



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

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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July 17, 2013

COPY

Ken Kraft, Administrator
State Hospital North
300 Hospital Drive
Orofino, ID 83544

RE: State Hospital North, Provider #

Dear Mr. Kraft:

This is to advise you of the findings of the Fire Life Safety & Construction survey at State Hospital North, which was concluded on July 10, 2013.

Enclosed is a Statement of Deficiencies/Plan of Correction form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction.

An acceptable plan of correction (PoC) contains the following elements:

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the PoC is effective in bringing the Hospital into compliance, and that the hospital remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
- The administrator's signature and the date signed on page 1 of the Form CMS-2567.

Ken Kraft, Administrator
July 17, 2013
Page 2 of 2

After you have completed your Plan of Correction, return the original to this office by **July 30, 2013**, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please write or call this office at (208) 334-6626.

Sincerely,

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

MARK P. GRIMES
Supervisor
Facility Fire Safety & Construction Program

MPG/pt
Enclosures

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43506	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 - ENTIRE HOSPITAL B. WING: _____	(X3) DATE SURVEY COMPLETED 07/10/2013
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NAME OF PROVIDER OR SUPPLIER STATE HOSPITAL NORTH	STREET ADDRESS, CITY, STATE, ZIP CODE 300 HOSPITAL DRIVE OROFINO, ID 83544
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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) COMPLETE DATE
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B 000	<p>16.03.14 Initial Comments</p> <p>The Hospital was constructed and opened in April 1995. The building is Type V(111) construction and is 58,430 square feet in size with nine exits to grade. The Administration area is wood framed with 2" by 6" studs and 5/8" gypsum board. There are two patient housing units in the facility that are secure and exit door control is maintained with magnetic locks, key operation, and fire alarm activation. The two patient housing units are a mixed construction type consisting of concrete, cinderblock, and steel studs with 5/8" gypsum board. The building is single story with an upper level mechanical loft which contains the HVAC equipment and the building's plumbing system. There is an automatic sprinkler system installed throughout the facility that is tied into the fire alarm system which is off-site monitored. The fire alarm consists of system smoke detectors located at corridor smoke doors, patient sleeping rooms and the mechanical loft. Pull stations are key activated, and the portable fire extinguisher cabinets are secured, on-site staff are required to carry keys at all times. Emergency power and lighting are provided by an on-site generator. The facility is currently licensed for sixty beds.</p> <p>The following deficiencies were cited at the above facility during the Fire/Life Safety survey conducted on July 11, 2013. The facility was surveyed in accordance with IDAPA 16.03.14 and the 1985 Edition of the Life Safety Code.</p> <p>The survey was conducted by:</p> <p>Tom Mroz CFI-II Health Facility Surveyor Facility Fire Safety and Construction</p>	B 000		
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RECEIVED
JUL 30 2013
FACILITY STANDARDS

Bureau of Facility Standards

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



TITLE *Administrative* (X8) DATE *7/30/13*

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43606	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 - ENTIRE HOSPITAL B. WING _____	(X3) DATE SURVEY COMPLETED 07/10/2013
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BB161	Continued From page 1	BB161		
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, and national codes concerning fire and life safety that are applicable to hospitals.</p> <p>General Requirements. General requirements for the fire and life safety standards for a hospital are that:</p> <p>The hospital shall be structurally sound and shall be maintained and equipped to assure the safety of patients, employees, and the public.</p> <p>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.</p> <p>This Rule is not met as evidenced by: Based on observation and interview, the facility failed to maintain smoke barrier doors that would close and resist the passage of smoke. The deficient practice affected two of five smoke compartments, staff, and 21 residents. The facility has the capacity for 60 beds and at the time of the survey the census was 44.</p> <p>Findings include:</p> <p>Based on observation and interview, the facility failed to assure that all doors in smoke barriers were self-closing and sealed against the passage of smoke. This potentially exposed residents to a smoke or fire environment. This deficient practice affected approximately 22 residents as well as staff in two of thirteen smoke compartments. The facility has the capacity for 60 beds and at the time of the survey the census was 44.</p>	BB161		

