



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](mailto:fsb@dhw.idaho.gov)

May 26, 2011

Wade Johnson, Administrator  
Weiser Memorial Hospital  
645 East 5th Street  
Weiser, Idaho 83672

RE: Weiser Memorial Hospital, Provider ID# 131307

Dear Mr.. Johnson:

This is to advise you of the findings of the Medicare/Licensure Fire Life Safety Survey, which was concluded at Weiser Memorial Hospital, on May 19, 2011.

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.

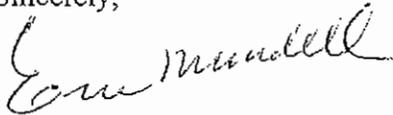
Wade Johnson, Administrator  
May 26, 2011  
Page 2 of 2

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **June 8, 2011**, and keep a copy for your records.

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 cursive script that reads "Eric Mundell".

ERIC MUNDELL  
Health Facility Surveyor  
Facility Fire Safety and Construction Program

EM/lj

Enclosure

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

Printed: 05/26/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>131307</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/19/2011</b>
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NAME OF PROVIDER OR SUPPLIER <b>WEISER MEMORIAL HOSPITAL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>645 EAST 5TH STREET WEISER, ID 83672</b>
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K 000	<p><b>INITIAL COMMENTS</b></p> <p>The hospital consists of a single-story protected non-combustible building constructed in 1950 with a partial, un-finished basement. The original building has undergone minor interior remodels since the original construction.</p> <p>A single-story addition was completed in 1994 to include a new surgical suite and maternity center. The 1994 addition is two (2) hour separated from the original building. The 1994 addition included a fire alarm system upgrade and was a conversion of the original surgery suite to an extended emergency department suite protected throughout by a new automatic fire extinguishing system. To the south of the main hospital entry is a two (2) hour separated clinic which is not part of the hospital occupancy.</p> <p>The following deficiencies were cited during the survey conducted on May 19, 2011. The facility was surveyed under the National Fire Protection Association, LIFE SAFETY CODE 101, 2000 Edition, Chapter 19 Existing Health Care Occupancies and 42 CFR 482.41(b). The census was 8.</p> <p>The fire and life safety survey was conducted by:</p> <p>Eric Mundell REHS Health Facility Surveyor Facility Fire/Life Safety &amp; Construction Program</p>	K 000	<p style="text-align: center;"><b>RECEIVED</b></p> <p style="text-align: center;">JUN 06 2011</p> <p style="text-align: center;"><b>FACILITY STANDARDS</b></p>	
K 018	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only</p>	K 018		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>CEO</b>	(X6) DATE <b>6/6/11</b>
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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 018	<p>Continued From page 1</p> <p>required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to prohibit the use of roller latches that prevent complete closing and latching of sleeping room doors that may pop open in the event of smoke/heat build-up in corridors and sleeping rooms. The deficient practice would potentially affect three of three smoke compartments, eight of eight patients, and occupants of the building. The census was eight.</p> <p>The findings include:</p> <p>Observation during the tour on May 19, 2011 between 11:50 a.m. and 1:50 p.m., disclosed that roller latches were installed on the following room doors: sleeping rooms 11-14, 17-20, 25-27.</p> <p>Facilities Director #1 stated during interview on May 19, 2011 at 11:50 a.m. that the facility was aware of the roller latch issues and that doors were slowly being upgraded to doors that were equipped with positive latching hardware, but not</p>	K 018		

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K 018	Continued From page 2 all had been changed.  The census was verified through a census report provided by the facility and the finding acknowledged by Facilities Director #1.  National Fire Protection Association 101 Standard reference: 19.3 PROTECTION 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.2.	K 018	1-There are 15 beds set up and staffed for use at WMH. Patient room doors will be replaced by doors that meet the NFPA standards. 2-The Facility Director and Facility Design/Project Manager identified 17 doors that are or have the potential to be patient room doors. Of these 17 doors 3 have already been replaced by doors that meet the current NFPA codes. 3-WMH has contacted Bill Broome of The Masonry Center in Meridian Idaho to obtain pricing for 14 new patient room doors that will meet NFPA standards. These new doors will not only meet the latching standards but will also be a true 4' wide door helping ease the transfer of patients in and out of the rooms. WMH has also started the process in securing bids from local contractors to install the doors. 4-The WMH facilities department's master list is to replace the 14 patient room doors. Progress will be reported quarterly to the Infection Control/EOC Committee until all patient room doors have been replaced. 5-The bidding process will be able to be completed by the 60 day deadline, but demolition and construction of the new doors will require additional time. WMH asks that an additional 4 months be given past the 60 day deadline for completion of the construction process		
K 025	NFPA 101 LIFE SAFETY CODE STANDARD  Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel 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. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4  This Standard is not met as evidenced by: Based on observation and interview the facility failed to maintain smoke wall barriers. The deficient practice affected three of three wings	K 025		Bid Completion July 26, 2011  Construction Completion <del>Nov. 26, 2012</del> Nov. 26, 2011  <i>[Signature]</i>	

