IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
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DIVISION OF LICENSING & CERTIFICATION
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October 30, 2015

Alan Bird, Administrator
Franklin County Medical Center
44 North First East
Preston, ID 83263

RE: Franklin County Medical Center, Provider ID# 131322

Dear Mr. Bird:

This is to advise you of the findings of the Medicare/Licensure Fire Life Safety Survey, which was concluded at Franklin County Medical Center, on October 21, 2015.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicare deficiencies and a similar form listing State licensure deficiencies. If applicable, a similar State Form will be provided listing licensure health 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.

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 **November 12, 2015.**

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,

MARK P. GRIMES
Supervisor
Facility Fire Safety and Construction Program

MPG/lj

Enclosure

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	131322	A. BUILDING 01 - ENTIRE HOSPITAL B. WING _____	10/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN COUNTY MEDICAL CENTER	44 NORTH FIRST EAST PRESTON, ID 83263

(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 (111) which is fully sprinklered and smoke detection is provided throughout. Original construction was in 1961 with subsequent additions and remodels, the most recent being completed in 2015. Currently the facility is licensed for 20 hospital beds. The following deficiencies were cited during the annual fire/life safety survey conducted on October 21, 2015. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, New Health Care Occupancy, in accordance with 42 CFR 485.623. The Survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	K 000	RECEIVED NOV 13 2015 FACILITY STANDARDS	
K 029	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This Standard is not met as evidenced by: Based on observation and operational testing, the facility failed to ensure that hazardous areas were	K 029	K029-Door Closer for the Central Supply Area: 1-The corrective action for Tag K029 was to reinstall the self-closing device that had been disabled; by 11/10/15. 2-We will perform a facility wide inspection to identify any other hazardous areas that do not have a self-closing device. If any areas are found to not have such a device; a self-closing device will be installed.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Asst Adm CEO-Admin 11/11/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 029	Continued From page 1 protected with self-closing doors. Failure to provide self-closing doors to hazardous areas could allow smoke and dangerous gases to pass into corridors, affecting egress during a fire event. This deficient practice affected patients, staff and visitors on the date of the survey. The facility is licensed for 20 hospital beds and had a census of 16 on the day of the survey. Findings include: During the facility tour conducted on October 21, 2015 from 10:00 AM to 4:00 PM, observation of the Central Supply storage area across from the main Kitchen revealed the area measured approximately twelve (12) feet by twelve (12) feet (144 square feet), housing combustible paper products such as paper towels, napkins and cleaning supplies. Operational testing of this door revealed the door would not self-close. Further inspection revealed the self-closing device installed on the door had been disabled. Actual NFPA standard: 3.3.13.2 Area, Hazardous. An area of a structure or building that poses a degree of hazard greater than that normal to the general occupancy of the building or structure, such as areas used for the storage or use of combustibles or flammables; toxic, noxious, or corrosive materials; or heat-producing appliances. 18.3.2 Protection from Hazards. 18.3.2.1* Hazardous Areas. Any hazardous area shall be protected in accordance with Section 8.4. The areas described in Table 18.3.2.1 shall be protected as indicated.	K 029	3-As part of their monthly fire inspection, the maintenance staff will inspect the entire facility for hazardous areas without door closures. 4-Each month the Maintenance Supervisor will monitor the inspection process to make sure it is performed. The Maintenance Supervisor will report his findings related to door closures to the safety committee, quarterly, for the next year or until the safety committee deems that it doesn't need to be reported any longer. 5-The corrective action was completed on 11/10/2015. Please see attached photo of the corrective action.	

