



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
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CERTIFIED MAIL: 7012 3050 0001 2128 2606

October 10, 2014

John Williams, Administrator
Oneida County Hospital & Long Term Care Facility
PO Box 126
Malad, ID 83252-0126

Provider #: 135062

**RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER
LETTER**

Dear Mr. Williams:

On **September 30, 2014**, a Facility Fire Safety and Construction survey was conducted at **Oneida County Hospital & Long Term Care Facility** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. Please provide **ONLY ONE** completion date for each federal and state tag in column (X5) Completion Date to signify when you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date

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Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign both Statement of Deficiencies and Plan of Correction, Form CMS-2567 and State Form, in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **October 23, 2014**. Failure to submit an acceptable PoC by **October 23, 2014**, may result in the imposition of civil monetary penalties by **November 11, 2014**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- 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,
- Include dates when corrective action will be completed.
- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567 and the state licensure survey report, State Form.

All references to federal regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **November 4, 2014**, (Opportunity to Correct). Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **November 4, 2014**. A change in the seriousness of the deficiencies on **November 4, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **November 4, 2014**, includes the following:

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Denial of payment for new admissions effective **December 30, 2014**.
42 CFR §488.417(a)

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **March 30, 2015**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Mark P. Grimes, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **September 30, 2014**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

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Go to the middle of the page to Information Letters section and click on State and select the following:

BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process
2001-10 IDR Request Form

This request must be received by **October 23, 2014**. If your request for informal dispute resolution is received after **October 23, 2014**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,



Mark P. Grimes, Supervisor
Facility Fire Safety and Construction

MPG/lj
Enclosures

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

Printed: 10/09/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135062	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 09/30/2014
NAME OF PROVIDER OR SUPPLIER ONEIDA COUNTY HOSP & LTC FAC		STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 126 MALAD, ID 83252		
(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
K 000	INITIAL COMMENTS The facility is a single story, Type II (211) construction with a large basement originally built/completed November 24, 1970 with an addition in 1993. Currently the facility is licensed for 33 NF beds. The building also contains a 11 bed hospital. The following deficiencies were cited during the annual fire/life safety survey conducted on September 30, 2014. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70. The Survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	K 000	<i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truths of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it.</i> K012F • Corrective action for identified areas/residents. The facility's Maintenance Supervisor used an appropriate fire/smoke related sealant on the two (2) unsealed ¾" conduits identified during survey. (See attached picture labeled 1 demonstrating completed corrective action). The facility's Maintenance Supervisor replaced the ceiling tiles in the northwest corridor observed during survey with appropriately rated ceiling tiles that fit the area without gaps. (See attached picture labeled 2 demonstrating completed corrective action). The facility's Maintenance Supervisor re-established an appropriate smoke barrier wall and ceiling that will resist the passage of smoke and prohibit the passage of smoke and dangerous gases between smoke compartments during a fire event. The area was first built up with 2x4's running the span of the compromised area. Appropriately rated drywall and sealant were then constructed around the identified area to form a compliant smoke barrier. (See attached pictures 3 and 4 showing the compromised area before and after corrective action). • Identification of residents with potential to be affected. All residents have a potential to be affected.	10/21/14
K 012 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure smoke barrier walls and ceilings would resist the passage of smoke. Failure to ensure smoke barrier continuity could allow the passage of smoke and dangerous gases between smoke compartments during a fire event. This deficient practice affected 11 residents in the long term care and 5 patients in the hospital, all staff and visitors in 2 of 4 smoke compartments on the date of the survey. The	K 012		

