



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

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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September 26, 2014

Jim Broyles, Administrator
Benewah Community Hospital
229 South 7th Street
St Maries, ID 83861

RE: Benewah Community Hospital, Provider ID# 131317

Dear Mr. Broyles:

This is to advise you of the findings of the Medicare/Licensure Fire Life Safety Survey, which was concluded at Benewah Community Hospital, on September 16, 2014.

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.

Jim Broyles, Administrator
September 26, 2014
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 9, 2014**.

Thank you for the courtesies extended to our staff during our 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', with a long horizontal line 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

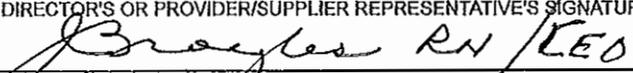
Printed: 09/25/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131317	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - ADDITION & RENNOVATION B. WING _____	(X3) DATE SURVEY COMPLETED 09/16/2014
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NAME OF PROVIDER OR SUPPLIER BENEWAH COMMUNITY HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 229 SOUTH 7TH STREET ST MARIES, ID 83861
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K 000	<p>INITIAL COMMENTS</p> <p>The hospital is a four story Type II (222) structure separated by two hour construction to the original single story hospital building. The entire hospital is protected throughout by an automatic fire extinguishing system design/installed per NFPA Std 13 for light hazard occupancy and has a supervised manual fire alarm system with partial detection.</p> <p>The following deficiencies were cited at the above facility during a recertification survey conducted on September 16, 2014. The facility was surveyed under the Life Safety Code, 2000 Edition, New Health Care Occupancies in accordance with 42 CFR 282.41(b) and IDAPA 16.03.14, Rules and Minimum Standards for Hospitals in Idaho.</p> <p>The survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	K 000	<p>RECEIVED</p> <p>OCT 10 2014</p> <p>FACILITY STANDARDS</p>	
K 012	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Building construction type and height meets one of the following: 18.1.6.2, 18.1.6.3, 18.2.5.1</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that smoke barrier walls were maintained to resist the passage of smoke. Failure to ensure smoke barrier continuity would allow smoke and dangerous gases to pass freely between smoke compartments during a fire. This</p>	K 012		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE	(X6) DATE 10-8-14
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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 012	<p>Continued From page 1</p> <p>deficient practice affected no patients, all staff and visitors in 1 of 5 smoke compartments in the basement Administration section of the building on the date of the survey. The facility is licensed for 19 hospital beds and had a census of 5 on the day of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on September 19, 2014 from 12:45 PM to 1:15 PM, observation of the Incoming Records room abutting the center stairwell found two (2) four-inch diameter open holes cut through the drywall into an area underneath the building main floor identified as the Dirt Room by the Facility Manager. When asked, the Facility Manager stated he was not aware these holes were left unsealed.</p> <p>2) During the facility tour conducted on September 19, 2014 from 12:45 PM to 1:15 PM, observation of the Mechanical Room on the basement floor found an approximately four-inch diameter unsealed drain pipe passing through the wall into the suspended ceiling in the adjacent corridor and into what the Facility Manager had identified as the Dirt Room. Further observation found the pipe was unsealed at all penetrations across the corridor. When interviewed, the Facility Manager stated this was a new drain installed by the plumbing contractor and he was not aware the installation was unsealed.</p> <p>3) During the facility tour conducted on September 19, 2014 from 12:45 PM to 1:15 PM, observation of the ceiling tiles located directly outside of the Mechanical Room on the basement floor found a dislodged ceiling tile with an approximately 3/4 inch by sixteen inch gap to the</p>	K 012		
		K012 #1	Sheet rock repaired, fire calked. See attachment 'A'	10/6/2014
		K012 #2	Pipe sealed at all walls See attachment 'B'	10/6/2014

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K 012	<p>Continued From page 2</p> <p>concealed space above. When interviewed, the Facility Manager stated he was not aware this ceiling tile had become dislodged.</p> <p>4) During the facility tour conducted on September 19, 2014 from 12:45 PM to 1:15 PM, observation of the Outpatient Records room ceiling found a missing ceiling tile. When interviewed, the Facility Manager stated he was not aware of the missing ceiling tile.</p> <p>Actual NFPA standard:</p> <p>18.3.7.3 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 hour. Exception No. 1: Where an atrium is used, smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with Exception No. 2 to 8.2.5.6(1). Not less than two separate smoke compartments shall be provided on each floor. Exception No. 2*: Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems.</p> <p>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.</p>	K 012 #3 K012 #4	<p>Tile replaced See attachment 'C'</p> <p>Tile replaced See attachment 'D'</p>	10/6/2014 10/6/2014