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K 025	<p>Continued From page 3</p> <p>sampled and eight of eight patients. The census was eight.</p> <p>The findings include:</p> <p>Observation on May 19, 2011 at 1:50 p.m. disclosed the south smoke wall of the operating room suite had been penetrated and there was no fire caulking to close the opening that contained a two-inch fire sprinkler pipe and blue wires. The penetration was located above the ceiling tile assembly at the cross-corridor doors leading from the suite to the surgical wing.</p> <p>Facilities Director #1 stated during interview on May 19, 2011 at 1:50 p.m. that the facility was not aware that the wires and sprinkler pipe had been installed through an unsealed penetration in the smoke wall.</p> <p>The census was verified through a census report provided by the facility and the finding acknowledged by Facilities Director #1.</p> <p>National Fire Protection Association 101 Standard reference:</p> <p>8.3.6 Penetrations and Miscellaneous Openings in Floors and Smoke Barriers. 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 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</p>	K 025	<p>1-The unsealed penetration is now sealed so no individuals will be affected by the deficiency.</p> <p>2-The Facilities Department has gone through the entire facility and checked for additional unsealed penetrations.</p> <p>3-Weiser Memorial Hospital projects be done up to current health code standards. To help ensure these standards are met WMH has contracted with Mike Kenley to do our Architect Design and Project Management. Part of every project will be scheduled walk through and inspections.</p> <p>4-The Project Manager along with the Facilities Director will help ensure that these types of deficiencies do not reoccur.</p> <p>5-The corrective action has already occurred and functioning very well as shown by our last two projects that required Idaho Department of Health &amp; Welfare approval and inspection, the Radiology remodel and the remodel of three patient rooms.</p>	Completed 6/2/2011

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K 025	Continued From page 4 an approved device that is designed for the specific purpose.	K 025		
K 050	<p>19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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. 19.7.1.2</p> <p>This Standard is not met as evidenced by: Based on record review and staff interview, the facility failed to provide documentation of fire drills for each shift on a quarterly basis. Lack of fire drill documentation would not allow the management or the safety committee to evaluate rapid and efficient response of staff during a fire incident and would potentially affect eight of eight patients and occupants of the building. The census was eight.</p> <p>The findings include:</p> <p>Record review on May 19, 2011 at 10:25 a.m. disclosed that records for drills were not available to review for the last two quarters of 2010 with one exception for one drill held on September 30, 2010. No further fire drill documentation was</p>	K 050		

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K 050	<p>Continued From page 5 available to review for the last half of 2010.</p> <p>Facilities Director #1 stated during interview on May 19, 2011 at 10:25 a.m. that the previous director had not recorded fire drills that were held for the last half of 2010 and that there was no documentation to show the drills had been held. Facilities Director #1 went on to say that the only reason the September 2010 drill was recorded was that the he had taken it upon himself to conduct and document a drill.</p> <p>The lack of documentation would not allow for review by managing staff to verify that staff participating in drills were familiar with procedures in case of fire.</p> <p>The census was verified through a census report provided by the facility and the finding acknowledged by Facilities Director #1.</p> <p>National Fire Protection Association 101 Standard reference: 19.7.1.2* 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.</p>	K 050	<p>1- Having started in January of 2011, WMH is having a day shift fire drill for month 1&amp;2 of the quarter, month 3 will have two night shift fire drills. Fire Drills are now scheduled per the disaster drill team.</p> <p>2-WMH is reviewing fire drill procedure, teaching fire extinguisher procedures, teaching about the hospital smoke compartments, and reviewing health care evacuation in new employee orientation and charge nurse training class.</p> <p>3-In the past years only one person was in charge of fire drills, performed them, and kept records of them. The hospital now has a disaster committee made up of five people who are responsible for fire drills and are monitored by the performance improvement committee.</p> <p>4-In order to ensure that the deficiency does not reoccur the hospital performance improvement committee is reviewing fire drills at every monthly meeting.</p> <p>5-WMH adopted these measures in Jan. 2011 and will continue to hold monthly fire drills, record them and report to the performance improvement committee.</p>	Completed Dec. 2011
K 062	NFPA 101 LIFE SAFETY CODE STANDARD	K 062		

