



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

RECEIVED
MAY 09 2013

April 26, 2013

David Butler, Administrator
North Canyon Medical Center
267 North Canyon Dr
Gooding, ID 83330

FACILITY STANDARDS

RE: North Canyon Medical Center, Provider ID# 131302

Dear Mr. Butler:

This is to advise you of the findings of the Medicare/Licensure Fire Life Safety Survey, which was concluded at North Canyon Medical Center, on April 17, 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.

David Butler, Administrator

April 26, 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 May 8, 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 'Mark P. Grimes', with a long horizontal line extending to the right.

MARK P. GRIMES

Supervisor

Facility Fire Safety and Construction Program

MPG/lg

Enclosure



NORTH CANYON
MEDICAL CENTER

May 16, 2013

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MAY 17 2013

FACILITY STANDARDS

Idaho Department of Health & Welfare
Bureau of Facility Standards
Attn: Mark Grimes
Facility Fire Safety and Construction Program
PO Box 83720
Boise, ID, 83720-0009

Dear Mr. Grimes,

Enclosed you will find the Plan of Correction for the Medicare /Licensure Fire Life Safety Survey conducted at North Canyon Medical Center on April 17, 2013.

Please let me know if you have questions: glenn.diede@ncm-c.org or 208-934-9694.

Sincerely,

Glenn Diede
Director of Engineering

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

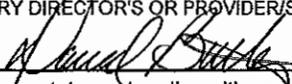
Printed: 04/24/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131302	(X2) MULTIPLE CONSTRUCTION A. BUILDING 1A - NORTH CANYONE MEDICAL CENTER B. WING _____	(X3) DATE SURVEY COMPLETED 04/17/2013
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NAME OF PROVIDER OR SUPPLIER NORTH CANYON MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 267 NORTH CANYON DR GOODING, ID 83330
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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 hospital is a 53,000 square foot single story Type II(111) protected construction. Plans were approved in 2008 and building construction completed in June of 2010. The building is protected throughout by a complete automatic fire extinguishing system designed/installed per NFPA Standard 13 for light hazard occupancy. There is a complete fire alarm system throughout including smoke detection in the corridors and open areas. There are multiple exits that discharge to grade and, an exit at the corridor opening to the physically attached, but two (2) hour separated, business/administrative/clinic office building The Essential Electrical System is supplied by a diesel powered, on-site automatic generator. Medical gases and vacuum are supplied by a level 1 piped system.</p> <p>The hospital building was surveyed as a New Health Care Occupancy based upon applicable requirements set forth in the Life Safety Code, 2000 Edition and 42 CFR 482.41.</p> <p>The following deficiencies were cited during the recertification life safety survey conducted on April 17, 2013.</p> <p>The surveyor conducting the survey was:</p> <p>Tom Mroz, CFI-II Health Facility Surveyor Facility Fire/Life Safety & Construction Program</p>	K 000	<p style="text-align: center;">RECEIVED MAY 17 2013 FACILITY STANDARDS</p>	
K 025	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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 protected by fire-rated glazing or by wired glass</p>	K 025		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE CEO	(X6) DATE 5-16-13
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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.

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K 025	<p>Continued From page 1</p> <p>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</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to maintain the smoke resistive properties of a smoke barrier wall. This potentially exposed residents to a smoke or fire environment. The deficient practice affected two of five smoke compartments, staff and 4 patients. The facility is licensed for 15 beds and had a census of 4 on the day of survey.</p> <p>Findings include:</p> <p>Observation on 04/18/13 at 03:05 p.m., revealed a three inch circular penetration in the space within a data cable pipe above the ceiling at the cross corridor door by the surgery changing room. Interview on 04/18/13 at 03:05 p.m., with the facility Director of Engineering revealed that the facility was not aware of the unsealed penetration in the smoke barrier wall.</p> <p>The findings were acknowledged by the Chief Executive Officer and verified by the facility Director of Engineering at the exit interview on 04/18/13.</p> <p>Actual NFPA Standard: NFPA 101, 18.3.7.3 Any required smoke barrier shall be constructed</p>	K 025	<p>1.) Penetrations were sealed after discovery using appropriately rated fire stopping materials.</p> <p>2.) The Engineering department will conduct an assessment throughout the facility to document and repair any additional penetrations.</p> <p>3.) Quarterly above ceiling inspections of firewalls have been scheduled and a process will be established to assure contractors and vendors will receive instruction regarding fire barriers and their work is inspected by Engineering staff prior to work being considered complete.</p> <p>4.) These activities will be monitored by the Director of Engineering and documented through a quarterly smoke/fire wall inspection PM.</p>	05/31/13

