

COPY



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

IDAHO DEPARTMENT OF
HEALTH & WELFARE

DEBBY RANSOM, R.N., R.H.I.T. – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

March 21, 2013

Louis Kraml, Administrator
Idaho Doctors Hospital
350 North Meridian Street
Blackfoot, ID 83221

RE: Idaho Doctors Hospital, Provider ID# 130067

Dear Mr. Kraml:

This is to advise you of the findings of the Medicare/Licensure Fire Life Safety Survey, which was concluded at Idaho Doctors Hospital, on March 14, 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.

Louis Kraml, Administrator
March 21, 2013
Page 2 of 2

After each deficiency has been answered and dated, the administrator should sign both the CMS Form 2567 and State Form in the spaces provided on the bottom of the first pages of each of the respective forms and return the originals to this office by **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.

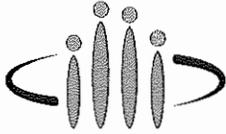
Sincerely,

A handwritten signature in black ink, appearing to read 'MPG', followed by a long horizontal flourish.

MARK P. GRIMES
Supervisor
Facility Fire Safety and Construction Program

MPG/nw

Enclosure



BINGHAM MEMORIAL HOSPITAL

Your Health, Your Community, Your Hospital

98 Poplar Street
Blackfoot, Idaho 83221
208.785.4100
208.785.3806 - fax
www.binghammemorial.org

April 1, 2013

Attention: Mark Grimes

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APR 02 2013

FACILITY STANDARDS

Dear Mr. Grimes,

I have attached the Plan of Correction for the Fire and Life Survey for Idaho Doctors Hospital on March 13-14, 2013. If you need anything else please feel free to contact me.

We greatly appreciated the professionalism and courtesies Taylor extended to the staff during his visit. It was greatly appreciated by them all.

Sincerely,

Jason Jensen
Administrator- Skilled Nursing & Rehabilitation
208-785-4101

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

Printed: 03/19/2013
FORM APPROVED
OMB NO. 0938-0391

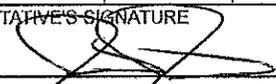
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130067	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/14/2013
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NAME OF PROVIDER OR SUPPLIER IDAHO DOCTORS HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 350 NORTH MERIDIAN STREET BLACKFOOT, ID 83221
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	INITIAL COMMENTS The hospital is a 11,000 s.f. single story, protected wood frame structure. Construction of the hospital commenced in early 2003 and was completed in March 2004. The initial license was issued on July 12, 2004 for eight (8) beds. The building is protected throughout by an automatic fire extinguishing system designed/installed per NFPA Std 13 for a light hazard occupancy. A complete, addressable fire alarm system, including smoke detection throughout, is provided and the system is off-site monitored. Emergency power is supplied by an on-site diesel powered generator set designed/installed per NFPA Std 99 for a Type 1 Essential Electrical System. Piped in medical gasses and vacuum are provided. There is a single smoke barrier partition wall the sub-divides the building into two (2) smoke compartments. There are two (2) remote exits directly to grade as well as a main entry to the hospital. The following deficiencies were cited during the Life Safety Code survey conducted on March 13 and 14, 2013. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, New Health Care Occupancy, adopted 11 March, 2003 in accordance with 42 CFR 482.41 The surveyor conducting the survey was: Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction	K 000		
K 025	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one-hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are	K 025	K025 Identified Residents: All residents, visitors, and staff members were identified to be effected.	4/12/13

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FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator-SNF	(X6) DATE 4/1/13
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

Printed: 03/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130067	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/14/2013
NAME OF PROVIDER OR SUPPLIER IDAHO DOCTORS HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 350 NORTH MERIDIAN STREET BLACKFOOT, ID 83221		
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K 025	Continued From page 1 protected by fire-rated glazing or by wired glass panels in approved frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 18.3.7.3, 18.3.7.5, 18.1.6.3 This Standard is not met as evidenced by: Based on observation and interview the facility did not ensure that smoke barriers were constructed and maintained to provide at least a one-hour fire resistance rating. Openings in smoke barriers can allow smoke and fire gasses to enter other smoke compartments in the event of a fire. Findings include: During the tour of the facility on March 14, 2013 at 8:39 AM, observation of the smoke wall above the smoke doors by room #136 revealed two holes in the wall that were each approximately one inch in size. When questioned about the penetrations the Maintenance Supervisor stated that the openings had been created for IT cabling to pass through and had not been sealed.	K 025	Corrective Action: The holes in the smoke wall above the smoke doors by room #136 were sealed with 3M Fire Barrier Caulk. Ongoing Compliance: The Engineering Director and/or designee will randomly audit 2 areas per week for any penetrations of walls. Quality Assurance: The Engineering Director and/or designee will monitor for compliance. Areas of concern will be addressed as needed PRN or at monthly QA(Quality Assurance) meeting.	
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	K 029	K029 Identified Residents: All residents, visitors, and staff members were identified to be effected.	4/12/13

