

COPY



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

February 22, 2011

Vaughn Ward, Administrator
Northwest Specialty Hospital
1593 East Polston Avenue
Post Falls, ID 83854

RE: Northwest Specialty Hospital, Provider #130066

Dear Mr. Ward:

This is to advise you of the findings of the Medicare/Licensure survey at Northwest Specialty Hospital, which was concluded on February 4, 2011.

Enclosed is your copy of a Statement of Deficiencies/Plan of Correction, form 2567, listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction.

An acceptable plan of correction (PoC) contains the following elements:

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the PoC is effective in bringing the hospital into compliance, and that the hospital remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
- The administrator's signature and the date signed on page 1 of the Form CMS-2567.

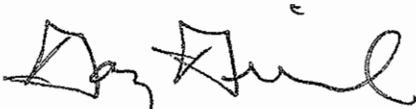
After you have completed your Plan of Correction, return the original to this office by

Vaughn Ward, Administrator
February 22, 2011
Page 2 of 2

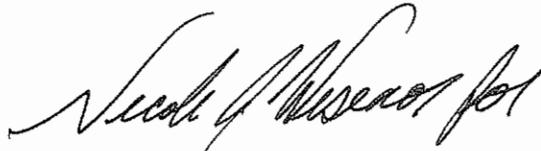
March 7, 2011, and keep a copy for your records.

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

Sincerely,



GARY GUILLES
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

GG/srm
Enclosures



DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
Consortium For Quality Improvement and Survey & Certification Operations
Western Consortium – Division of Survey & Certification

IMPORTANT NOTICE – PLEASE READ CAREFULLY

February 24, 2011

Vaughn Ward, CEO
Northwest Specialty Hospital
1593 East Polston Avenue
Post Falls, ID 83854

CMS Certification Number: 13-0066

Re: Results of Sample Validation Survey

Dear Mr. Ward:

The Centers for Medicare and Medicaid Services (CMS) is confirming the results of the sample validation survey, completed by the Idaho Bureau of Facility Standards (State survey agency) on February 4, 2011, at Northwest Specialty Hospital.

CMS finds that your acute care hospital is in compliance with all the Medicare Conditions of Participation and will continue to be certified as meeting Medicare requirements. We have forwarded a copy of this letter and the findings from the survey to the Joint Commission.

It is not a requirement to submit a plan of correction; however, under federal disclosure rules, findings of the inspection, including the plan of correction submitted by the facility, become publicly disclosable if requested within ninety days of completion.

You may therefore wish to submit your plans for correcting both the health (A-Tags) and life safety code (K-Tags) deficiencies cited. An acceptable plan of correction contains the following elements:

- The plan for correcting each specific deficiency cited;
- The plan should address improving the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- All plans of correction must demonstrate how the hospital has incorporated its improvement actions into its Quality Assessment and Performance Improvement (QAPI) program, addressing improvements in its systems in order to prevent the likelihood of the deficient practice reoccurring. The plan must include the monitoring and tracking procedures to ensure the plan of correction is effective and that specific deficiencies cited remain corrected and/or in compliance with the regulatory requirements; and

Denver Regional Office
1600 Broadway, Suite 700
Denver, CO 80202

San Francisco Regional Office
90 7th Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

Seattle Regional Office
2201 Sixth Avenue, RX-48
Seattle, WA 98121

- The plan must include the title of the person responsible for implementing the acceptable plan of correction.

Please send a copy of your plan of correction within 10 days receipt of this letter to CMS and the State survey agency. **If you choose to not submit a plan a correction, please sign and date the first page of each Form CMS-2567 and return to CMS.**

Kate Mitchell, Division of Survey and Certification
Centers for Medicare and Medicaid Services
2201 Sixth Avenue, Mail Stop RX-48
Seattle, Washington 98121

And

Sylvia Creswell, Supervisor
Idaho Bureau of Facility Standards – DHW
PO Box 83720
Boise, ID 83720-0036

We thank you for your cooperation, and look forward to working with you on a continuing basis in the administration of the Medicare program. Please contact Kate Mitchell of my staff at (206) 615-2432 if you need additional information.

Sincerely,

for

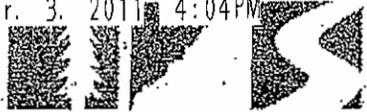
Kate Mitchell

Steven Chickering, Associate Regional Administrator
Western Consortium, Division of Survey and Certification

Enclosure

cc: Idaho Bureau of Facility Standards
CMS Central Office
Joint Commission

Mar. 3. 2011 4:04PM



**NORTHWEST
SPECIALTY HOSPITAL**

1593 E. Polston Avenue No. 0782 P. 1/25
Post Falls, ID 83854
Phone (208) 262-2300
Fax (208) 262-2390

facsimile transmittal sheet

To: Sylvia Creswell Fax: 208-364-1888

From: Karenia Twidt Date: 3/3/11

Re: CMS Survey Response Pages: 25

CC: _____

Urgent For Review Please Comment Please Reply Please Recycle

Notes: Please let me know if I could improve upon my Plan of Actions. I appreciate the recommendations.
Thank you,
Karenia Twidt

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FACILITY STANDARDS

This fax and any files transmitted with it may contain information that is privileged and confidential. It is the property of the Northwest Specialty Hospital and is intended only for the use of the intended recipient. If you have received this fax in error, do not disseminate, distribute, forward, print or copy this fax or any of its contents. Destroy/purge the fax and all of its attachments and notify the sender immediately. Any misuse or abuse may result in disciplinary action and /or legal liability. Unauthorized interception of this fax is a violation of federal law.

