IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

October 4, 2018

Wendy Stoehr, Administrator
Advanced Dermatology and Skin Surgery
1807 N. Hutchinson Rd.
Spokane Valley, WA 99212-2444

RE: Advanced Dermatology And Skin Surgery, Provider #13C0001070

Dear Ms. Stoehr:

This is to advise you of the findings of the Medicare Fire Life Safety Survey, which was concluded at Advanced Dermatology And Skin Surgery on September 27, 2018.

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.

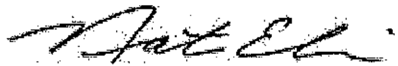
3. Identify the date each deficiency has been, or will be, corrected.

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 **October 17, 2018,** 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, option 3.

Sincerely,



Nate Elkins
Supervisor
Facility Fire Safety & Construction Program

NE/lj

Enclosures

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October 4, 2018

Wendy Stoehr, Administrator
Advanced Dermatology and Skin Surgery
1807 N. Hutchinson Rd.
Spokane Valley, WA 99212-2444

RE: Advanced Dermatology And Skin Surgery, Provider #13C0001070

Dear Ms. Stoehr:

This is to advise you of the findings of the Emergency Preparedness Survey, which was concluded at Advanced Dermatology And Skin Surgery on September 27, 2018.

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 <u>all</u> 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. <u>Sign and date the form</u>(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 **October 17, 2018,** 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, option 3.

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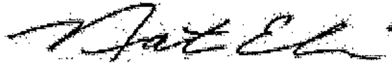


Nate Elkins
Supervisor
Facility Fire Safety & Construction Program

NE/lj

Enclosures

PRINTED: 10/03/2018
FORM APPROVED
OMB NO. 0938-0391

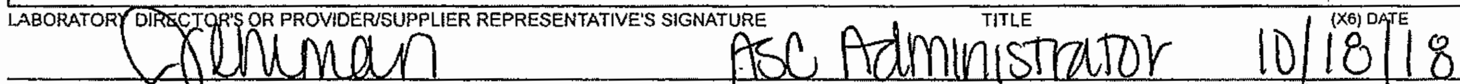
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13C0001070	A. BUILDING ______ B. WING ______	09/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADVANCED DERMATOLOGY AND SKIN SURGERY	1700 WEST RIVERSTONE DRIVE COEUR D'ALENE, ID 83814

(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
E 000	Initial Comments The Ambulatory Surgery Center (ASC) is located in a portion of the first floor of a medical office building, Type V (111) construction built in 2011. There are three (3) procedure rooms, and one (1) area for pre/post-operative patients. The ASC portion of the medical office building is separated from the general office practice by a two (2) hour separation. The building has a monitored fire alarm system with sprinklers throughout but does not have smoke detection. The Essential Electrical System is supplied by a natural gas powered, on-site automatic generator. There are four (4) exits from the ASC, with exit access through the general medical practice. The following deficiency was cited during the initial Emergency Preparedness Survey conducted on September 27, 2018. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 416.54. The Survey was conducted by: Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction	E 000	RECEIVED NOV 27 2018 FACILITY STANDARDS	
E 039	EP Testing Requirements CFR(s): 416.54(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing.	E 039		

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



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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 039	Continued From page 1 The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group	E 039	Long Term Care	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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	13C0001070	A. BUILDING ______ B. WING ______	09/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E 039	Continued From page 2 discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to test the emergency preparedness plan annually. Failure to test the emergency preparedness plan annually, has the potential to hinder staff response during a disaster. This deficient practice affected staff and visitors on the date of the survey. Findings Include: Review of the facility Emergency Preparedness (EP) plan on September 27, 2018, from approximately 10:15 AM to 12:30 PM, revealed a written EP testing program, and both a full-scale, community-based exercise and a facility-based exercise. However, there had not been a full-scale, community-based exercise in the last 12 months. The last known full-scale exercise was August 2017. When asked, the Administrator stated the facility had not yet participated in a community-based full-scale exercise this year. Reference: 42 CFR 483.73 (d) (2)	E 039	Religious Nonmedical Health Care Institution Organ Procurement Organization	

