IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSSELL S. BARRON– Director

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DIVISION OF LICENSING & CERTIFICATION
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
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December 15, 2017

Carol Lugar, Administrator
Boise Endoscopy Center
425 West Bannock
Boise, ID 83702

RE: Boise Endoscopy Center, Provider #13C0001024

Dear Ms. Lugar:

This is to advise you of the findings of the Medicare Fire Life Safety Survey, which was concluded at Boise Endoscopy Center on December 1, 2017.

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. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.

2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.

3. Identify the date each deficiency has been, or will be, corrected.

4. 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 28, 2017,** and keep a copy for your records.

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

Sincerely,

Nate Elkins
Supervisor
Facility Fire Safety & Construction Program

NE/lj

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13C0001024	A. BUILDING _____ B. WING _____	12/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOISE ENDOSCOPY CENTER	425 WEST BANNOCK BOISE, ID 83702

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E 000	Initial Comments Unless otherwise indicated, the general use of the terms "facility" or "facilities" refers to all provider and suppliers affected by this regulation. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. The Endoscopy Center (i.e., Ambulatory Surgery Center) is housed on the lower level of the Office Occupancy of the Physician Practice and is separated from the Office Occupancy by a one (1) hour rated wall/floor/ceiling assembly. The plans for the center were approved in October 1998 with completion / occupancy on December 22, 1998. the building's construction type is protected wood frame (i.e., V111). The Center is protected throughout by a complete fire alarm / smoke detection system; there are two (2) remotely located exits from the floor; and, there are portable fire extinguishers throughout. Medical gas and vacuum systems are provided per NFPA Std 99 for a Level 1 system. Emergency power is an automatic fuel fired generator. Emergency lighting is provided battery backup units. The following deficiencies were cited during the Emergency Preparedness Survey conducted on December 1, 2017. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73. The surveyor conducting the survey was: Linda Chaney Health Facility Surveyor	E 000	RECEIVED JAN 0 2 2018 FACILITY STANDARDS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Clinical Director	12/20/17

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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E 000	Continued From page 1	E 000		
	Facility Fire Safety & Construction			
E 001	Establishment of the Emergency Program (EP) CFR(s): 416.54 The [facility, except for Transplant Center] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. This CONDITION is not met as evidenced by: Based on record review and interview, the facility failed to establish and maintain a current, comprehensive Emergency Preparedness program which includes policies and procedures in accordance with 42 CFR 483.73. Failure to meet this standard has the potential to hinder facility response during an emergency. § 416.54	E 001		

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E 006	Plan Based on All Hazards Risk Assessment CFR(s): 416.54(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* *[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. *[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. This STANDARD is not met as evidenced by: Based on record review, the facility failed to provide a facility-based and community-based risk assessment, utilizing an all-hazards approach. Lack of a risk assessment reduced the flexibility to develop and maintain a plan that is tailored to the specific needs of the facility.	E 006	An all hazards risk assessment will be completed and documented. This will include a facility and community based risk assessment utilizing an all hazards approach. This is assigned to the clinical director.	1/19/18

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E 006	Continued From page 3 Findings Include: During review of the emergency preparedness plan, documentation stated the facility incorporated a risk assessment completed by the county and prepared the plan based on local disasters outlined by the county. Upon review, no specific documentation was provided to show a facility based and community based risk assessment.	E 006		
E 013	Development of EP Policies and Procedures CFR(s): 416.54(b) (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants,	E 013		

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E 013	Continued From page 4 staff, or the public. The policies and procedures must be reviewed and updated at least annually. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This STANDARD is not met as evidenced by: Based on record review, the facility failed to provide policies and procedures based on the facility- and community-based risk assessment utilizing an all-hazards approach. Lack of a risk assessment that drives the development of policies and procedures reduced the flexibility to develop and maintain a plan that is tailored to the specific needs of the facility. Findings Include: During review of the emergency preparedness plan, documentation stated the facility incorporated a risk assessment completed by the county and prepared the plan based on local disasters outlined by the county. Upon review, no specific documentation was provided to show a facility based and community based risk assessment to drive the current policies and procedures the facility currently has in place	E 013	Documentation will be incorporated to demonstrate a facility's community based risk assessment to drive current policies and procedures This will be reviewed and updated annually by the clinical director	1/19/18

