



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

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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BUREAU OF FACILITY STANDARDS
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September 19, 2012

Todd Winder, Administrator
Oneida County Hospital
PO Box 126
Malad City, ID 83252

RE: Oneida County Hospital, Provider ID# 131303

Dear Mr. Winder:

This is to advise you of the findings of the Medicare/Licensure Fire Life Safety Survey, which was concluded at Oneida County Hospital, on September 11, 2012.

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.

Todd Winder, Administrator
September 18, 2012
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 **October 2, 2012**.

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 'Mark P. Grimes', with a long horizontal flourish extending to the right.

MARK P. GRIMES
Supervisor
Facility Fire Safety and Construction Program

MPG/lj

Enclosure

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

Printed: 09/18/2012
FORM APPROVED
OMB NO. 0938-0391

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D&H
SEP 23 2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131303	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE HOSPITAL B. WING _____	(X3) DATE SURVEY COMPLETED 09/11/2012
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NAME OF PROVIDER OR SUPPLIER ONEIDA COUNTY HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 150 NORTH 200 WEST MALAD CITY, ID 83252
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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	<p>INITIAL COMMENTS</p> <p>The facility is a single story with basement, Type II (211) building completed in November 1970, with a 1993 addition. Currently the hospital is licensed for 11 beds. There is an attached Nursing Facility licensed for 33 beds and is considered part of the same building.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on September 11, 2012. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 485.623.</p> <p>The Survey was conducted by:</p> <p>Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction</p>	K 000	<p>The statements made herein on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies or of the correctness of the conclusion set forth herein. The plan of correction is requisite to continued program participation.</p> <p>K029</p>	10/10/12
K 029	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This Standard is not met as evidenced by: Based on observation and operational testing it was determined that the facility did not ensure</p>	K 029	<p>1 Our assessment determined that 1 residents may be affected 4 Staff members could be affected. Corrective measures are stated below.</p> <p>2 All residents and staff.</p> <p>3 1. Mechanical Room to be fitted with self-closing device. 2. Combustibles to be removed.</p> <p>4 Facility Safety Committee will monitor</p>	

FACILITY STANDARDS

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Judd V. Winder</i>	TITLE CEO	(X6) DATE 9-28-12
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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	Continued From page 1 that hazardous areas were provided with self closing doors. This deficiency can allow smoke and fire gases to spread beyond the hazardous area in the event of a fire occurring in the rooms. The facility had a census of three patients on the day of survey. This deficiency affected one patient and four staff members in one of two smoke compartments. Findings include: During the tour of the facility on September 11, 2012, at 10:55 AM, observation of operational testing of the door to the hot water heater mechanical room revealed that the door would not self close when released from the open position. The door was not equipped with a self closing device. This was observed and noted by the Maintenance Supervisor and Surveyor.	K 029	compliance during rounds. Deficits will be reported immediately to the maintenance department for correction. This plan of correction is integrated into the quality assurance program for further follow-up as necessary	
K 056	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This Standard is not met as evidenced by: Based on observation and interview the facility	K 056	K056 1 For all residents identified, fire extinguishing system will be upgraded to include sprinkler protection of combustible overhangs. 2 All residents admitted to facility. 3 Installation of fire extinguishing system of building overhangs will be planned and completed. Extension requested for completion of project. 4 Facility administrator will oversee completion of corrective action. Facility Safety Committee will monitor compliance	10/6/12

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 056	<p>Continued From page 2</p> <p>did not ensure that the sprinkler system was installed in accordance NFPA 13. Unprotected areas can allow a fire to grow, accelerate and spread. The facility had a census of three patients on the day of survey. These deficiencies affected all patients, staff members and visitors present on the day of the survey.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. During the tour of the facility on September 11, 2012 at 10:45 AM, observation of the main entrance to the facility revealed a combustible overhang above the entrance that is approximately thirty feet by nine feet in size that does not have any sprinkler protection. When questioned about the lack of sprinkler protection the Maintenance Supervisor stated that he was aware that the overhang was required to have sprinkler protection. 2. During the tour of the facility on September 11, 2012 at 11:05 AM, observation of an exit by the radiology department revealed a combustible overhang above the exit discharge that is approximately nineteen feet by nineteen feet in size that does not have any sprinkler protection. When questioned about the lack of sprinkler protection the Maintenance Supervisor stated that he was aware that the overhang was required to have sprinkler protection. <p>Actual NFPA Standard:</p> <p>5-13.8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 ft (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.</p>	K 056	during monthly safety meetings. This plan of correction is integrated into the quality assurance program for further follow-up as necessary	

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Bureau of Facility Standards

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B 000	16.03.14 Initial Comments The facility is a single story with basement, Type II (211) building completed in November 1970, with a 1993 addition. Currently the hospital is licensed for 11 beds. There is an attached Nursing Facility licensed for 33 beds and is considered part of the same building. The following deficiencies were cited during the annual fire/life safety survey conducted on September 11, 2012. The facility was surveyed in accordance with IDAPA 16.03.14 and the 1985 Edition of the Life Safety Code. The survey was conducted by: Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction	B 000	The statements made herein on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies or of the correctness of the conclusion set forth herein. The plan of correction is submitted as is requisite to continued program participation.	
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: Refer to Federal K tags on the CMS 2567; 1. K029 Hazardous Areas.	BB161	BB161 REFER TO K029 REFER TO K056	<i>ID1612</i>

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FACILITY STANDARDS

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

Todd V. Wanda

TITLE

CEO

(X6) DATE

9-28-12

Bureau of Facility Standards

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BB161	Continued From Page 1 2. K056 Sprinkler System Installation.	BB161		