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

November 14, 2018

Tom Ross, Administrator
Syringa Surgical Center
1630 -23rd Avenue, Suite 902
Lewiston, ID 83501

RE: Syringa Surgical Center, Provider #13C0001054

Dear Mr. Ross:

This is to advise you of the findings of the Medicare Fire Life Safety Survey, which was concluded at Syringa Surgical Center on Noveinber 2, 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 **November 27, 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

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
	13C0001054	A. BUILDING 01 - ENTIRE SURGERICAL CENTER B. WING _____	11/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYRINGA SURGICAL CENTER	1630 -23RD AVENUE. SUITE 902 LEWISTON, ID 83501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The facility occupies approximately one-half (i.e. 1,600 s.f.) in the upper level of a two-story Business occupancy of type V (111) construction. The building was originally built in 2004 and is equipped with an automatice sprinkler system in accordance with NFPA 13 and interconnected fire alarm/smoke detection system with off-site monitoring. Emergency power is supplied by an on-site spark-fired, Type I EES generator. Piped in medical gases have been installed per NFPA Std 99 for Level I systems as modified. There are two (2) portable multipurpose 2A10BC fire extinguishers in the facility. There are two (2) remotely located exits to grade as well as an enclosed stairway to the one hour separated lower level office occupancy. A one (1) hour separation wall is provided between the facility and the adjoining general offices of the practicing physician. The following deficiencies were cited during the fire/life safety survey conducted on November 2, 2018. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Chapter 21, Existing Ambulatory Health Care Occupancies, in accordance with 42 CFR 416.44 (b). The survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	K 000		
K 345	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm Systems - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying	K 345		

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

D Moore RN — RN, Director of Training — 11/21/18

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13C0001054	A. BUILDING 01 - ENTIRE SURGERICAL CENTER B. WING _____	11/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYRINGA SURGICAL CENTER	1630 -23RD AVENUE. SUITE 902 LEWISTON, ID 83501

(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 345	Continued From page 1 with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This Standard is not met as evidenced by: Based on record review, the facility failed to ensure fire alarm systems were maintained in accordance with NFPA 72. Failure to conduct sensitivity testing on non-addressable fire alarm systems could hinder system response during a fire event. Findings include: During review of facility fire alarm inspection records conducted on 11/2/18 from approximately 9:00 - 10:00 AM, no record was provided indicating a sensitivity testing was conducted within the last five years. Actual NFPA standard: NFPA 72 Chapter 14 Inspection, Testing, and Maintenance 14.4.5.3.1 Sensitivity shall be checked within 1 year after installation. 14.4.5.3.2 Sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with 14.4.5.3.3. 14.4.5.3.3 After the second required calibration test, if sensitivity tests indicate that the device has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years.	K 345		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13C0001054	A. BUILDING 01 - ENTIRE SURGERICAL CENTER B. WING _____	11/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYRINGA SURGICAL CENTER	1630 -23RD AVENUE. SUITE 902 LEWISTON, ID 83501

(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 2	K 353		
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, the facility failed to ensure fire suppression systems were maintained in accordance with NFPA 25. Failure to conduct quarterly waterflow alarm testing and inspect installed anti-freeze systems by concentration, has the potential to hinder system performance during a fire event and increase potential flash-over during an activation. Findings include: During review of facility fire suppression system maintenance and inspection records conducted on 11/2/18 from 8:30 AM to 12:00 PM, no records were available for quarterly waterflow alarm inspections, or five year internal piping inspection. Further review of the provided inspection report	K 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13C0001054	A. BUILDING 01 - ENTIRE SURGERICAL CENTER B. WING _____	11/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYRINGA SURGICAL CENTER	1630 -23RD AVENUE. SUITE 902 LEWISTON, ID 83501

