



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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3232 Elder Street
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October 19, 2016

Jeff Daniels, Administrator
Idaho Doctors Hospital
350 N Meridian Street
Blackfoot, ID 83221-1625

RE: Idaho Doctors Hospital, Provider ID# 130067

Dear Mr. Daniels:

This is to advise you of the findings of the Medicare/Licensure Fire Life Safety Survey, which was concluded at Idaho Doctors Hospital, on October 12, 2016.

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,

Jeff Daniels, Administrator
October 19, 2016
Page 2 of 2

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 1, 2016.**

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,



NATE ELKINS
Supervisor
Facility Fire Safety and Construction Program

NE/lj

Enclosures

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

Printed: 10/19/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130067	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/12/2016
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NAME OF PROVIDER OR SUPPLIER IDAHO DOCTORS HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 350 N MERIDIAN STREET BLACKFOOT, ID 83221
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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 hospital is a 11,000 s.f. single story, protected wood frame structure, with and upper floor mechanical mezzanine. Construction of the hospital commenced in early 2003 and was completed in March 2004. The initial license was issued on July 12, 2004 for eight (8) beds. The building is protected throughout by an automatic fire extinguishing system designed/installed per NFPA 13 for light hazard occupancy. A complete, addressable fire alarm system, including smoke detection throughout, is provided and the system is off-site monitored. Emergency power is supplied by an on-site diesel powered generator set designed/installed per NFPA Std 99 for a Type 1 Essential Electrical System. Piped in medical gasses and vacuum are provided. There is a single smoke barrier wall dividing the building into two (2) smoke compartments. The following deficiencies were cited during the Life Safety Code survey conducted on October 12, 2016. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, New Health Care Occupancy, in accordance with 42 CFR 482.41. The surveyor conducting the survey was: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	K 000		
K 027	NFPA 101 LIFE SAFETY CODE STANDARD Doors in smoke barriers have at least a 20 minute fire protection rating or are at least 1 3/4 inch thick solid bonded core wood. Non- rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14.	K 027	K 027 The corrective action/actions to be accomplished for those individuals found to have been affected is the following smoke barrier doors were adjusted to properly ... Continued on page 2	10/12/16

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OCT 28 2016
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>D Jeffrey Daniels</i>	TITLE CEO	(X6) DATE 10/27/16
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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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K 027	Continued From page 1 Swinging doors shall be arranged so that each door swings in an opposite direction. Doors shall be self-closing and rabbets, bevels or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.5, 18.3.7.6, 18.3.7.8 This Standard is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure that smoke barrier doors would fully self-close. Failure of smoke barrier doors to close could allow by-products of combustion to pass between smoke compartments, hindering the ability to defend in place during a fire or other emergency. This deficient practice affected all patients, staff and visitors on the date of the survey. The facility is licensed for 8 hospital beds and had a census of 3 on the day of the survey. Findings include: During the facility tour conducted on October 12, 2016 from approximately 10:00 AM to 11:00 AM, observation and operational testing of the cross-corridor doors in the smoke barrier revealed that 1 of 2 would not fully self-close and latch. Interview of the Maintenance Supervisor revealed he was not aware the door was not fully closing as designed. Actual NFPA standard: 18.3.7.6* Doors in smoke barriers shall comply with 8.3.4 and shall be self-closing or automatic-closing in accordance with 18.2.2.2.6. 8.3.4 Doors. 8.3.4.1* Doors in smoke barriers shall close the opening	K 027	K 027 Continued from page 1 ...self-close by Cory Winterbottom, Lead Technician. See Work Order (WO) #11797 (Tab 1). We will identify other individuals having the potential to be effected by the same deficient practice by the same corrective action to include all smoke barrier doors will be added to the PM schedule for Cory Winterbottom, Lead Technician. The measures will be put in place/systematic change to ensure deficient practices does not reoccur is to include all smoke barrier doors will be added to the PM schedule for Cory Winterbottom, Lead Technician. The corrective action will be monitored to ensure the deficient practice will not reoccur is the PM schedule for smoke barrier doors will be audited and reported to the safety committee quarterly. The dates of the corrective action was completed by 10/12/2016.	10/12/16

