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IDAHO DEPARTMENT OF HEALTH & WELFARE

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March 21, 2013

Christopher Noland, Administrator
Benewah Community Hospital
229 South 7th Street
Saint Maries, ID 83861

RE: Benewah Community Hospital, Provider ID# 131317

Dear Mr. Noland:

This is to advise you of the findings of the Medicare/Licensure Fire Life Safety Survey, which was concluded at Benewah Community Hospital, on March 13, 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;

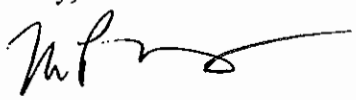
4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,

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.

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 **April 2, 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,



MARK P. GRIMES
Supervisor
Facility Fire Safety and Construction Program

MPG/nw

Enclosure

Printed: 03/20/2013
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 B. WING	(X3) DATE SURVEY COMPLETED
	131317		03/13/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEWAH COMMUNITY HOSPITAL	229 SOUTH 7TH STREET SAINT MARIES, ID 83861

(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 000	INITIAL COMMENTS The hospital is a four story Type II (222) structure separated by two hour construction to the original single story hospital building. The entire hospital is protected throughout by an automatic fire extinguishing system design/installed per NFPA Std 13 for light hazard occupancy and has a supervised manual fire alarm system with partial detection. The following deficiencies were cited at the above facility during a recertification survey conducted on March 13, 2013. The facility was surveyed under the Life Safety Code, 2000 Edition, New Health Care Occupancies in accordance with 42 CFR 482.41(b) The life safety survey was conducted by: Mark P. Grimes, Supervisor Facility Fire Safety and Construction Program	K 000	RECEIVED APR 11 2013 FACILITY STANDARDS	
K 012	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following: 18.1.6.2, 18.1.6.3, 18.2.6.1 This Standard is not met as evidenced by: Based upon observation and interview the facility failed to ensure proper smoke barrier protection between the first and second floors and second and third floors. This deficient practice could allow smoke on one floor to move into and through smoke compartments on multiple floors. The facility is licensed for 19 beds and had a census of six on the day of the survey, this practice affected all patients and staff.	K 012	K012 -Identified personnel: No patients were affected but patients and staff had the potential to be affected. K012-Corrective Actions: The smoke penetrations identified in tower mechanical rooms between 1st and 2nd, and 2nd and 3rd floors were not effectively sealed during construction and will be corrected and sealed by Polin and Young Construction. Penetrations are above and below in mechanical rooms. K012-Ongoing Compliance: The Facility Manager will continue to monitor the construction activities to ensure items are properly completed. K012-Quality Assurance: The Facility Manager has in place a preventive maintenance monthly schedule to identify and correct any fire or smoke penetrations. Work orders will be assigned and closed out every 30 days.	4/9/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	CEO	4/11/13

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 Findings include: During the tour of the facility on March 13, 2013 between 11:30 AM and 5:30 PM observation revealed unsealed conduits located in the electrical rooms on the second floor and first floor communicated between floors, when observed with the room light out, visible light was observed from the adjacent floors above or below, these gaps could allow smoke to migrate prior to heat from a fire to cause the intumescent seals activating. When asked about the unsealed penetrations, the Facility Manager, stated he had been told that the intumescent assemblies where adequate, although he questioned that protection would provide smoke barrier protection. Actual NFPA Standard: 18.3.7.3 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 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. 8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as	K 012		

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K 012	Continued From page 2 follows: (1) The space between the penetrating item and the smoke barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (2) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (3) Where designs take transmission of vibration into consideration, any vibration isolation shall meet one of the following conditions: a. It shall be made on either side of the smoke barrier. b. It shall be made by an approved device that is designed for the specific purpose.	K 012		
K 029	NFPA 101 LIFE SAFETY CODE STANDARD 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 This Standard is not met as evidenced by: Based upon observation and interview the facility failed to ensure hazardous areas doors were self	K 029	K029-Identified personnel: No patients were affected but patients and staff had the potential to be affected in the OR corridor.	4/19/13