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E 026	Roles Under a Waiver Declared by Secretary CFR(s): 416.54(b)(6) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This STANDARD is not met as evidenced by: Based on record review, it was determined the facility failed to document a current plan for the facility role under an 1135 waiver as declared by the Secretary and the provisions of care at an alternate site if identified by emergency management officials. Failure to plan for alternate means of care and the role under an 1135 waiver has the potential to limit facility recovery in the event of an emergency. Findings include:	E 026		

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E 026	Continued From page 6 During review of the provided policies and procedures revealed the facility did not have a current policy or procedure that addressed the facility role during a disaster event under the 1135 waiver.	E 026	a policy/procedure will be developed to address the facility role during a disaster. This will be assigned to the clinical director	1/19/18
E 032	Primary/Alternate Means for Communication CFR(s): 416.54(c)(3) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. This STANDARD is not met as evidenced by: Based on record review, the facility failed to provide an emergency preparedness communication plan that addresses alternate means for communication. Failure to provide alternate means limits the ability to communicate effectively Findings Include: During review of the emergency preparedness plan, documentation implied a communication system was in place but no specific approach	E 032	an alternative means of communication will be established to communicate with staff & agencies in the event of a disaster. The alternative means will be cell phones. This will be included in the policy and assigned to the clinical director.	1/19/18

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

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E 032	Continued From page 7 was documented for a primary and alternate way of communication.	E 032		
E 036	EP Training and Testing CFR(s): 416.54(d) (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph	E 036	A mandatory staff meeting is scheduled for 1/23/18 for training on the emergency preparedness and testing of the program. The plan will be reviewed annually by the clinical director. Documentation of the training annually will be maintained by the assistant clinical director.	1/23/18

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E 036	Continued From page 8 (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually. This STANDARD is not met as evidenced by: Based on record review, the facility failed to provide a training and testing program that is based on the emergency plan. Failure to ensure training and testing of the emergency plan hinders staff response during an emergency event. Findings Include: During review of the emergency preparedness plan, no specific documentation was completed showing all employees were trained on the current Emergency Preparedness Plan.	E 036	The training and testing program will be addressed in the orientation program and documented on the Orientation checklist. The program and training will reviewed annually. This is assigned to the assistant clinical director.	1/19/18
E 037	EP Training Program CFR(s): 416.54(d)(1) (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following:	E 037	Emergency preparedness training will occur annually and be documented. A staff mtg is scheduled on 1/23/18 @ 330 for training - Responsibility is assigned to the ACS & CA.	1/23/18

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E 037	Continued From page 9 (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. This is what's in SOM but is missing here. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least annually. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency	E 037		

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E 037	Continued From page 10 preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting	E 037	Initial training will occur c/in 2 wks of hire. Detail to be added to orientation checklist assigned to ACD	1/19/18

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E 037	Continued From page 11 equipment. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually. This STANDARD is not met as evidenced by: Based on record review, the facility failed to provide a training and testing program that is based on the emergency plan. Failure to ensure training and testing of the emergency plan hinders staff response during an emergency event.	E 037	Training will include Roles & responsibilities of each person present when the emergency preparedness plan is implemented. assigned to ACD	1/23/18

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E 037	Continued From page 12 Findings Include: During review of the emergency preparedness plan, no documentation was found to show initial training completed for all employees on the Emergency Preparedness Plan.	E 037	A More detailed description will be added to the Orientation Checklist assigned to A CD. This will serve as documentation of initial training.	1/19/18

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	13C0001024	A. BUILDING **02 - ENTIRE ASC FLOOR AND WING** B. WING _____	**12/01/2017**

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K 000	INITIAL COMMENTS The Endoscopy Center (i.e., Ambulatory Surgery Center) is housed on the lower level of the Office Occupancy of the Physician Practice and is separated from the Office Occupancy by a one (1) hour rated wall/floor/ceiling assembly. The plans for the center were approved in October 1998 with completion / occupancy on December 22, 1998. the building's construction type is protected wood frame (i.e., V111). The Center is protected throughout by a complete fire alarm / smoke detection system; there are two (2) remotely located exits from the floor; and, there are portable fire extinguishers throughout. Medical gas and vacuum systems are provided per NFPA Std 99 for a Level 1 system. Emergency power is an automatic fuel fired generator. Emergency lighting is provided battery backup units. The following deficiencies were cited during the fire/life safety survey conducted on December 1, 2017. The survey was conducted under applicable provisions set forth in the Life Safety Code, 2012 Edition, Chapter 21, Existing Ambulatory Health Care Occupancies, 42 CFR 416.44(b) and 42 CFR 483.73. The surveyor conducting the survey was: Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction	K 000	RECEIVED JAN 0 2 2018 FACILITY STANDARDS	
K 291	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2 hour duration	K 291		

