October 21, 2016

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 13, 2016, 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 (XS) 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
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 3, 2016. Failure to submit an acceptable PoC by November 3, 2016, may result in the imposition of civil monetary penalties by November 23, 2016.

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. If a State Form was issued as well, it should also be signed, dated and returned.

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 17, 2016, (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 17, 2016. A change in the seriousness of the deficiencies on November 17, 2016, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by November 17, 2016, includes the following:
Denial of payment for new admissions effective **January 13, 2017**.

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 13, 2017**, 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 Nate Elkins, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, option 3; 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 13, 2016**, 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:

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 3, 2016**. If your request for informal dispute resolution is received after **November 3, 2016**, 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, option 3.

Sincerely,

(Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosures
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER:** ONEIDA COUNTY HOSPITAL & LONG TERM C

**STREET ADDRESS, CITY, STATE, ZIP CODE:** 150 NORTH 200 WEST MALAD, ID 83252

**DATE SURVEY COMPLETED:** 10/13/2016

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>K000</td>
<td>INITIAL COMMENTS</td>
<td></td>
<td>K000</td>
<td></td>
<td>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths of the facts alleged or the 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.</td>
</tr>
<tr>
<td>K012</td>
<td>NFPA 101 LIFE SAFETY CODE STANDARD SS=F</td>
<td>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 one-hour rated corridor walls were maintained to resist the passage of smoke and fire. Failure to maintain rated smoke partitions as designed could allow smoke, fire and the by products of combustion to pass between compartments during a fire event. This deficient practice affected 15 residents, staff and visitors on the date of the survey. The facility is licensed for 33 SNF/NF beds and had a census of 30 on the day of the survey.</td>
<td>K012</td>
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**LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE**

**FORM CMS-2567(02-99) Previous Versions Obsolete**

Printed: 10/20/2016

**RELU21**

If continuation sheet Page 1 of 11
Findings include:

During the facility tour conducted on October 13, 2016 from approximately 1:00 PM to 2:00 PM, an above the ceiling inspection revealed two (2), approximately six inch by six inch holes in the one-hour corridor wall at rooms 106/107 and an approximately twelve inch by twelve inch hole at room 124. When asked, the Maintenance Engineer stated he was not aware of these penetrations prior to the survey.

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.

Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

<table>
<thead>
<tr>
<th>PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:</th>
<th>MULTIPLE CONSTRUCTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. BUILDING 01 - ENTIRE BUILDING</td>
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<tr>
<td>B. WING</td>
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**PROVIDER'S PLAN OF CORRECTION**

Each corrective action should be cross-referenced to the appropriate deficiency.

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<tbody>
<tr>
<td>K025</td>
<td>Continued From page 2 constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that smoke barriers were maintained to resist the passage of smoke. Failure to maintain smoke and fire resistive properties of fire-rated assemblies could allow smoke, fire and the by products of combustion to pass between smoke compartments hindering the ability to defend in place. This deficient practice affected 15 residents, staff and visitors on the date of the survey. The facility is licensed for 33 SNF/NF beds and had a census of 30 on the day of the survey. Findings include: 1) During the facility tour conducted on October 13, 2016 from approximately 10:00 AM to 12:00 PM, inspection of the Maintenance shop revealed three (3) unsealed holes in the ceiling. When asked, the Maintenance Engineer stated the holes were from the removal of piping during a recent roof replacement. 2) During the facility tour conducted on October 13, 2016 from approximately 1:00 PM to 2:00 PM, observation above the ceiling at the door entering the Administration wing revealed three (3) unsealed conduits passing through the rated assembly, which measured approximately one-inch diameter. Actual NFPA standard:</td>
<td>K025</td>
<td>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths of the facts alleged or the 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.</td>
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- **Corrective action for identified areas/residents.**
  - During survey it was determined that the facility failed to meet this Standard specifically related to the need for an appropriately rated smoke/fire door in the cross hall just before it intersects with the facility's west hall. To correct this oversight, the fabrication of an appropriately rated smoke/fire door was ordered and purchased.
- **Identification residents with potential to be affected.**
  - All residents have the potential to be affected.
- **Measures to prevent occurrence.**
  - All other doors throughout the facility were reviewed for appropriate smoke/fire ratings. No other doors were found to be out of compliance. The door identified has been ordered and will be installed immediately upon arrival. This will bring all doors into compliance with the Standard.
- **Monitoring and Quality Assurance**
  - The Maintenance Supervisor and Administrator conducted an audit of all facility doors and all doors were brought into compliance. Progress will be reported to the Quality Assurance Committee (QAC) monthly and as needed until a lesser frequency is deemed appropriate.
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<tbody>
<tr>
<td>K 025</td>
<td>Continued From page 3 19.3.7.3</td>
<td>K 025</td>
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<td>Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour. Exception No. 1: Where an atrium is used, smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with Exception No. 2 to 8.2.5.6(1). Not less than two separate smoke compartments shall be provided on each floor. Exception No. 2*: Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.3 has been provided for smoke compartments adjacent to the smoke barrier. 8.3.2* Continuity. Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces. Exception: A smoke barrier required for an occupied space below an interstitial space shall not be required to extend through the interstitial space, provided that the construction assembly forming the bottom of the interstitial space provides resistance to the passage of smoke equal to that provided by the smoke barrier.</td>
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<tr>
<td>K 029</td>
<td>NFPA 101 LIFE SAFETY CODE STANDARD</td>
<td>K 029</td>
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One hour fire rated construction (with 0 hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:**