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K 029	Continued From page 3 closing. This deficient practice could allow smoke and gases to enter an exit access corridor or suite affecting egress. The facility is licensed for 19 and had a census of six on the day of the survey. Findings include: During the facility tour on March 13, 2013 at approximately 4:30 PM observation revealed the doors protecting the soiled workroom and clean workroom within the surgical suite were not self-closing or automatic closing. Interview with the Facility Manager revealed the facility was unaware the doors were not self closing. See K056 also. Actual NFPA standard: 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. 8.4.1.1* Protection from any area having a degree of hazard greater than that normal to the general occupancy of the building or structure shall be provided by one of the following means: (1) Enclose the area with a fire barrier without windows that has a 1-hour fire resistance rating in accordance with Section 8.2. (2) Protect the area with automatic extinguishing systems in accordance with Section 9.7. (3) Apply both 8.4.1.1(1) and (2) where the hazard is severe or where otherwise specified by Chapters 12 through 42. 8.4.1.3	K 029	K029-Corrective Actions: Doors to soiled and cleaned work rooms within the surgical suite require door closers since installation of a new autoclave. Benewah Engineers will install door closers on these doors and a preventive maintenance monthly schedule will ensure positive latching. K029-Ongoing Compliance: The Facility Manager will continue to monitor the preventive maintenance activities to ensure items are properly completed and in compliance. K029-Quality Assurance: The Facility Manager has in place a preventive maintenance monthly schedule to identify and correct any fire or smoke door that does not have positive latching. Work orders will be assigned and closed out every 30 days.	4/19/13

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K 029	Continued From page 4 Doors in barriers required to have a fire resistance rating shall have a 3/4-hour fire protection rating and shall be self-closing or automatic-closing in accordance with 7.2.1.8.	K 029		
K 038	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1 This Standard is not met as evidenced by: Based upon observation and interview the facility failed to ensure immediate access to not less than two exits at all times. Failure to provide at least two means of egress could allow people to become trapped. This deficient practice potentially affected any nighttime emergency room patients and visitors. The facility is licensed for 19 and had a census of six on the day of the survey. Findings include: During the facility tour on March 13, 2013 at approximately 2:00 PM, observation and interview revealed the exit access corridor off the Emergency Department waiting area was locked after public hours, leaving only a single exit from the waiting area and corridor. Access doors to the ED exit access corridor, and the Main lobby exit access are locked by card reader locks after hours creating looked dead ends. The Facility Manager acknowledged being aware of this situation and stated he was working with contractors to correct it. Actual NFPA Standards:	K 038	K038-Identified personnel: No patients were affected but patients and staff had the potential to be affected in the ED corridor after lobby normal operating hours. K038-Corrective Actions: Emergency Department doors will have delayed egress panic bars as listed in exception # 2 allowing such doors as long as complying with 7.2.1.6.1. Polin and Young Construction has been authorized to revise doors to meet code requirements as we are still in close out phase of construction project. K038-Ongoing Compliance: The Facility Manager will continue to monitor the preventive maintenance activities to ensure items such as egress doors are in compliance.	5/17/13

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K 038	Continued From page 5 18.2.1 General. Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7. Exception: As modified by 18.2.2 through 18.2.11. 18.2.5.1 Every habitable room shall have an exit access door leading directly to an exit access corridor. Exception No. 1: If there is an exit door opening directly to the outside from the room at ground level. Exception No. 2: Exit access from a patient sleeping room with not more than eight patient beds shall be permitted to pass through one intervening room to reach the exit access corridor. Exception No. 3: Exit access from a special nursing suite shall be permitted to pass through one intervening room to reach the exit access corridor where the arrangement allows for direct and constant vistial supervision by nursing personnel. Exception No. 4: Exit access from a suite of rooms, other than patient sleeping rooms, shall be permitted to pass through not more than two adjacent rooms to reach the exit access corridor where the travel distance within the suite is in accordance with 18.2.5.8. 18.2.5.9 Every corridor shall provide access to not less than two approved exits in accordance with Sections 7.4 and 7.5 without passing through any intervening rooms or spaces other than corridors or lobbies. 18.2.2.2.4	K 038	K038-Quality Assurance: The Facility Manager has in place a preventive maintenance monthly schedule to identify and correct any fire or smoke door that does not have positive latching. Egress doors are inventoried and monitored.	5/17/13