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130066	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/04/2011
NAME OF PROVIDER OR SUPPLIER NORTHWEST SPECIALTY HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 1593 EAST POLSTON AVENUE POST FALLS, ID 83854		
(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	16.03.14 Initial Comments The following deficiency was cited during the state licensure survey of your hospital. Surveyors conducting the licensure review were: Gary Guiles, RN, HFS, Team Leader Aimee Hastriter, RN, HFS	B 000		
BB118	16.03.14.200.04 Discharge Planning 04. Discharge Planning. Administration shall provide a procedure to screen each patient for discharge planning needs. If discharge planning is necessary, a qualified person shall be designated responsible for such planning. The hospital shall have a transfer agreement with a Medicare and/or Medicaid skilled nursing home. If there is a common governing board for a hospital and a skilled nursing home, a policy statement concerning transfers will be sufficient. (10-14-88) This Rule is not met as evidenced by: Refer to A800 as it relates to the lack of a procedure to screen patients for discharge planning needs.	BB118	Refer to Plan of Correction A 800, 808, 809	

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 FACILITY STANDARDS

[Signature] DON 3/8/11

Bureau of Facility Standards

TITLE

(X6) DATE

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

STATE FORM

8500

602M11

If continuation sheet 1 of 1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130066	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/04/2011
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A 000 INITIAL COMMENTS

The following deficiencies were cited during the validation survey of your hospital. Surveyors conducting the validation were:

Gary Guiles, RN, HFS, Team Leader
Aimee Hastriter, RN, HFS

Acronyms used in this report include:

CRNA - Certified Registered Nurse Anesthetist
DME = Durable Medical Equipment
DON - Director of Nursing
PACU - Post-Anesthesia Care Unit
PICC = Peripherally Inserted Central Catheter
pt = patient
QAPI = Quality Assessment/Performance Improvement

A 117 482.13(a)(1) PATIENT RIGHTS: NOTICE OF RIGHTS

A hospital must inform each patient, or when appropriate, the patient's representative (as allowed under State law), of the patient's rights, in advance of furnishing or discontinuing patient care whenever possible.

This STANDARD is not met as evidenced by: Based on staff interview, and review of medical records, it was determined the hospital failed to inform 26 of 26 surgical patients (#s 1-6 and #s 11-30), whose records were reviewed, of their rights. This prevented the hospital from promoting and protecting each patient's rights. Findings include:

1. Medical records for 26 of 26 surgical patients (#s 1-6 and #s 11-30) contained a form labeled "PATIENT RIGHTS AND RESPONSIBILITIES."

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MAR 06 2011

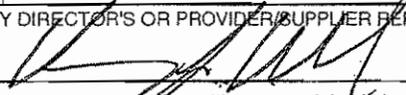
FACILITY STANDARDS

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IDVR CENTRAL OFFICE

A 117-Action: Rights and Responsibilities policy and information provided to the patient upon admission was revised to include appropriate contact information for Director of Nurses, ID Bureau of Facility Standards, and Joint Commission; including the process of how to file a complaint or grievance.

All posters within the facility have been updated, and new patient information sheets have been ordered.

The Director Nurses is responsible for ensuring continual compliance.
Completion date: 3/2/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE CEO	(X6) DATE 3/3/11
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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 their 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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NAME OF PROVIDER OR SUPPLIER NORTHWEST SPECIALTY HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1593 EAST POLSTON AVENUE POST FALLS, ID 83854
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A 117	Continued From page 1 The form did not contain the following rights: * The patient has the right to participate in the development and implementation of his or her plan of care. * The patient has the right to have a family member or representative of his or her choice and his or her own physician notified promptly of his or her admission to the hospital. * The patient has the right to personal privacy. * The patient has the right to receive care in a safe setting. * The right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. The DON was interviewed on 2/02/11 at 9:25 AM. She confirmed the above rights were not listed on forms given to patients.	A 117	A 117 continued: The Rights have been added to the existing policy and information provided to the patient upon admission in the format requested. The changes will ensure clear communication of Patient Rights The Director of Nurses is responsible for ensuring continual compliance. Completion date: 3/2/2011	
A 118	482.13(a)(2) PATIENT RIGHTS: GRIEVANCES The hospital failed to inform patients of all of their rights. The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records and hospital policies, it was determined the hospital failed to ensure 26 of 26 surgical patients (#1-6 and #11-30), whose records were reviewed, were informed of whom to contact to file a grievance. This decreased the likelihood that patients who were dissatisfied with their care would be able to file a grievance. Findings include:	A 118	A 118- 482.13 (a)(2) Patient Rights: Grievances. The patient Rights and Responsibilities revision included a revision to the contact information of where a patient could file a complaint or grievance. Clear contact information and process to file a complaint or grievance was included. Clear contact information will provide appropriate guidance for patients. The Director of Nurses is responsible for continual compliance. Completion date: 3/2/2011	

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A 118	<p>Continued From page 2</p> <p>The hospital's policy "CONCERNS, COMPLAINTS, GRIEVANCES," revised 2/07, stated "All patients have a right to file a grievance, obtain information on how to file a grievance...B. Notification: All patients are notified of their right to file a grievance and the procedures to follow should they desire to do so. Patient information is provided at the time of admission and is used for the notification."</p> <p>The form "PATIENT RIGHTS AND RESPONSIBILITIES," that Patients #1-#6 and #11-#30 were given on admission, stated patients had the right "To express complaints concerning your care and have such complaints resolved in a timely manner." The form did not mention grievances and did not include a process to file a grievance, nor did it identify whom to file the grievance with. In addition, the form stated patients could notify the "Idaho Department of Health" if they felt their complaints had not been answered. The "Idaho Department of Health" did not regulate the hospital and was not an appropriate agency to notify. The form did not include contact information for the state survey agency.</p> <p>The DON was interviewed on 2/02/11 at 9:25 AM. She confirmed the patient rights form did not mention grievances or whom patients could contact to file a grievance.</p> <p>The hospital did not notify patients whom to contact to file a grievance.</p>	A 118	<p>A 118 continued: Revision of forms and policies to reflect additional information has been completed.</p> <p>The Idaho Department of Health and Welfare has been revised to include: Idaho Bureau of Facility Standards. 3232 Elder Street, P.O. Box 83720, Boise, ID 83705-0036 (208) 334-6626 fsb@dhw.idaho.gov This information is listed under the information for who to contact to file a grievance. The Director of Nurses is responsible for continual compliance. Completion date: 3/2/2011</p>	
A 123	<p>482.13(a)(2)(iii) PATIENT RIGHTS: NOTICE OF GRIEVANCE DECISION</p> <p>At a minimum: In its resolution of the grievance, the hospital</p>	A 123	<p>A 123 482.13 (a)(2)(iii) Patient Rights: Notice of Grievance Decision-continued--</p>	