RECEIVED
OCT 23 2014
FACILITY STANDARDS

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

TITLE

(X6) DATE

Sam Burbank

CEO ADMINISTRATOR

10/21/14

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 facility is licensed for 33 SNF/NF beds and had a census of 29 on the day of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on September 30, 2014 from 2:00 PM to 3:00 PM, observation above the ceiling at the smoke barrier doors leading from the hospital into the long term care unit located adjacent to the main lobby found two (2) unsealed 3/4" conduits passing through the smoke barrier wall. Interview of the Maintenance Engineer found he was unaware these pipes had not been sealed when installed.</p> <p>2) During the facility tour conducted on September 30, 2014 from 2:00 PM to 3:00 PM, observation of the ceiling tiles in the northwest corridor found two (2) tiles out of place with approximately 1/4" by 4" gaps and two (2) chipped ceiling tiles with approximately 1/2" by 1/2" open gaps.</p> <p>3) During the facility tour conducted on September 30, 2014 from 2:00 PM to 3:00 PM, observation above the ceiling at the smoke door located in the corridor facing the service wing found that a portion of the smoke barrier wall had been removed leaving an approximately three foot wide by twelve inch tall gap.</p> <p>Further investigation of this area found two (2) approximately fourteen inch by two foot openings cut into the intersecting smoke barrier wall which ran north to south. When asked, the Maintenance Engineer indicated he was not aware of these penetrations. Further interview during the exit conference conducted on September 30, 2014 from 3:00 PM to 4:00 PM revealed the</p>	K 012	<ul style="list-style-type: none"> • Measures to prevent occurrence. The Maintenance Supervisor inspected all open areas to validate that no other areas were similarly compromised. All areas identified as being potentially out of compliance were corrected. • Monitoring and Quality Assurance To validate that appropriate smoke barriers are being maintained, the Maintenance Supervisor or designee will conduct audits of facility three times a week to demonstrate facility compliance. Any identified trends will be reported to the Quality Assurance Committee monthly and as needed until a lesser frequency is deemed appropriate. • Compliance date is 10/23/2014 	10/21/14

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K 012	<p>Continued From page 2</p> <p>Administrator and the Maintenance Engineer believed these two open areas were the result of prior remodeling that had not been sealed.</p> <p>Actual NFPA standard:</p> <p>Finding (1)</p> <p>8.2.4.4.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through smoke partitions shall be protected as follows:</p> <p>(1) The space between the penetrating item and the smoke partition shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of limiting the transfer of smoke.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(2) Where the penetrating item uses a sleeve to penetrate the smoke partition, the sleeve shall be solidly set in the smoke partition, and the space between the item and the sleeve shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of limiting the transfer of smoke.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(3) Where designs take transmission of vibrations into consideration, any vibration isolation shall meet one of the following conditions:</p> <p>a. It shall be made on either side of the smoke partitions.</p> <p>b. It shall be made by an approved device that is designed for the specific purpose.</p> <p>Finding (2&3)</p>	K 012		

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K 012	Continued From page 3 8.3 SMOKE BARRIERS 8.3.2* Continuity. Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces. Exception: A smoke barrier required for an occupied space below an interstitial space shall not be required to extend through the interstitial space, provided that the construction assembly forming the bottom of the interstitial space provides resistance to the passage of smoke equal to that provided by the smoke barrier.	K 012	<i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truths of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it.</i>	10/21/14
K 038 SS=D	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. 19.2.1 This Standard is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to maintain readily accessible means of exit access. Failure to allow rapid means of exit access has the potential to impede escape in the event of a fire or other emergency. This deficient practice affected no residents, staff and visitors in 2 of 4 smoke compartments on the date of survey. The facility is licensed for 33 SNF/NF beds and had a census of 28 on the date of survey.	K 038	K038D • Corrective action for identified areas/residents. Prior to survey completion, the facility's Maintenance Supervisor addressed the items blocking egress from room 110 by removing these items. The facility's Maintenance Supervisor replaced the locks on rooms 110, 129, 133 and the Beauty Salon with locks that allow for a one-step unlatch that is compliant with the demonstration given during survey. • Identification of residents with potential to be affected: All residents have a potential to be affected. • Measures to prevent occurrence. The Maintenance Supervisor or designee will educate appropriate facility staff regarding Life Safety codes pertaining to the storage of equipment in hallways. The Maintenance Supervisor and Nursing Home Administrator performed an audit of all similar locks in the facility and replaced any similar locks with approved locking units. • Monitoring and Quality Assurance To validate that exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1.19.2.1, the Maintenance Supervisor or designee will conduct audits of facility three times a week to demonstrate facility compliance. Any identified trends will be reported to the Quality Assurance Committee monthly and as needed until a lesser frequency is deemed appropriate. Compliance date is 10/23/2014	

