



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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DAVE JEPPESEN – Director

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DIVISION OF LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T. – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
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January 14, 2019

Shawn Lapray, Administrator
Teton Peaks At Eastern ID Regional Medical Center
PO Box 2077
Idaho Falls, ID 83403-2077

RE: Teton Peaks At Eastern ID Regional Medical Center, Provider #13L001

Dear Mr. Lapray:

This is to advise you of the findings of the Medicaid Survey, at Teton Peaks At Eastern ID Regional Medical Center, which was conducted on January 10, 2019.

Enclosed are two Statement of Deficiencies/Plan of Correction Form CMS-2567, listing 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;
5. The plan must include the title of the person responsible for implementing the acceptable plan of correction; and

Shawn Lapray, Administrator

January 14, 2019

Page 2 of 2

6. Include dates when corrective action(s) 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.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **January 28, 2019**, and keep a copy for your records.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Nate Elkins, Supervisor, Facility Fire Safety and Construction or Nicole Wisenor, Co-Supervisor, Non-Long Term Care at (208) 334-6626, option 4.

Sincerely,



NICOLE WISENOR, Supervisor
Non-Long Term Care

NW/pmt
Enclosures



Behavioral Health Center
at *EIRMC*
Compassion • Safety • Excellence

Shawn LaPray
Executive Director of Behavioral Health
Eastern Idaho Regional Medical Center
P.O. Box 2077 • Idaho Falls, ID 83403-2077
Telephone 208.227.2110
Fax 208.227.2362

Idaho Bureau of Facility Standards
Attn: Nicole Wisenor
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009

RECEIVED

JAN 28 2019

FACILITY STANDARDS

Dear Ms. Wisenor:

Enclosed is our Plan of Correction to ensure Teton Peaks at Eastern Idaho Regional Medical Center maintains compliance with CMS regulations for Psychiatric Residential Treatment Facilities.

I want to thank you and your team for a productive and collaborative survey earlier this month. We appreciate the opportunity to be Idaho's first PRTF and we are committed to setting a high standard of care in our partnership with the state.

Thank you.

Shawn LaPray, Executive Director of Behavioral Health

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

PRINTED: 01/11/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13L001	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/10/2019
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NAME OF PROVIDER OR SUPPLIER TETON PEAKS AT EASTERN ID REGIONAL MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2280 EAST 25TH STREET IDAHO FALLS, ID 83403
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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N 000	Initial Comments The following deficiency was cited during the recertification survey conducted from 1/7/19 - 1/10/19. The survey was conducted by: Monica Meister, QIDP, MEd, Team Leader Jim Troutfetter, QIDP, MEd	N 000	<p style="text-align: center;">RECEIVED</p> <p style="text-align: center;">JAN 28 2019</p> <p style="text-align: center;">FACILITY STANDARDS</p>	
N 207	FACILITY REPORTING CFR(s): 483.374(b) Reporting of serious occurrences. The facility must report each serious occurrence to both the State Medicaid agency and, unless prohibited by State law, the State designated Protection and Advocacy system. Serious occurrences that must be reported include; - a resident's death; - a serious injury to a resident as defined in section §483.352 of this part; and - a resident's suicide attempt. (1) Staff must report any serious occurrence involving a resident to both the State Medicaid agency and the State designated Protection and Advocacy system by no later than close of business the next business day after a serious occurrence. The report must include - the name of the resident involved in the serious occurrence, - a description of the occurrence and, - the name, street address, and telephone number of the facility. This ELEMENT is not met as evidenced by: Based on record review and staff interview, it	N 207		Plan of Correction (POC): Develop process to report all reportable events, including suicide attempts. Process for implementing POC: Policy revised to clearly define reportable events and to define who will report and how reporting will occur. Monitoring & tracking procedures ensuring the POC is effective: Compliance will be monitored by comparing internal occurrence reports with a report log that will be maintained by the Case Manager. Process improvement actions incorporated into the QAPI program: Results will be tracked by the Quality Specialist and reported at quarterly Quality Meetings. Individual responsible: Clinical Manager