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A 123	<p>Continued From page 3</p> <p>must provide the patient with written notice of its decision that contains the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of complaint logs, grievance reports, and hospital policies, it was determined the hospital failed to ensure a written response was provided to 3 of 4 complainants who filed grievances. This impacted 3 of 4 patients (#31, #32, and #33), who's grievance files were reviewed. This resulted in a lack of clarity and closure about the resolution of the grievances and had the potential to interfere with patient understanding and satisfaction. Findings include:</p> <p>1. The policy "CONCERNS, COMPLAINTS, GRIEVANCES," revised 2/07, stated all patients had a right to file a grievance. The policy stated a written response to the grievance would be generated within 60 days. This policy was not followed. Examples include:</p> <p>a. The complaint log documented a grievance related to the care of Patient #31 was received on 8/03/10. A report of the grievance documented it had been investigated. A written response to the complainant was not documented.</p> <p>The DON was interviewed on 2/02/11 at 9:25 AM. She stated she had spoken with the complainant related to the grievance for Patient #31 but had not provided that person with a written response. She stated if complainants seemed satisfied with a verbal response, they were not provided with a</p>	A 123	<p>A 123 NWSH had followed complaint and grievance resolution, but had not provided written notice to patients who stated that the complaint was resolved via phone conversation. All grievances had received the recommended letter of response. This process has been revised to <u>require all resolutions be followed with a written response</u>. This will provide a clear written resolution, and documentation of contact with the patient who filed the complaint, and contact information for further concerns.</p> <p>The Director of Nurses is responsible for continual compliance.</p> <p>The Performance Improvement Committee will monitor compliance by review of the complaint log on a quarterly basis.</p> <p>Completion date 3/2/2011</p>	

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A 123	<p>Continued From page 4 written response to grievances.</p> <p>b. The complaint log documented a grievance related to the care of Patient #32 was received on 3/17/10. A report of the grievance documented it had been investigated. A written response to the complainant was not documented.</p> <p>The DON was interviewed on 2/02/11 at 9:25 AM. She stated she had spoken with the complainant related to the grievance for Patient #32 but had not provided that person with a written response.</p> <p>c. The complaint log documented a grievance related to the care of Patient #33 was received on 5/03/10. A report of the grievance documented it had been investigated. A written response to the complainant was not documented.</p> <p>The DON was interviewed on 2/02/11 at 9:25 AM. She stated she had spoken with the complainant related to the grievance for Patient #33 but had not provided that person with a written response.</p>	A 123	<p>A 123 - 100% of patient surveys are read by staff and the Director of nurses. Patients are encouraged to communicate concerns relating to the care they received while at Northwest Specialty Hospital. Physicians, staff, and ancillary personnel are eager to correct problems and concerns, and appreciate the opportunity to improve.</p>	
A 450	<p>482.24(c)(1) MEDICAL RECORD SERVICES</p> <p>All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of medical records, it was determined the hospital failed to ensure the medical records for 26 of 26 surgical</p>	A 450	<p>A 450- 482.24(c)(1) Medical Records Services- Documentation consistent with hospital policies and procedures: Continued-</p>	

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A 450	<p>Continued From page 5</p> <p>patients (#s 1-6 and #s 11-30), whose records were reviewed, contained documentation of personal care. This resulted in the inability of the hospital to determine if care had been provided. Findings include:</p> <p>The hospital had 2 nursing units, the Monitored Care Unit and the Inpatient Unit. "NURSE PROGRESS NOTES," used by nurses to document care on the Inpatient Unit, did not contain specific spaces to document personal cares, such as bathing and oral care. The medical records of 26 surgical patients (#s 1-6 and #s 11-30) were reviewed. None of these records contained documentation of all personal care being provided. For example, occasionally, the nurse would document personal care in narrative form in progress notes but this was sporadic in all of the inpatient medical records.</p> <p>The Director for Quality and Risk Management of the hospital's parent corporation was interviewed on 2/02/11 at 2:45 PM. She stated personal cares were being provided. She said the "NURSE PROGRESS NOTES" for the Inpatient Unit did not include specific places for staff to document personal care and agreed staff did not document personal care.</p>	A 450	<p>Documentation forms have been revised to include daily care provided to the patient. Bathing and oral care are consistently provided, and documentation to support this care is now appropriately documented.</p> <p>Monitoring of this process will occur during chart audits, and reported to the Performance Improvement Committee on a quarterly basis.</p> <p>The Director of Nurses is responsible for continual compliance.</p> <p>Completion date: 3/2/2011</p>	
A 800	<p>The hospital failed to document personal care for patients.</p> <p>482.43(a) CRITERIA FOR DISCHARGE EVALUATIONS</p> <p>The hospital must identify at an early stage of hospitalization all patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning.</p>	A 800	<p>A 800 482.43(a) Criteria For Discharge Evaluations- The hospital's process for identifying a patient's needs was in place. (continued)</p>	

