



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

IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

DEBBY RANSOM, R.N., R.H.I.T. -- Chief  
BUREAU OF FACILITY STANDARDS  
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P.O. Box 83720  
Boise, Idaho 83720-0009  
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January 17, 2013

RECEIVED  
JAN 29 2013

John Olson, Administrator  
Walter Knox Memorial Hospital  
1202 East Locust Street  
Emmett, ID 83617

FACILITY STANDARDS

RE: Walter Knox Memorial Hospital, Provider ID #131318

Dear Mr. Olson:

This is to advise you of the findings of the Medicare/Licensure Fire Life Safety Survey, which was concluded at Walter Knox Memorial Hospital, on January 8, 2013.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicare deficiencies and a similar form listing State licensure 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,
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.

John Olson, Administrator  
January 17, 2013  
Page 2 of 2

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 **January 30, 2013.**

Thank you for the courtesies extended to me during my visit. If you have any questions, please call our office at (208) 334-6626.

Sincerely,

A handwritten signature in black ink, appearing to read 'MPG', followed by a long horizontal line extending to the right.

MARK P. GRIMES  
Supervisor  
Facility Fire Safety and Construction Program

MPG/nw

Enclosure



*Serving All of Gem County*  
1202 East Locust Emmett, Idaho 83617  
Phone (208) 365-3561 Fax (208) 365-4176

January 28, 2013

**RECEIVED**  
JAN 29 2013

Mark Grimes  
Idaho Department of Health & Welfare  
PO Box 83720  
Boise, ID 83720-0009

**FACILITY STANDARDS**

Dear Mr. Grimes,

Enclosed is our response to the January 17, 2013 Medicare/Licensure Fire Life Safety Survey.

If you have any questions, please call contact me (208) 901-3210 or by email at [johno@wkmh.org](mailto:johno@wkmh.org).

Sincerely,

John N. Olson  
Chief Executive Officer

*"Caring is what we do best"*

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

PRINTED: 01/16/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  131318	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE HOSPITAL BUILD B. WING _____	(X3) DATE SURVEY COMPLETED  01/08/2013
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NAME OF PROVIDER OR SUPPLIER  WALTER KNOX MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1202 EAST LOCUST STREET EMMETT, ID 83617
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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 single story, protected wood frame structure that was originally constructed in 1967. In mid 1998 a major addition/renovation was started with Phase 1 and Phase 2 completed in mid 1999 and mid 2004 respectively. The building is protected throughout by a complete automatic fire extinguishing system; an addressable fire alarm system; and a Essential Electrical System including a on-site diesel powered automatic generator. A total of eight (8) exits to grade are provided in addition to an outside entry/exit at the ED canopy and a service entry at the kitchen. A total of sixteen (16) beds occupy two (2) wings that were constructed as part of Phase 1.  The following deficiencies were cited at the above facility during the Fire/Life Safety survey conducted on January 8, 2013. The facility was surveyed under the Life Safety Code 2000 Edition, Existing Health Care Occupancy adopted March 11, 2003, in accordance with CFR 42, 485.623.  The surveyor conducting the survey were:  Tom Mroz, CFI-II Health Facility Surveyor Fire/Life Safety and Construction	K 000		
K 012	NFPA 101 LIFE SAFETY CODE STANDARD  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	K 012		

**RECEIVED**  
JAN 29 2013  
**FACILITY STANDARDS**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>John H. Olson</i>	TITLE CEO	(X8) DATE 1-28-13
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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 012	Continued From page 1  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the smoke resistive properties of a smoke barrier ceiling and floor. This potentially allows the spread of smoke to other areas of the facility, exposing patients to a smoke or fire environment. The deficient practice affected staff and 1 patient in one of seven smoke compartments. The facility has the capacity for 16 beds with a census of 1 the day of survey.  Findings include:  During the facility tour on 01/08/13 at 12:33 p.m., observed penetrations in the soiled utility closet, one through the ceiling approximately 4 foot by 4 inches square and the second through the floor, approximately 1/2 inch gap in the annular space around a 3 inch pipe. Interview with the Maintenance Supervisor disclosed the facility was unaware of the penetrations.  The findings were acknowledged by the Chief Executive Officer and verified by the Maintenance Supervisor during the exit conference on 01/08/13.  Actual NFPA Standards: NFPA 101, 8.2.4.2 Smoke partitions shall extend from the floor to the underside of the floor or roof deck above, through any concealed spaces, such as those above suspended ceilings, and through interstitial structural and mechanical spaces.	K012	K012 The ceiling tile in soiled utility closet was put back in place 01-09-13. Managers and staff will be reminded to watch in their areas for any ceiling tiles that are out of place or damaged so correction can occur. Maintenance staff will do visual inspections of ceiling tiles in the areas throughout the hospital as they work in the, and do additional checks when vendors or IT/IS work in an area. Ceiling tiles and smoke barriers will also be inspected during monthly walk throughs (rounds) to verify they are intact. The Gap in the floor around the pipe will be filled in with fire caulk and covered. This will be done by 2-15-13.	
K 027	NFPA 101 LIFE SAFETY CODE STANDARD  Door openings in smoke barriers have at least a	K 027		