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K 012	Continued From page 3 b. It shall be protected by an approved device that is designed for the specific purpose. (2) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve 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 an approved device that is designed for the specific purpose. (3) Where designs take transmission of vibration into consideration, any vibration isolation shall meet one of the following conditions: a. It shall be made on either side of the smoke barrier. b. It shall be made by an approved device that is designed for the specific purpose.	K 012		
K 027	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Swinging doors are arranged so that each door swings in an opposite direction. Doors are self-closing and rabbets, bevels or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.5, 18.3.7.6, 18.3.7.8	K 027		

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K 034	<p>Continued From page 6</p> <p>when pressure was applied to the panic hardware. Further testing revealed the door lock dropped when activated by the keypad, ruling out an Immediate Jeopardy. Interview of the Facility Manager indicated this door was not operating due to a previous electrical issue caused by recent lightning activity in the area. He further stated he was awaiting additional parts for repair.</p> <p>The above findings were further acknowledged by the Administrator and Facility Manager during the exit conference conducted on September 16, 2014 from 6:00 PM to 7:00 PM.</p> <p>Actual NFPA standard:</p> <p>7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed-egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met.</p> <p>(a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6.</p> <p>(b) The doors shall unlock upon loss of power controlling the lock or locking mechanism.</p> <p>(c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than</p>	K 034	<p>Parts replaced and the door is operational and in good condition See attachment 'E'</p>	10/6/2014

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K 034	Continued From page 7 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) * On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS	K 034		
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 ensure that exit access was immediately available without the use of a tool or key from the egress side. Failure to allow immediate exiting capabilities could accidentally trap occupants during an emergency. This deficient practice affected all patients, staff and visitors on the date of the survey. The facility is licensed for 19 Hospital beds and had a census of 5 on the day of the survey. Findings include: 1) During the facility tour conducted on September 16, 2014 from 2:15 PM to 4:00 PM,	K 038		

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K 038	<p>Continued From page 10</p> <p>located not less than 34 in. (86 cm), and not more than 48 in. (122 cm), above the finished floor. Doors shall be operable with not more than one releasing operation.</p> <p>Exception No. 1*: Egress doors from individual living units and guest rooms of residential occupancies shall be permitted to be provided with devices that require not more than one additional releasing operation, provided that such device is operable from the inside without the use of a key or tool and is mounted at a height not exceeding 48 in. (122 cm) above the finished floor. Existing security devices shall be permitted to have two additional releasing operations. Existing security devices other than automatic latching devices shall not be located more than 60 in. (152 cm) above the finished floor. Automatic latching devices shall not be located more than 48 in. (122 cm) above the finished floor.</p> <p>Exception No. 2: The minimum mounting height for the releasing mechanism shall not be applicable to existing installations.</p> <p>18.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side.</p> <p>Exception No. 1: Door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. (See 18.1.1.1.5 and 18.2.2.2.5.)</p> <p>Exception No. 2*: Delayed-egress locks complying with 7.2.1.6.1 shall be permitted, provided that not more than one such device is located in any egress path.</p>	K 038		

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K 038	Continued From page 11 Exception No. 3: Access-controlled egress doors complying with 7.2.1.6.2 shall be permitted.	K 038		
K 050	NFPA 101 LIFE SAFETY CODE STANDARD 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. 18.7.1.2 This Standard is not met as evidenced by: Based on record review and interview, the facility failed to ensure that fire drills were conducted once per shift per quarter. Failure to adequately train staff could hinder proper response during a fire or emergency event. This deficient practice affected all patients, staff and visitors on the date of the survey. The facility is licensed for 19 hospital beds and had a census of 5 on the day of the survey. Findings include: During record review of the facility conducted on September 16, 2014 from 10:00 AM to 11:45 AM, review of the facilities fire drill reports failed to produce a second shift fire drill for the drills conducted during the first and third quarters. When asked, the Facility Manager stated he had only been conducting fire drills during the daytime shift when he was present. Actual NFPA standard:	K 050	Will continue to perform dayshift fire drills monthly and will conduct swing shift fire drills every quarter with documentation.	10/8/14