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A 800	<p>Continued From page 6</p> <p>This STANDARD is not met as evidenced by: Based on staff interview, and review of medical records and hospital policies, it was determined the hospital failed to develop a system to identify patients who were likely to suffer adverse health consequences upon discharge if there was not adequate discharge planning. This affected 5 of 6 patients (#13, #23, #24, #28, and #30), whose records were reviewed for discharge planning screening. The lack of a system to identify patients with discharge planning needs at an early stage had the potential to delay discharge planning. Findings include:</p> <p>The policy "DISCHARGE PLANNING POLICY," effective 9/01/03, stated "Discharge planning and educational needs will be evaluated as part of the admission assessment. Patients who are likely to suffer adverse health consequences upon discharge without adequate discharge planning are identified and appropriate discharge planning personnel are notified." The policy included 11 indicators to identify patients who needed discharge planning, such as patients over 70, patients who might require durable medical equipment at home, pregnant minors, etc.</p> <p>The Case Manager was interviewed on 2/03/11 at 3:00 PM. She stated nurses assessed patients on admission to identify potential discharge planning needs. She stated nurses used the "Initial Nursing Assessment" forms to identify patients who needed discharge planning. This was not the case, however. Examples of patients who were not screened for discharge planning needs include:</p> <p>a. Patient #23's medical record documented a 65 year old female who had a section of her sigmoid</p>	A 800	<p>A 800- 482.43(a) Continued-Northwest Specialty Hospital has a policy in place for early identification of high risk patients who may require discharge planning assistance. Staff at each level of the patient contact are involved in the assessment of needs, and communicate with the Case Manager/Discharge Planning Nurse. The process was reexamined, and the policy reviewed. Forms were revised to show consistent screening processes, and with all components necessary to address all the potential needs of the patient. The form was approved by the Medical Staff on 2/10/2011. Staff education was completed to clarify the individual roles in patient assessment of need for referral for Discharge planning.</p> <p>This process change will improve patient care by identifying patients in need early in the process.</p> <p>The Director of Nurses is responsible for continual compliance.</p> <p>Completion date: 3/2/2011</p>	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130066	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/04/2011
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NAME OF PROVIDER OR SUPPLIER NORTHWEST SPECIALTY HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1593 EAST POLSTON AVENUE POST FALLS, ID 83854
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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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A 800	<p>Continued From page 7</p> <p>colon removed. She was admitted on 11/24/10 and discharged on 12/15/10. Her "Initial Nursing Assessment," dated 11/24/10 at 10:00 AM, contained boxes labeled "Case Management: Notified Discharge Planning" and "Identified potential needs upon discharge." These boxes were marked "no."</p> <p>The PACU Manager was interviewed on 2/04/11 at 10:05 AM. She stated she often completed the "Initial Nursing Assessment" form when patients were assessed pre-operatively. She reviewed Patient #23's "Initial Nursing Assessment." She stated the boxes marked no, which related to discharge planning, meant the questions about discharge planning had not been asked.</p> <p>b. Patient #24's medical record documented a 77 year old male who was admitted on 12/27/10 and discharged on 12/30/10 for a post-surgical infection of his right knee. A medical record of his prior admission documented he was hospitalized at Northwest Specialty Hospital from 12/21/10-12/22/10. A screen to identify if he may need a discharge planning evaluation was not present in his record.</p> <p>The Discharge Planner was interviewed on 2/09/11 at 11:45 AM. She confirmed a screen to identify if he needed a discharge planning evaluation had not been completed.</p> <p>c. Patient #28's medical record documented a 58 year old male who had a tracheostomy performed to treat sleep apnea. He was admitted on 11/09/10 and discharged on 11/13/10. His "Initial Nursing Assessment," dated 11/09/10 at 8:57 AM, contained boxes labeled "Case Management: Notified Discharge Planning" and</p>	A 800	<p>A 800</p> <p>Staff education has been completed to include the proper use of the forms, and referral to the Case Manager/Discharge Planning Nurse.</p> <p>Staff were informed of the necessity to clearly screen patients for potential needs, and to initiate the process of Case Management as soon as need is identified.</p> <p>Communication with appropriate personnel is crucial to the successful outcome of the patient. The review did show that documentation of the process was deficient, this has been corrected as of 2/10/2011. The Director of Nurses is responsible for continual compliance.</p> <p>Completion date: 2/10/2011</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/24/2011
FORM APPROVED
OMB NO. 0938-0391

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A 800	<p>Continued From page 8</p> <p>"Identified potential needs upon discharge." These boxes were marked "no."</p> <p>The PACU Manager was interviewed on 2/04/11 at 10:05 AM. She reviewed Patient #28's "Initial Nursing Assessment." She stated the boxes marked no related to discharge planning meant the questions about discharge planning had not been asked.</p> <p>d. Patient #30's medical record documented an 84 year old male who had left total shoulder replacement surgery. He was admitted on 1/17/11 and discharged on 1/20/11. His "Initial Nursing Assessment," dated 1/17/11 at 9:17 AM, contained boxes labeled "Case Management: Notified Discharge Planning" and "Identified potential needs upon discharge." These boxes were marked "no."</p> <p>The PACU Manager was interviewed on 2/04/11 at 10:05 AM. She reviewed Patient #30's "Initial Nursing Assessment." She stated the boxes marked no, which related to discharge planning, meant the questions about discharge planning had not been asked.</p> <p>e. Patient #13's medical record documented a 68 year old female with ovarian cancer who had surgery to repair a perforated bowel and remove the tumor. She was admitted on 12/27/10 and discharged on 12/30/10. Her "Initial Nursing Assessment," dated 12/27/10 at 1:45 PM, contained boxes labeled "Case Management: Notified Discharge Planning" and "Identified potential needs upon discharge." These boxes were marked "no."</p> <p>The PACU Manager was interviewed on 2/04/11</p>	A 800		