(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 3 established the anti-freeze solution installed in the suppression system was tested according to temperature and not listed as to the type of anti-freeze installed, or the concentration of the mix. Actual NFPA standard: NFPA 101 21.7.6 Maintenance and Testing. See 4.6.12. 4.6.12.4 Any device, equipment, system, condition, arrangement, level of protection, fire resistive construction, or any other feature requiring periodic testing, inspection, or operation to ensure its maintenance shall be tested, inspected, or operated as specified elsewhere in this Code or as directed by the authority having jurisdiction. NFPA 25 5.1.3 Obstruction Investigations. The procedures outlined in Chapter 14 shall be followed where there is a need to conduct an obstruction investigation. 5.3.3 Waterflow Alarm Devices. 5.3.3.1 Mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly. 5.3.4* Antifreeze Systems. The freezing point of solutions in antifreeze shall be tested annually by measuring the specific gravity with a hydrometer or refractometer and adjusting the solutions if necessary. 5.3.4.1* Solutions shall be in accordance with	K 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13C0001054	A. BUILDING 01 - ENTIRE SURGERICAL CENTER B. WING _____	11/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYRINGA SURGICAL CENTER	1630 -23RD AVENUE. SUITE 902 LEWISTON, ID 83501

(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 4 Table 5.3.4.1(a) and Table 5.3.4.1(b). 5.3.4.1.1* Listed CPVC sprinkler pipe and fittings shall be protected from freezing with glycerin only. The use of diethylene, ethylene, or propylene glycols shall be specifically prohibited. 5.3.4.1.2 The concentration of antifreeze solution shall be limited to the minimum necessary for the anticipated minimum temperature. 5.3.4.2 The use of antifreeze solutions shall be in accordance with any state or local health regulations. Chapter 14 Obstruction Investigation 14.1* General. This chapter shall provide the minimum requirements for conducting investigations of fire protection system piping for possible sources of materials that could cause pipe blockage. 14.2 Internal Inspection of Piping. 14.2.1 Except as discussed in 14.2.1.1 and 14.2.1.4 an inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. Additional reference: NFPA 25 TIA 11-1	K 353		
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.	K 511		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13C0001054	A. BUILDING 01 - ENTIRE SURGERICAL CENTER B. WING _____	11/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYRINGA SURGICAL CENTER	1630 -23RD AVENUE. SUITE 902 LEWISTON, ID 83501

(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 511	Continued From page 5 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, the facility failed to ensure safe electrical installations in accordance with NFPA 70 and UL 1363. Use of relocatable power taps (RPTs) for non-listed installations, has the potential to expose patients, staff and visitors to electrical shock and the risk of arc fires. Findings include: During the facility tour conducted on 11/2/18 from 9:30 - 10:00 AM, observation of the waiting area in the main entrance revealed a microwave and a coffee maker plugged into a RPT. Actual NFPA standard: NFPA 70 110.2 Approval. The conductors and equipment required or permitted by this Code shall be acceptable only if approved. Informational Note: See 90.7, Examination of Equipment for Safety, and 110.3, Examination, Identification, Installation, and Use of Equipment. See definitions of Approved, Identified, Labeled, and Listed. 110.3 Examination, Identification, Installation, and Use of Equipment. (A) Examination. In judging equipment, considerations such as the following shall be evaluated:	K 511		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13C0001054	A. BUILDING 01 - ENTIRE SURGERICAL CENTER B. WING _____	11/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYRINGA SURGICAL CENTER	1630 -23RD AVENUE. SUITE 902 LEWISTON, ID 83501

(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 511	Continued From page 6 (1) Suitability for installation and use in conformity with the provisions of this Code Informational Note: Suitability of equipment use may be identified by a description marked on or provided with a product to identify the suitability of the product for a specific purpose, environment, or application. Special conditions of use or other limitations and other pertinent information. Suitability of equipment may be evidenced by listing or labeling. (2) Mechanical strength and durability, including, for parts designed to enclose and protect other equipment, the adequacy of the protection thus provided (3) Wire-bending and connection space (4) Electrical insulation (5) Heating effects under normal conditions of use and also under abnormal conditions likely to arise in service (6) Arcing effects (7) Classification by type, size, voltage, current capacity, and specific use (8) Other factors that contribute to the practical safeguarding of persons using or likely to come in contact with the equipment (B) Installation and Use. Listed or labeled equipment shall be installed and used in accordance with any instructions included in the listing or labeling. Additional reference: UL 1363 XBYS.GuideInfo Relocatable Power Taps	K 511		
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	K 712		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13C0001054	A. BUILDING 01 - ENTIRE SURGERICAL CENTER B. WING _____	11/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYRINGA SURGICAL CENTER	1630 -23RD AVENUE. SUITE 902 LEWISTON, ID 83501