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K 050	Continued From page 12 18.7.1.2* 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.	K 050		
K 064	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure fire extinguishers were properly signed per NFPA 10. Failure to ensure extinguishers are signed could result in the wrong extinguisher being used for its intended hazard during a fire. This deficient practice affected all patients, staff and visitors using the kitchen/dining area on the date of the survey. The facility is licensed for 19 hospital beds and had a census of 5 on the day of the survey. Findings include: During the facility tour conducted on September	K 064		

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K 064	Continued From page 13 16, 2014 from 12:15 PM to 2:30 PM, observation of the K-style fire extinguisher located in the main kitchen found it was not properly signed for its intended use. Further observation of the Kitchen revealed the pass-through for food and dishes was directly open to the main dining area. Interview of the Facility Manager indicated he was not aware this sign was missing. Actual NFPA standard: 2-3.2* Fire extinguishers provided for the protection of cooking appliances that use combustible cooking media (vegetable or animal oils and fats) shall be listed and labeled for Class K fires. Exception: Extinguishers installed specifically for these hazards prior to June 30, 1998. 2-3.2.1 A placard shall be conspicuously placed near the extinguisher that states that the fire protection system shall be activated prior to using the fire extinguisher.	K 064	New sign at (K) fire extinguisher placed on wall above extinguisher See attachment 'F'	10/6/2014
K 072	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that exit access was maintained free of obstacles. Failure to provide instant use of exits at all times could prevent the safe evacuation of occupants during and emergency. This deficient practice affected all patients staff and visitors in the X-ray department on the date	K 072		

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K 072	Continued From page 14 of the survey. The facility is licensed for 19 hospital beds and had a census of 5 on the day of the survey. Findings include: During the facility tour conducted on September 16, 2014 from 3:30 PM to 4:30 PM, observation of the south exit from the X-ray department found the access to the exit was impeded by a portable X-ray machine and (2) soiled linen/trash receptacles located directly outside the door entering the MRI area. When asked, the Facility Manager stated he was aware these items were not allowed to be stored in this location. (See tag K 075) Actual NFPA standard: 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K 072	X-Ray machine was moved out of access corridor. Soiled linen receptacles moved out. See attachment 'G'	10/6/2014
K 074	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 18.7.5.1, 1, NFPA 13	K 074		

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

Printed: 09/25/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131317	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - ADDITION & RENNOVATION B. WING _____	(X3) DATE SURVEY COMPLETED 09/16/2014
NAME OF PROVIDER OR SUPPLIER BENEWAH COMMUNITY HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 229 SOUTH 7TH STREET ST MARIES, ID 83861		
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K 074	Continued From page 15 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4, 18.7.5.3 This Standard is not met as evidenced by: Based on record review, interview and physical inspection, the facility failed to ensure curtains were installed in accordance with NFPA 701. Failure to ensure the flame resistive properties of curtains and loosely hanging decorations would allow fires to develop and spread beyond incipient stages. This deficient practice affected all patients, staff and visitors on the date of the survey. The facility is licensed for 19 hospital beds and had a census of 5 on the day of the survey. Findings include: During the facility tour conducted on September 16, 2014 from 12:15 PM to 3:30 PM, observation and physical inspection of curtains installed in rooms 205, 209 and 211 found that only the cubicle privacy curtains were tagged for flame spread ratings in accordance with NFPA 701. Window curtains installed in these rooms were not tagged indicating the flame spread properties of the fabric and did not reveal they had been chemically treated when physically examined. Actual NFPA standard: 10.3.1*	K 074	Have located and have on hand all fire codes for drapes, furnishings, and fabrics. Found in records and is on file.	10/7/2014