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A 800	Continued From page 9 at 10:05 AM. She stated the boxes marked no, which related to discharge planning, meant the questions about discharge planning had not been asked.	A 800		
A 808	<p>The hospital failed to screen patients for potential discharge planning needs at an early stage.</p> <p>482.43(b)(3) POST-HOSPITAL SERVICES</p> <p>The discharge planning evaluation must include an evaluation of the likelihood of a patient needing post-hospital services and of the availability of the services.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview, and review of medical records and hospital policies, it was determined the hospital failed to evaluate the likelihood of patients needing post-hospital services and of the availability of those services. This affected 4 of 6 patients (#13, #23, and #24, and #28), whose records were reviewed for discharge planning and had the potential to affect all inpatients. The lack of a system to evaluate the likelihood of patients needing post-hospital services had the potential to impede appropriate discharge planning. Findings include:</p> <p>1. Patient #13's medical record documented a 68 year old female with ovarian cancer who had surgery to repair a perforated bowel and remove the tumor. She was admitted on 12/27/10 and discharged on 12/30/10. The only note by the Case Manager, dated 12/29/10 at 10:30 AM, stated Patient #13 had been referred for possible placement to a long term acute care hospital.</p> <p>The Case Manager was interviewed on 2/03/11 at 3:00 PM. She confirmed the documentation for</p>	A 808	<p>A 808 482.43(b)(3) Post Hospital Services- The revision of the Discharge Planning included the addition of any post-hospital services that would be necessary; to include outpatient physical therapy or occupational therapy, skilled nursing facilities, rehabilitation including Durable Medical Equipment. This form include a well documented timeline, contact information, and discussions between the patient and their family clearly demonstrating the patients involvement in the discharge planning process and the collaborative efforts between the healthcare disciplines. The Case Manager/Discharge Planning Nurse works with the Preop/PACU Manager to maintain compliance with the standard. Completed 3/2/2011</p>	

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A 808	<p>Continued From page 10</p> <p>Patient #13. She stated an evaluation of discharge needs had been done but was not documented.</p> <p>2. Patient #24's medical record documented a 77 year old male who had irrigation and debridement of a right knee wound. He was admitted on 12/21/10 and discharged on 12/29/10. An evaluation of the likelihood of Patient #29 needing post-hospital services and of the availability of the services was not documented. The only discharge planning note on the record was documented on 12/29/10 at 11:00 AM. It stated "Met [with] pt re: D/C planning. Will have PICC line placed & then return here for Q12 hr [Vancomycin] over the weekend-Pt [illegible]-Will cont. to follow as needed."</p> <p>The Case Manager was interviewed on 2/03/11 at 3:00 PM. She confirmed the documentation for Patient #24. She stated an evaluation of discharge needs had been done but was not documented.</p> <p>3. Patient #23's medical record documented a 65 year old female who had a section of her sigmoid colon removed. She was admitted on 11/24/10 and discharged on 12/15/10. An evaluation of the likelihood of Patient #23 needing post-hospital services and of the availability of the services was not documented. Two discharge planning notes by the Case Manager were documented. The first was dated 12/09/10 and was not timed. It stated the patient had chosen a home health agency for services after discharge. The second note was dated 12/15/10 at 3:00 PM. It stated home health was not appropriate for Patient #23 and she was being admitted to a long term care facility.</p>	A 808	<p>A 808 Continued:</p> <p>Chart Audit will be completed on 20 identified high risk patients per month, to confirm the appropriate documentation of the Discharge Planning process. The chart audit will confirm that specific criteria were addressed to meet specific needs of the patients. The audit will be reviewed by the Performance Improvement Committee on a quarterly basis to confirm compliance with the policy. Readmission rates and patient satisfaction in relation to whether the patients feel like their needs were met upon discharge will continue to be monitored. The Director of Nurses is responsible for the continual compliance. Completed 2/10/2011</p>	
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A 808	<p>Continued From page 11</p> <p>The Case Manager was interviewed on 2/03/11 at 3:00 PM. She confirmed the documentation for Patient #23. She stated an evaluation of discharge needs had been done but was not documented.</p> <p>4. Patient #28's medical record documented a 58 year old male who had a tracheostomy performed to treat sleep apnea. He was admitted on 11/09/10 and discharged on 11/13/10. An evaluation of the likelihood of Patient #28 needing post-hospital services and of the availability of the services was not documented. A case management note dated 11/09/10 at 2:00 PM, stated Patient #28 had a specific DME company before surgery but it did not include what services he might need after hospitalization.</p> <p>The Case Manager was interviewed on 2/09/11 at 11:45 AM. She confirmed the documentation for Patient #28. She stated an evaluation of Patient #28's discharge planning needs had been done but was not completely documented. She stated a much more thorough evaluation of discharge planning needs was done than was documented on all patients. She conceded a system to ensure a consistent discharge planning evaluation was conducted had not been developed.</p> <p>The hospital failed to evaluate the likelihood of patients needing post-hospital services and of the availability of the services.</p>	A 808	<p>A 808 Discharge Planning All items addressed and will be monitored for compliance. Director of Nurses is responsible for monitoring compliance. Completed 2/10/2011</p>	
A 809	<p>482.43(b)(4) SELF CARE PATIENT EVALUATION</p> <p>The discharge planning evaluation must include an evaluation of the likelihood of a patient's capacity for self-care or of the possibility of the</p>	A 809		