(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 712	Continued From page 7 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 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 ensure fire drills were conducted in accordance with NFPA 101. Failure to perform fire drills quarterly for each shift has the potential to hinder staff response in the event of a fire. Findings include: 1) During review of provided facility maintenance records conducted on 11/2/18 from 8:45 - 10:30 AM, no records were provided demonstrating fire drills were performed during the first and second quarter of 2018. 2) Interview of the nurse assisting in the survey revealed she was aware of the missing fire drills. Actual NFPA standard: 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.	K 712		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13C0001054	A. BUILDING 01 - ENTIRE SURGERICAL CENTER B. WING _____	11/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYRINGA SURGICAL CENTER	1630 -23RD AVENUE. SUITE 902 LEWISTON, ID 83501

(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 912	Continued From page 8	K 912		
K 912	Electrical Systems - Receptacles CFR(s): NFPA 101 Electrical Systems - Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99) This Standard is not met as evidenced by: Based on record review and observation, the facility failed to ensure hospital grade outlets were maintained in accordance with NFPA 99. Lack of required periodic testing for hospital grade outlets in patient care areas has the potential to hinder early detection of incipient failures and affect patient outcome during procedures. Findings include: 1) During review of facility maintenance and inspection records conducted on 11/2/18 from 8:30 - 10:00 AM, no records were available indicating the annual inspection for the installed hospital-grade outlets. 2) During the facility tour conducted on 11/2/18 from 10:00 AM - 12:00 PM, observation of installed electrical outlets revealed the facility operating room and patient prep/recovery area were equipped with hospital-grade outlets. Actual NFPA standard: NFPA 99	K 912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13C0001054	A. BUILDING 01 - ENTIRE SURGERICAL CENTER B. WING _____	11/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYRINGA SURGICAL CENTER	1630 -23RD AVENUE. SUITE 902 LEWISTON, ID 83501

(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 912	Continued From page 9 6.3.3.2 Receptacle Testing in Patient Care Rooms. 6.3.3.2.1 The physical integrity of each receptacle shall be confirmed by visual inspection. 6.3.3.2.2 The continuity of the grounding circuit in each electrical receptacle shall be verified. 6.3.3.2.3 Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed. 6.3.3.2.4 The retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 g (4 oz).	K 912		

Syringa Surgical Center
Providers Plan of Correction

ID Tag	Providers Plan of Correction
K345	Fire alarm - 5 year Sensitivity testing with Fisher Systems scheduled and occurred on 11/21/18. No issues verbally reported. Final report is not completed at this time and will follow when received. Call placed to Fisher Systems on 11/26/18. Tag completed 11/21/18 – Report to follow. Date of compliance – When report is complete. Expected time one week. 12/3/18
K353	Fire sprinkler system – 5 year inspection with back flushing of the Fire Sprinkler System, water flow alarm check, internal piping inspection and anti-freeze system scheduled to be completed on 12/27/18 by Fire Control Sprinkler Systems Inc. See attached agreement and schedule. Date of Compliance 12/27/18. Scheduled by M. Moree RN, Director in training.
K511	Extension cords on microwave and coffee pot were removed. Coffee pot extension cord removed on 11/5/18. Microwave extension cord was removed on 11/19/18 when plan of correction was received. This tag has been completed with no further follow up indicated.
K712	Fire drill reports from first and second quarter have not been located. Fire drills for the third and fourth quarter have been completed with plan to conduct as required in 2019. Center policy has been reviewed and will be followed. See attached in-service/drill plan set up by M. Moree RN, Director in training 2018 and acting Director beginning 1/1/19.
K912	All electrical outlets were checked on 11/20/18. See attached document from Flerchinger Electric. Placed on 2019 Calendar for yearly inspection. This tag has been completed with no additional follow up required until 11/2019