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	13C0001070	A. BUILDING 01 - ADVANCED DERMATOLOGY AND SKIN SURGERY B. WING ______	09/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADVANCED DERMATOLOGY AND SKIN SURGERY	1700 WEST RIVERSTONE DRIVE COEUR D'ALENE, ID 83814

(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 Ambulatory Surgery Center (ASC) is located in a portion of the first floor of a medical office building, Type V (111) construction built in 2011. There are three (3) procedure rooms, and one (1) area for pre/post-operative patients. The ASC portion of the medical office building is separated from the general office practice by a two (2) hour separation. The building has a monitored fire alarm system with sprinklers throughout but does not have smoke detection. The Essential Electrical System is supplied by a natural gas powered, on-site automatic generator. There are four (4) exits from the ASC, with exit access through the general medical practice. The following deficiencies were cited during the fire/life safety survey conducted on September 27, 2018. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Chapter 21, Existing Ambulatory Health Care Occupancies and Chapter 39, Existing Business Occupancies in accordance with 42 CFR 416.44. The surveyor conducting the survey was: Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction	K 000	RECEIVED NOV 27 2018 FACILITY STANDARDS	
K 131	Multiple Occupancies CFR(s): NFPA 101 Multiple Occupancies - Sections of Ambulatory Health Care Facilities Multiple occupancies shall be in accordance with 6.1.14. Sections of ambulatory health care facilities shall be permitted to be classified as other	K 131		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: ASC Administrator (X6) DATE: 10/18/18

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 131	Continued From page 1 occupancies, provided they meet both of the following: * The occupancy is not intended to serve ambulatory health care occupants for treatment or customary access. * They are separated from the ambulatory health care occupancy by a 1 hour fire resistance rating. Ambulatory health care facilities shall be separated from other tenants and occupancies and shall meet all of the following: * Walls have not less than 1 hour fire resistance rating and extend from floor slab to roof slab. * Doors are constructed of not less than 1-3/4 inches thick, solid-bonded wood core or equivalent and is equipped with positive latches. * Doors are self-closing and are kept in the closed position, except when in use. * Windows in the barriers are of fixed fire window assemblies per 8.3. Per regulation, ASCs are classified as Ambulatory Health Care Occupancies, regardless of the number of patients served. 20.1.3.2, 21.1.3.3, 20.3.7.1, 21.3.7.1,42 CFR 416.44 This STANDARD is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to provide proper separation from other tenants and occupancies. Failure to separate occupancies with rated assemblies provides potential extension of fire and smoke during a fire event. This deficient practice affected staff and visitors on the date of the survey. Findings include: During the facility tour on September 27, 2018, from approximately 2:15 PM to 3:00 PM, observation and operational testing of the doors	K 131		

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K 131	Continued From page 2 between the medical practice and ASC at the nurse's station and business office revealed they were not self-closing. When asked, the Administrator stated the facility was not aware the doors needed to be self-closing. Actual NFPA standard: NFPA 101 21.3.7.1 Ambulatory health care facilities shall be separated from other tenants and occupancies and shall meet all of the following requirements: (1) Walls shall have not less than a 1-hour fire resistance rating and shall extend from the floor slab below to the floor or roof slab above. (2) Doors shall be constructed of not less than 1-3/4 in. (44 mm) thick, solid-bonded wood core or the equivalent and shall be equipped with positive latches. (3) Doors shall be self-closing and shall be kept in the closed position, except when in use. (4) Any windows in the barriers shall be of fixed fire window assemblies in accordance with Section 8.3.	K 131		
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: o Corridor is at least 6 feet wide. o Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols. o Dispensers shall have a minimum of 4-foot horizontal spacing. o Not more than an aggregate of 10 gallons of fluid or 1135 ounces of aerosol are used in a	K 325		