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A 809	<p>Continued From page 12</p> <p>patient being cared for in the environment from which he or she entered the hospital.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview, and review of medical records and hospital policies, it was determined the hospital failed to evaluate patients' capacity for self-care and the possibility of patients being cared for in their home environment after discharge. This affected 4 of 6 patients (#13, #23, #24, and #28), whose records were reviewed for discharge planning screening, and had the potential to affect all inpatients. The lack of a system to evaluate patients' capacity for self-care had the potential to interfere with the timely discharge of patients. Findings include:</p> <p>1. Patient #13's medical record documented a 68 year old female with ovarian cancer who had surgery to repair a perforated bowel and remove the tumor. She was admitted on 12/27/10 and discharged on 12/30/10. The only note by the Case Manager, dated 12/29/10 at 10:30 AM, stated Patient #13 had been referred for possible placement to a long term acute care hospital. An evaluation of her capacity for self-care or of the possibility of her being cared for in her home environment was not documented.</p> <p>The Case Manager was interviewed on 2/03/11 at 3:00 PM. She confirmed the documentation for Patient #13. She stated a discharge planning evaluation had been done but was not documented.</p> <p>2. Patient #24's medical record documented a 77 year old male who had irrigation and debridement of a right knee wound. He was admitted on 12/21/10 and discharged on 12/29/10. An</p>	A 809	<p>A 809 482.43 (b)(4)</p> <p>Self care Patient Evaluation: The revised Discharge Planning process includes an evaluation of the likelihood of a patient's capacity for self-care or the possibility of the patient being cared for in the environment from which he or she entered the hospital. This evaluation is completed using information obtained from Physical Therapy evaluation, Nursing assessment and high risk screening criteria initiated upon admission. Interview with the patient and the Discharge Planning Nurse using a collaborative multidisciplinary approach is completed. Patients and families are actively involved in the process.</p> <p>The Case Manager/Discharge planning Nurse is responsible for the process, and the Director of Nurses is responsible for maintaining compliance.</p> <p>Completed on 2/10/2011</p>	

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A 809	<p>Continued From page 13</p> <p>evaluation of his capacity for self-care or of the possibility of his being cared for in his home environment was not documented. The only discharge planning note on the record was documented on 12/29/10 at 11:00 AM. It stated "Met [with] pt re: D/C planning. Will have PICC line placed & then return here for Q12 hr [Vancomycin] over the weekend-Pt [illegible]-Will cont. to follow as needed."</p> <p>The Case Manager was interviewed on 2/03/11 at 3:00 PM. She confirmed the documentation for Patient #24. She stated an evaluation of discharge needs had been done but was not documented.</p> <p>3. Patient #23's medical record documented a 65 year old female who had a section of her sigmoid colon removed. She was admitted on 11/24/10 and discharged on 12/15/10. An evaluation of her capacity for self-care or of the possibility of her being cared for in her home environment was not documented. Two discharge planning notes by the Case Manager were documented. The first was dated 12/09/10 and was not timed. It stated the patient had chosen a home health agency for services after discharge. The second note was dated 12/15/10 at 3:00 PM. It stated home health was not appropriate for Patient #23 and she was being admitted to a long term care facility.</p> <p>The Case Manager was interviewed on 2/03/11 at 3:00 PM. She confirmed the documentation for Patient #23. She stated an evaluation of discharge needs had been done but was not documented.</p> <p>4. Patient #28's medical record documented a 58 year old male who had a tracheostomy performed</p>	A 809	<p>A 809</p> <p>Northwest Specialty Hospital monitors the outcome data of patient satisfaction surveys on an ongoing basis. In relation to the question: <i>During your hospital stay, did doctors, nurses or other hospital staff talk with you about whether you would have the help you needed when you left the hospital?</i></p> <p>Outcome data showed an annual score of 493.3 or 98.6% of patients reported satisfaction.</p> <p>Documentation has been improved. With an improved emphasis, the patient with identified needs can be appropriately provided with the necessary resources and assistance required for recovery.</p> <p>The Director of Nurses is responsible for maintaining compliance and monitoring of the process.</p> <p>Completed 2/10/2011</p>	

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A 809	Continued From page 14 to treat sleep apnea. He was admitted on 11/09/10 and discharged on 11/13/10. An evaluation of his capacity for self-care or of the possibility of his being cared for in his home environment was not documented.	A 809		
A 843	The Case Manager was interviewed on 2/09/11 at 11:45 AM. She confirmed the documentation for Patient #28. She stated an evaluation of Patient #28's discharge planning needs had been done but was not completely documented. She stated a much more thorough evaluation of discharge planning needs was done than was documented on all patients. She conceded that a system to ensure a consistent discharge planning evaluation was conducted had not been developed. The hospital failed to evaluate patients' capacity for self-care and the possibility of patients being cared for in their home environment. 482.43(e) REASSESSMENT OF DISCHARGE PLANNING PROCESS The hospital must reassess its discharge planning process on an on-going basis. The reassessment must include a review of discharge plans to ensure that they are responsive to discharge needs. This STANDARD is not met as evidenced by: Based on staff interview and review of quality improvement documents and hospital policies, it was determined the hospital failed to ensure the discharge planning process was reassessed on an on-going basis. This prevented the hospital from identifying deficiencies with its discharge planning process. It also prevented the hospital from determining whether or not staff were	A 843	A 843 482.43(e) Reassessment of Discharge Planning Process Monthly chart audit of 20 high risk patients will be completed, and reviewed by the Performance Improvement to ensure the Discharge planning process is responsive to specific patient needs. Staff education was completed on the identification of high risk patients, and review of the Discharge planning process, most importantly, how it starts with the first patient encounter. Performance Improvement data will be monitored on a monthly basis involving staff in the audit process. The Director of Nurses is responsible for continual compliance and monitoring of the process. Completed 2/10/2011	

