



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

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

TAMARA PRISOCK – ADMINISTRATOR  
DIVISION OF LICENSING & CERTIFICATION  
DEBRA RANSOM, R.N., R.H.I.T., Chief  
BUREAU OF FACILITY STANDARDS  
3232 Eklar 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 & Long Term Care Facility  
PO Box 126  
Malad, ID 83252-0126

Provider #: 135062

**RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER**

Dear Mr. Williams:

On **October 22, 2015**, a Facility Fire Safety and Construction survey was conducted at **Oneida County Hospital & Long Term Care Facility** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid 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, answer each deficiency and state the date when each will be completed. Please provide **ONLY ONE** completion date for each federal and state tag in column (X5) Completion Date to signify when you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator

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should sign the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office. If a State Form with deficiencies was issued, it should be signed, dated and returned along with the CMS-2567 Form.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **November 16, 2015**. Failure to submit an acceptable PoC by **November 16, 2015**, may result in the imposition of civil monetary penalties by **December 2, 2015**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- 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,
- Include dates when corrective action will be completed.
- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567 and the state licensure survey report, State Form.

All references to federal regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **November 26, 2015**, (Opportunity to Correct). Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **November 26, 2015**. A change in the seriousness of the deficiencies on **November 26, 2015**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **November 26, 2015**, includes the following:

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Denial of payment for new admissions effective **January 22, 2016**.  
42 CFR §488.417(a)

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **April 22, 2016**, if substantial compliance is not achieved by that time.

**Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.**

If you believe these deficiencies have been corrected, you may contact Mark P. Grimes, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **October 22, 2015**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

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Go to the middle of the page to Information Letters section and click on State and select the following:

BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process  
2001-10 IDR Request Form

This request must be received by **November 16, 2015**. If your request for informal dispute resolution is received after **November 16, 2015**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,



Mark P. Grimes, Supervisor  
Facility Fire Safety and Construction

MPG/lj

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135062</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/22/2015</b>
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NAME OF PROVIDER OR SUPPLIER <b>ONEIDA COUNTY HOSPITAL &amp; LONG TERM C</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>150 NORTH 200 WEST MALAD, ID 83252</b>
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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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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 SS=F	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 27 residents, staff and visitors on the date of the survey. The facility is licensed for 33 SNF/NF beds and had a census of 27 on the day of the	K 064	<b>K064F</b>  <ul style="list-style-type: none"> <li>• <b>Corrective action for identified areas/residents.</b> 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.</li> <li>• <b>Identification of residents with potential to be affected.</b> All residents have a potential to be affected.</li> <li>• <b>Measures to prevent occurrence.</b> Work orders were created for all extinguishers identified as being out of compliance and work has begun relocating fire extinguishers to appropriate heights.</li> <li>• <b>Monitoring and Quality Assurance</b> 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.</li> <li>• <b>Compliance date is 11/26/2015</b></li> </ul> <p style="text-align: center;">RECEIVED NOV 18 2015 FACILITY STANDARDS</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE 	(X6) DATE <b>11/1/15</b>
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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:  <b>135062</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/22/2015</b>
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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 of installed portable fire extinguishers revealed the following:</p> <p>1) On the upper floor, fire extinguishers labeled #1, #2 and #3 measured 68 inches from the floor to the top of the extinguisher.</p> <p>2) Maintenance, I/T room and extinguisher labeled #5 on the upper floor measured 61 inches from the floor to the top of the extinguisher.</p> <p>3) On the upper floor, extinguishers abled #6 and #7 measured 62-1/2 inches from the floor to the top of the extinguisher.</p> <p>4) In the basement, extinguisher labeled #1 measured 61-1/2 inches from the floor to the top of the extinguisher.</p> <p>Interview with the Maintenance Supervisor revealed that he was not aware these extinguishers were not mounted at the correct 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</p>	K 064		

*[Handwritten signatures and initials]*

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K 064	Continued From page 2 not more than 31/2 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).	K 064		

*John W. [Signature]*      *CEO 10/11/15*