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K 027	<p>Continued From page 2</p> <p>20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. 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. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that corridor smoke doors closed shut. This potentially allows the spread of smoke to other areas of the facility, exposing patients to a smoke or fire environment. The deficient practice affected staff and 1 patient in two of seven smoke compartments. The facility has the capacity for 16 licensed beds with a census of 1 on the day of the survey.</p> <p>Findings include:</p> <p>Observation on 01/08/13 at 12:28 p.m., revealed the cross corridor smoke doors separating Med Surgery and the Main Corridor would not close shut upon release of the magnetic hold-open device. Interview with the facility Maintenance Supervisor on 01/08/13 at 12:28 p.m., indicated the facility was not aware the door would not close shut.</p> <p>The finding was acknowledged by the Chief Executive Office and verified by the Maintenance Supervisor at the exit interview on 01/08/13.</p>	K 027	<p>K027 The door casing was repaired 1-22-2013 by local vendor, Custom Glass to ensure door closes completely. All door operations will be checked during the monthly safety rounds and logged.</p>		

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K 027	Continued From page 3	K 027		
K 038	<p>Actual NFPA standard: NFPA 101 19.3.7.6</p> <p>Doors in smoke barriers shall comply with 8.3.4 and shall be self-closing or automatic-closing in accordance with 19.2.2.2.6. Such doors in smoke barriers shall not be required to swing with egress travel.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide exit doors that were operable without special knowledge and maintain an exit free of obstructions. This potentially prevents patients from leaving a smoke or fire environment. The deficient practices affected two of seven smoke compartments, staff and 1 patient. The facility has the capacity for 16 beds with a census of 1 the day of survey.</p> <p>Findings include:</p> <p>1.) Observation on 01/08/13 at 12:28 p.m., revealed that the exit off of the Acute Care wing discharged onto a 6' x 6' landing and an approximate 15' walkway that were covered in approximately 2-3 inches of snow with no clear path leading to a public way. The exit was identified as a required emergency exit on the</p>	K 038	K038 Maintenance will remove snow and or ice as necessary to provide for safe egress and provide ice melt and shovels at critical entrances/exits for staff to use during severe weather of during off hours. All fire exits will be checked monthly during fire drills and safety rounds.	

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K 038	<p>Continued From page 4</p> <p>facility evacuation plan and was identified by an emergency illuminated exit sign. Interview with the Maintenance Supervisor on 01/08/13 at 12:28 p.m., revealed that the facility does not use the designated exit, and was not aware that it was required to be kept clean of snow and provide a surface usable for evacuation by patients with walkers or wheelchairs during all weather conditions for travel to the public way.</p> <p>2.) Observation on 01/08/13 at 12:28 p.m. revealed that the cross corridor doors in the Administration wing were found to be capable of being locked with a magnetic lock requiring a key pad entry to exit thereby eliminating the second means of egress from the Administration wing. Interview on 01/08/13 at 12:28 p.m., with the Maintenance Supervisor revealed the facility was not aware of the requirement to be able to open the exit door without special knowledge.</p> <p>The findings were acknowledged by the Chief Executive Officer and verified by the Maintenance Supervisor at the exit interview on 01/08/13.</p> <p>Actual NFPA Standards:</p> <p>Item #1</p> <p>NFPA 101, 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.</p> <p>Item #2</p> <p>NFPA 101, 19.2.1</p>	K 038	<p>K038 Facility fire monitoring vendor will disconnect key-pad to eliminate locking and allow for normal fire door operation. This will be done on or before 2-28-13.</p> <p><i>REMOVE MAGNETIC DEVICE</i></p>	

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K 038	Continued From page 5 Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7.  7.2.1.5 Locks, Latches, and Alarm Devices. 7.2.1.5.1 Doors shall be arranged to be opened readily from the egress side whenever the building is occupied. Locks, if provided, shall not require the use of a key, a tool, or special knowledge or effort for operation from the egress side.	K 038		
K 046	NFPA 101 LIFE SAFETY CODE STANDARD  Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined that the facility had not ensured that battery powered emergency lighting monthly and annual testing was being performed. This potentially diminishes patient's visibility in a smoke or fire environment. The deficient practices affected seven of seven smoke compartments, staff and 1 patient. The facility has the capacity for 16 beds with a census of 1 the day of survey.  The findings include:  Record review on 01/08/13 at 1:30 p.m., disclosed that there was no record of monthly or annual testing of battery packs in emergency lighting located throughout the facility. Interview with the facility Maintenance Supervisor on 01/08/13 at 1:30 p.m., disclosed that monthly logs	K 046	K046 Monthly checks will be done and documented beginning 2-15-13 to verify operation of lighting systems with additional annual 1.5 hour lighting checks to occur and documented.	