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K 029	Continued From page 2 This Standard is not met as evidenced by: Based on observation and interview the facility did not ensure that hazardous areas were constructed and maintained to provide at least a one-hour fire resistance rating. Openings in hazardous areas can allow smoke and fire gasses to escape the room in the event of a fire occurring in the hazardous area. Findings include: During the tour of the facility on March 14, 2013 at 9:09 AM, observation of the electrical room revealed a hole in the wall near the ceiling that was approximately four inches in size. When questioned about the penetration the Maintenance Supervisor stated that the opening had been created for IT cabling to pass through and had not been sealed.	K 029	Corrective Action: The hole in the wall near the ceiling of the electrical room was sealed with 3M Fire Barrier Caulk. Ongoing Compliance: The Engineering Director and/or designee will randomly audit 2 hazardous areas per week for any penetrations of walls. Quality Assurance: The Engineering Director and/or designee will monitor for compliance. Areas of concern will be addressed as needed PRN or at monthly QA(Quality Assurance) meeting.	
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 on record review and interview it was determined that the facility had not ensured that the automatic fire sprinkler system was being maintained in accordance with NFPA 25. Proper automatic fire sprinkler system maintenance helps to ensure system reliability.	K 062	K062 Identified Residents: All residents, visitors, and staff members were identified to be effected. Corrective Action: The 5-year fire sprinkler system internal obstruction investigation inspection was completed on 3/18/13. Ongoing Compliance: The Engineering Director and/or designee will put onto a schedule when the next 5-year inspection will be due in accordance with NFPA 25.	4/12/13

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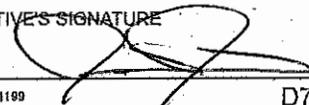
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K 062	<p>Continued From page 3 The findings include:</p> <p>During record review on March 13, 2013 at 3:59 PM, the facility was unable to produce a documented 5-year sprinkler system internal obstruction investigation inspection. When questioned about the 5-year inspection the Maintenance Supervisor stated that he was unable to produce any further documentation.</p> <p>Actual NFPA Standard:</p> <p>NFPA 101® Life Safety Code © 2000 Edition 9.7.5 Maintenance and Testing. All automatic sprinkler and standpipe systems required by this Code shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems.</p> <p>NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems 1998 Edition</p> <p>2-2 Inspection. Gauges Test 5 years Obstruction investigation Maintenance 5 years or as needed</p>	K 062	<p>Quality Assurance: The Engineering Director and/or designee will monitor for compliance. Areas of concern will be addressed as needed PRN or at monthly QA(Quality Assurance) meeting.</p>	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130067	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/14/2013
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B 000	16.03.14 Initial Comments The hospital is a 11,000 s.f. single story, protected wood frame structure. Construction of the hospital commenced in early 2003 and was completed in March 2004. The initial license was issued on July 12, 2004 for eight (8) beds. The building is protected throughout by an automatic fire extinguishing system designed/installed per NFPA Std 13 for a light hazard occupancy. A complete, addressable fire alarm system, including smoke detection throughout, is provided and the system is off-site monitored. Emergency power is supplied by an on-site diesel powered generator set designed/installed per NFPA Std 99 for a Type 1 Essential Electrical System. Piped in medical gasses and vacuum are provided. There is a single smoke barrier partition wall the sub-divides the building into two (2) smoke compartments. There are two (2) remote exits directly to grade as well as a main entry to the hospital. The following deficiencies were cited during the Life Safety Code survey conducted on March 13 and 14, 2013. The facility was surveyed under IDAPA 16.03.14 Rules and Minimum Standards for Hospitals in Idaho. The survey was conducted by: Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction	B 000		
BB169	16.03.14.520.02 Drills The plan shall be rehearsed annually. This Rule is not met as evidenced by: Based upon record review and interview, it was determined that the facility failed to ensure that the facility conducted an annual disaster drill. This	BB169	BB169 Identified Residents: All residents, visitors, and staff members were identified to be effected.	4/12/13

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Idaho form
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE Administrator-SNF (X6) DATE 4/11/13

STATE FORM 021199 D78R21 If continuation sheet 1 of 2

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130067	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/14/2013
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BB169	Continued From Page 1 deficiency has the potential for the facility's inability to effectively manage the care, health and safety of patients and other individuals when a major disruptive event may occur. Findings include: During record review of the facility's disaster plan on March 13, 2013 at 3:15 PM, it was revealed that there was not a documented annual disaster drill. When questioned about the disaster plan and a lack of a documented annual drill the Facility manager stated that he was unaware that the facility was required to conduct an annual drill in accordance with the facility's disaster plan.	BB169	Corrective Action: The facility conducted an annual disaster drill on 3/28/13. Ongoing Compliance: The Engineering Director and/or designee will schedule a disaster drill each year for the facility. Quality Assurance: The Engineering Director and/or designee will monitor for compliance. Areas of concern will be addressed as needed PRN or at monthly QA(Quality Assurance) meeting.	