Bureau of Facility Standards

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BB161	Continued From page 2 Observation on 07/11/13 at 11:20 a.m. revealed an approximately 1/2" gap between the cross corridor smoke doors located at Quad 3 D Hall when they were in the fully closed position. Interview with the facility Maintenance Engineer on 07/11/13 at 11:20 a.m. revealed that the facility was not aware that the smoke door was not smoke tight. The finding was acknowledged Maintenance Engineer at the exit interview on 07/11/13 Actual NFPA Standard: NFPA 101, 6-2.2.5 Every opening in a fire barrier shall be protected to limit the spread of fire and restrict the movement of smoke from one side of the fire barrier to the other.	BB161	POC for deficiency #BB161 shall be corrected ASAP but no later than 12/31/13 by installing all applicable and listed smoke seals to doors with deficiencies SHN Maintenance supervisor Mark Flerchinger shall be responsible for implementation of POC All receipts and dates of installation shall be documented and filed for future inspection.	As soon as 8/30/13 but no later than 12/31/13
BB163	16.03.14.510.03 Electrical Safety A continued effort shall be made to provide an electrically safe environment within the hospital. Written policies and procedures shall be established for, but not limited to, the following: Methods and frequency of testing, verification of performance, and use specifications for all hospital electrical patient care equipment. All new equipment shall be tested prior to use and in no case shall the retesting interval exceed one (1) year; and Periodic evaluation of the electrical distribution system and all nonpatient care equipment. Inspection and testing of nonclinical equipment shall be performed at regular intervals to be determined by the chief maintenance engineer; and Specific restrictions on the use of extension cords and adapters. Extension cords shall be used in emergency situations only, be of the grounded type and have wire gauge compatible to the piece	BB163		

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BB163	Continued From page 3 of equipment being used; and Prohibition of the use of personal electrical equipment by patients and employees. Specific items may be allowed if the hospital adopts formal policies for defining and inspecting them. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to provide a remote emergency stop station and document weekly inspections of the emergency generator system. The deficient practice affected all thirteen smoke compartments, staff, and residents. The facility has the capacity for 60 beds with a census of 44 the day of survey. Findings include: 1.) Observation on 07/11/13 at 11:45 a.m., of the facility's generator revealed it did not have the required remote manual stop station. Interview with the Maintenance Engineer 07/11/13 at 11:45 a.m., revealed the facility was not aware of the requirement. 2.) Observation during record review on 07/11/13 at 9:49 a.m., of the facility's generator weekly inspection logs revealed during the calendar year of 2013 there were no documented weekly inspections for the fifth week of January, the third and fourth week in February 2013. Documented Weekly inspections were also missing for the second week in September and the fifth week in October 2012. Interview with the Maintenance Engineer on 07/11/13 at 9:49 a.m., revealed the facility was aware two weeks were missing due to staff vacation but were not aware of the remaining missing inspections. The finding was acknowledged by the Maintenance Engineer at the exit interview on 07/11/13.	BB163	POC for deficiency # BB163 Correction to this deficiency has been in the Planning stage since 7/26/12. Plans include bringing SHN facility "up to code" with changes and additions to emergency circuits to include remote manual stop for Emergency Generator. Upon approval fiscal year 2015, SHN Maintenance Supervisor Mark Flenchinger shall be responsible for implementation of POC. All receipts and dates of installation shall be documented and filed for future inspection. Request for extension of completion date will be filed prior to 8/30/13	8/1/14