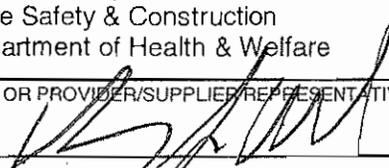
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A 843	Continued From page 15 following its discharge planning policies. Findings include: The hospital's quality improvement program was reviewed with the DON on 2/03/11, beginning at 11:30 AM. The DON stated she was responsible for the hospital's QAPI program. The DON stated discharge plans had not been reviewed in the past year in order to assess the hospital's discharge planning process. The hospital failed to assess the discharge planning process.	A 843	A 843 Discharge planning has been added to the Performance Improvement process using criteria specifically suggested by the CMS surveyors on the January 2011 survey. 20 high risk patient charts will be audited on a monthly basis for appropriate discharge planning process documentation and reported to the Performance Improvement Committee. The audits were initiated in Feb 2011. The Director of Nurses is responsible for the QAPI program. Completed 2//2011	

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K 000	<p>INITIAL COMMENTS</p> <p>Northwest Specialty Hospital is a two story structure with a finished basement and parking garage whose original construction was completed in August of 2003, an addition was added in 2010. The addition included operating rooms and patient rooms, with a parking structure, separated by two hour construction. The construction type is II (222) with a complete automatic fire extinguishing system throughout. The main floor contains approximately 58,000 square feet and is divided into four (4) smoke zones. The basement, which is non-patient use, contains approximately 8,000 square feet in a single smoke zone. The parking garage is approximately 8400 square feet.</p> <p>Fire safety features include complete sprinkler coverage; a fully addressable fire alarm system, a Type I Essential Electrical System; Level 1 piped in medical gas/vacuum systems; multiple exits to grade from the main level; three exits from the basement level with two being to grade; portable fire extinguishers throughout; eight (8) foot wide exit access corridors, four (4) foot wide corridor doors; and three (3) smoke barrier partition walls on the main level.</p> <p>The following deficiencies were found during the Life Safety Code Validation survey conducted on January 31 and February 1, 2011. with applicable fire/life safety requirements set forth under 42 CFR 482.41.</p> <p>The survey was conducted by:</p> <p>Mark P. Grimes, Supervisor Facility Fire Safety & Construction Idaho Department of Health & Welfare</p>	K 000	<p style="text-align: center;">RECEIVED MAR 08 2011 FACILITY STANDARDS</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER/REPRESANTATIVE'S SIGNATURE 	TITLE CEO	(X6) DATE 3/3/11
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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 029	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based upon observation and interview the facility failed to ensure hazardous areas are properly separated. Failure of doors to self close and latch securely allows smoke and gases to spread during a fire event.</p> <p>Findings include:</p> <p>During the facility tour on January 31, 2011 and on February 1, 2011 observation of hazardous areas revealed:</p> <p>1) On January 31, 2011 at approximately 4:18 PM the Kitchen door separating the kitchen from the corridor was found to not self close and positively latch. This finding was witnessed and acknowledged by the Director of Maintenance.</p> <p>2) On January 31, 2011 at approximately 4:25 PM, the Morgue room in the basement was being used as clean linen storage (bagged) while awaiting off site removal. The bags filled the area to waist level creating a hazardous area. The door did not self close and positively latch. This finding was witnessed and acknowledged by the Director of Maintenance.</p> <p>3) On January 31, 2011 at approximately 4:45</p>	K 029	<p>#1) K 029 NFPA 101 Life Safety Code- The Director of Maintenance adjusted the door closer to ensure that the latch engaged securely. Plant Maintenance Manager is responsible for compliance. Completion date: 1/31/2011 To monitor compliance a monthly preventative maintenance form has been created to document function checks of all self closing doors.</p> <p>#2) K 029 NFPA 101- The Director of Maintenance removed the linen bags, adjusted the door to latch properly. This incident resulted as a one time incident related to the transfer of services to a new linen service. Maintenance staff were provided on the spot education as to the importance of maintaining egress and fire safety. Plant Maintenance is responsible for continual compliance. Documentation will occur on previous mentioned form.</p>	

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K 029	Continued From page 2 PM the interior separation wall between the Mechanical room and the electrical room, was not sealed where it intersects the exterior wall. The gap was gradual from minute to nearly 1/2 inch at the top of the wall. Interview with the Director of Maintenance confirmed this wall had not been modified since the original construction in 2003. When light on either side of the wall intersection was shut off light passing through could clearly be seen. 4) On February 1, 2011 at approximately 9:15 AM the storage room across from Patient Room #24 was found to not self close and positively latch. This finding was witnessed and acknowledged by the Director of Maintenance. Actual NFPA reference: NFPA 101, the Life Safety Code, 2000 Edition 18.3.2.1 Hazardous Areas. Any hazardous area shall be protected in accordance with Section 8.4. The areas described in Table 18.3.2.1 shall be protected as indicated.	K 029	#4) K 029 NFPA 101 Life Safety Code- The Director of Maintenance adjusted the door closer to ensure that the latch engaged securely. Plant Maintenance Manager is responsible for compliance. Completion date: 1/31/2011 To monitor compliance a monthly preventative maintenance form has been created to document function checks of all self closing doors.	
K 046	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 18.2.9.1 This STANDARD is not met as evidenced by: Based upon observation and interview the facility failed to ensure emergency lighting devices were maintained in an operational condition. Failure of emergency lighting units can cause disorientation during a fire event or power outage.	K 046		