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K 038	Continued From page 6 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1: Door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. (See 18.7.1.1.5 and 18.2.2.2.6.) Exception No. 2: Delayed-egress locks complying with 7.2.1.6.1 shall be permitted, provided that not more than one such device is located in any egress path. Exception No. 3: Access-controlled egress doors complying with 7.2.1.6.2 shall be permitted.	K 038	K038-Quality Assurance: The Facility Manager has in place a preventive maintenance monthly schedule to identify and correct any fire or smoke door that does not have positive latching. Egress doors are inventoried and monitored.	5/17/13
K 050	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2 This Standard is not met as evidenced by: Based upon record review and interview conducted on March 18, 2013 the facility failed to ensure fire drills were conducted at least once per shift per quarter during the last 12 months. Failure to train personnel in emergency procedures could result in panic and confusion in a true emergency. The facility is licensed for 19	K 050	K050-Identified personnel: No patients were affected but patients and staff had the potential to be affected in the event of a fire alarm. K050-Corrective Actions: Fire drills have been scheduled and conducted since October 1, 2012 on a regular basis. Facility Manager was hired and reported for work Oct 1, 2012. Records before this date were inadequate.	3/13/13

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K 050	Continued From page 7 beds and had a census of six on the day of the survey. Findings include: During the record review conducted on March 13, 2013 records were not available to demonstrate that drills were conducted at least once per shift, per quarter. No records could be located to document any drills were conducted during the second and third quarter of 2012. when questioned the facility manager could not produce drill records for the missing quarters. This deficient practice was acknowledged by the Facility Manager. Actual NFPA standard: 18.7.1.2* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building.	K 050	K050-Ongoing Compliance: The Facility Manager will continue to monitor the preventive maintenance activities to ensure items such as fire drills are in compliance. K050-Quality Assurance: The Facility Manager has in place a preventive maintenance monthly schedule to identify and correct any fire system failure. Preventive Maintenance schedule has been generated and is documented monthly for fire drills.	3/13/13
K 056	NFPA 101 LIFE SAFETY CODE STANDARD There is an automatic sprinkler system, installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, with approved components, devices, and equipment, to provide	K 056	K056-Identified personnel: No patients were affected but patients and staff had the potential to be affected in the event of a fire within the OR corridor.	4/15/13

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K 056	Continued From page 8 complete coverage of all portions of the facility. The system is maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. There is a reliable, adequate water supply for the system. The system is equipped with waterflow and tamper switches which are connected to the fire alarm system. 18.3.5. This Standard is not met as evidenced by: Based upon observation and interview the facility failed to ensure automatic sprinkler protection was provided in accordance with NFPA 13 standards. Failure to ensure automatic sprinkler protection can result in rapid fire growth and injuries. The facility is licensed for 19 beds and had a census of six on the day of the survey. Findings include: 1) During the tour on March 13, 2013 at approximately 4:30 PM, observation revealed a newly created sterilizer closet created between the soiled and clean workroom in the surgical suite, the new space was not protected by automatic sprinklers. During a discussion of the space, the Facility Manager stated he was unaware that this new space was not afforded coverage by the building sprinkler system. See K029 also. Actual NFPA standard: NFPA 13, Standards for the Installation of	K 056	K056-Corrective Actions: Installation of a new autoclave during construction did not include engineered plans from M and W Engineering to add additional sprinkler coverage above autoclave. Item has been scheduled with Patriot Fire to install sprinkler heads by Facility Manager. K056-Ongoing Compliance: The Facility Manager will continue to monitor the preventive maintenance activities to ensure items such as fire sprinklers are inspected and in compliance. K056-Quality Assurance: The Facility Manager has in place a preventive maintenance monthly schedule to identify and correct any fire system failure. Preventive Maintenance schedule has been generated and is documented monthly for fire sprinklers.	4/15/13