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Executive Director of Behavioral Health* (X6) DATE *1/28/19*

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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N 207	<p>Continued From page 1</p> <p>was determined the facility failed to report each serious occurrence to the State Medicaid agency for 5 of 5 residents (Residents #1 and #7 - #10) who attempted suicide during their stay at the facility. This resulted in the potential lack of advocacy to occur on behalf of the residents residing at the facility. The findings included:</p> <p>1. The facility's Serious Occurrence incidents, dated 10/13/18 - 12/4/18, were not reported to the state Medicaid agency, as follows:</p> <ul style="list-style-type: none"> - 10/13/18: Resident #7 attempted suicide by tying the collar from a T-shirt around her neck. - 10/26/18: Resident #8 attempted suicide by wrapping a shower curtain around her neck. - 11/14/18: Resident #9 attempted suicide by tying a torn piece of fabric from scrubs around her neck. - 11/22/18: Resident #1 self-reported that she tied a blanket around her neck. - 12/4/18: Resident #10 attempted suicide by wrapping a shower curtain around her neck. <p>During an interview on 1/7/19 from 1:50 - 2:20 p.m., the Quality Specialist stated the incidents were reported to facility's Chief Executive Officer, the residents' guardians, specific out-of-state agencies, and specific insurance companies. The Quality Specialist stated the incidents were not reported to the state Medicaid agency.</p> <p>The facility failed to report each serious occurrence to the State Medicaid agency.</p>	N 207	- - -		

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E 000	Initial Comments The facility is located inside the Behavioral Health Center, owned and operated under Eastern Idaho Regional Medical Center and is situated within a municipal fire district with both state and federal EMS services available. The facility comprises 1 of 4 units in the off-campus building, originally constructed in 1983. The building is a Type V(111) structure and is fully sprinklered with an interconnected fire alarm system and off-site monitoring. There is a diesel-fired emergency electrical system (EES) generator on site for backup emergency power. The facility is currently licensed for 29 PRTF beds and had a census of 13 on the date of the survey. The following deficiencies were cited during the Emergency Preparedness survey conducted on January 8 and 9, 2019. The facility was surveyed in accordance with the Emergency Preparedness rule as established by CMS, in accordance with 42 CFR 441.184. The survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction Plan Based on All Hazards Risk Assessment CFR(s): 441.184(a)(1)-(2)	E 000		
E 006	[(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk	E 006		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Executive Director of Behavioral Health	(X6) DATE 1/28/19
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 006	<p>Continued From page 1 assessment, utilizing an all-hazards approach.*</p> <p>*[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents.</p> <p>*[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients.</p> <p>(2) Include strategies for addressing emergency events identified by the risk assessment.</p> <p>* [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to include a facility-based hazard vulnerability analysis (HVA) in the development of the Emergency Operations Plan (EOP), policies and procedures. Failure to identify facility relevant risks has the potential to hinder staff training and emergency response during disasters. This deficient practice affected 13 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During the review of the provided EOP conducted on 1/8/19 from 1:00 - 3:00 PM, no documentation was determined to be included which demonstrated a facility-based risk assessment</p>	E 006	<p>Plan of Correction (POC): Administrator will complete a Hazard Vulnerability Analysis specific to the building which contains the PRTF.</p> <p>Process for implementing POC: Consult with hospital Emergency Management coordinator to ensure the plan is unique to the building and aligned with the general hospital.</p> <p>Monitoring & tracking procedures ensuring the POC is effective: HVA will be updated annually.</p> <p>Process improvement actions incorporated into the QAPI program: Will be reported to the hospital Emergency Management Committee.</p> <p>Individual responsible: Executive Director of Behavioral Health</p>	3/1/2019
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E 006	Continued From page 2 was conducted. Interview of the Administrator and the document author revealed the facility was using the hospital community-based risk assessment, but a specific facility-based assessment had yet to be conducted.	E 006		
E 009	Reference: 42 CFR 441.184(a)(1)-(2) Local, State, Tribal Collaboration Process CFR(s): 441.184(a)(4) ((a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. † [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the dialysis facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware	E 009	Plan of Correction (POC): Executive Director of Behavioral Health will join healthcare coalition committee for Emergency Preparedness and maintain ongoing participation in local meetings and planning. Process for implementing POC: Partner with hospital Emergency Management coordinator to join healthcare coalition as a representative of the hospital's behavioral health facility. Monitoring & tracking procedures ensuring the POC is effective: Regular attendance at healthcare coalition meetings by Executive Director or designee. Process improvement actions incorporated into the QAPI program: Executive Director or designee will implement preparedness elements as indicated by involvement in the coalition. Individual responsible: Executive Director of Behavioral Health	3/1/2019