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

Clinical Director 12/28/17

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 291	Continued From page 1 is provided automatically in accordance with 7.9. 20.2.9.1, 21.2.9.1, 7.9 This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to provide monthly and annual emergency lighting test documentation. Failure to test the emergency lighting could inhibit egress of patients during an emergency. Findings include: During review of the emergency lighting test logs on December 1, 2017, from approximately 10:00 AM to 12:10 PM, records revealed no documentation for a monthly thirty (30) second test of the emergency lighting during the months of October and November 2017. There was also no record of an annual ninety (90) minute test of the emergency lighting. When asked, the Administrator stated the facility was unaware the tests were not completed or documentation maintained. Actual NFPA reference: NFPA 101 19.2.9 Emergency Lighting. 19.2.9.1 Emergency lighting shall be provided in accordance with Section 7.9. 7.9.3 Periodic Testing of Emergency Lighting Equipment. 7.9.3.1 Required emergency lighting systems shall be tested in accordance with one of the three options offered by 7.9.3.1.1, 7.9.3.1.2, or 7.9.3.1.3. 7.9.3.1.1 Testing of required emergency lighting systems shall be permitted to be conducted as follows: (1) Functional testing shall be conducted monthly,	K 291	Annual testing completed 12/12/17 by Alloway Electric. See attached log for documentation of monthly testing to include Oct/Nov 2017. Monthly and annual testing assigned to Tracey Price Finney chg Nurse.	

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K 291	Continued From page 2 with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, except as otherwise permitted by 7.9.3.1.1(2). (2)*The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction. (3) Functional testing shall be conducted annually for a minimum of 1-1?2 hours if the emergency lighting system is battery powered. (4) The emergency lighting equipment shall be fully operational for the duration of the tests required by 7.9.3.1.1(1) and (3). (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. 7.9.3.1.2 Testing of required emergency lighting systems shall be permitted to be conducted as follows: (1) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall be provided. (2) Not less than once every 30 days, self-testing/self-diagnostic battery-operated emergency lighting equipment shall automatically perform a test with a duration of a minimum of 30 seconds and a diagnostic routine. (3) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall indicate failures by a status indicator. (4) A visual inspection shall be performed at intervals not exceeding 30 days. (5) Functional testing shall be conducted annually for a minimum of 1-1?2 hours. (6) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall be fully operational for the duration of the 1-1?2-hour test. (7) Written records of visual inspections and tests shall be kept by the owner for inspection by the	K 291		

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K 291	Continued From page 3 authority having jurisdiction. 7.9.3.1.3 Testing of required emergency lighting systems shall be permitted to be conducted as follows: (1) Computer-based, self-testing/self-diagnostic battery-operated emergency lighting equipment shall be provided. (2) Not less than once every 30 days, emergency lighting equipment shall automatically perform a test with a duration of a minimum of 30 seconds and a diagnostic routine. (3) The emergency lighting equipment shall automatically perform annually a test for a minimum of 1-1?2 hours. (4) The emergency lighting equipment shall be fully operational for the duration of the tests required by 7.9.3.1.3(2) and (3). (5) The computer-based system shall be capable of providing a report of the history of tests and failures at all times.	K 291		
K 321	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas must meet one of the following: *Contain 1 hour rated enclosure when non-sprinklered *Sprinkler protected with smoke resistive separation *Severe Hazard locations contain sprinkler protection and 1 hour separation with 3/4 hour rated self-closing doors 20.3.2, 21.3.2, 38.3.2, 38.3.2.2, 39.3.2.1, 39.3.2.2, 8.7 This STANDARD is not met as evidenced by: Based on observation, and interview, the facility failed to ensure that hazardous areas were	K 321		