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K 062	<p>Continued From page 6</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This Standard is not met as evidenced by: Based on record review and staff interview, the facility failed to provide documentation for quarterly inspections of the automatic fire sprinkler system. The deficient practice would affect eight of eight patients, staff and occupants of the building. The census was eight.</p> <p>The findings include:</p> <p>Record review on May 19, 2011 at 10:15 a.m. disclosed that the facility had not maintained documentation of quarterly inspections of the automatic fire sprinkler system.</p> <p>Facilities Director #1 stated and verified during interview on May 19, 2011 at 10:50 a.m., that the facility had not completed paperwork, either recording, or describing the quarterly fire sprinkler inspections, and that he was not aware of the requirement. Lack of quarterly fire sprinkler inspections may lead to slow or no response of the system in case of fire.</p> <p>The census was verified through a census report provided by the facility and the finding acknowledged by Facilities Director #1.</p> <p>National Fire Protection Association 101 Standard reference:</p>	K 062	<p>1-In order to comply with NFPA standards WMH has a service contract with Simplex Grinnell to perform the quarterly, semi annual, and annual inspections.</p> <p>2-With our service contract in place with Simplex Grinnell no other persons will be effected by the deficiency.</p> <p>3-Service contract with local company that will ensure quarterly, semi annual, and annual inspection on sprinkler system.</p> <p>4-Facilities Department will monitor the inspections to ensure that they are happening at the appropriate intervals.</p> <p>5-Service contract was entered into with Simplex Grinnell on June 1, 2011</p>
			Completed June 2, 2011



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K 144	<p>Continued From page 8</p> <p>would affect eight of eight patients, staff and occupants of the building. The census was eight.</p> <p>The findings include:</p> <p>Record review on May 19, 2011 at 10:35 a.m. disclosed that the facility had not recorded testing of the generator to show weekly inspections and monthly operation.</p> <p>Facilities Director #1 stated and verified during interview on May 19, 2011 at 10:35 a.m., that the facility had not completed paperwork either recording or describing the generator tests, maintenance checks, and who had conducted the testing.</p> <p>The census was verified through a census report provided by the facility and the finding acknowledged by Facilities Director #1.</p> <p>National Fire Protection Association Standard 99 reference:</p> <p>3-4.4.1 Maintenance and Testing of Essential Electrical System. 3-4.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches. (a) Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-4.3.1. Maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6. (b) Inspection and Testing. 1. * Test Criteria. Generator sets shall be tested</p>	K 144		

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K 144	Continued From page 9 twelve (12) times a year with testing intervals between not less than 20 days or exceeding 40 days. Generator sets serving emergency and equipment systems shall be in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6. 2. Test Conditions. The scheduled test under load conditions shall include a complete simulated cold start and appropriate automatic and manual transfer of all essential electrical system loads. 3. Test Personnel. The scheduled tests shall be conducted by competent personnel. The tests are needed to keep the machines ready to function and, in addition, serve to detect causes of malfunction and to train personnel in operating procedures.	K 144	1-WMH was doing monthly test on generators and documenting those tests. WMH has converted over to Emergency Generator form left by the inspector. 2-No others will be effected by the deficiency as WMH is using the form given to us by the inspector and doing weekly and monthly checks. 3-In the past WMH had one person in charge of the generators and taking care of the monthly test. The WMH facilities department now has three individuals who know how to operate the generators and perform the test. The test have been put on the facilities calendar so the department will have a reminder every month to accomplish these tasks. 4-Along with an electrical record of the check list facilities will also be keeping a hard copy of the checklist to ensure that the tests are happening at the appropriate intervals. 5-These steps have already been put into action by the facilities department.	Completed June 6, 2011	