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

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K 027	Continued From page 2 leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles.	K 027		
K 029	NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas shall be enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors shall be self-closing or automatic closing in accordance with 7.2.1.8. Hazardous areas are protected by a sprinkler system in accordance with 9.7, 18.3.2.1, 18.3.5.1. This Standard is not met as evidenced by: Based on observation and operational testing, the facility failed to ensure hazardous areas which open to the corridor were protected with self-closing doors. Failure to protect hazardous areas with self-closing doors could allow byproducts of combustion to pass into corridors, affecting egress of patients during a fire. This deficient practice affected all patients, staff and visitors on the day of the survey. The facility is licensed for 8 hospital beds and had a census of 3 on the day of the survey. Findings include: During the facility tour conducted on October 12, 2016 from approximately 10:00 AM to 11:00 AM, observation and operational testing of the Laundry Room door revealed it would not fully self-close when activated. Actual NFPA standard: 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,	K 029	K 029 The corrective action/actions to be ac- complished for those individuals found to have been affected is the following hazardous area doors were adjusted to properly self-close by Cory Winterbottom, Lead Technician. See Work Order (WO) #11798 (Tab 2). We will identify other individuals having the potential to be effected by the same deficient practice by the same corrective action to include all hazardous area doors will be added to the PM schedule for Cory Winterbottom, Lead Technician. The measures will be put in place/system- atic change to ensure deficient practices does not reoccur is to include all hazard- ous area doors will be added to the PM schedule for Cory Winterbottom, Lead Technician. The corrective action will be monitored to ensure the deficient practice will not reoccur is the PM schedule for hazardous area doors will be audited and reported to the safety committee quarterly. The dates of the corrective action was completed by 10/12/2016.	10/12/16

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K 029	Continued From page 3 such as areas used for the storage or use of combustibles or flammables; toxic, noxious, or corrosive materials; or heat-producing appliances. 7.2.1.8 Self-Closing Devices. 7.2.1.8.1* A door normally required to be kept closed shall not be secured in the open position at any time and shall be self-closing or automatic-closing in accordance with 7.2.1.8.2.	K 029			
K 062	NFPA 101 LIFE SAFETY CODE STANDARD Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This Standard is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure fire suppression systems were maintained in accordance with NFPA 25. Failure to conduct required testing and ensure adequate number of replacement sprinkler pendants are available could result in a lack of system performance during a fire. This deficient practice affected all patients, staff and visitors on the date of the survey. The facility is licensed for 8 hospital beds and had a census of 3 on the day of the survey. Findings include: 1) During review of provided facility fire suppression system inspection records conducted on October 12, 2016 from approximately 8:30 AM to 9:00 AM, no record was provided indicating a quarterly inspection was performed during the third quarter of 2016. Interview of the Maintenance Supervisor revealed he was not aware the third quarter inspection had	K 062	K 062 1) The corrective action/actions to be accomplished for those individuals found to have been affected is the following is to create a PM in the work order system to ensure that the fire suppression contractor is notified in a timely manner to complete the required quarterly schedule by Cory Winterbottom, Lead Technician. The measures will be put in place/systematic change to ensure deficient practices does not reoccur is to create a PM in the work order system to ensure that the fire suppression contractor is notified in a timely manner to complete the required quarterly schedule. The corrective action will be monitored to ensure the deficient practice will not reoccur by Josh Maynard, Director of Engineering. The dates of the corrective action will ... Continued on page 5	10/28/16	

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K 062	Continued From page 5 returning the system to service is furnished. 2-4.1.5 The stock of spare sprinklers shall be as follows: (a) For protected facilities having under 300 sprinklers -no fewer than 6 sprinklers (b) For protected facilities having 300 to 1000 sprinklers -no fewer than 12 sprinklers (c) For protected facilities having over 1000 sprinklers -no fewer than 24 sprinklers	K 062	K 147 The corrective action/actions to be ac- complished for those individuals found to have been affected is that all junction boxes cited had cover plates installed on 10/12/2016 by John Chiverall, Main- tenance Technician and Tom Gifford, Maintenance Technician. See Work Order (WO) #11799 (Tab 4).	10/12/16
K 147	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This Standard is not met as evidenced by: Based on observation, the facility failed to maintain safe electrical installations by eliminating exposure to energized conductors. Failure to provide protection against accidental contact with exposed wiring could result in electrocution or fires by arcing. This deficient practice affected all patients, staff and visitors on the date of the survey. The facility is licensed for 8 beds and had a census of 3 on the day of the survey. Findings include: 1) During the facility tour conducted on October 12, 2016 from approximately 10:00 AM to 12:00 PM, observation of the upper floor mechanical space revealed four (4) electrical junction boxes with exposed wiring, approximately four inches square in size. In addition, further observation of the fire suppression riser room revealed one (1) junction box with exposed wiring approximately four inches square. 2) During the facility tour conducted on October	K 147	We will identify other individuals having the potential to be effected by the same deficiency practice by the creation of a quarterly PM to inspect junction boxes by Cory Winterbottom, Lead Technician. The measures will be put in place/sys- tematic change to ensure deficient prac- tices does not reoccur is by the creation of a quarterly PM to inspect junction boxes by Josh Maynard, Director of Engineering. The corrective action will be monitored to ensure the deficient practice will not reoccur is by the creation of a quarterly PM to inspect junction boxes and report to Safety Committee. The dates of the corrective action was completed on 10/12/2016.	