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K 025	Continued From page 2 in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1 hour. Actual NFPA Standard: NFPA 101, 8.3.6.1 (1) a. and b. 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 by filling the space between the penetrating item and the smoke barrier with a material that is capable of maintaining the smoke resistance of the smoke barrier or it shall be protected by an approved device that is designed for the specific purpose.	K 025		
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 on observation and interview, the facility failed to provide an exit door that was operable without special knowledge. This potentially prevents staff from leaving a smoke or fire environment. The deficient practices affected one of five smoke compartments, staff, and no patients. The facility has the capacity for 15 beds with a census of 4 the day of survey. Findings include: Observation on 04/18/13 at 03:28 p.m., revealed that the door labeled exit from the surgery changing room to the surgery corridor was found to be locked with a magnetic lock requiring a card swipe to exit thereby eliminating the second means of egress from the surgery changing	K 038	1.) Magnetic door lock will be removed from the exit door and placed on the door entering the Surgery suite from the main corridor. 2.) The Engineer staff has conducted an inspection of the facility to find similar occurrences. 3.) Findings have been shared with Administration and Department Directors. These findings will also be shared with the door security installation vendor. 4.) These activities will be monitored by the Director of Engineering and documented through a Monthly Smoke/Fire Door PM.	05/31/13

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K 038	Continued From page 3 room. Interview on 04/18/13 at 03:28 p.m., with the Director of Engineering revealed the facility was not aware of the requirement to be able to open the exit door without special knowledge. The finding was acknowledged by the Chief Executive Officer and verified by the Director of Engineering at the exit interview on 04/18/13. Actual NFPA Standards: NFPA 101, 18.2.1 Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7. 7.2.1.5 Locks, Latches, and Alarm Devices. 7.2.1.5.1 Doors shall be arranged to be opened readily from the egress side whenever the building is occupied. Locks, if provided, shall not require the use of a key, a tool, or special knowledge or effort for operation from the egress side.	K 038		
K 052	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This Standard is not met as evidenced by: Based on observation, record review, and interview, the facility failed to provide a documented annual inspection, testing and	K 052	1.) An Annual Inspection has been scheduled with the Fire Alarm Vendor for the completion of inspection in May. 2.) Findings have been shared with Administration and Department directors. 3.) The Annual Inspection has been added to the facility PM list. 4.) These activities will be monitored by the Director of Engineering and documented through an Annual Fire Alarm System PM.	05/31/13

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K 052	<p>Continued From page 4</p> <p>maintenance report for the fire alarm system. The deficient practice affected five of five smoke compartments, staff, and 4 patients. The facility is licensed for 15 beds with a census of 4 the day of survey.</p> <p>Findings include:</p> <p>During record review of the facility's fire alarm inspection and testing reports for the 12 month period prior to the day of survey on 04/17/13 at 12:45 p.m., the facility was unable to provide a documented annual inspection report for the fire alarm system. The last annual inspection was performed on 02/10/12. Interview with the Director of Engineering on 04/17/13 at 12:45 p.m., revealed that the facility was not aware the fire alarm system inspection was past due..</p> <p>The finding was acknowledged by the Chief Executive Officer and verified by the Director of Engineering at the exit interview on 04/17/13.</p> <p>Actual NFPA Standards: NFPA 101, 9.6.1.4 A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm Code, unless an existing installation, which shall be permitted to be continued in use, subject to the approval of the authority having jurisdiction.</p> <p>NFPA 72, 7-3.2 Testing. Testing shall be performed in accordance with the schedules in Chapter 7 or more often if required by the authority having jurisdiction.</p>	K 052		
K 131	NFPA 101 LIFE SAFETY CODE STANDARD	K 131		

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K 131	<p>Continued From page 5</p> <p>Emergency procedures are established for controlling chemical spills in accordance with NFPA 99. 10.2.1.3.2</p> <p>This Standard is not met as evidenced by: Based on interview and record review, the facility failed to provide documentation of procedures for controlling chemical spills within the laboratory. This resulted in the potential for the facility's inability to effectively deal with the care, health and safety of patients, staff and other individuals should a chemical spill occur. The facility has the capacity for 15 beds with a census of 4 the day of survey. Findings include:</p> <p>The facility could not produce written procedures for chemical spills within the hospital laboratory. There was no plan available detailing procedures for controlling chemical spills. Interview with the laboratory manager on 04/18/13 at 02:15 p.m., indicated the facility was unable to provide laboratory specific procedures for controlling chemical spills.</p> <p>The finding was acknowledged by the Chief Executive Officer and verified by the Director of Engineering at the exit interview on 04/18/13.</p> <p>Actual NFPA Standard: NFPA 99, Chapter 10, Laboratories 10-2.1.3.2 Emergency procedures shall be established for controlling chemical spills.</p>	K 131	<p>1.) Laboratory director is completing policies pertaining to the management of chemical spills within the laboratory. 2.) Findings have been shared with Administration and Department directors 4.) Laboratory Director will review departmental policies and procedures annually.</p>	05/31/13
K 132	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Continuing safety education and supervision are provided, incidents are reviewed monthly, and procedures are reviewed annually in accordance with NFPA 99. 10.2.1.4.2</p>	K 132		