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K 056	Continued From page 9 Sprinkler Systems 1999 Edition Finding 1) 5-1* Basic Requirements. 5-1.1* The requirements for spacing, location, and position of sprinklers shall be based on the following principles: (1) Sprinklers installed throughout the premises (2) Sprinklers located so as not to exceed maximum protection area per sprinkler (3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution Exception No. 1: For locations permitting omission of sprinklers, see 5-13.1, 5-13.2, and 5-13.9. Exception No. 2: When sprinklers are specifically tested and test results demonstrate that deviations from clearance requirements to structural members do not impair the ability of the sprinkler to control or suppress a fire, their positioning and locating in accordance with the test results shall be permitted. Exception No. 3: Clearance between sprinklers and ceilings exceeding the maximum specified in 5-6.4.1, 5-7.4.1, 5-8.4.1, 5-9.4.1, 5-10.4.1, and 5-11.4.1 shall be permitted provided that tests or calculations demonstrate comparable sensitivity and performance of the sprinklers to those installed in conformance with these sections.	K 056		
K 147	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2 This Standard is not met as evidenced by: Based upon observation and interview the facility	K 147		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 B. WING	(X3) DATE SURVEY COMPLETED
	131317		03/13/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEWAH COMMUNITY HOSPITAL	229 SOUTH 7TH STREET SAINT MARIES, ID 83861

(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 147	Continued From page 10 failed to ensure electrical safety in accordance with NFPA 99 and 70. The facility failed to ensure the safe use and selection of electrical equipment The facility is licensed for 10 beds and had a census of six, all kitchen and surgical staff were affected by this deficient practice. Findings include: 1) During the facility tour on March 13, 2013 at 5:06 PM observation revealed; four electrical panels in the kitchen hallway across from the warewashing area; the panel switches were exposed and not covered or guarded by an enclosure or secured from tampering, was openly exposed to a wet area approximately six feet away, and had a trash receptacle stored in front of one panel. The circuit breakers were openly exposed to the hallway with no enclosure to prevent tampering or reflect splashing water from the warewash area. Panel boards are required to be enclosed and guarded, with clear access. When asked about the electrical panels, the Facility Manager stated he had been told that the panels were ok because they were in a locked room. 2) During the facility tour on March 13, 2013 at approximately 3:30 PM observation of the recovery room revealed an extension cord, plugged into an outlet and run through a hole in a cabinet to power a sump style pump from the ice maker drain. The extension cord was taped to the pump wiring plug to prevent it from being pulled loose. Interview with the Facility Manager indicated he was unaware of the extension cord being used. 3) During the facility tour on March 13, 2013 at approximately 4:00 PM, observation of Operating	K 147	K147-ITEM 1. Identified personnel: No patients were affected but staff had the potential to be affected in the event of an electrical issue with the open electrical panel in the kitchen area. K147-Corrective Actions: Installation of a new electrical service panel during construction did not include engineered plans from M and W Engineering to add a cover for the kitchen electrical panel. Polin and Young has agreed to cover this installation with construction reserve funds. K147-Ongoing Compliance: The Facility Manager will continue to monitor the preventive maintenance activities to ensure items such as electrical safety. K147-Quality Assurance: The Facility Manager has in place a safety rounding schedule to identify and correct any safety related issues regarding compliance. The Management Team will conduct monthly rounds for safety and forward documents and findings to CEO and Board.	5/17/13

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K 147	Continued From page 11 Room 2, revealed two (2) heavy duty yellow 30 amp relocatable power taps (RPT) powering patient care equipment. There was no identifying UL listing marks or tags identifying the RPT's as being listed for use with patient care equipment. Interview with the Facility Manager revealed he was unaware the RPT's were not listed for patient care use. Actual NFPA standards: NFPA 70 National Electrical Code, 1999 Finding 1 240.30 General. (A) Protection from Physical Damage. Overcurrent devices shall be protected from physical damage by one of the following: (1) Installation in enclosures, cabinets, cutout boxes, or equipment assemblies (2) Mounting on open-type switchboards, panelboards, or control boards that are in rooms or enclosures free from dampness and easily ignitible material and are accessible only to qualified personnel. (B) Operating Handle. The operating handle of a circuit breaker shall be permitted to be accessible without opening a door or cover. 240.32 Damp or Wet Locations. Enclosures for overcurrent devices in damp or wet locations shall comply with 312.2(A). 110.26 Spaces About Electrical Equipment. Sufficient access and working space shall be provided and maintained about all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons.	K 147		

