18 on the day of the survey. Findings include: During the review of the facility records conducted on February 24, 2015 from 8:45 AM to 12:00 PM, review of the damper service records from 2012 indicated that smoke/fire damper number 079 was found to be defective and in the closed position. Further review found no indication this damper had been repaired. Interview of Maintenance staff found it was unclear as to the status of the repair of this smoke control. Review of plans indicated this damper served the operating suite. Actual NFPA standard: 4-3* Smoke Dampers. 4-3.1 Smoke dampers shall be controlled by an automatic alarm initiating device. Smoke	K 130	K130 PLAN: Lewis Mechanical will inspect the dampers to ensure dampers in question are properly working. RESPONSE: Lewis Mechanical verified the location and proper function of damper number 079 and several others in that area. All dampers have been located and labeled. All documentation has been updated in the maintenance office. EVIDENCE: 1) Tab 2 Section 1 - Lewis Corporation Documentation 2) Tab 2 Section 2 - Damper List	3/9/15

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K 130	Continued From page 7 dampers shall be permitted to be positioned manually from a command station.	K 130		
K 147	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2 This Standard is not met as evidenced by: Based on observation, the facility failed to ensure electrical installations were maintained in accordance with NFPA 70. Failure to maintain electrical installations could result in electrocution or fire. This deficient practice affected the basement level of the facility on the date of the survey. The facility is licensed for 43 beds and had a census of 18 on the day of the survey. Findings include: During the facility tour conducted on February 24, 2015 from 12:45 PM to 4:00 PM, observation of the Mechanical room and Disposable Supply in the basement found two open four-inch square electrical boxes in the Mechanical room and one in Disposable Supply, both with exposed wiring. Actual NFPA standard: 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 closed to afford protection substantially equivalent to the wall of the equipment. Where metallic	K 147	K147 PLAN: 1) Update Policy # 1276 Contractors and Outside Service Companies, to include a Construction Rounds and Compliance Checklist. 2) Update MVH Policy # 1275 Safety Policy to include Contractor and Outside Service Safety. RESPONSE: The two electrical boxes were covered during the State Inspection. MVH Policy #1276 and #1275 have been updated. EVIDIDENCE: 1) Tab 3 Section 1 - MVH Policy #1275 refer to Section 16 2) Tab 3 Section 2 - MVH Policy # 1276 including the Construction Rounds and Compliance Checklist 3) Tab 3 Section 3 - Policy Orientation Sign Off Sheet	3/13/15

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	130066	A. BUILDING 01 - ENTIRE HOSPITAL B. WING	02/24/2015

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K 147	Continued From page 8 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. (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. (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. 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). (A) Openings to Be Closed. Openings through which conductors enter shall be adequately closed....	K 147		

Bureau of Facility Standards

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B 000	16.03.14 Initial Comments The hospital building is Type I fire resistive two (2) story structure with a finished basement. Total square footage within the hospital is 80,000+ (i.e., 11,000+ basement; 44,000+ main level; and 25,000+ second floor). Construction of the hospital was completed in November 2002. The building is fully sprinklered; has a complete fire alarm/smoke detection system throughout; a Type I essential electrical system; multipe exits from each level; and, smoke barrier partitions on each level. Medical office buildings are attached at each end of the hospital building and are separated from the hospital building by four (4) hour rated wall assemblies. The following deficiencies were cited at the above facility during the annual Fire/Life Safety survey conducted on February 24, 2015. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy and in accordance with 42 CFR 482.41 and IDAPA 16.03.14, Rules and Minimum standards for Hospitals in Idaho. The survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	B 000	Please refer to K Tags on the attached CMS form for Plan of Correction response.	
BB161	16.03.14.510 Fire and Life Safety Standards Buildings on the premises used as a hospital shall meet all the requirements of local, state, and national codes concerning fire and life safety that are applicable to hospitals. General Requirements. General requirements for the fire and life safety standards for a hospital are that:	BB161		

Idaho form

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: NED H. HYARD — TITLE: ECO — (X6) DATE: 3/18/2015

Bureau of Facility Standards

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	130085	A. BUILDING 01 - ENTIRE HOSPITAL B. WING	02/24/2015

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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: Please refer to federal "K" tags on CMS 2567: K-012 Construction standards K-038 Means of Egress K-054 Smoke detection K-130 Damper controls K-147 Electrical	BB161		