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B 000	<p>16.03.14 Initial Comments</p> <p>The hospital consists of a single-story protected non-combustible building constructed in 1950 with a partial, un-finished basement . The original building has undergone minor interior remodels since the original construction.</p> <p>A single-story addition was completed in 1994 to include a new surgical suite and maternity center. The 1994 addition is two (2) hour separated from the original building. The 1994 addition included a fire alarm system upgrade and was a conversion of the original surgery suite to an extended emergency department suite protected throughout by a new automatic fire extinguishing system. To the south of the main hospital entry is a two (2) hour separated clinic which is not part of the hospital occupancy.</p> <p>The following deficiencies were cited during the survey conducted on May 19, 2011. The facility was surveyed under the National Fire Protection Association, LIFE SAFETY CODE 101, 2000 Edition, Chapter 19 Existing Health Care Occupancies and Idaho Administrative Procedures Act 16.03.14. Rules and Minimum Standards for Hospitals in Idaho. The census was 8.</p> <p>The fire and life safety survey was conducted by:</p> <p>Eric Mundell REHS Health Facility Surveyor Facility Fire/Life Safety &amp; Construction Program</p>	B 000	<p style="text-align: center; font-size: 2em; opacity: 0.5;">RECEIVED</p> <p style="text-align: center; font-size: 1.2em; opacity: 0.5;">JUN 06 2011</p> <p style="text-align: center; font-size: 1.2em; opacity: 0.5;">FACILITY STANDARDS</p>	
BB499	<p>16.03.14.510.01 Fire &amp; Life Safety Standards, General Require</p> <p>510. FIRE AND LIFE SAFETY STANDARDS.</p>	BB499		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>131307</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/19/2011</b>
NAME OF PROVIDER OR SUPPLIER <b>WEISER MEMORIAL HOSPITAL</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>645 EAST 5TH STREET WEISER, ID 83672</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
BB499	Continued From Page 1  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. (10-14-88)  01. General Requirements. General requirements for the fire and life safety standards for a hospital are that: (10-14-88)  a. The hospital shall be structurally sound and shall be maintained and equipped to assure the safety of patients, employees, and the public. (10-14-88)  b. 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. (10-14-88)  This RULE: is not met as evidenced by: Refer to federal CMS form 2567 and K tags K018, K025, K050, K062, and K144.	BB499	Please see the above steps on how WMH will resolve past deficiencies and prevent the deficiencies from happening again for K tags K018, K025, K050, K062 and K144.	
BB516	16.03.14.520.02 Drills  02. Drills. The plan shall be rehearsed annually. (10-14-88)  This RULE: is not met as evidenced by: Based on record review and facility staff interview, the facility had failed to provide documentation of a drill or rehearsal supporting the facility disaster plan. The deficient practice potentially affects the capability of the facility to respond to either an internal or community disaster/emergency. The census was eight.  The findings include:	BB516		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>131307</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/19/2011</b>
NAME OF PROVIDER OR SUPPLIER <b>WEISER MEMORIAL HOSPITAL</b>		STREET ADDRESS, CITY, STATE ZIP CODE <b>645 EAST 5TH STREET WEISER, ID 83672</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
BB516	Continued From Page 2  Record review conducted on May 19, 2011 at 11:05 a.m. disclosed that documentation of a rehearsal of one annual facility external disaster drill had not been completed. Facilities Director #1 stated and verified during interview on May 19, 2011 at 11:25 a.m., after a discussion of the requirement for completion of a drill, that the facility had not completed paperwork recording or describing a drill.  The census was verified through a census report provided by the facility and the finding acknowledged by Facilities Director #1.  <b>520.DISASTER PLANS.</b> The hospital shall have written plans for the care of casualties from both external and internal disasters. The plans shall be developed with the assistance of all appropriate community resources. The plan shall be reviewed and/or revised at least annually.  <b>01. External Disaster Plan.</b> The hospital shall develop a plan for external disasters for the area served and within the capability of the facility.  The plan shall contain the following elements: a. Availability of basic utilities, including food, water, and essential medical supplies; and b. A procedure for notifying and assigning personnel; and c. Unified medical command; and d. Space and procedure for triage; and (10-14-88) e. Procedure for casualty transfer to appropriate facility; and f. Agreement with other agencies for communications; and  <b>02. Drills.</b> The plan shall be rehearsed annually.	BB516	1-WMH will contact current Washington County Disaster Coordinator and schedule an annual disaster drill. 2-In order to keep others being affected by the same practice WMH will schedule and carry out the disaster plan annually. 3- Coordinating the disaster plan will be the responsibility of the WMH drill team who reports to the performance improvement committee. 4-With the WMH drill team reporting and communicating to the performance improvement committee numerous people will be involved in the process and making sure that it happens. 5-The deficiency will be resolved with in the 60 day time period.	Completed July 26, 2011

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