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K 029	Continued From page 2 8.4 SPECIAL HAZARD PROTECTION 8.4.1 General. 8.4.1.1* Protection from any area having a degree of hazard greater than that normal to the general occupancy of the building or structure shall be provided by one of the following means: (1) Enclose the area with a fire barrier without windows that has a 1-hour fire resistance rating in accordance with Section 8.2. (2) Protect the area with automatic extinguishing systems in accordance with Section 9.7. (3) Apply both 8.4.1.1(1) and (2) where the hazard is severe or where otherwise specified by Chapters 12 through 42.	K 029		
K 062	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25; 9.7.5 This Standard is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure anti-freeze protection in fire suppression systems were tested and documented for concentration in accordance with NFPA 25. Failure to properly test and maintain sprinkler systems could result in these systems not performing as designed during a fire event. This deficient practice affected patients, staff and visitors on the date of the survey. The facility is licensed for 20 hospital beds and had a census of 16 on the day of the survey.	K 062	K062-Sprinkler System: 1-The corrective action for K062 will be to drain the deficient antifreeze loops and to install new antifreeze that meets and is in accordance with NFPA 25. This will be performed on November 19, 2015 by Gem State Fire Protection. 2-There are no other potential areas in the facility that are affected by this deficient practice because all other areas are covered by a dry sprinkler system. 3-The sprinkler system will be inspected on an annual basis by Viking Sprinkler Company to ensure the deficient practice does not recur. 4-The Maintenance	

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K 062	Continued From page 3 Findings include: 1) During record review of the facility fire suppression system inspection reports conducted on October 21, 2015 from 8:45 AM to 10:00 AM, documentation of the antifreeze solution revealed the system was being tested for temperature and not percentage of concentration. Interview of the Maintenance Supervisor found he was not aware of the requirement to test these systems by percentage to indicate their concentration, not the temperature rating of protection. 2) During the facility tour conducted on October 21, 2015 from 10:00 AM to 4:00 PM, observation of the sprinkler riser inspection tags revealed two (2) inspected anti-freeze loops. Further observation of the inspection tags found both tags had been documented as to the temperature of the anti-freeze protection and not the percentage of concentration. Actual NFPA standard: NFPA 25 2-3.4* Antifreeze Systems. The freezing point of solutions in antifreeze shall be tested annually by measuring the specific gravity with a hydrometer or refractometer and adjusting the solutions if necessary. Solutions shall be in accordance with Tables 2-3.4(a) and (b). The use of antifreeze solutions shall be in accordance with any state or local health regulations. [See Table 2-3.4(b).]	K 062	Supervisor/designee will ensure that the sprinkler system is inspected on the last quarter of each year by a licensed sprinkler contractor in accordance with NFPA 25. The Maintenance Supervisor will report to the safety committee after each annual inspection. 5- The corrective action will be performed on November 19, 2015 by Gem State Fire Protection.	
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. 19.3.5.6, NFPA 10	K 064	K064-Portable Fire Extinguishers: 1-The corrective action for Tag K064 was to remove all existing fire extinguishers and replace them	

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K 064	Continued From page 4 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that portable fire extinguishers were installed in accordance with NFPA 10. Failure to install fire extinguishers at the appropriate height could hinder response during a fire event. This deficient practice affected patients, staff and visitors on the date of the survey. The facility is licensed for 20 hospital beds and had a census of 16 on the day of the survey. Findings include: During the facility tour conducted on October 21, 2015 from 10:00 AM to 4:00 PM, physical inspection of 4 of 4 fire extinguishers revealed they were installed at heights measured from the floor to the top of the extinguisher ranging from 64 inches to 69-1/2 inches. Interview of the Maintenance Supervisor confirmed this condition was widespread and no further documentation was deemed necessary. Actual NFPA standard: NFPA 10 1-6.10 Fire extinguishers having a gross weight not exceeding 40 lb (18.14 kg) shall be installed so that the top of the fire extinguisher is not more than 5 ft (1.53 m) above the floor. Fire extinguishers having a gross weight greater than 40 lb (18.14 kg) (except wheeled types) shall be so installed that the top of the fire extinguisher is	K 064	with a 5 lb. extinguisher to ensure that NFPA 10 standards are met and maintained. 2-The Maintenance Supervisor has done a facility wide inspection to identify any other areas with portable extinguishers that do not meet the NFPA 10 standards. 3-If a new extinguisher is to be replaced; the Maintenance Supervisor/designee will ensure that it meets the NFPA 10 standards. 4-The maintenance staff will perform and document monthly extinguisher checks to ensure that NFPA 10 standards are maintained. The Maintenance Supervisor will report regarding the monthly extinguisher checks to the safety committee each quarter, for the next year or until the safety committee deems that it doesn't need to be reported any longer. 5-The corrective action occurred on October 30, 2015; at which time all extinguishers were replaced with 5 lb., ABC extinguishers in accordance with NFPA 10 regulations.	