135062

**MULTIPLE CONSTRUCTION**

**A. BUILDING 01 - ENTIRE BUILDING**

**STATE DATE SURVEY COMPLETED:**

10/13/2016

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| K 029 | | | Continued From page 4 the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that hazardous area doors were not prevented from self-closing. Failure of hazardous area doors to self-close could allow smoke, fire and byproducts of combustion to pass into corridors, affecting the egress of residents during a fire event. This deficient practice affected 15 residents, staff and visitors on the date of the survey. The facility is licensed for 33 SNF/NF beds and had a census of 30 on the date of the survey. Findings include: During the facility tour conducted on October 13, 2016 from approximately 1:00 PM to 2:00 PM, observation of the doors which enter the Kitchen from the corridor revealed the following:

1) The door entering the Kitchen from the corridor off the dining room was held open with a soda syrup cylinder.
2) The door entering the Kitchen from the corridor across from the Dietary office revealed the door was held open with a rubber door chock.
3) The door entering the Kitchen from the corridor by the Maintenance office and through the dishwashing station room was held open with a dish soap box.
4) The door entering the Kitchen from the corridor next to the walk in freezer was held open with a rubber door chock. | K 029 | | Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths of the facts alleged or the 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. |

**Corrective action for identified areas/residents.**

Facility staff informed of violation upon Surveyor's exit. All doors that were propped open were closed immediately. Facility Administrator conducted immediate education with Dietary Manager and Dietician.

**Identification residents with potential to be affected.**

All residents have the potential to be affected.

**Measures to prevent occurrence.**

Door stops removed from area and signs placed on doors that all doors were to be closed unless directly attended by staff and are not to be propped open.

**Monitoring and Quality Assurance**

The Dietary Manager, or designee, will conduct audits of all kitchen entryways to ensure that doors are properly closed and not being propped open unless the door is being directly attended by a staff member. These audits will occur three time a week for two weeks, then weekly for four weeks. Audit findings will be reviewed with the Administrator weekly for four weeks. Progress will be reported to the Quality Assurance Committee (QAC) monthly and as needed until a lesser frequency is deemed appropriate.
Interview of the Maintenance Engineer revealed he was aware of the requirement to not obstruct these self-closing doors. This finding was substantiated by the Administrator and the Maintenance Engineer during the exit conference conducted on October 13, 2016 from approximately 2:00 PM to 3:00 PM.

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, such as areas used for the storage or use of combustibles or flammables; toxic, noxious, or corrosive materials; or heat-producing appliances.

19.3.2 Protection from Hazards.
19.3.2.1 Hazardous Areas.
Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:
(1) Boiler and fuel-fired heater rooms
(2) Central/bulk laundries larger than 100 ft² (9.3 m²)
(3) Paint shops
(4) Repair shops
(5) Soiled linen rooms
### SUMMARY STATEMENT OF DEFICIENCIES

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<th>Providing's Plan of Correction (Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency)</th>
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<tr>
<td>K029</td>
<td>Continued From page 5</td>
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6. (5) Trash collection rooms

7. Rooms or spaces larger than 50 ft² (4.6 m²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction.

8. Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.

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.

7.2.1.8.2 In any building of low or ordinary hazard contents, as defined in 6.2.2.2 and 6.2.2.3, or where approved by the authority having jurisdiction, doors shall be permitted to be automatic-closing, provided that the following criteria are met:

1. Upon release of the hold-open mechanism, the door becomes self-closing.
2. The release device is designed so that the door instantly releases manually and upon release becomes self-closing, or the door can be readily closed.
3. The automatic releasing mechanism or medium is activated by the operation of approved smoke detectors installed in accordance with the requirements for smoke detectors for door release service in NFPA 72, National Fire Alarm Code®.
4. Upon loss of power to the hold-open device,
Continued From page 7

the hold-open mechanism is released and the

doors become self-closing.