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K 046	Continued From page 6 were not available for review to show that monthly testing was being conducted to determine fully operational lighting.  Actual NFPA 101 reference:  7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 1-1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction.	K 046		
K 062	NFPA 101 LIFE SAFETY CODE STANDARD  Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5  This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to provide quarterly and 5 year internal piping inspections of the automatic sprinkler system as required. This has the potential of exposing residents to a fire/smoke environment. The deficient practice affected seven of seven smoke compartments, staff, and 1 patient. The facility has the capacity for 16 beds with a census of 1 the day of survey.	K 062		

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K 062	Continued From page 7  Findings include:  1.) Observation during record review on 01/08/13 at 10:30 a.m., of the facility's sprinkler testing reports for the last 12 month period, the facility was unable to provide documented quarterly test reports of water flow, supervisory, and pressure switch devices. Interview with the Maintenance Supervisor on 01/08/13 at 10:30 a.m., revealed the facility was not aware of the requirements for quarterly testing water flow alarms, supervisory, and pressure switch devices for the sprinkler system.  2.) Observation during record review of the facility's sprinkler testing reports for the last 60 month period on 01/08/13 at 10:35 a.m., the facility documented 5 year internal piping inspection was last performed in 2006. Interview with the Maintenance Supervisor 01/07/13 at 10:35 a.m., revealed the facility was not aware of the 5 year internal piping inspection was past due.  The finding was acknowledged by the Chief Executive Officer and verified by the Maintenance Supervisor at the exit interview on 01/08/13.  Actual NFPA Standard:  Item #1  NFPA 101, 4.6.12.1. Every required sprinkler system shall be continuously maintained in proper operating condition.  NFPA 25, 2-3.3. Water flow alarm devices	K 062	K062 Maintenance personnel will perform and document quarterly tests of water flow alarm devices. Vendor will perform first test on or before 2-15-13 and every quarter thereafter.  Vendor will do a five year internal piping inspection on or before 2-15-13 and every 5 years thereafter.  <i>Vendor will perform 1st test only</i> <i>TECH STAFF WILL CONTINUE REN</i>	

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K 062	Continued From page 8 including, but not limited to, mechanical water motor gongs, vane-type water-flow devices, and pressure switches that provide audible or visual signals shall be tested quarterly.  Item #2  NFPA 25, 10-2.2 Obstruction Prevention. Systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This investigation shall be accomplished by examining the interior of a dry valve or preaction valve and by removing two cross main flushing connections.	K 062			
K 076	NFPA 101 LIFE SAFETY CODE STANDARD  Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.  (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.  (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4  This STANDARD is not met as evidenced by:	K 076			

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K 076	<p>Continued From page 9</p> <p>Based on observation and interview, the facility failed to provide the required protective features for storage of nitrous oxide and oxygen. This has the potential for a fire and explosive hazard exposure to the staff. The deficient practice affected one of seven smoke compartments, staff, and no patients. The facility has the capacity for 16 beds with a census of 1 the day of survey.</p> <p>Findings include:</p> <p>1.) On 01/08/13 1:15 p.m., it was observed that the storage of 6 "K" type oxygen cylinders in the compressed gas storage room, were not individually secured and located to prevent falling or being knocked over. Interview with the Maintenance Supervisor on 01/08/13 1:15 p.m., revealed that the facility was not aware of the requirement that oxygen gas cylinders were to be individually secured and located to prevent falling or being knocked over.</p> <p>2.) On 01/08/13 1:20 p.m., it was observed that the storage of 2 "K" type nitrous oxide cylinders in the compressed gas storage room, were not individually secured and located to prevent falling or being knocked over. Interview with the Maintenance Supervisor on 01/08/13 at 1:20 p.m. revealed that the facility was not aware of the requirement that were to be individually secured and located to prevent falling or being knocked over.</p> <p>The finding was acknowledged by the Chief Executive Officer and verified by the Maintenance Supervisor at the exit interview on 01/18/13.</p>	K 076	<p>K076 Maintenance will secure all oxygen tanks in storage by with chains to wall or floor stands on or before 2-15-13.</p> <p>Maintenance will secure nitrous oxide tanks in storage by by chains to wall or floor stands on of before 2-15-13.</p> <p>Checks to verify security of tanks to be done during monthly safety rounds and documented.</p>	