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K 064	Continued From page 5 not more than 31/2 ft (1.07 m) above the floor. In no case shall the clearance between the bottom of the fire extinguisher and the floor be less than 4 in. (10.2 cm).	K 064		
K 147	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This Standard is not met as evidenced by: Based on observation, the facility failed to ensure electrical installations were installed and maintained in a safe manner for sealing boxes with exposed wiring. Failure to cover electrical installations with exposed wiring could result in fires by arcing or electrocution. This deficient practice affected patients, staff and visitors on the date of the survey. The facility is licensed for 20 hospital beds and had a census of 16 on the day of the survey. Findings include: During the facility tour conducted on October 21, 2015 from 10:00 AM to 4:00 PM, the following areas were discovered to have electrical installations with exposed wiring: 1) The I/T training room had two (2) open electrical junction boxes approximately 3-1/2 inches in diameter with exposed wiring. 2) The I/T equipment room abutting the training room referenced in finding (1) had an open four inch square electrical junction box with exposed wiring. Interview of the Maintenance Supervisor indicated	K 147	K147-Uncovered Electrical Boxes: 1-The corrective action for Tag K147 was to find and cover all exposed and/or unsealed electrical boxes. 2-The maintenance staff will identify all areas having the potential for deficient practice by inspecting the entire facility for uncovered/unsealed electrical boxes. Once discovered each electrical box will be covered and/or sealed. 3-The Maintenance Supervisor/designee will inform all electricians working in the facility that all electrical boxes shall be covered/sealed at the end of each work day or when the job is completed. The maintenance staff will perform a nightly inspection of construction areas to ensure that all boxes are covered and /or sealed. 4-The maintenance staff will perform a monthly inspection of the facilities to ensure that there are no electrical boxes that are uncovered or unsealed. The	

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K 147	Continued From page 6 he was not aware of the exposed wiring from these installations. Actual NFPA standard: NFPA 70 110.12 Mechanical Execution of Work. Electrical equipment shall be installed in a neat and workmanlike manner. (A) Unused Openings. Unused cable or raceway openings in boxes, raceways, auxiliary gutters, cabinets, cutout boxes, meter socket enclosures, equipment cases, or housings shall be effectively closed to afford protection substantially equivalent to the wall of the equipment. Where metallic plugs or plates are used with nonmetallic enclosures, they shall be recessed at least 6 mm (¼ in.) from the outer surface of the enclosure. (B) Subsurface Enclosures. Conductors shall be racked to provide ready and safe access in underground and subsurface enclosures into which persons enter for installation and maintenance. (C) Integrity of Electrical Equipment and Connections. Internal parts of electrical equipment, including busbars, wiring terminals, insulators, and other surfaces, shall not be damaged or contaminated by foreign materials such as paint, plaster, cleaners, abrasives, or corrosive residues. There shall be no damaged parts that may adversely affect safe operation or mechanical strength of the equipment such as parts that are broken; bent; cut; or deteriorated by corrosion, chemical action, or overheating. 314.17 Conductors Entering Boxes, Conduit Bodies, or Fittings. Conductors entering boxes, conduit bodies, or fittings shall be protected from abrasion and shall comply with 314.17(A) through (D).	K 147	Maintenance Supervisor/designee will make sure that the inspection has taken place and is documented. The Maintenance Supervisor will report to the safety committee quarterly, regarding his findings, for the next year or until the safety committee deems that it doesn't need to be reported any longer.5-The corrective action was completed on 11-11-2015. Please see attached photos.	