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K 325	Continued From page 3 single smoke compartment outside a storage cabinet, excluding one individual dispenser per room. o Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30. o Dispensers are not installed within 1 inch of an ignition source. o If floor is carpeted, the building is fully sprinkler protected. o ABHR does not exceed 95% alcohol. o Operation of the dispenser shall comply with Section 20.3.2.6(11) or 21.3.2.6(11). o ABHR is protected against inappropriate access. 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. This deficient practice affected staff and visitors on the date of the survey. Findings include: During the review of facility inspection records on September 27, 2018, from approximately 12:30 PM to 2:10 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	K 325		

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K 325	Continued From page 4	K 325		

installed.

Actual NFPA standard:

NFPA 101

21.3.2.6* 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 NFPA 30B, 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 21.3.2.6(6).
(6) One dispenser per room complying with 21.3.2.6(2) or (3), and located in the room, shall not be required to be included in the aggregated quantity specified in 21.3.2.6(5).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 325	Continued From page 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. (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	K 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 325	Continued From page 6 with the manufacturer's care and use instructions each time a new refill is installed.	K 325		
K 353	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____________________ b) Who provided system test ____________________________ c) Water system supply source __________________________ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on record review, observation and interview, the facility failed to inspect, test and maintain the fire suppression system in accordance with NFPA 25. Failure to maintain fire suppression systems could hinder system performance during a fire event. This deficient practice affected staff and visitors on the date of the survey. Findings include: During the review of facility inspection records on September 27, 2018, from approximately 12:30	K 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13C0001070	A. BUILDING 01 - ADVANCED DERMATOLOGY AND SKIN SURGERY B. WING ______	09/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADVANCED DERMATOLOGY AND SKIN SURGERY	1700 WEST RIVERSTONE DRIVE COEUR D'ALENE, ID 83814

(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 353	Continued From page 7 PM to 3:00 PM, no documentation could be produced for quarterly inspections of the sprinkler system. When asked, the Administrator stated the facility was not aware of the requirement for quarterly sprinkler inspections. Actual NFPA standard: NFPA 101 9.7.5 Maintenance and Testing. All automatic sprinkler and standpipe systems required by this Code shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25 5.2.5 Waterflow Alarm and Supervisory Devices. Waterflow alarm and supervisory alarm devices shall be inspected quarterly to verify that they are free of physical damage. 5.3.3.1 Mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly. (See Table 5.1.1.2 Summary of Sprinkler System Inspection, Testing, and Maintenance)	K 353		
K 712	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded	K 712		

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	13C0001070	A. BUILDING 01 - ADVANCED DERMATOLOGY AND SKIN SURGERY B. WING ______	09/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 712	Continued From page 8	K 712		

announcement may be used instead of audible alarms.
21.7.1.4 through 21.7.1.7
This STANDARD is not met as evidenced by:
Based on record review and interview, the facility failed to provide documentation of required fire drills, one per shift per quarter. Failure to perform fire drills on each shift quarterly could result in confusion and hinder the safe evacuation of patients during a fire event. This deficient practice affected staff and visitors on the date of the survey.

Findings include:

During record review on September 27, 2018, from approximately 12:30 PM to 2:10 PM, fire drill documentation revealed the facility failed to perform a fire drill for the second quarter of 2018 and fourth quarter of 2017. When asked, the Administrator stated the facility was unaware of the missing fire drills.

Actual NFPA standard:

NFPA 101
21.7.1.4* Fire drills in ambulatory health care facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions.
21.7.1.5 Patients shall not be required to be moved during drills to safe areas or to the exterior of the building.
21.7.1.6 Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions.