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BB163	Continued From page 4 Actual NFPA Standard: Item 1.) NFPA 110 3-5.5.5; All Level 1 installations shall have a remote manual stop station of a type similar to a break glass station located outside the room housing the prime mover (when so installed) or elsewhere on the premises when the prime mover is located outside the building. Item 2.) NFPA 110, 6-4.1. Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at intervals of not more than 30 days.	BB163	PEC, for deficiency # BB163 (#2) Correction to this deficiency has been implemented as of 7/16/13 such that on the date of generator exercise, there shall be a Maintenance Engineer available to log hours and operation. SHN Maintenance Supervisor Mark Fletcher shall be responsible for all generator exercise logs.	7/16/13
BB165	16.03.14.510.05 Emergency Plans Emergency Plans for Protection and Evacuation of Patients. The hospital shall develop a prearranged written plan for employee response for protection of patients and for orderly evacuation of residents in case of an emergency. A diagram of the building noting the locations of exits, extinguishers, and fire alarm pull stations along with written emergency instructions shall be available within each department of the hospital. Emergency plans shall be thoroughly tested and used as necessary to assure rapid and efficient function. Fire drills shall be planned by key personnel and conducted on an unannounced basis. Fire drills shall be held as required by the "Life Safety Code." This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to provide fire drills for three of four quarters reviewed. Failure to train personnel in emergency procedures could result in panic and confusion in an emergency situation. The deficient practice would affect thirteen of thirteen smoke compartments, all patients, and	BB165		

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BB165	<p>Continued From page 5</p> <p>occupants of the building.</p> <p>The findings include:</p> <p>Observation during record review on 07/11/13 at 9:50 a.m. revealed that for the 1st, 2nd, and 3rd shift for the 1st and 2nd quarter of 2013, the 1st, 2nd and 3rd shift for the 3rd quarter of 2012 and the 1st shift for the 4th quarter of 2012 no fire drills were documented as being conducted. Interview on 07/11/13 at 9:50 a.m. with the Maintenance Engineer disclosed that the facility was aware the drills were not performed.</p> <p>The finding was acknowledged Maintenance Engineer at the exit interview on 07/11/13.</p> <p>Actual NFPA Standard IDAPA 16.03.14.05. c Fire drills shall be planned by key personnel and conducted on an unannounced basis. Fire drills shall be held as required by the "Life Safety Code"</p> <p>NFPA 101, 31-4.1.3 Fire exit drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions except that the movement of infirm or bed-ridden patients to safe areas or to the exterior of the building is not required. 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.</p>	BB165	<p>POC for deficiency # BB165 7/24/13 SHN Maintenance Supervisor Mark Flerchinger acknowledges no drills were formally documented for previously stated shifts during previously stated quarters of corresponding years. During these periods, new methods to execute fire drills were discussed, implemented, evaluated, and modified. New plans for executing SHN fire drills was implemented on 7/20/13 as documented on Fire Alarm monitoring printout. Maint. Fire Drill Form documentation was not filled out on this drill and filed for inspection in a timely manner due to Maintenance Supervisor going on vacation. Drill has since been documented and successful. Fire Drills are back on schedule as they should be. Maintenance Supervisor Mark Flerchinger shall be responsible for documentation of scheduled fire drills.</p>	

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BB516 BB518	Continued From page 6 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 observation, record review, and interview on 07/11/13 at 10:10 a.m. It was determined the facility failed to conduct an annual external disaster drill. Failure to perform an annual disaster plan drill could result in the facility's inability to effectively deal with the care, health and safety of patients, staff and other individuals when a major disruptive event occurs. Findings include: The facility's emergency preparedness plan, undated, was reviewed. There was no record of an emergency preparedness drill being conducted annually to test the plan's effectiveness. Interview on 07/11/13 at 10:10 a.m. with the Maintenance Engineer disclosed that the facility was not aware the annual disaster drill was not performed. The finding was acknowledged by the Maintenance Engineer at the exit interview on 07/11/13.	BB516 BB516	POC for deficiency # BB516 SHW Maintenance Supervisor Mark Flerchinger shall be responsible for implementing annual external disaster drill. SHW Environment of Care Committee will evaluate plans currently implemented, and revise if necessary. EOC committee will also talk with local fire and police departments to devise an updated plan to execute such drill.	NO later than 7/30/13