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K 147	Continued From page 12 (A) Working Space. Working space for equipment operating at 600 volts, nominal, or less to ground and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A)(1), (2), and (3) or as required or permitted elsewhere in this Code. (1) Depth of Working Space. The depth of the working space in the direction of live parts shall not be less than that specified in Table 110.26(A)(1) unless the requirements of 110.26(A)(1)(a), (b), or (c) are met. Distances shall be measured from the exposed live parts or from the enclosure or opening if the live parts are enclosed. Table 110.26(A)(1) Working Spaces Nominal Voltage to Ground - Minimum Clear Distance Condition 1 - Condition 2 - Condition 3 0-150 900 mm (3 ft) 900 mm (3 ft) 900 mm (3 ft) 151-600 900 mm (3 ft) 1 m (3½ ft) 1.2 m (4 ft) Finding 2 110.3 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. (2) Mechanical strength and durability, including, for parts designed to enclose and protect other	K 147	K147-ITEM 2. Identified personnel: No patients were affected but staff and patients had the potential to be affected in the event of an electrical issue with the extension cord being utilized on the ice machine. K147-Corrective Actions BCH Journeyman Electrician rewired the ice machine in order to alleviate the need for an extension cord. K147-Ongoing Compliance: The Facility Manager will continue to monitor the preventive maintenance activities to ensure items such as electrical safety. K147-Quality Assurance: The Facility Manager has in place a safety rounding schedule to identify and correct any safety related issues regarding compliance. The Management Team will conduct monthly rounds for safety and forward documents and findings to CEO and Board.	3/13/13

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K 147	Continued From page 13 equipment, the adequacy of the protection thus provided (3) Wire-bending and connection space (4) Electrical insulation (5) Heating effects under normal conditions of use and also under abnormal conditions likely to arise in service (6) Arcing effects (7) Classification by type, size, voltage, current capacity, and specific use (8) Other factors that contribute to the practical safeguarding of persons using or likely to come in contact with the equipment (B) Installation and Use. Listed or labeled equipment shall be installed and used in accordance with any instructions included in the listing or labeling. Finding 3 Actual NFPA Standards: NFPA 99 Standard for Health Care Facilities 1999 Edition 8-3.2.1.2 All Patient Care Areas. Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters. NFPA 70 National Electrical Code 1999 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	K 147	K147-ITEM 3. identified personnel: No patients were affected but staff and patients had the potential to be affected in the event of an electrical issue with the extension cord and non UL listed power supplies being utilized in the OR. K147-Corrective Actions BCH Journeyman Electrician removed the non-UL listed power supplies, and ensured that OR Manager had adequate outlets on the wall for all of the equipment. If required for use, all power taps will meet UL 1363 K147-Ongoing Compliance: The Facility Manager will continue to monitor the safety rounding activities to ensure items such as electrical safety are observed. K147-Quality Assurance: The Facility Manager has in place a safety rounding schedule to identify and correct any safety related issues regarding compliance and forward documents and findings to CEO and Board.	3/13/13

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K 147	Continued From page 14 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 labelling. 2. Mechanical strength and durability, including, for parts designed to enclose and protect other equipment, the adequacy of the protection thus provided 3. Wire-bending and connection space 4. Electrical insulation 5. Heating effects under normal conditions of use and also under abnormal conditions likely to arise in service 6. Arcing effects 7. Classification by type, size, voltage, current capacity, and specific use 8. Other factors that contribute to the practical safeguarding of persons using or likely to come in contact with the equipment (b) Installation and Use. Listed or labeled equipment shall be installed and used in accordance with any instructions included in the listing or labelling. UL 1363 RELOCATABLE POWER TAPS (XBYS) Relocatable Power TapsXBYS USE AND INSTALLATION This category covers relocatable power taps rated 250 V ac or less, 20 A or less. They are intended for indoor use as relocatable multiple outlet extensions of a single branch circuit to supply laboratory equipment, home workshops, home movie lighting controls, musical instrumentation, and to provide outlet receptacles for computers, audio and video equipment, and other equipment. They consist of one attachment plug and a single length of flexible cord	K 147		