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
	13C0001070	A. BUILDING 01 - ADVANCED DERMATOLOGY AND SKIN SURGERY B. WING ______	09/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADVANCED DERMATOLOGY AND SKIN SURGERY	1700 WEST RIVERSTONE DRIVE COEUR D'ALENE, ID 83814

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K 712	Continued From page 9 21.7.1.7 When drills are conducted between 9:00 p.m. and 6:00 a.m. (2100 hours and 0600 hours), a coded announcement shall be permitted to be used instead of audible alarms.	K 712		
K 911	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section, any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the Essential Electrical System (EES) generator was equipped with a remote manual stop station in accordance with NFPA 110. Failure to provide a remote manual stop station has the potential to prevent shutdown of the emergency generator during a system malfunction, or unintentional operation. This deficient practice affected staff and visitors on the date of the survey. Findings include: During the facility tour on September 27, 2018, from approximately 2:15 PM to 3:00 PM, a remote manual stop station for the EES generator could not be located. When asked, the	K 911	See attached Letter Request to remove generator from P&P manual Governing Board unanimously voted to remove the generator from the 1700 W. Riverstone premises.	

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	13C0001070	A. BUILDING 01 - ADVANCED DERMATOLOGY AND SKIN SURGERY B. WING ______	09/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 911	Continued From page 10 Administrator stated the facility was not equipped with a remote stop station. Actual NFPA standard: NFPA 99 6.4.1.1.16.2 Safety indications and shutdowns shall be in accordance with Table 6.4.1.1.16.2. (SEE TABLE) NFPA 110 5.6.5.6* All installations shall have a remote manual stop station of a type to prevent inadvertent or unintentional operation located outside the room housing the prime mover, where so installed, or elsewhere on the premises where the prime mover is located outside the building. 5.6.5.6.1 The remote manual stop station shall be labeled.	K 911		
K 916	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the EES (Essential Electrical System) was installed in accordance with NFPA 99. Failure to provide an alarm annunciator for	K 916	See attached Request to remove Generator from P;P manual.	

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

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	13C0001070	A. BUILDING 01 - ADVANCED DERMATOLOGY AND SKIN SURGERY B. WING	09/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 916	Continued From page 11	K 916		

the EES could hinder early notification of equipment failures, leaving the facility without emergency power during an outage. This deficient practice affected staff and visitors on the date of the survey.

Findings include:

During the facility tour conducted on September 27, 2018, from approximately 2:15 PM to 3:00 PM, observation of the work stations and other areas throughout the facility, revealed the facility did not have an alarm annunciator for the EES. When asked, the Administrator stated the facility was not aware of the requirement for an alarm annunciator for the generator.

Actual NFPA standard:

NFPA 99
Chapter 6 Electrical Systems
6-4 Essential Electrical System Requirements - Type 1.
6.4.1.1.17 Alarm Annunciator. A remote annunciator that is storage battery powered shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station (see 700.12 of NFPA 70, National Electrical Code). The annunciator shall be hard-wired to indicate alarm conditions of the emergency or auxiliary power source as follows:
(1) Individual visual signals shall indicate the following:
(a) When the emergency or auxiliary power source is operating to supply power to load
(b) When the battery charger is malfunctioning
(2) Individual visual signals plus a common

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	13C0001070	A. BUILDING 01 - ADVANCED DERMATOLOGY AND SKIN SURGERY B. WING ______	09/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADVANCED DERMATOLOGY AND SKIN SURGERY	1700 WEST RIVERSTONE DRIVE COEUR D'ALENE, ID 83814

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K 916	Continued From page 12 audible signal to warn of an engine generator alarm condition shall indicate the following: (a) Low lubricating oil pressure (b) Low water temperature (below that required in 6.4.1.1.11) (c) Excessive water temperature (d) Low fuel when the main fuel storage tank contains less than a 4-hour operating supply (e) Overcrank (failed to start) (f) Overspeed	K 916		
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 circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of	K 918		