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E 009	Continued From page 3 of the dialysis facility's needs in the event of an emergency. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to demonstrate collaboration with EP officials either on a local or federal level. Failure to collaborate with local and federal EP officials has the potential to hinder facility awareness of available resources and appropriate contacts during a disaster or emergency. This deficient practice affected 13 residents, staff and visitors on the date of the survey. Findings include: During review of the provided EOP conducted on 1/8/19 from 1:00 - 3:00 PM, documentation did not indicate any collaboration efforts for local EMS contacts such as the local healthcare coalition or EP officials by the PRTF. When asked if the facility had been attending healthcare coalition meetings or had contacted local EMS personnel to review response procedures, the Administrator stated the PRTF had not yet participated in healthcare coalition meetings or been in contact with these officials.	E 009		
E 013	Reference: 42 CFR 441.184(a)(4) Development of EP Policies and Procedures CFR(s): 441.184(b) (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of	E 013		

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E 013	<p>Continued From page 4 this section. The policies and procedures must be reviewed and updated at least annually.</p> <p>*Additional Requirements for PACE and ESRD Facilities:</p> <p>[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least annually.</p> <p>[For ESRD Facilities at §494.82(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area.</p> <p>This STANDARD is not met as evidenced by: Based on record review the facility failed to ensure the policies and procedures were aligned</p>	E 013	<p>Plan of Correction (POC): Administrator will, upon completion of the HVA, develop policies and procedures based on the identified risks.</p> <p>Process for implementing POC: Consult with hospital Emergency Management coordinator to ensure the plan is unique to the building and aligned with the general hospital.</p> <p>Monitoring & tracking procedures ensuring the POC is effective: Policies will be reviewed and revised according to updates to the HVA on an annual basis.</p> <p>Process improvement actions incorporated into the QAPI program: Will be reported to the hospital Emergency Management Committee.</p> <p>Individual responsible: Executive Director of Behavioral Health</p>	3/15/2019

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E 013	Continued From page 5 with the facility EOP based on the development of a facility-based risk assessment. Failure to conduct a facility-based risk assessment, has the potential to develop policies and procedures that are not aligned risks associated with either the facility's specific structure, or geographic location. This deficient practice affected 13 residents, staff and visitors on the date of the survey. Findings Include: During review of the provided facility EOP conducted on 1/8/19 from 1:00 - 3:00 PM, policies and procedures were determined to be relevant to those risks and practices associated with the main hospital and not relevant to the PRTF location. No documentation was provided indicating the facility had performed a facility-based risk assessment (refer to E-0006).	E 013		
E 020	Reference: 42 CFR 441.184(b) Policies for Evac. and Primary/Alt. Comm. CFR(s): 441.184(b)(3) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] Safe evacuation from the [facility], which includes consideration of care and treatment needs of	E 020		