Fire/Life Safety Survey 2018

Syringa Surgery Center, Lewiston, ID

Prepared by M. Moree RN, Director of Surgery in training

11/21/18 11/21/18

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

November 14, 2018

Tom Ross, Administrator
Syringa Surgical Center
1630 -23rd Avenue, Suite 902
Lewiston, ID 83501

RE: Syringa Surgical Center, Provider #13C0001054

Dear Mr. Ross:

This is to advise you of the findings of the Emergency Preparedness Survey, which was concluded at Syringa Surgical Center on November 2, 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 **November 27, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13C0001054	A. BUILDING _____ B. WING _____	11/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYRINGA SURGICAL CENTER	1630 -23RD AVENUE. SUITE 902 LEWISTON, ID 83501

(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 facility occupies approximately one-half (i.e. 1,600 s.f.) in the upper level of a two-story Business occupancy of type V (111) construction. The building was originally built in 2004 and is equipped with an automatice sprinkler system in accordance with NFPA 13 and interconnected fire alarm/smoke detection system with off-site monitoring. Emergency power is supplied by an on-site spark-fired, Type I EES generator. Piped in medical gases have been installed per NFPA Std 99 for Level I systems as modified. There are two (2) portable multipurpose 2A10BC fire extinguishers in the facility. There are two (2) remotely located exits to grade as well as an enclosed stairway to the one hour separated lower level office occupancy. A one (1) hour separation wall is provided between the facility and the adjoining general offices of the practicing physician. The following deficiencies were cited during the Emergency Preparedness survey conducted on November 2, 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: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	E 000	RECEIVED NOV 29 2018 FACILITY STANDARDS	
E 007	EP Program Patient Population CFR(s): 416.54(a)(3) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least	E 007		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Director in training (X6) DATE: 11/21/18

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13C0001054	A. BUILDING _____ B. WING _____	11/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYRINGA SURGICAL CENTER	1630 -23RD AVENUE. SUITE 902 LEWISTON, ID 83501

(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 007	Continued From page 1 annually. The plan must do the following:] (3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.] This Standard is not met as evidenced by: Based on review of the facility Emergency Plan, Policies and Procedures (EOP), the facility failed to ensure a policy was provided demonstrating the types of services the facility could provide to outside agencies and officials during an emergency. Failure to provide a policy and procedure for the types of services the facility can provide during an emergency, has the potential to limit continuity of care and surge capabilities during a disaster.	E 007		
	Findings include: During review of the provided EOP on 11/2/18, no documentation was provided indicating the policy and procedure for demonstrating to emergency agencies, the types of services the ASC (Ambulatory Surgical Center) has the ability to provide during a disaster. Reference: 42 CFR 416.54 (a) (3)			
E 024	Policies/Procedures-Volunteers and Staffing CFR(s): 416.54(b)(5) [(b) Policies and procedures. The [facilities] must	E 024		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13C0001054	A. BUILDING _____ B. WING _____	11/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYRINGA SURGICAL CENTER	1630 -23RD AVENUE. SUITE 902 LEWISTON, ID 83501

(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 024	Continued From page 2 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:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. This Standard is not met as evidenced by: Based on review of the provided EOP, it was determined the facility failed to document policies and procedures for the use of volunteers during an emergency. Lack of a volunteer policy has the potential to hinder continuity of care and limit the facility available resources during a disaster. Findings include:	E 024		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13C0001054	A. BUILDING _____ B. WING _____	11/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYRINGA SURGICAL CENTER	1630 -23RD AVENUE. SUITE 902 LEWISTON, ID 83501