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K 321	Continued From page 4 protected with a one hour fire rated enclosure. Failure to provide one hour smoke/fire protection for hazardous areas could allow smoke/fire and dangerous gases to pass freely into corridors and hinder egress of occupants during a fire event. Findings include: During the facility tour on December 1, 2017, from approximately 12:15 PM to 1:30 PM, observation of the following hazardous areas revealed penetrations in the walls and/or ceiling that would not resist the passage of smoke and fire. IT/Storage room (larger than fifty square feet) had penetrations above the ceiling tile between the room and the hallway. There were also penetrations in ceiling and the wall between the IT/Storage room and the mechanical room. Mechanical/Generator room had multiple penetrations in the walls including an approximately 2" x 6" rectangular hole between the generator room and the mechanical room. When asked, the Maintenance Supervisor stated the facility was not aware the penetrations needed to be sealed. Actual NFPA standard: NFPA 101 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.7.1. 19.3.2.1.3 The doors shall be self-closing or automatic-closing.	K 321	Contractor will be onsite 1/4/18 @ 3P to patch drywall and fire caulk. Assigned to Adam Eldred	1/4/18

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K 321	Continued From page 5 19.3.2.1.5 Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Rooms with soiled linen in volume exceeding 64 gal (242 L) (6) Rooms with collected trash in volume exceeding 64 gal (242 L) (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard	K 321		
K 325	Alcohol Based Hand Rub Dispenser (ABHR) CFR(s): NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces of aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an	K 325		

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K 325	Continued From page 6 ignition source * If floor is carpeted, the building is fully sprinkler protected * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 20.3.2.6, 21.3.2.6, 8.7.3.1, CFR 416.44 This STANDARD is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure Alcohol Based Hand Rub Dispensers (ABHR) were maintained. Failure to test and document the operation of ABHR dispensers in accordance with the manufacturer's care and use instructions each time a new refill is installed could result in inadvertently spilling flammable liquids, increasing the risk of fires. Findings include: During the review of facility inspection records on December 1, 2017 from approximately 10:00 AM to 12:10 PM, no records were available indicating ABHR dispensers were tested in accordance with manufacturer's care and use instructions when a new refill is installed. ABHR dispensers were observed throughout the facility and when asked, the Administrator stated the facility was not aware of the requirement to test ABHR dispensers each time a new refill is installed. Actual NFPA standard:	K 325	Policy has been written and reviewed with housekeeping supervisor. Copy of policy sent with supervisor. 3x5 index cards with requirements for testing placed in all ABHR dispensers with area to date & initial after inspection and testing upon refilling. Supervisor will email Tracy Bronken when housekeeping staff training and review of policy complete	1/19/18

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K 325	Continued From page 7 NFPA 101 19.3.2.6* Alcohol-Based Hand-Rub Dispensers. Alcohol-based hand-rub dispensers shall be protected in accordance with 8.7.3.1, unless all of the following conditions are met: (1) Where dispensers are installed in a corridor, the corridor shall have a minimum width of 6 ft (1830 mm). (2) The maximum individual dispenser fluid capacity shall be as follows: (a) 0.32 gal (1.2 L) for dispensers in rooms, corridors, and areas open to corridors (b) 0.53 gal (2.0 L) for dispensers in suites of rooms (3) Where aerosol containers are used, the maximum capacity of the aerosol dispenser shall be 18 oz. (0.51 kg) and shall be limited to Level 1 aerosols as defined in NFPA30B, Code for the Manufacture and Storage of Aerosol Products. (4) Dispensers shall be separated from each other by horizontal spacing of not less than 48 in. (1220 mm). (5) Not more than an aggregate 10 gal (37.8 L) of alcohol-based hand-rub solution or 1135 oz (32.2 kg) of Level 1 aerosols, or a combination of liquids and Level 1 aerosols not to exceed, in total, the equivalent of 10 gal (37.8 L) or 1135 oz (32.2 kg), shall be in use outside of a storage cabinet in a single smoke compartment, except as otherwise provided in 19.3.2.6(6). (6) One dispenser complying with 19.3.2.6 (2) or (3) per room and located in that room shall not be included in the aggregated quantity addressed in 19.3.2.6(5). (7) Storage of quantities greater than 5 gal (18.9 L) in a single smoke compartment shall meet the requirements of NFPA 30, Flammable and Combustible Liquids Code.	K 325	Policy emailed to all endo staff	12/20/17