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K 147	<p>Continued From page 6</p> <p>12, 2016 from approximately 2:00 PM to 3:00 PM, an above the ceiling inspection outside room 136 revealed two (2) electrical junction boxes with exposed wiring, approximately four inches square.</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 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. (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.</p> <p>314.17 Conductors Entering Boxes, Conduit Bodies, or Fittings.</p>	K 147		

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K 147	Continued From page 7 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

STATEMENT OF DEFICIENCIES AND CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130067	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/12/2016
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B 000	<p>16.03.14 Initial Comments</p> <p>The hospital is a 11,000 s.f. single story, protected wood frame structure with an upper level mechanical mezzanine. Construction of the hospital commenced in early 2003 and was completed in March 2004. The initial license was issued on July 12, 2004 for eight (8) beds. The building is protected throughout by an automatic fire extinguishing system designed/installed per NFPA 13 for light hazard occupancy. A complete, addressable fire alarm system, including smoke detection throughout, is provided and the system is off-site monitored. Emergency power is supplied by an on-site diesel powered generator set designed/installed per NFPA Std 99 for a Type 1 Essential Electrical System. Piped in medical gasses and vacuum are provided. There is a single smoke barrier wall dividing the building into two (2) smoke compartments.</p> <p>The following deficiencies were cited during the Life Safety Code survey conducted on October 12, 2016. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, New Health Care Occupancy, in accordance with 42 CFR 482.41 and IDAPA 16.03.14 Rules and Minimum Standards for Hospitals in Idaho.</p> <p>The surveyor conducting the survey was:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	B 000		
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>	BB161		

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FACILITY STANDARDS

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

D. Jeffrey Daniels

TITLE
CEO

(X6) DATE
10/27/16

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130067	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/12/2016
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BB161	Continued From Page 1 General Requirements. General requirements for the fire and life safety standards for a hospital are that: 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 "K" tags on CMS form 2567: K-027 Smoke barrier doors K-029 Hazardous areas K-062 Sprinkler system maintenance K-147 Electrical maintenance	BB161	K 027 The corrective action/actions to be accomplished for those individuals found to have been affected is the following smoke barrier doors were adjusted to properly self-close by Cory Winterbottom, Lead Technician. See Work Order (WO) #11797. We will identify other individuals having the potential to be effected by the same deficient practice by the same corrective action to include all smoke barrier doors will be added to the PM schedule for Cory Winterbottom, Lead Technician. The measures will be put in place/ systematic change to ensure deficient practices does not reoccur is to include all smoke barrier doors will be added to the PM schedule for Cory Winterbottom, Lead Technician. The corrective action will be monitored to ensure the deficient practice will not reoccur is the PM schedule for smoke barrier doors will be audited and reported to the safety committee quarterly. The dates of the corrective action was completed by 10/12/2016. K 029 The corrective action/actions to be accomplished for those individuals found .. Continued on next page	10/12/16

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Bureau of Facility Standards

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BB161	Continued From Page 1 General Requirements. General requirements for the fire and life safety standards for a hospital are that: 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 "K" tags on CMS form 2567: K-027 Smoke barrier doors K-029 Hazardous areas K-062 Sprinkler system maintenance K-147 Electrical maintenance	BB161	K 147 Continued from previous page quarterly ...PM to inspect junction boxes. The measures will be put in place/ systematic change to ensure deficient practices does not reoccur is by the creation of a quarterly PM to inspect junction boxes. The corrective action will be monitored to ensure the deficient practice will not reoccur is by the creation of a quarterly PM to inspect junction boxes. The dates of the corrective action was completed on 10/12/2016.	10/12/16

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