(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 024	Continued From page 3 During review of the EOP conducted on 11/2/18 from 8:45 - 10:30 AM, records did not indicate the facility had a policy for the use of volunteers during a disaster. Reference: 42 CFR 416.54 (b) (6)	E 024		
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 the facility role under an 1135 waiver as declared by the Secretary. Failure to define the role of the facility under an 1135	E 026		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13C0001054	A. BUILDING _____ B. WING _____	11/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYRINGA SURGICAL CENTER	1630 -23RD AVENUE. SUITE 902 LEWISTON, ID 83501

(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 026	Continued From page 4 waiver, has the potential to limit facility continuity of operations during an emergency that affects an area or region. Findings include: During review of the provided EOP conducted on 11/2/18 from 8:45 - 10:30 AM, documentation provided revealed the facility did not have in place a policy or procedure addressing their role under an 1135 waiver during a declaration of disaster. Reference: 42 CFR 416.54 (b) (8)	E 026		
E 030	Names and Contact Information CFR(s): 416.54(c)(1) [(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:]	E 030		
	(1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13C0001054	A. BUILDING _____ B. WING _____	11/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYRINGA SURGICAL CENTER	1630 -23RD AVENUE. SUITE 902 LEWISTON, ID 83501

(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 030	Continued From page 5 (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's	E 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13C0001054	A. BUILDING _____ B. WING _____	11/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYRINGA SURGICAL CENTER	1630 -23RD AVENUE. SUITE 902 LEWISTON, ID 83501

(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 030	Continued From page 6 Donation Service Area (DSA). This Standard is not met as evidenced by: Based on record review, it was established the facility failed to provide a communication plan with contact information of volunteer agencies. Failure to include available volunteers in the EOP communication plan, has the potential to hinder continuity of operations and emergency response during a disaster. Findings Include: During review of the provided EOP conducted on 11/2/18, from 8:45 - 10:45 AM, revealed the communication plan for the facility did not include contact information for volunteers or volunteer agencies. Reference: 42 CFR 416.54 (c) (1)	E 030		
E 031	Emergency Officials Contact Information CFR(s): 416.54(c)(2) [(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: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, or local emergency preparedness staff.	E 031		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13C0001054	A. BUILDING _____ B. WING _____	11/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYRINGA SURGICAL CENTER	1630 -23RD AVENUE. SUITE 902 LEWISTON, ID 83501

(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 031	Continued From page 7 (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. This Standard is not met as evidenced by: Based on record review, it was established the facility failed to develop a EOP which included a communication plan that provided contact information for emergency officials and other sources of assistance. Failure to include contact information for emergency officials and other means of assistance in the EOP, has the potential to hinder both internal and external emergency response by personnel during a disaster.	E 031		
	Findings Include: During review of the provided EOP conducted on 11/2/18 from 8:45 - 10:30 AM, review of the plan failed to indicate contact information for emergency officials and other sources of assistance at the facility's disposal during the event of a disaster. Reference: 42 CFR 416.54 (c) (2)			
E 033	Methods for Sharing Information CFR(s): 416.54(c)(4)-(6) [(c) The [facility] must develop and maintain an emergency preparedness communication plan	E 033		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13C0001054	A. BUILDING _____ B. WING _____	11/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYRINGA SURGICAL CENTER	1630 -23RD AVENUE. SUITE 902 LEWISTON, ID 83501

(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 033	Continued From page 8 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: (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care. (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.102(c), CORFs under §485.68(c), and RHCs/FQHCs under §491.12(c).] (6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4). *[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative. *[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4). This Standard is not met as evidenced by: Based on record, the facility failed to demonstrate a current plan for the method utilized for sharing information such as medical documentation and patient information with other healthcare	E 033		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13C0001054	A. BUILDING _____ B. WING _____	11/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYRINGA SURGICAL CENTER	1630 -23RD AVENUE. SUITE 902 LEWISTON, ID 83501