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K 325	Continued From page 8 (8) Dispensers shall not be installed in the following locations: (a) Above an ignition source within a 1 in. (25 mm) horizontal distance from each side of the ignition source (b) To the side of an ignition source within a 1 in. (25 mm) horizontal distance from the ignition source (c) Beneath an ignition source within a 1 in. (25 mm) vertical distance from the ignition source (9) Dispensers installed directly over carpeted floors shall be permitted only in sprinklered smoke compartments. (10) The alcohol-based hand-rub solution shall not exceed 95 percent alcohol content by volume. (11) Operation of the dispenser shall comply with the following criteria: (a) The dispenser shall not release its contents except when the dispenser is activated, either manually or automatically by touch-free activation. (b) Any activation of the dispenser shall occur only when an object is placed within 4 in. (100 mm) of the sensing device. (c) An object placed within the activation zone and left in place shall not cause more than one activation. (d) The dispenser shall not dispense more solution than the amount required for hand hygiene consistent with label instructions. (e) The dispenser shall be designed, constructed, and operated in a manner that ensures that accidental or malicious activation of the dispensing device is minimized. (f) The dispenser shall be tested in accordance with the manufacturer's care and use instructions each time a new refill is installed.	K 325		

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K 372	Continued From page 9	K 372		
K 372	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2 hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 21.3.7.5, 21.3.7.6, 8.5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that smoke barriers were maintained. Failure to maintain smoke barriers could allow smoke and dangerous gases to pass freely between compartments affecting egress during a fire event. Findings include: During the facility tour on December 1, 2017, from approximately 12:15 PM to 1:30 PM, observation of the smoke barrier wall between the "break room" hallway and the patient recovery room revealed multiple penetrations above the ceiling tile. When asked, the Administrator stated the facility was unaware of the penetrations. Actual NFPA standard: NFPA 101 (2012) 19.1.1.4.1.1 Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected	K 372	Shilo 1/23/18 January 3, 2018 ~~Shilo~~ on site to review options for suppression	

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K 372	Continued From page 10 by approved self-closing fire door assemblies. (See also Section 8.3.) 8.3.5.1* Firestop Systems and Devices Required. Penetrations for cables, cable trays, conduits, pipes, tubes, combustion vents and exhaust vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a fire barrier shall be protected by a firestop system or device. The firestop system or device shall be tested in accordance with ASTM E 814, Standard Test Method for Fire Tests of Through Penetration Fire Stops, or ANSI/UL 1479, Standard for Fire Tests of Through-Penetration Firestops, at a minimum positive pressure differential of 0.01 in. water column (2.5 N/m2) between the exposed and the unexposed surface of the test assembly	K 372		
K 511	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 20.5.1, 21.5.1, 21.5.1.2, 9.1.1, 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that electrical systems were	K 511		

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K 511	Continued From page 11 installed and maintained correctly. Failure to ensure proper electrical installations could result in electrocution or arc fire. Findings include: During the facility tour on December 1, 2017, from approximately 12:15 PM to 1:30 PM, observation of the electrical panel labeled "CP" in the mechanical room revealed there were seven (7) missing blanks. When asked, the Administrator stated the facility was unaware of the missing blanks. Actual NFPA standard: NFPA 101 9.1.2 Electrical Systems. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless such installations are approved existing installations, which shall be permitted to be continued in service. 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	K 511		

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K 511	Continued From page 12 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.	K 511		
K 918	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for four continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder	K 918	EC. Power Systems provided education on the generator. Hz frequency will be recorded monthly. Assigned to Tracy Price Finney. 1/19/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13C0001024	A. BUILDING 02 - ENTIRE ASC FLOOR AND WING B. WING _____	12/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOISE ENDOSCOPY CENTER	425 WEST BANNOCK BOISE, ID 83702

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K 918	Continued From page 13 circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the EPS (Emergency Power Supply) generator was inspected weekly and tested monthly. Failure to inspect and test the facility EPS has the potential to hinder the system response during a power loss. Findings include: During review of provided facility inspection and testing records conducted on December 1, 2017 from approximately 10:00 AM to 12:10 PM, records indicated the weekly inspections for the EPS were missing for the weeks of March 19-25, October 1-7, and October 8-14, 2017. The documentation provided did not indicate the load obtained during monthly load tests. Actual NFPA standard: NFPA 110 8.4 Operational Inspection and Testing. 8.4.1* EPSSs, including all appurtenant components, shall be inspected weekly and exercised under load at least monthly.	K 918	Oversight of the log book is assigned to the Chg Nurse Tracy Price Finney 12/11/17	

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