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E 020	<p>Continued From page 8</p> <p>evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.</p> <p>*[For RNHCs at §403.748(b)(3) and ASCs at §418.54(b)(2):] Safe evacuation from the [RNHC or ASC] which includes the following: (i) Consideration of care needs of evacuees. (ii) Staff responsibilities. (iii) Transportation. (iv) Identification of evacuation location(s). (v) Primary and alternate means of communication with external sources of assistance.</p> <p>* [For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at §494.62(b)(2):] Safe evacuation from the [CORF; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services; and ESRD Facilities], which includes staff responsibilities, and needs of the patients.</p> <p>* [For RHCs/FQHCs at §491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients. This STANDARD is not met as evidenced by: Based on record review, the facility failed to ensure the evacuation of the unique resident population to an alternate care facility including transportation and locations that could ensure continuity of care. Failure to provide the facility population with evacuation procedures that</p>	E 020	<p>Plan of Correction (POC): Executive Director will develop procedures for evacuation protocols.</p> <p>Process for implementing POC: Consult with hospital Emergency Management coordinator to ensure the procedures are implementable and specific to the population of the PRTF.</p> <p>Monitoring & tracking procedures ensuring the POC is effective: Drills and tabletop discussions to ensure effectiveness of procedures.</p> <p>Process improvement actions incorporated into the QAPI program: Will be reported to the hospital Emergency Management Committee.</p> <p>Individual responsible: Executive Director of Behavioral Health</p>	3/15/2019

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
E 020	Continued From page 7 ensure continuity of care at alternative locations has the potential to hinder the process and create an unsafe or secure condition for those residents during a disaster. This deficient practice affected 13 residents, staff and visitors on the date of the survey. Findings include: During review of provided EOP conducted on 1/8/19 from 1:00 - 3:00 PM, no documentation was included in the policies and procedures demonstrating the PRTF was addressed, but established these were focused on the hospital and its patient population. Further review did not establish documentation which indicated the means of transportation during an evacuation, or the inclusion of how the unique population of the PRTF would be managed during this period. In addition, those alternate care sites listed did not indicate another PRTF location was included. Reference: 42 CFR 441.184(b)(3)	E 020			
E 025	Arrangement with Other Facilities CFR(s): 441.184(b)(7) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must	E 025			

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NAME OF PROVIDER OR SUPPLIER TETON PEAKS AT EASTERN ID REGIONAL MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2280 EAST 28TH STREET IDAHO FALLS, ID 83403		
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E 025	<p>Continued From page 8 address the following:]</p> <p>*[For Hospices at §418.113(b), PRFTs at §441.184.(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients.</p> <p>*[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (6)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients.</p> <p>*[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure arrangements had been made with alternate PRTF facilities for housing of residents during disasters. Failure to develop arrangements with other PRTF facilities has the potential to limit facility options for continuity of care during a disaster that renders the primary location uninhabitable. This deficient practice affected 13 residents, staff and visitors on the date of the survey.</p>	E 025	<p>Plan of Correction (POC): Develop an MOU with at least one PRTF in the greater northwest region.</p> <p>Process for implementing POC: Executive Director will draft and propose MOU to interested PRTFs.</p> <p>Monitoring & tracking procedures ensuring the POC is effective: MOU to be signed and updated regularly.</p> <p>Process improvement actions incorporated into the QAPI program: Will be reported to the hospital Emergency Management Committee.</p> <p>Individual responsible: Executive Director of Behavioral Health</p>	3/15/2019	

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E 025	Continued From page 9 Findings include: During review of the provided EOP conducted on 1/8/19 from 1:00 - 3:00 PM, no records were provided demonstrating alternate arrangements were in effect with other PRTF facilities. When asked if there were any arrangements with other PRTF facilities, the Administrator stated he was not aware of any arrangements currently in effect. (Additional reference E-0020) Reference: 42 CFR 441.184(b)(7)	E 025		
E 030	Names and Contact Information CFR(s): 441.184(c)(1) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For RNHCs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff.	E 030		

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NAME OF PROVIDER OR SUPPLIER TETON PEAKS AT EASTERN ID REGIONAL MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2280 EAST 25TH STREET IDAHO FALLS, ID 83403		
(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	
E 030	<p>Continued From page 10</p> <p>(ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCs. (v) Volunteers.</p> <p>*[For ASCs at §418.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers.</p> <p>*[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices.</p> <p>*[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers.</p> <p>*[For OPOs at §486.380(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff.</p>	E 030	<p>Plan of Correction (POC): Update contact information sheets to include other PRTF facilities with whom this PRTF arranges an MOU.</p> <p>Process for implementing POC: Once MOUs are signed, contact information sheet will be updated to include those PRTFs.</p> <p>Monitoring & tracking procedures ensuring the POC is effective: Contact information sheet will be updated annually.</p> <p>Process improvement actions incorporated into the QAPI program: Will be reported to the hospital Emergency Management Committee.</p> <p>Individual responsible: Executive Director of Behavioral Health</p>	3/15/2019	