(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 033	Continued From page 9 providers during an emergency. Failure to provide information with other healthcare providers during and emergency, has the potential to hinder patient continuity of care of if initiating transfer or evacuation during an emergency. Findings include: During review of the EOP conducted on 11/2/18 from 8:45 - 10:30 AM, review of the provided policies and procedures failed to demonstrate the method used for sharing information across provider types and ensure the security and confidentiality of patient information as required. Reference: 42 CFR 416.54 (c) (4) - (6)	E 033		
E 034	Information on Occupancy/Needs CFR(s): 416.54(c)(7) [(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: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For Inpatient Hospice at §418.113:] (7) A means	E 034		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13C0001054	A. BUILDING _____ B. WING _____	11/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYRINGA SURGICAL CENTER	1630 -23RD AVENUE. SUITE 902 LEWISTON, ID 83501

(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 034	Continued From page 10 of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. This Standard is not met as evidenced by: Based on record review, the facility failed to provide a communication plan for sharing information on its ability to provide assistance with emergency management officials. Failure to provide a plan to share information with emergency personnel on the facility's abilities to provide assistance during a disaster, has the potential to hinder response assistance and continuation of care for the patients served. Findings include: On 11/2/18 from 8:45 - 10:30 AM, review of the provided EOP failed to indicate what method the facility would use to share information on its capabilities and abilities to provide assistance when communicating with emergency management officials. Reference: 42 CFR 416.54 (c)(7)	E 034		
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	E 036		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13C0001054	A. BUILDING _____ B. WING _____	11/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYRINGA SURGICAL CENTER	1630 -23RD AVENUE. SUITE 902 LEWISTON, ID 83501

(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 036	Continued From page 11 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 (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 and interview, the facility failed to provide a training and testing program that is based on the contents included in the EOP. Failure to test staff's knowledge of procedures implemented in the activation of the EOP, has the potential to hinder staff response during an emergency. Findings Include: During review of the EOP and associated	E 036		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13C0001054	A. BUILDING _____ B. WING _____	11/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYRINGA SURGICAL CENTER	1630 -23RD AVENUE. SUITE 902 LEWISTON, ID 83501

(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 036	Continued From page 12 inservices conducted on 11/2/18 from 8:45 - 10:30 AM, no specific documentation was provided demonstrating all staff were tested on any specific training program implemented on the Emergency Preparedness Plan. Interview of the nurse assisting the review process established the facility had yet to implement a testing program for staff on the contents of the EOP. Reference: 42 CFR 416.54 (d)	E 036		
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: (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.	E 037		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13C0001054	A. BUILDING _____ B. WING _____	11/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYRINGA SURGICAL CENTER	1630 -23RD AVENUE. SUITE 902 LEWISTON, ID 83501

(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 037	Continued From page 13 (iv) Demonstrate staff knowledge of emergency procedures. *[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 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	E 037		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13C0001054	A. BUILDING _____ B. WING _____	11/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYRINGA SURGICAL CENTER	1630 -23RD AVENUE. SUITE 902 LEWISTON, ID 83501

(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 037	Continued From page 14 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 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	E 037		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13C0001054	A. BUILDING _____ B. WING _____	11/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYRINGA SURGICAL CENTER	1630 -23RD AVENUE. SUITE 902 LEWISTON, ID 83501

(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 037	Continued From page 15 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 and interview, the facility failed to provide an annual training and orientation training program that is based on the contents included in the EOP. Failure to provide both existing staff and newly hired staff, training on those procedures implemented in the activation of the EOP, has the potential to hinder staff response during an emergency. Findings Include: During review of the EOP and associated inservices conducted on 11/2/18 from 8:45 - 10:30 AM, no specific documentation was provided demonstrating a staff training program had been implemented on the Emergency Preparedness Plan. Interview of the nurse assisting the review process established the facility had yet to implement a full annual training program for staff on the contents of the EOP.	E 037		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13C0001054	A. BUILDING _____ B. WING _____	11/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYRINGA SURGICAL CENTER	1630 -23RD AVENUE. SUITE 902 LEWISTON, ID 83501

