IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK-- ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
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
FAX 208-364-1888

December 10, 2015

Joe Cladouhos, Administrator
Syringa General Hospital
607 W. Main Street
Grangeville, ID 83530

RE: Syringa General Hospital, Provider # 131315

Dear Mr. Cladouhos:

This is to advise you of the findings of the Medicare/Licensure Fire Life Safety Survey, which was concluded at your facility, Syringa General Hospital, on November 30, 2015.

Enclosed is your copy of a Statement of Deficiencies/Plan of Correction, State form, which states that no State deficiencies were noted at the time of the survey.

Also enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicare 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;

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,

4. 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.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **December 23, 2015**, and keep a copy for your records.

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

Enclosures

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 |
|---|---|---|---|
| | 131315 | A. BUILDING 01 - ENTIRE HOSPITAL<br>B. WING | 11/30/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SYRINGA GENERAL HOSPITAL | 607 W MAIN STREET<br>GRANGEVILLE, ID 83530 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCI (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATOR OR LSC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (XS) COMPLETION DATE |
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| K 000 | INITIAL COMMENTS<br><br>The hospital is a Type V (111) two story structure with a partial basement under the original building and a partial non-patient upper level of the original building. All patient sleeping/use areas are restricted to the main/ground level. The original building was constructed around 1940 with subsequent remodeling and additions to include a major renovation/addition completed in the fall of 1989 and an expansion of the Emergency/Radiology departments in 1999. The facility is protected throughout by a complete automatic fire extinguishing system. Additional fire safety features include a fire alarm system with smoke detection in common areas, and at some barrier partition door assemblies; portable fire extinguishers throughout; a smoke barrier partition (i.e., two smoke compartments) on the main floor; and, an essential electrical system (i.e., diesel powered generator).<br><br>The following deficiencies were cited during the fire/life safety survey conducted on November 30, 2015. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 485.623.<br><br>The Survey was conducted by:<br><br>Sam Burbank<br>Health Facility Surveyor<br>Facility Fire Safety and Construction | K 000 | | |
| K 020 | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with | K 020 | | |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Bill Spencer | Director of Facilities | 12/18/15 |

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 020 | Continued From page 1<br>8.2.5.6. 19.3.1.1.<br><br>This Standard is not met as evidenced by:<br>Based on observation and operational testing the facility failed to ensure that stairwell doors communicating between floors would self-close and latch. Failure to provide doors communicating between floors which self-close and latch could allow fires and the by-products of combustion to pass between floors, exposing patients to those risks associated with fire events. This deficient practice affected all patients, staff and visitors on the date of the survey. The facility is licensed for 16 Hospital beds and had a census of 6 on the day of the survey.<br><br>Findings include:<br><br>During the facility tour conducted on November 30, 2015 from 12:30 PM to 3:30 PM, observation and operational testing of the stairwell door from the main level of the hospital to the lower basement level revealed it would not self-close and latch.<br><br>Actual NFPA standard:<br><br>19.3 PROTECTION<br>19.3.1 Protection of Vertical Openings.<br>19.3.1.1<br>Any vertical opening shall be enclosed or protected in accordance with 8.2.5. Where enclosure is provided, the construction shall have not less than a 1-hour fire resistance rating.<br>Exception No. 1: Unprotected vertical openings in accordance with 8.2.5.8 shall be permitted.<br>Exception No. 2: Exception No. 1 to 8.2.5.6(1) shall not apply to patient sleeping and treatment | K 020 | K020<br>Part of our door PM is to check for closure and latching monthly. We suspect this failure was due to construction on the floor above. On **December 1st** the facility department fixed the issue and we will more vigilant during our daily travels to watch for these kinds of issues while under construction. We will also add this to our ILSM hazard surveillance Inspection during construction. | 12/1/15 |

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| K 020 | Continued From page 2<br>rooms.<br>Exception No. 3: Multilevel patient sleeping areas in psychiatric facilities shall be permitted without enclosure protection between levels, provided that all the following conditions are met:<br>(a) The entire normally occupied area, including all communicating floor levels, is sufficiently open and unobstructed so that a fire or other dangerous condition in any part is obvious to the occupants or supervisory personnel in the area.<br>(b) Egress capacity is sufficient to provide simultaneously for all the occupants of all communicating levels and areas, with all communicating levels in the same fire area being considered as a single floor area for purposes of determination of required egress capacity.<br>(c) The height between the highest and lowest finished floor levels shall not exceed 13 ft (4 m); the number of levels shall not be restricted.<br>Exception No. 4: Unprotected openings in accordance with 8.2.5.5 shall not be permitted.<br>Exception No. 5: Where a full enclosure of a stairway that is not a required exit is impracticable, the required enclosure shall be permitted to be limited to that necessary to prevent a fire originating in any story from spreading to any other story.<br>19.3.1.2<br>A door in a stair enclosure shall be self-closing and shall normally be kept in the closed position.<br>Exception: Doors in stair enclosures held open under the conditions specified by 19.2.2.2.6 and 19.2.2.2.7. | K 020 | | |
| K 062 | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>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 | K 062 | | |