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NAME OF PROVIDER OR SUPPLIER BENEWAH COMMUNITY HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 229 SOUTH 7TH STREET ST MARIES, ID 83861		
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K 074	Continued From page 16 Where required by the applicable provisions of this Code, draperies, curtains, and other similar loosely hanging furnishings and decorations shall be flame resistant as demonstrated by testing in accordance with NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films.	K 074	Have located and have on hand all fire codes for drapes, furnishings, and fabrics. Found in records and is on file.	10/7/2014
K 075	NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq. ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9 sq. m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 18.7.5.5 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure highly combustible material was stored in a safe manner. Failure to provide proper protection of hazardous storage would result in smoke and dangerous gases to pass freely through corridors during a fire hindering egress capabilities. This deficient practice affected all patients, staff and visitors using the X-ray department on the date of the survey. The facility is licensed for 19 hospital beds and had a census of 5 on the day of the survey. Findings include:	K 075		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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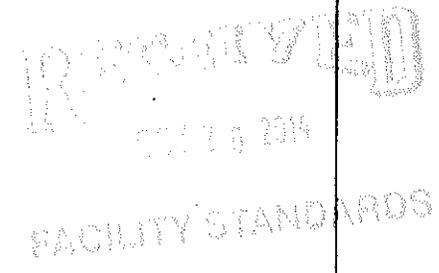
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131317	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - ADDITION & RENNOVATION B. WING _____	(X3) DATE SURVEY COMPLETED 09/16/2014	
NAME OF PROVIDER OR SUPPLIER BENEWAH COMMUNITY HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 229 SOUTH 7TH STREET ST MARIES, ID 83861		
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K 075	<p>Continued From page 17</p> <p>1) During the facility tour conducted on September 16, 2014 from 3:30 PM to 4:30 PM, observation of the area outside the bathroom in the X-ray department found (2) 32 gal. soiled linen and trash storage receptacles stored in this location. When interviewed, the Facility Manager stated he was not aware of the requirement to contain these receptacles in a hazardous area storage.</p> <p>2) During the facility tour conducted on September 16, 2014 from 3:30 PM to 4:30 PM, observation of the exit access from the X-ray department to the southwest exit found (2) 32 gal. soiled linen and trash storage receptacles stored in this area. When asked, staff in the area stated these were used to store used garments and trash accumulated during X-ray procedures.</p> <p>(See K 072)</p> <p>Actual NFPA standard:</p> <p>18.7.5.5 Soiled linen or trash collection receptacles shall not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gal/ft² (20.4 L/m²). A capacity of 32 gal (121 L) shall not be exceeded within any 64-ft² (5.9-m²) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) shall be located in a room protected as a hazardous area when not attended. Exception: Container size and density shall not be limited in hazardous areas.</p>	<p>K 075</p> <p>#1</p> <p>K075 #2</p>	<p>Linen collection reduced to 1 container 32 gal. capacity. See attachment "H"</p> <p>Linen collection reduced to 1 container 32 gal. capacity. See attachment "I"</p>	<p>10/6/2014</p> <p>10/6/2014</p>

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IDG1AX	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 02 - ENTIRE HOSPITAL INCLUDES WING B. WING _____	(X3) DATE SURVEY COMPLETED 09/16/2014
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NAME OF PROVIDER OR SUPPLIER BENEWAH COMMUNITY HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 229 SOUTH 7TH STREET ST MARIES, ID 83861
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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
B 000	<p>16.03.14 Initial Comments</p> <p>The hospital is a four story Type II (222) structure separated by two hour construction to the original single story hospital building. The entire hospital is protected throughout by an automatic fire extinguishing system design/installed per NFPA Std 13 for light hazard occupancy and has a supervised manual fire alarm system with partial detection.</p> <p>The following deficiencies were cited at the above facility during a recertification survey conducted on September 16, 2014. The facility was surveyed under the Life Safety Code, 2000 Edition, New Health Care Occupancies in accordance with 42 CFR 282.41(b).</p> <p>The survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	B 000		
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>	BB161		

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *James R. Brayles RN Administrator / DNS* TITLE _____ 10-17-14 (X6) DATE
STATE FORM 6599 BOLZ21 If continuation sheet 1 of 2 10/08/14

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IDC1AX	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 02 - ENTIRE HOSPITAL INCLUDES WING B. WING _____	(X3) DATE SURVEY COMPLETED 09/16/2014
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NAME OF PROVIDER OR SUPPLIER BENEWAH COMMUNITY HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 229 SOUTH 7TH STREET ST MARIES, ID 83861
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BB161	<p>Continued From page 1</p> <p>This Rule is not met as evidenced by: Refer to the following deficiencies on CMS 2567:</p> <ul style="list-style-type: none"> K 012 Building construction continuity K 027 Smoke compartment doors K 034 Delayed egress locks K 038 Egress locking impediments K 050 Fire drills K 062 Sprinkler maintenance K 064 Fire extinguisher signage K 072 Exit obstructions K 074 Flame spread ratings of interior finishes K 075 Hazardous storage 	BB161		