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K 147	Continued From page 15 terminated in a single enclosure in which one or more receptacles are mounted. They may, in addition, be provided with fuses or other supplementary overcurrent protection, switches, suppression components and/or indicator lights in any combination, or connections for cable, communications, telephone and/or antenna. Relocatable power taps are intended to be directly connected to a permanently installed branch circuit receptacle. Relocatable power taps are not intended to be series connected (daisy chained) to other relocatable power taps or to extension cords. Relocatable power taps are not intended for use at construction sites and similar locations. Relocatable power taps are not intended to be permanently secured to building structures, tables, work benches or similar structures, nor are they intended to be used as a substitute for fixed wiring. The cords of relocatable power taps are not intended to be routed through walls, windows, ceilings, floors or similar openings. Relocatable power taps have not been investigated and are not intended for use with general patient care areas or critical patient care areas of health care facilities as defined in Article 517 of ANSI/NFPA 70, "National Electrical Code."	K 147		

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B 000	16.03.14 Initial Comments The hospital is a four story Type II (222) structure separated by two hour construction to the original single story hospital building. The entire hospital is protected throughout by an automatic fire extinguishing system design/installed per NFPA Std 13 for light hazard occupancy and has a supervised manual fire alarm system with partial detection. The following deficiencies were cited at the above facility during a recertification survey conducted on March 13, 2013. The facility was surveyed under the Life Safety Code, 2000 Edition, New Health Care Occupancies in accordance with 42 CFR 482.41(b) and IDAPA 16.03.14 Rules and Minum Standards for Hospitals in Idaho. The life safety survey was conducted by: Mark P. Grimes, Supervisor Facility Fire Safety and Construction Program	B 000	K012-Identified personnel: No patients were affected but patients and staff had the potential to be affected. K012-Corrective Actions: The smoke penetrations identified in tower mechanical rooms between 1st and 2nd, and 2nd and 3rd floors were not effectively sealed during construction and will be corrected and sealed by Polin and Young Construction. Penetrations are above and below in mechanical rooms. K012-Ongoing Compliance: The Facility Manager will continue to monitor the construction activities to ensure items are properly completed. K012-Quality Assurance: The Facility Manager has in place a preventive maintenance monthly schedule to identify and correct any fire or smoke penetrations. Work orders will be assigned and closed out every 30 days.	4/9/13
BB161	16.03.14.510 Fire and Life Safety Standards 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: The hospital shall be structurally sound and shall be maintained and equipped to assure the safety of patients, employees, and the public. On the premises of all hospitals where natural or man-made hazards are present, suitable fences, guards, and railings shall be provided to protect patients, employees, and the public. This RULE: is not met as evidenced by:	BB161	K029-Identified personnel: No patients were affected but patients and staff had the potential to be affected in the OR corridor.	4/19/13

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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	TITLE	(X6) DATE
[signature]	CEO	4/11/13

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NAME OF PROVIDER OR SUPPLIER BENEWAH COMMUNITY HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 229 SOUTH 7TH STREET SAINT MARIES, ID 83861		

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BB161	Continued From Page 1 Refer to the following deficiencies identified on Federal Form 2567 K 0012 Smoke Barrier Penetrations K 0029 Hazardous Areas K 0038 Locked Exit Access K 0050 Fire Drills K 0056 Lack of Sprinkler Protection K 0147 Electrical Safety	BB161	K029-Corrective Actions: Doors to soiled and cleaned work rooms within the surgical suite require door closers since installation of a new autoclave. Benewah Engineers will install door closers on these doors and a preventive maintenance monthly schedule will ensure positive latching. K029-Ongoing Compliance: The Facility Manager will continue to monitor the preventive maintenance activities to ensure items are properly completed and in compliance. K029-Quality Assurance: The Facility Manager has in place a preventive maintenance monthly schedule to identify and correct any fire or smoke door that does not have positive latching. Work orders will be assigned and closed out every 30 days.	4/19/13
			K038-Identified personnel: No patients were affected but patients and staff had the potential to be affected in the ED corridor after lobby normal operating hours.	5/17/13