(5) The release by means of smoke detection of
one door in a stair enclosure results in closing all
doors serving that stair. 

NFPA 101 LIFE SAFETY CODE STANDARD

Heating, ventilating, and air conditioning comply
with the provisions of section 9.2 and are installed
in accordance with the manufacturer's
specifications. 19.5.2.1, 9.2, NFPA 90A,
19.5.2.2

This Standard is not met as evidenced by:

Based on observation, the facility failed to ensure
the proper clearance from heat sources to
combustibles. Wall mounted cadet heaters have
a historical documentation of related fires when
safe clearances are not maintained. This deficient
practice affected staff and visitors on the date of
the survey. The facility is licensed for 33 SNF/NF
beds and had a census of 30 on the day of the
survey.

Findings include:

During the facility tour conducted on October 13,
2016 from approximately 1:00 PM to 2:00 PM,
observation of a wall mounted cadet heater in the
small conference room and the Beauty Salon
revealed the heater in the conference room had
combustible decorations (dried plants) and a
couch directly in front of the heater, with
approximately five inches of clearance to
combustibles. In the beauty salon, the heater was
obstructed by the salon chair with approximately
twelve inches of clearance.

Actual NFPA standard:

19.5.2 Heating, Ventilating, and Air Conditioning.

Preparation and/or execution of this plan does not
constitute admission or agreement by the provider of
the truths of the facts alleged or the 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.

Corrective action for identified
areas/residents.

The wall mounted cadet heaters
observed during survey were removed on
10/17/16 & 10/18/16.

Identification residents with potential to
be affected.

All residents have the potential to be affected.

Measures to prevent occurrence.

Maintenance Supervisor conducted a
sweep of the facility to determine if any other
areas had cadet heaters in them. No other
cadet heaters found.

Monitoring and Quality Assurance

The Maintenance Supervisor, or
designee, will conduct a sweep of all
facility areas weekly for four weeks to
assure that no wall mounted cadet
heaters have been missed. Results of
these sweeps will be reviewed with the
Administrator weekly. Progress will be
reported to the Quality Assurance
Committee (QAC) monthly and as
needed until a lesser frequency is
deemed appropriate.
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</thead>
<tbody>
<tr>
<td>K067</td>
<td></td>
<td>19.5.2.1 Heating, ventilating, and air conditioning shall comply with the provisions of Section 9.2 and shall be installed in accordance with the manufacturer's specifications. Exception: As modified in 19.5.2.2.</td>
<td>K067</td>
<td></td>
<td>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths of the facts alleged or the 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.</td>
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| K147 | SS=F | 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 and prevent exposure to energized conductors. Failure to provide protection against accidental contact with energized, exposed wiring could result in electrocution or fires by arcing. This deficient practice affected 15 residents, staff and visitors on the date of the survey. The facility is licensed for 33 SNF/NF beds and had a census of 30 on the day of the survey. | K147 |         | • Corrective action for identified areas/residents. 
The four (4) exposed electrical boxes identified during survey were replaced on 10/21/16. 
• Identification residents with potential to be affected. 
All residents have the potential to be affected. 
• Measures to prevent occurrence. 
Maintenance Supervisor conducted a sweep of the facility to determine if any other areas had exposed electrical. No other exposed electrical/boxes found. 
• Monitoring and Quality Assurance 
The Maintenance Supervisor, or designee, will conduct a sweep of all facility areas weekly for four weeks to assure that no exposed electrical/boxes have been missed. Results of these sweeps will be reviewed with the Administrator weekly. Progress will be reported to the Quality Assurance Committee (QAC) monthly and as needed until a lesser frequency is deemed appropriate. |
K 147 Continued From page 9

During the facility tour conducted on October 13, 2016 from approximately 1:00 PM to 2:00 PM, an above the ceiling inspection at the smoke barrier cross corridor doors located next to room 107 revealed four (4) electrical boxes with exposed wiring, approximately four inches by four inches in size.

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 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.
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<tr>
<td>K 147</td>
<td>Continued From page 10 314.17 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......</td>
<td>K 147</td>
<td>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
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**NAME OF PROVIDER OR SUPPLIER:** ONEIDA COUNTY HOSPITAL & LONG TERM CARE

**STREET ADDRESS, CITY, STATE, ZIP CODE:** 150 NORTH 200 WEST MALAD, ID 83252