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	13C0001070	A. BUILDING 01 - ADVANCED DERMATOLOGY AND SKIN SURGERY B. WING ______	09/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADVANCED DERMATOLOGY AND SKIN SURGERY	1700 WEST RIVERSTONE DRIVE COEUR D'ALENE, ID 83814

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K 918	Continued From page 13 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 generator for the EES (Essential Electrical System) was maintained in accordance with NFPA 110. Failure to inspect and test EES generators could result in a lack of system reliability during a power loss. This deficient practice affected staff and visitors on the date of the survey. Findings include: During review of the facility generator inspection and testing records on September 27, 2018, from approximately 12:30 PM to 2:10 PM, the facility failed to provide documentation for weekly inspections, monthly load tests and a three-year, four-hour load test. When asked, the Administrator stated the facility was unaware of the missing inspections and load test requirements. 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. 8.4.9* Level 1 EPSS shall be tested at least once within every 36 months.	K 918		

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K 918	Continued From page 14 8.4.9.1 Level 1 EPSS shall be tested continuously for the duration of its assigned class (see Section 4.2). 8.4.9.2 Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 continuous hours. 8.4.9.3 The test shall be initiated by operating at least one transfer switch test function and then by operating the test function of all remaining ATSs, or initiated by opening all switches or breakers supplying normal power to all ATSs that are part of the EPSS being tested. 8.4.9.4 A power interruption to non-EPSS loads shall not be required. 8.4.9.5 The minimum load for this test shall be as specified in 8.4.9.5.1, 8.4.9.5.2, or 8.4.9.5.3. 8.4.9.5.1 For a diesel-powered EPS, loading shall be not less than 30 percent of the nameplate kW rating of the EPS. A supplemental load bank shall be permitted to be used to meet or exceed the 30 percent requirement. 8.4.9.5.2 For a diesel-powered EPS, loading shall be that which maintains the minimum exhaust gas temperatures as recommended by the manufacturer. 8.4.9.5.3 For spark-ignited EPSs, loading shall be the available EPSS load. 8.4.9.6 The test required in 8.4.9 shall be permitted to be combined with one of the monthly tests required by 8.4.2 and one of the annual tests required by 8.4.2.3 as a single test. 8.4.9.7 Where the test required in 8.4.9 is combined with the annual load bank test, the first 3 hours shall be at not less than the minimum loading required by 8.4.9.5 and the remaining hour shall be at not less than 75 percent of the nameplate kW rating of the EPS.	K 918		

Prefix Tag	How deficiency will be corrected	Person Responsible for Correction	Date Correction will be completed	Monitors for Compliance
E 039	To ensure regulations for emergency preparedness testing, we have added the necessary testing procedures to our annual list of requirements. (See attachment) The list is to include the following: • Community/Facility based exercise • Table top exercise • Additional Emergency Preparedness exercise This list will be kept both in the ASC binders of all ASC employees and the emergency preparedness binder. The ASC Administrator attended a work place violence webinar on 10/11/2018. Information from this will be used for a table top exercise before the end of the year. ASC has registered the staff for a "Shakedown Washington" drill on 11/5/2018. The ASC administrator will also be attending the Idaho, region 1 coalition on 10/19/2018. From here more information will be gathered for future exercises.	Jennifer Lowman, ASC Administrator	10/11/2018	All requirements will be monitored by the ASC Administrator quarterly to ensure all requirements are being met.
K 131	Self-closing devices have been added to the two doors that failed the survey. Instillations of the self-closing devices will be done on 10/26/2018 by Modern Glass in Coeur d' Alene. These doors are located between the medical practice and the ASC, as well as the business office and the ASC. These doors will continue to be closed during business hours to ensure proper separation from the ASC.	Wendy Stoehr, Administrator	10/26/2018	The self-closing doors will be monitored daily by the ASC staff to ensure proper regulations are being met. If there are any concerns or malfunctions, the staff shall report such events to the ASC administrator for immediate attention.
K 325	To ensure proper maintenance and usage of the alcohol based hand rub dispensers, a bundle of 10 cm x 7 cm small log cards have been created. These will be kept in the ABHR devices to ensure they are checked every time a new unit is added.	Jennifer Lowman, ASC Administrator	10/11/2018	The ASC Administrator will monitor weekly to verify proper maintenance is being performed. The staff was trained of proper usage on 10/11/2018.