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

Continuation from sheet 2 of 2

Provider's Plan of Correction (Each corrective action should be cross-referenced to the appropriate deficiency)	Completion Date
K038-Corrective Actions: Emergency Department doors will have delayed egress panic bars as listed in exception # 2 allowing such doors as long as complying with 7.2.1.6.1. Polin and Young Construction has been authorized to revise doors to meet code requirements as we are still in close out phase of construction project.	5/17/13
K038-Ongoing Compliance: The Facility Manager will continue to monitor the preventive maintenance activities to ensure items such as egress doors are in compliance:	
K038-Quality Assurance: The Facility Manager has in place a preventive maintenance monthly schedule to identify and correct any fire or smoke door that does not have positive latching. Egress doors are inventoried and monitored.	
K050-Identified personnel: No patients were affected but patients and staff had the potential to be affected in the event of a fire alarm.	3/13/13
K050-Corrective Actions: Fire drills have been scheduled and conducted since October 1, 2012 on a regular basis. Facility Manager was hired and reported for work Oct 1, 2012. Records before this date were inadequate.	
K050-Ongoing Compliance: The Facility Manager will continue to monitor the preventive maintenance activities to ensure items such as fire drills are in compliance.	
K050-Quality Assurance: The Facility Manager has in place a preventive maintenance monthly schedule to identify and correct any fire system failure. Preventive Maintenance schedule has been generated and is documented monthly for fire drills.	
K056-Identified personnel: No patients were affected but patients and staff had the potential to be affected in the event of a fire within the OR corridor.	4/15/13
K056-Corrective Actions: Installation of a new autoclave during construction did not include engineered plans from M and W Engineering to add additional sprinkler coverage above autoclave. Item has been scheduled with Patriot Fire to install sprinkler heads by Facility Manager.	
K056-Ongoing Compliance: The Facility Manager will continue to monitor the preventive maintenance activities to ensure items such as fire sprinklers are inspected and in compliance.	
K056-Quality Assurance: The Facility Manager has in place a preventive maintenance monthly schedule to identify and correct any fire system failure. Preventive Maintenance schedule has been generated and is documented monthly for fire sprinklers.	

Continuation from sheet 2 of 2

Provider's Plan of Correction (Each corrective action should be cross-referenced to the appropriate deficiency)	Completion Date
K147-ITEM 1. Identified personnel: No patients were affected but staff had the potential to be affected in the event of an electrical issue with the open electrical panel in the kitchen area.	5/17/13
K147-Corrective Actions: Installation of a new electrical service panel during construction did not include engineered plans from M and W Engineering to add a cover for the kitchen electrical panel. Polin and Young has agreed to cover this installation with construction reserve funds.	
K147-Ongoing Compliance: The Facility Manager will continue to monitor the preventive maintenance activities to ensure items such as electrical safety.	
K147-Quality Assurance: The Facility Manager has in place a safety rounding schedule to identify and correct any safety related issues regarding compliance. The Management Team will conduct monthly rounds for safety and forward documents and findings to CEO and Board.	
K147-ITEM 2. Identified personnel: No patients were affected but staff and patients had the potential to be affected in the event of an electrical issue with the extension cord being utilized on the ice machine.	3/13/13
K147-Corrective Actions BCH Journeyman Electrician rewired the ice machine in order to alleviate the need for an extension cord.	
K147-Ongoing Compliance: The Facility Manager will continue to monitor the preventive maintenance activities to ensure items such as electrical safety.	
K147-Quality Assurance: The Facility Manager has in place a safety rounding schedule to identify and correct any safety related issues regarding compliance. The Management Team will conduct monthly rounds for safety and forward documents and findings to CEO and Board.	
K147-ITEM 3. Identified personnel: No patients were affected but staff and patients had the potential to be affected in the event of an electrical issue with the extension cord and non UL listed power supplies being utilized in the OR.	3/13/13
K147-Corrective Actions BCH Journeyman Electrician removed the non-UL listed power supplies, and ensured that OR Manager had adequate outlets on the wall for all of the equipment. If required for use, all power taps will meet UL 1363	
K147-Ongoing Compliance: The Facility Manager will continue to monitor the safety rounding activities to ensure items such as electrical safety are observed.	
K147-Quality Assurance: The Facility Manager has in place a safety rounding schedule to identify and correct any safety related issues regarding compliance and forward documents and findings to CEO and Board.	