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| K 062 | Continued From page 3<br><br>This Standard is not met as evidenced by:<br>Based on observation and interview, the facility failed to ensure fire suppression system sprinkler pendants were free of paint. Failure to maintain fire suppression sprinkler systems free from paint could inhibit system performance during a fire event. This deficient practice affected 6 patients, staff and visitors on the date of the survey. The facility is licensed for 16 hospital beds and had a census of 6 on the day of the survey.<br><br>Findings include:<br><br>During the facility tour conducted on November 30, 2015 from 2:00 PM to 3:30 PM, observation of the installed fire suppression system revealed five (5) painted sprinkler pendants in the basement level. Interview of the Director of Facilities revealed he was not aware these pendants had been painted.<br><br>Actual NFPA standard:<br><br>NFPA 25<br>2-2 Inspection.<br>2-2.1 Sprinklers.<br>2-2.1.1*<br>Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.<br>Exception No. 1*: Sprinklers installed in concealed spaces such as above suspended ceilings shall not require inspection. | K 062 | K062<br><br>The facility department does most of the painting on site and are trained to be very careful of fire sprinkler heads. On December 1st we contacted our vendor Simplex Grinnell and placed a work order to get the five heads replaced. We will put in our monthly PM and will also bring it to the attention of our vendor Simplex Grinnell that it is part of their annual inspection to look for those issues. Simplex has said work will be completed by Mid January. | 1/15/16 |

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| K 062 | Continued From page 4<br>Exception No. 2: Sprinklers installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown. | K 062 | | |
| K 211 | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor:<br>o The corridor is at least 6 feet wide<br>o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms)<br>o The dispensers have a minimum spacing of 4 ft from each other<br>o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet.<br>o Dispensers are not installed over or adjacent to an ignition source.<br>o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623<br><br>This Standard is not met as evidenced by:<br>Based on observation, the facility failed to ensure that alcohol based hand rub dispensers were not installed above an ignition source in accordance with NFPA and CMS requirements. Installation of alcohol based hand rub dispensers above ignition sources such as electrical outlets or switches could result in fires from ignited vapors. This deficient practice affected all patients, staff and visitors utilizing the X-ray department on the date of the survey. The facility is licensed for 16 Hospital beds and had a census of 6 on the day of the survey. | K 211 | | |

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| K 211 | Continued From page 5<br>Findings include:<br><br>During the facility tour conducted on November 30, 2015 from 12:30 PM to 3:30 PM, observation of the X-ray department revealed an alcohol based hand rub dispenser installed directly over an outlet where leaking fluid could result in a fire.<br><br>Actual NFPA and CMS requirements:<br><br>TIA 00-1 (NFPA 101-2000)<br>19.3.2.7* Alcohol-based Hand-rub Solutions. Alcohol-based hand-rub dispensers shall be protected in accordance with 8.4.3 unless all of the following conditions are met:<br>(1) Where dispensers are installed in a corridor, the corridor shall have a minimum width of 6 ft (1.8 m).<br>(2) The maximum individual dispenser fluid capacity shall be:<br>(a) 0.3 gallons (1.2 liters) for dispensers in rooms, corridors, and areas open to corridors<br>(b) 0.5 gallons (2.0 liters) for dispensers in suites of rooms<br>(3) The dispensers shall have a minimum horizontal spacing of 4 ft (1.2 m) from each other.<br>(4) Not more than an aggregate 10 gallons (37.8 liters) of alcohol-based hand rub solution shall be in use in a single smoke compartment outside of a storage cabinet.<br>(5) Storage of quantities greater than 5 gallons (18.9 liters) in a single smoke compartment shall meet the requirements of NFPA 30, Flammable and Combustible Liquids Code.<br>(6) The dispensers shall not be installed over or directly adjacent to an ignition source.<br>(7) In locations with carpeted floor coverings, dispensers installed directly over carpeted surfaces shall be permitted only in sprinklered smoke compartments | K 211 | K211<br>To help insure this does not happen again we discussed it in the facility department. We moved the existing ABHR December 1st and relocated it to a safe location. Facility Department installed this and it was an oversite on our part. | 12/1/15 |

Bureau of Facility Standards

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| | IDJBI2 | A. BUILDING: 01 - ENTIRE HOSPITAL<br>B. WING _____ | 11/30/2015 |

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| B 000 | 16.03.14 Initial Comments<br><br>The hospital is a Type V (111) two story structure with a partial basement under the original building and a partial non-patient upper level of the original building. All patient sleeping/use areas are restricted to the main/ground level. The original building was constructed around 1940 with subsequent remodeling and additions to include a major renovation/addition completed in the fall of 1989 and an expansion of the Emergency/Radiology departments in 1999. The facility is protected throughout by a complete automatic fire extinguishing system. Additional fire safety features include a fire alarm system with smoke detection in common areas, and at some barrier partition door assemblies; portable fire extinguishers throughout; a smoke barrier partition (i.e., two smoke compartments) on the main floor; and, an essential electrical system (i.e., diesel powered generator).<br><br>The following deficiencies were cited during the fire/life safety survey conducted on November 30, 2015. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy in accordance with 42 CFR 485 623 and IDAPA 16.03.14, Rules and Minimum Standards for Hospitals in Idaho.<br><br>The survey was conducted by:<br><br>Sam Burbank<br>Health Facility Surveyor<br>Facility Fire Safety and Construction | B 000 | | |
| BB161 | 16.03.14.510 Fire and Life Safety Standards<br><br>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 | BB161 | Please see CMS Form 2567 | |

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Bill Spencer — TITLE: Director of Facilities — (X6) DATE: 12/18/15

Bureau of Facility Standards

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| BB161 | Continued From page 1<br>are applicable to hospitals.<br>General Requirements. General requirements for the fire and life safety standards for a hospital are that:<br>The hospital shall be structurally sound and shall be maintained and equipped to assure the safety of patients, employees, and the public.<br>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.<br><br>This Rule is not met as evidenced by:<br>Please refer to federal "K" tags:<br><br>K-020 Doors to vertical openings<br>K-062 Sprinkler maintenance<br>K-211 Alcohol based hand rub installations | BB161 | Please reference CMS Form 2567 | |



Bill Spencer

Bureau of Facility Standards

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