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

PRINTED: 01/16/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>131318</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02 - ENTIRE HOSPITAL BUILD</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/08/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>WALTER KNOX MEMORIAL HOSPITAL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1202 EAST LOCUST STREET EMMETT, ID 83617</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)	(X6) COMPLETION DATE
K 076	Continued From page 10 Actual NFPA Standard: NFPA 99, 4-3.1.1.1 Cylinder and Container Management. Cylinders in service and in storage shall be individually secured and located to prevent falling or being knocked over.	K 076		
K 144	NFPA 101 LIFE SAFETY CODE STANDARD  Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.  This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to document weekly and monthly inspections on the emergency generator and its components. This potentially exposed residents to loss of illumination of exit egress, fire and smoke alarms, and life support equipment during power outage. The deficient practice affected all seven smoke compartments, staff and all patients. The facility has the capacity for 16 beds and at the time of the survey the census was 1.  Findings include:  1.) Observation during a review of the facility's emergency generator reports for the 12 months preceding the survey on 01/08/13 at 11:45 a.m., the facility was unable to provide documented	K 144		

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NAME OF PROVIDER OR SUPPLIER  WALTER KNOX MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 1202 EAST LOCUST STREET EMMETT, ID 83617		
(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 144	<p>Continued From page 11</p> <p>weekly inspections of the facility generator. Interview with the facility Maintenance Supervisor on 01/08/13 at 11:45 a.m. revealed that the facility was not aware of the requirement for weekly documented inspections of the emergency generator and all of its components.</p> <p>2.) Observation during a review of the facility's emergency generator reports for the 12 months preceding the survey on 01/08/13 at 11:50 a.m., the facility was unable to provide documented monthly load test reports of the facility generator. Interview with the facility Maintenance Supervisor on 01/08/13 at 11:50 a.m. revealed that the facility was not aware of the requirement for monthly documented load tests of the emergency generator and all of its components.</p> <p>The finding was acknowledged by the Chief Executive Officer and verified by the Maintenance Supervisor at the exit interview on 01/08/13.</p> <p>Actual NFPA Standard:</p> <p>Item #1</p> <p>NFPA 110, 6.4.1 and 6.4.2. Level 1 and level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load monthly for a minimum of 30 minutes. NFPA Standard: NFPA 110, 6-3.4. A written record of the EPSS inspections, tests, exercising, operation, and repairs shall be maintained on the premises.</p> <p>Item #2</p> <p>NFPA 110 6-4.1</p>	K 144	<p>K144 Maintenance will perform and document weekly generator inspections. Maintenance will perform and document monthly load testing.</p> <p>Vendor will perform and document initial test on or before 2-15-13.</p>		

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NAME OF PROVIDER OR SUPPLIER  <b>WALTER KNOX MEMORIAL HOSPITAL</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1202 EAST LOCUST STREET EMMETT, ID 83617</b>		
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K 144	Continued From page 12 Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly.	K 144			

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NAME OF PROVIDER OR SUPPLIER <b>WALTER KNOX MEMORIAL HOSPITAL</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1202 EAST LOCUST STREET EMMETT, ID 83617</b>		
(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) COMPLETE DATE
B 000	<p>16.03.14 Initial Comments</p> <p>The hospital is a single story, protected wood frame structure that was originally constructed in 1967. In mid 1998 a major addition/renovation was started with Phase 1 and Phase 2 completed in mid 1999 and mid 2004 respectively. The building is protected throughout by a complete automatic fire extinguishing system; an addressable fire alarm system; and an Essential Electrical System including a on-site diesel powered automatic generator. A total of eight (8) exits to grade are provided in addition to an outside entry/exit at the ED canopy and a service entry at the kitchen. A total of sixteen (16) beds occupy two (2) wings that were constructed as part of Phase 1.</p> <p>The following deficiencies were cited at the above facility during the annual Fire/Life Safety survey conducted on January 8, 2013. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with IDAPA 16.03.14.</p> <p>The surveyor conducting the survey were:</p> <p>Tom Mroz, CFI II Health Facility Surveyor Fire/Life 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. 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</p>	BB161		

**RECEIVED**  
JAN 29 2013  
**FACILITY STANDARDS**

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

*John N. Oh*

TITLE

CEO

(X6) DATE

1-28-13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>131318</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02 - ENTIRE HOSPITAL BUILD</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/08/2013</b>
NAME OF PROVIDER OR SUPPLIER <b>WALTER KNOX MEMORIAL HOSPITAL</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1202 EAST LOCUST STREET EMMETT, ID 83617</b>		
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BB161	Continued From Page 1  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: Refer to the following Federal "K" tags on the CMS - 2567:  1. K012 - Penetrations  2. K027 - Corridor Doors  3. K038 - Exits  4. K046 - Emergency Lighting  5. K062 - Fire Sprinkler System  6. K076 - Compressed Gas Cylinders  7.K144 - Generator	BB161		

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.