K 353	During the inspection on 8/28/2018 we were unable to provide documentation of quarterly sprinkler system maintenance due to misinformation. After learning of the correct regulations, we have arranged to have the sprinkler system inspected quarterly instead of annually. To ensure proper inspection of the sprinkler system in the future, the Administrator will schedule quarterly inspections with Patriot Fire.	Wendy Stoehr, Administrator	10/11/2018	The ASC Administrator will keep a copy of the inspection in the ASC binder labeled "Fire". This binder will be monitored quarterly.
K 712	During the inspection on 8/28/2018 we were unable to provide documentation of quarterly fire drills for 4th quarter of 2017, as well as 2nd quarter of 2018. To ensure this doesn't happen again we have created a "Drills" binder. The "Drills" binder is to include the following: • Fire Drills • Evacuation Drills • Work Place Violence Drills • Code Blue Drills These drills will be done at expected as well as unexpected times to ensure proper testing takes place. Although I cannot correct the past mistake, I can assure you through proper organization and documentation we will be able to meet the annual requirements.	Jennifer Lowman, ASC Administrator	10/11/2018	The ASC Administrator will hold all future drill meetings, both expected and unexpected. The ASC Administrator will monitor the "Drills" binder quarterly to ensure proper requirements are being met.
K 911	An on-site meeting has been scheduled with Pacific Power Products on Tuesday, October 23, 2018 to inspect the building for the remote stop station. If a solution cannot be met by NFDA99 regulations, a cost estimate will be provided and submitted to CMS with a solution to the guidelines. Advanced Dermatology will move forward with the plan to install the remote stop station within the next two weeks. The project will be completed by the end of November.	Wendy Stoehr, Administrator	11/30/2018	Letter submitted to Nate Elkins Regarding change in policy & Procedure due to NFPA101 (category 3 facility)

K 916	An on-site meeting has been scheduled with Pacific Power Products on Tuesday, October 23, 2018 to discuss the cost of replacing the generator that includes an annunciator panel. The building was designed and built in the year of 2011. The generator that was installed is not equipped to include an annunciator. Wendy Stoehr is planning to request a waiver from CMS as the cost of a new generator may pose a significant financial hardship to Advanced Dermatology. An email has been submitted to Linda Chaney to discuss the process and review the necessity of a new generator with an annunciator panel for our facility. If the waiver is denied, you can be assured Advanced Dermatology will move forward to be in compliance with the Fire, Life & Safety regulations.	Wendy Stoehr, Administrator	11/30/2018	Letter submitted to Nate Elkins Regarding change in policy & procedure due to EES & NFPA 101
K 918	A calendar style log has been created to ensure proper testing and maintenance on the generator. The log includes the weekly inspections, monthly load test, as well as the 3 year 4 hour load test. The generator will be inspected weekly as well as monthly by the building manager, with back up from the ASC Administrator. This is to ensure the inspections are done when the main staff member is out. The 3 year 4 hour load test will be performed by Pacific Power Products and documented appropriately. A copy of this documentation as well as a copy of completed weekly logs will be kept in the maintenance binder in the front office as well as the ASC "Fire" binder.	Wendy Stoehr, Administrator/Jennifer Lowman, ASC Administrator	10/16/2018 11/26/2018	May be removed upon approval of K911 & K916 After discussion with Nate Elkins, Supervisor Fire, Life, Safety & Construction program. The Governing Board of Advanced Dermatology & Skin Surgery 1700 W. Riverstone Ave Coeur d'Alene, ID 83814 Has voted unanimously to remove the generator from the premises.