



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK -- ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

November 2, 2015

John Williams, Administrator
Oneida County Hospital
150 North 200 West
Malad, ID 83252

RE: Oneida County Hospital, Provider ID# 131303

Dear Mr. Williams:

This is to advise you of the findings of the Medicare/Licensure Fire Life Safety Survey, which was concluded at Oneida County Hospital, on October 22, 2015.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicare deficiencies and a similar form listing State licensure deficiencies. If applicable, a similar State Form will be provided listing licensure health 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,

John Williams, Administrator
November 2, 2015
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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 **November 16, 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

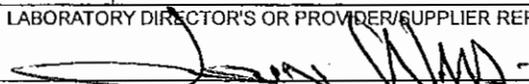
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Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131303	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE HOSPITAL B. WING _____	(X3) DATE SURVEY COMPLETED 10/22/2015
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NAME OF PROVIDER OR SUPPLIER ONEIDA COUNTY HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 150 NORTH 200 WEST MALAD, ID 83252
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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
K 000	INITIAL COMMENTS The facility is a single story with basement, Type II (211) building completed in November 1970, with a 1993 addition. Currently the hospital is licensed for 11 beds. There is an attached Nursing Facility licensed for 33 beds and is considered part of the same building. The following deficiencies were cited during the annual fire/life safety survey conducted on October 22, 2015. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 485.623. The Survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	K 000	<i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truths of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it.</i>	
K 064	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that portable fire extinguishers were installed in accordance with NFPA 10. Failure to install fire extinguishers at the proper height could hinder emergency response during a fire event. This deficient practice affected all patients, staff and visitors on the date of the survey. The facility is licensed for 11 hospital beds and had a census of 8 on the day of the	K 064	K064F <ul style="list-style-type: none"> • Corrective action for identified areas/residents. The facility's Maintenance Supervisor conducted a sweep to identify all fire extinguishers not in compliance with regards to mounted height. No other fire extinguishers were found to be out of compliance. • Identification of residents with potential to be affected. All residents have a potential to be affected. • Measures to prevent occurrence. Work orders were created for all extinguishers identified as being out of compliance and work has begun relocating fire extinguishers to appropriate heights. • Monitoring and Quality Assurance To validate that work orders are completed to bring all fire extinguishers into compliance, the Maintenance Supervisor or designee will conduct audits demonstrating work order progress weekly and will review these audits with the CEO. Progress will be reported to the Quality Assurance Committee monthly and as needed until a lesser frequency is deemed appropriate. • Compliance date is 11/26/2015 <p style="text-align: center;">RECEIVED NOV 18 2015 FACILITY STANDARDS</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE CEO	(X6) DATE 11/11/15
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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.

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

Printed: 10/29/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131303	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE HOSPITAL B. WING _____		(X3) DATE SURVEY COMPLETED 10/22/2015
NAME OF PROVIDER OR SUPPLIER ONEIDA COUNTY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 150 NORTH 200 WEST MALAD, ID 83252		
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K 064	<p>Continued From page 1 survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on October 22, 2015 from 10:00 AM to 3:00 PM, physical inspection installed portable fire extinguishers revealed that 3 of 3 extinguishers inspected measured 68 inches from the floor to the top of the extinguisher. Interview of the Maintenance Supervisor revealed the facility was not aware of these extinguishers being installed at the incorrect height.</p> <p>Actual NFPA standard:</p> <p>1-6.10 Fire extinguishers having a gross weight not exceeding 40 lb (18.14 kg) shall be installed so that the top of the fire extinguisher is not more than 5 ft (1.53 m) above the floor. Fire extinguishers having a gross weight greater than 40 lb (18.14 kg) (except wheeled types) shall be so installed that the top of the fire extinguisher is not more than 3 1/2 ft (1.07 m) above the floor. In no case shall the clearance between the bottom of the fire extinguisher and the floor be less than 4 in. (10.2 cm).</p>	K 064			

[Handwritten Signature] CEO

[Handwritten Signature]

Bureau of Facility Standards

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B 000	<p>16.03.14 Initial Comments</p> <p>The facility is a single story with basement, Type II (211) building completed in November 1970, with a 1993 addition. Currently the hospital is licensed for 11 beds. There is an attached Nursing Facility licensed for 33 beds and is considered part of the same building.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on October 22, 2015. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 485.623 and IDAPA 16.03.14 Rules and Minimum Standards for Hospitals in Idaho.</p> <p>The Survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	B 000	<p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truths of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it.</i></p> <p>BB161</p> <ul style="list-style-type: none"> • Corrective action for identified areas/residents. The facility's Maintenance Supervisor conducted a sweep to identify all fire extinguishers not in compliance with regards to mounted height. No other fire extinguishers were found to be out of compliance. • Identification of residents with potential to be affected. All residents have a potential to be affected. • Measures to prevent occurrence. Work orders were created for all extinguishers identified as being out of compliance and work has begun relocating fire extinguishers to appropriate heights. • Monitoring and Quality Assurance To validate that work orders are completed to bring all fire extinguishers into compliance, the Maintenance Supervisor or designee will conduct audits demonstrating work order progress weekly and will review these audits with the CEO. Progress will be reported to the Quality Assurance Committee monthly and as needed until a lesser frequency is deemed appropriate. • Compliance date is 11/26/2015 	
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.</p> <p>General Requirements. General requirements for the fire and life safety standards for a hospital are that:</p> <p>The hospital shall be structurally sound and shall be maintained and equipped to assure the safety of patients, employees, and the public.</p> <p>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.</p> <p>This Rule is not met as evidenced by: Please refer to Federal "K" tags:</p>	BB161	<p>RECEIVED</p> <p>NOV 18 2015</p> <p>FACILITY STANDARDS</p>	

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

[Signature]

TITLE

[Signature]

(X6) DATE

[Signature]

Bureau of Facility Standards

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BB161	Continued From Page 1 K-064 Fire Extinguishers	BB161		
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Jan WMA.

CEO 11/11/15