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K 046	Continued From page 3 Findings include: During the facility tour on February 1, 2011 at approximately 8:25 AM, the battery powered emergency lighting unit mounted on the wall of the Doctor's Lounge in the basement would not operate when tested. This testing was witnessed and acknowledged by the Director of Maintenance, who asked if a non-required emergency light was required to be maintained or could it be removed. Actual NFPA reference: NFPA 101, the Life Safety Code, 2000 Edition 18.2.9.1 Emergency lighting shall be provided in accordance with Section 7.9.	K 046	K 046 NFPA 101 Life Safety Code Standard- The battery pack was replaced by Plant Operations Manager. Completion date 2/1/2011. Compliance will be monitored using the existing monthly monitoring form.	
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. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based upon record review and interview the facility failed to ensure periodic maintenance and testing of the sprinkler system in accordance with NFPA 25. The lack of quarterly maintenance and testing could lead to a malfunction and the absence of an alarm being sounded during an event.	K 062		

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K 062	Continued From page 4 Findings include: Record review indicated annual testing of the sprinkler system was conducted on April 5, 2010 by an outside contractor and five year inspection had been conducted on June 26, 2009, but could produce no records of quarterly waterflow alarm testing. Interview with the Director of Maintenance indicated he was unaware of this requirement. Actual NFPA reference: NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 1998 Edition 2-3.3* Alarm Devices. Waterflow alarm devices including, but not limited to, mechanical water motor gongs, vane-type waterflow devices, and pressure switches that provide audible or visual signals shall be tested quarterly.	K 062	K 062 NFAP Life Safety Code Standard- Water flow alarm testing is now scheduled for quarterly testing, documented on the preventative maintenance form. The Plant Maintenance Manager is responsible for continual compliance. The testing was completed 2/25/2011.	
K 070	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 18.7.8 This STANDARD is not met as evidenced by: Based upon observation and interview the facility failed to ensure portable space heaters located in staff only non sleeping spaces were properly tested to ensure heating elements did not exceed	K 070	K 070 NFPA Life Safety Code Standard - Space heaters have been prohibited in sleeping areas. Policy revision included criteria to measure heating elements to ensure that they do not exceed 212 degrees F. (100 degrees C) upon initial evaluation and application of facility safety sticker. Space heaters will be checked for proper heat limitations on an annual basis. Checks completed 3/3/2011.	

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K 070	<p>Continued From page 5</p> <p>212 degrees Fahrenheit. Failure to test these devices could result in a fire within the facility.</p> <p>Findings include:</p> <p>1) During the facility tour on January 31, 2011 at approximately 4:30 PM, an oil filled portable space heater was discovered in the clean linen side of the laundry, this space is currently being used as a break or record keeping space. Interview with the Director of Maintenance disclosed he was unaware of the device being present and had not tested the unit's surface temperature.</p> <p>2) During the facility tour on February 1, 2011 at approximately 10:45 AM, an electric space heating device was observed in the finance office of the administrative area. The Director of Maintenance disclosed he was unaware of the device being present and had not tested the unit's surface temperature.</p> <p>Actual NFPA reference:</p> <p>NFPA 101 the Life Safety Code, 2000 Edition</p> <p>18.7.8 Portable Space-Heating Devices. Portable space-heating devices shall be prohibited in all health care occupancies. Exception: Portable space-heating devices shall be permitted to be used in nonsleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C).</p>	K 070	<p>K 070 NFPA Life Safety Code Standard - Space heaters have been prohibited in sleeping areas. Policy revision included criteria to measure heating elements to ensure that they do not exceed 212 degrees F. (100 degrees C) upon initial evaluation and application of facility safety sticker. Space heaters will be checked for proper heat limitations on an annual basis.</p> <p>Checks completed 3/3/2011.</p>	
K 147	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p>	K 147		

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K 147	<p>Continued From page 6</p> <p>This STANDARD is not met as evidenced by: Based upon observation and interview the facility failed to ensure adequate electrical receptacles were available thereby preventing the need for extension cords and multi plug adaptors. Failure to ensure the proper circuitry is available can overload circuits and cause a fire.</p> <p>Findings include:</p> <p>During the facility tour on February 1, 2011 at approximately 8:25 AM; observation revealed a computer in the Doctor's lounge in the basement being powered by a relocatable power tap (RPT), powered by a heavy duty extension cord, powered by a multi plug adaptor which was plugged into a duplex wall outlet. The extension cord and RPT were tightly bound with extreme bends by a plastic tie.</p> <p>Actual NFPA reference: NFPA 70, National Electrical Code, 199 Edition 110.3 Examination, Identification, Installation, and Use of Equipment. (A) Examination. In judging equipment, considerations such as the following shall be evaluated: (1) Suitability for installation and use in conformity with the provisions of this Code FPN: Suitability of equipment use may be identified by a description marked on or provided with a product to identify the suitability of the product for a specific purpose, environment, or application. Suitability of equipment may be evidenced by listing or labeling.</p>	K 147	<p>K 147 NFPA 101 Life safety Code Standard-Natl. Elec. Code- NFPA 70- The multi-outlet strip was removed upon discovery. An electrical contractor was consulted, an additional wall outlet was installed 2/7/2011 meeting NFPA 70. Plant Maintenance is responsible for compliance.</p>	

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K 147	<p>Continued From page 7</p> <p>(2) Mechanical strength and durability, including, for parts designed to enclose and protect other equipment, the adequacy of the protection thus provided</p> <p>(3) Wire-bending and connection space</p> <p>(4) Electrical insulation</p> <p>(5) Heating effects under normal conditions of use and also under abnormal conditions likely to arise in service</p> <p>(6) Arcing effects</p> <p>(7) Classification by type, size, voltage, current capacity, and specific use</p> <p>(8) Other factors that contribute to the practical safeguarding of persons using or likely to come in contact with the equipment</p> <p>(B) Installation and Use. Listed or labeled equipment shall be installed and used in accordance with any instructions included in the listing or labeling.</p>	K 147		