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K 132	Continued From page 6 This Standard is not met as evidenced by: Based on interview and record review, it was determined the facility failed to provide orientation and continuing safety education for laboratories. This resulted in the potential for the facility's inability to effectively deal with the care, health and safety of staff and other individuals should a laboratory emergency occur. The facility has the capacity for 15 beds with a census of 4 the day of survey. Findings include: The facility failed to provide orientation and continuing safety education for the hospital laboratory. Interview with the laboratory manager on 04/18/03 at 2:55 p.m., indicated the facility was unable to provide documented orientation and training records of new laboratory personnel. The finding was acknowledged by the Chief Executive Officer and verified by the Director of Engineering at the exit interview on 04/18/13. Actual NFPA Standard: NFPA 99, Chapter 10, Laboratories 10-2.1.4 Orientation and Training. 10-2.1.4.1 New laboratory personnel shall be taught general safety practices for the laboratory and specific safety practices for the equipment and procedures they will use. 10-2.1.4.2 Continuing safety education and supervision shall be provided, incidents shall be reviewed monthly, and procedures shall be reviewed annually.	K 132	Safety education is performed annually during the required employee education. Additionally, the Procedure Manual will be reviewed by staff annually.	05/31/13
K 136	NFPA 101 LIFE SAFETY CODE STANDARD Procedures for laboratory emergencies are developed. Such procedures include alarm	K 136		

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K 136	<p>Continued From page 7</p> <p>actuation, evacuation, and equipment shutdown procedures, and provisions for control of emergencies that could occur in the laboratory, including specific detailed plans for control operations by an emergency control group within the organization or a public fire department in accordance with NFPA 99, 10.2.1.3.1, 18.3.2.2.</p> <p>This Standard is not met as evidenced by: Based on interview and record review, it was determined the facility failed to provide documentation of procedures for laboratory emergencies. This resulted in the potential for the facility's inability to effectively deal with the care, health and safety of staff and other individuals should a laboratory emergency occur. Findings include:</p> <p>The facility could not produce procedures for laboratory emergencies within the hospital laboratory. There were no plans available detailing procedures for alarm actuation, evacuation and equipment shutdown procedures, and provisions for control of emergencies that could occur in the laboratory, including specific detailed plans for control operations by an emergency control group within the organization or a public fire department. There were no procedures established for extinguishing clothing fires. When asked about the plan, on 04/18/13 at 02:10 p.m. the facility's laboratory manager was unable to produce a plan specifically for the the laboratory.</p> <p>The finding was acknowledged by the Chief Executive Officer and verified by the Director of Engineering at the exit interview on 04/18/13.</p>	K 136	Laboratory specific emergency procedures will be incorporated into the departmental fire plan.	05/31/13

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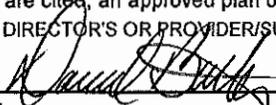
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K 136	Continued From page 8 Actual NFPA Standard: NFPA 99, Chapter 10, Laboratories 10-2.1.3 Emergency Procedures. 10-2.1.3.1 Procedures for laboratory emergencies shall be developed. Such procedures shall include alarm actuation, evacuation, and equipment shutdown procedures, and provisions for control of emergencies that could occur in the laboratory, including specific detailed plans for control operations by an emergency control group within the organization or a public fire department. 10-2.1.3.3 Emergency procedures shall be established for extinguishing clothing fires.	K 136		

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B 000	<p>16.03.14 Initial Comments</p> <p>The hospital is a 53,000 square foot single story Type II(111) protected construction. Plans were approved in September of 2008 and building construction completed in June of 2010. The building is protected throughout by a complete automatic fire extinguishing system designed/installed per NFPA Standard 13 for light hazard occupancy. There is a complete fire alarm system throughout including smoke detection in the corridors and open areas. There are multiple exits that discharge to grade and, an exit at the corridor opening to the physically attached, but two (2) hour separated, business/administrative/clinic office building. The Essential Electrical System is supplied by a diesel powered, on-site automatic generator. Medical gases and vacuum are supplied by a level 1 piped system.</p> <p>The hospital building was surveyed as a New Health Care Occupancy based upon applicable requirements set forth in the Life Safety Code, 2000 Edition and IDAPA 16.03.14 Rules and Minimum Standards for Hospitals in Idaho.</p> <p>The following deficiencies were cited during the recertification life safety survey conducted on April 17, 2013.</p> <p>The surveyor conducting the survey was:</p> <p>Tom Mroz, CFI-II Health Facility Surveyor Facility Fire/Life Safety & Construction Progra</p>	B 000	Please refer to the Federal Plan of Corrections	05/31/13
BB161	<p>16.03.14.510 Fire and Life Safety Standards</p> <p>Buildings on the premises used as a hospital shall meet all the requirements of local, state,</p>	BB161		

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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

CEO

(X6) DATE

5-16-13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131302	(X2) MULTIPLE CONSTRUCTION A. BUILDING 1A - NORTH CANYONE MEDICAL CENTER B. WING _____	(X3) DATE SURVEY COMPLETED 04/17/2013
NAME OF PROVIDER OR SUPPLIER NORTH CANYON MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 267 NORTH CANYON DR GOODING, ID 83330		
(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
BB161	Continued From Page 1 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 the following deficiencies identified on Federal Form 2567 K025 Penetrations K038 Exit Locking Arrangement K052 Fire Alarm K131 Procedures for Laboratory Spills K132 Laboratory Continuing Education K136 Procedures for Laboratory Emergencies	BB161		

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