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K 038	<p>Continued From page 4 Findings include:</p> <p>1) During the facility tour conducted on September 30, 2014 from 1:00 PM to 2:00 PM, observation of the hall leading from the exit of room 110 (Clean Linen) into the southwest corridor found it blocked by three (3) blood pressure equipment stands and one (1) 32 gal soiled linen receptacle. Interview of the Maintenance Engineer found he was not aware of why these items were stored in this location.</p> <p>2) During the facility tour conducted on September 30, 2014 from 1:00 PM to 2:00 PM, observation of doors to rooms 110, 129, 133 and the Beauty Salon found they were equipped with combination controlled deadbolt locks. When asked, the Maintenance Engineer stated the facility had been in the process of replacing these locks.</p> <p>Actual NFPA standard:</p> <p>7.2 MEANS OF EGRESS COMPONENTS</p> <p>Finding 1</p> <p>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.</p> <p>Finding 2</p> <p>7.2.1.5.4* A latch or other fastening device on a door shall be provided with a releasing device having an obvious method of operation and that is readily operated under all lighting conditions. The</p>	K 038		

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K 038	Continued From page 5 releasing mechanism for any latch shall be 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. 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. Exception No. 2: The minimum mounting height for the releasing mechanism shall not be applicable to existing installations.	K 038	<i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truths of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it.</i>	10/21/14
K 075 SS=E	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. 19.7.5.5	K 075	K075E <ul style="list-style-type: none"> • Corrective action for identified areas/residents. The facility's Maintenance Supervisor removed one of the two 32 gallon soiled linen containers observed in the hall outside the kitchen and maintenance office leaving only one (1) 32 gallon soiled linen receptacle. • Identification of residents with potential to be affected. All residents have a potential to be affected. • Measures to prevent occurrence. The Maintenance Supervisor or designee will educate appropriate facility staff regarding Life Safety codes pertaining to the storage of soiled linen and trash receptacles in facility hallways. The Maintenance Supervisor and Nursing Home Administrator performed an audit of all areas of the facility and removed any soiled linen/trash receptacles not in compliance with NFPA standard 19.7.5.5. • Monitoring and Quality Assurance To validate that soiled linen and trash receptacle storage is compliant with NFPA section 7.1.19.7.5.5, the Maintenance Supervisor or designee will conduct audits of facility three times a week to demonstrate facility compliance. Any identified trends will be reported to the Quality Assurance Committee monthly and as needed until a lesser frequency is deemed appropriate. Compliance date is 10/23/2014 	

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K 075	Continued From page 6 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 passing freely into corridors during a fire hindering egress capabilities. This deficient practice affected residents occupying the dining room, staff and visitors in 1 of 4 smoke compartments on the date of the survey. The facility is licensed for 33 SNF/NF beds and had a census of 29 on the day of the survey. Findings include: During the facility tour conducted on September 30, 2014 from 9:30 AM to 12:00 PM and again from 12:30 PM to 1:00 PM, observation of the hall outside of the Kitchen and the Maintenance office found two (2) 32 gal. receptacles stored in less than 64 square feet. When interviewed, the Maintenance Engineer stated he was not aware that this storage was not allowed. Actual NFPA standard: 19.7.5.5 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/ft ² (20.4 L/m ²). A capacity of 32 gal (121 L) shall not be exceeded within any 64-ft ² (5.9-m ²) 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.	K 075		

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K 075	Continued From page 7 Exception: Container size and density shall not be limited in hazardous areas.	K 075		

Bureau of Facility Standards

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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2.</p> <p>The facility is a single story, Type II (211) construction with a large basement originally built/completed November 24, 1970 with an addition in 1993. Currently the facility is licensed for 33 NF beds. The building also contains a 11 bed hospital.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on September 30, 2014. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70 and IDAPA 16.03.02, Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities.</p> <p>The Survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	C 000	<p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truths of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it.</i></p> <p>Please refer to the plan of correction for K tags 012, 038 and 075 on the attached Form 2567b.</p>	10/21/14
C 226	<p>02.106 FIRE AND LIFE SAFETY</p> <p>106. FIRE AND LIFE SAFETY. Buildings on the premises used as facilities shall meet all the requirements of local, state and national codes concerning fire and life safety standards that are applicable to health care facilities.</p> <p>This Rule is not met as evidenced by: Please refer to K tags on federal form CMS 2567.</p>	C 226		

RECEIVED
OCT 23 2014
FACILITY STANDARDS

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

James WMS.

TITLE

CEO/ADMINISTRATOR 10/21/14

(X6) DATE

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135062	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 09/30/2014
NAME OF PROVIDER OR SUPPLIER ONEIDA COUNTY HOSP & LTC FAC		STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 126 MALAD, ID 83252		
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C 226	Continued From Page 1 K 012 Continuity of smoke barriers K 038 Means of egress K 075 Combustible material storage	C 226		