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K 147	Continued From page 7 (A) Openings to Be Closed. Openings through which conductors enter shall be adequately closed.....	K 147		

Bureau of Facility Standards

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B 000	16.03.14 Initial Comments The facility is a single story type II (111) which is fully sprinklered and smoke detection is provided throughout. Original construction was in 1961 with subsequent additions and remodels, the most recent being completed in 2015. Currently the facility is licensed for 20 hospital beds. The following deficiencies were cited during the annual fire/life safety survey conducted on October 21, 2015. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, New Health Care Occupancy, in accordance with 42 CFR 485.623 and IDAPA 16.03.14 Rules and Minimum Standards for Hospitals in Idaho. The Survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	B 000	RECEIVED DEC - 7 2015 FACILITY STANDARDS	
BB161	16.03.14.510 Fire and Life Safety Standards Buildings on the premises used as a hospital shall meet all the requirements of local, state, and national codes concerning fire and life safety that are applicable to hospitals. General Requirements. General requirements for the fire and life safety standards for a hospital are that: The hospital shall be structurally sound and shall be maintained and equipped to assure the safety of patients, employees, and the public. On the premises of all hospitals where natural or man-made hazards are present, suitable fences, guards, and railings shall be provided to protect patients, employees, and the public. This Rule is not met as evidenced by: Please refer to federal "K" tag:	BB161	BB161- Fire and Life Safety Standards Refer to Federal Form CMS 2567 11/30/15 TBA	

Idaho form

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ DATE original 11/11/15 corrected 11/30/15

STATE FORM 021199 9E9O21 If continuation sheet 1 of 3

Bureau of Facility Standards

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BB161	Continued From Page 1 K-029 Hazardous areas K-062 Sprinkler Maintenance K-064 Fire Extinguishers K-147 Electrical installations	BB161		
BB499	16.03.14.510.01 Fire & Life Safety Standards, General Require 510. FIRE AND LIFE SAFETY STANDARDS. Buildings on the premises used as a hospital shall meet all the requirements of local, state, and national codes concerning fire and life safety that are applicable to hospitals. (10-14-88) 01. General Requirements. General requirements for the fire and life safety standards for a hospital are that: (10-14-88) a. The hospital shall be structurally sound and shall be maintained and equipped to assure the safety of patients, employees, and the public. (10-14-88) b. 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. (10-14-88) This Rule is not met as evidenced by: Based on observation and interview, the facility failed to maintain the smoke resistive properties of corridor suspended ceilings. Failure to provide continuity in corridor suspended ceilings could diminish the system capabilities for detection and suppression and allow smoke and dangerous gases to communicate between compartments. This deficient practice affected patients, staff and visitors on the date of the survey. The facility is	BB499	<u>BB499- Maintenance of Suspended Ceiling Tiles:</u> 1-The corrective action for tag BB499 is that all ceiling tile will be replaced when finished working in that area or at the end of each work day. 2-The maintenance staff will identify all other areas for potential breaches to the interstitial spaces by performing an immediate inspection by 11/9/2015. If there are any deficiencies, the ceiling tiles will be closed immediately. 3-A document has been developed to notify the Maintenance Supervisor and grant permission for all entities that may breach the interstitial space due to work performed above the ceiling. The maintenance supervisor will approve and sign off on all work to ensure that the space in maintained according to code.	

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BB499	Continued From Page 2 licensed for 20 hospital beds and had a census of 16 on the day of the survey. Findings include: During the facility tour conducted on October 21, 2015 from 10:00 AM to 4:00 PM, the following areas were found to have missing or gapped ceiling tiles exposing the interstitial space above: 1) The "Foundation" office was missing one (1) ceiling tile with one (1) tile having a gap of approximately two inches by four feet. 2) The corridor at the newly renovated patient rooms for LDR was missing five (5) ceiling tiles. Interview of the Maintenance Supervisor indicated he was not aware of these missing or gapped ceiling tiles. Actual NFPA standard: 8.2.2 Compartmentation. 8.2.2.1 Where required by Chapters 12 through 42, every building shall be divided into compartments to limit the spread of fire and restrict the movement of smoke.	BB499	4-There will be a monthly monitoring of the ceiling tile throughout the entire facility by the Maintenance Supervisor/designee to ensure that the deficient practice does not recur. This will be recorded and dated by them. The Maintenance Supervisor will report his findings related to missing/damaged ceiling tile to the safety committee, quarterly, for the next year or until the safety committee deems that it doesn't need to be reported any longer. 5-The corrective action was completed on 11/9/2015. Please see attached example of the new document and photos of the corrective action.	