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NAME OF PROVIDER OR SUPPLIER TETON PEAKS AT EASTERN ID REGIONAL MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2290 EAST 25TH STREET IDAHO FALLS, ID 83403		
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E 030	Continued From page 11 (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This STANDARD is not met as evidenced by: Based on record review, the facility failed to ensure the EOP communication plan included contact information for other PRTF facilities. Failure to included other PRTF facilities contact information has the potential to limit facility response and limit the available continuity of care to housed residents during a disaster. This deficient practice effected 13 residents, staff and visitors on the date of the survey. Findings include: During review of the provided EOP conducted on 1/8/19 from 1:00 - 3:00 PM, no documentation was provided indicating the contact information for other PRTF facilities. Reference: 42 CFR 441.184(c)(1) Integrated EP Program CFR(s): 441.184(e)	E 030			
E 042	(e) [or (f)] Integrated healthcare systems. If a [facility] is part of a healthcare system consisting of multiple separately certified healthcare facilities that elects to have a unified and integrated emergency preparedness program, the [facility] may choose to participate in the healthcare system's coordinated emergency preparedness program. If elected, the unified and integrated emergency preparedness program must- [do all of the	E 042			

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E 042	Continued From page 12 following:] (1) Demonstrate that each separately certified facility within the system actively participated in the development of the unified and integrated emergency preparedness program. (2) Be developed and maintained in a manner that takes into account each separately certified facility's unique circumstances, patient populations, and services offered. (3) Demonstrate that each separately certified facility is capable of actively using the unified and integrated emergency preparedness program and is in compliance [with the program]. (4) Include a unified and integrated emergency plan that meets the requirements of paragraphs (a)(2), (3), and (4) of this section. The unified and integrated emergency plan must also be based on and include the following: (i) A documented community-based risk assessment, utilizing an all-hazards approach. (ii) A documented individual facility-based risk assessment for each separately certified facility within the health system, utilizing an all-hazards approach. (5) Include integrated policies and procedures that meet the requirements set forth in paragraph (b) of this section, a coordinated communication plan, and training and testing programs that meet the requirements of paragraphs (c) and (d) of this section, respectively. This STANDARD is not met as evidenced by: Based on record review and interview, the facility	E 042	Plan of Correction (POC): Review and revise hospital's integrated plan to include relevant procedures for the unique needs of the PRTF location and its residents. Process for implementing POC: Executive Director will partner with hospital Emergency Management coordinator to review and revise the plan. Monitoring & tracking procedures ensuring the POC is effective: Plan will be reviewed and updated annually with input from the Executive Director of Behavioral Health. Process improvement actions incorporated into the QAPI program: Updates and relevant information will be reported to the hospital Emergency Management Committee. Individual responsible: Executive Director of Behavioral Health	3/15/2019

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E 042	<p>Continued From page 13</p> <p>failed to demonstrate the PRTF was meeting the requirements to participate in an integrated health system EOP. Failure to demonstrate the participation of an integrated health system EOP has the potential to create confusion for staff response and hinder training efforts if attempting to coordinate with another governing body, such as a parent hospital. This deficient practice affected 13 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During review of the provided EOP conducted on 1/8/19 from 1:00 - 3:00 PM, documentation of the policies and procedures in the EOP established this was written for the hospital and its satellite facilities, but no documentation was included for addressing the unique population or associated procedures of the PRTF and that the facility could actively use and integrate the hospital EOP in its program.</p> <p>Interview of the Administrator and the author of the EOP provided, confirmed the PRTF had not participated in the development of the EOP or the development of a facility-based risk assessment.</p> <p>Reference: 42 CFR 441.184(e)</p>	E 042			