(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 037	Continued From page 16 Reference: 42 CFR 416.54 (d)(1)	E 037		
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. 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	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13C0001054	A. BUILDING _____ B. WING _____	11/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYRINGA SURGICAL CENTER	1630 -23RD AVENUE. SUITE 902 LEWISTON, ID 83501

(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 039	Continued From page 17 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 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, it was determined the facility failed to complete two (2) full scale exercises in accordance with the rule. Failure to conduct full scale exercises has the potential to hinder staff emergency response during actual disasters. Findings Include: During review of provided facility EOP exercises conducted on 11/2/18 from 8:45 - 10:30 AM, documentation provided established the facility had conducted a full-scale tabletop exercise, but failed to document a second full-scale exercise. Reference: 42 CFR 416.54 (d) (2)	E 039		

Syringa Surgical Center
Providers Plan of Correction

ID Tag	Providers Plan of Correction
E007	Emergency/Disaster Policy for Emergency Preparedness has been updated on 11/20/18 by Director of Surgical Services and reviewed by Director in Training. Policy includes the patient client population of being podiatry patients, plastic and hand surgery patients and selected vein procedures. At this time Syringa Surgery Center is limited to this type of client. This tag has been completed and policy will be reviewed annually by Director of Surgical Services. See attached policy. See page 3 d.
E024 1/3/19 SH	Syringa Surgical Center will close during a disaster related to building space and physican availability. The 2018 Emergency Preparedness Policy updated includes volunteers will not be utilized at this center. This tag has been completed and policy will be reviewed annually by Director of Surgical Services. See attached policy. See page 3 b. ii
E026 1/3/19 SH	Regarding Waiver 1135 as stated in current Emergency Preparedness Policy facility would close during an external disaster and a Waiver would not be indicated. This tag has been completed and policy will be reviewed annually by Director of Surgical Services. See attached policy. See page 4 X.a
E030 1/3/19 SH	All phone numbers have been updated for staff. All emergency phone numbers are kept in Safety Binder under Emergency Operations Plan for City of Lewiston and Nez Perce County. Volunteers will not be utilized as Surgery Center will close related to small size, staff and unavailability of physicians should a crisis/external disaster occur. This tag has been completed. See attached phone list and Emergency Operations Plan phone list.
E031 SH 1/3/19	See plan of correction E030 and attached phone list. This tag has been completed.
E033 1/3/19 SH	Policy SA-32 for Hospital transfers of patient and records has been reviewed. Facility does not participate in electronic medical records, all patient records would be hand copied and transferred in a sealed envelope to ambulance crew for emergency transfers. See also policy SA-36. This tag has been completed and above policies attached for review.
E034 1/3/19 SH	The 2018 Emergency Preparedness Policy has been updated to include who would communicate with outside entities. Surgery center would close if an external disaster occurred and would be unable to accept any additional patients related to building size, supplies, staff and physicians being unavailable as they would be required to report to hospital. This tag has been completed. See page 2 V
	Plan of correction page 1

Syringa Surgical Center
Providers Plan of Correction

E036 ✓	Training and testing of the Emergency Preparedness Policy and Plan were reviewed with staff on 11/8/18 during staff in-service. Policy was read by staff with acknowledgment signed as well as test completed. Surgery center will continue to provide training and testing on yearly basis along with drills as required. Training will be lead by Director of Surgical Services or designee. This tag has been completed. See in-service review and testing attached along with tentative schedule of in-services for 2019
E037 ✓	Emergency Preparedness training for 2018 for all existing staff was completed on 11/8/18. Any new employees will be trained upon hire for the Emergency Preparedness plan and on-going annually. This tag has been completed. See E036
E039	Table top exercise was completed and accepted prior to survey. Additional internal/hands of exercise was completed after facility in-service on 11/8/18 with review of in-service and active hands on drill attached for review. Hands on review occurred 11/13/18 with staff that was present on that date. This tag has been completed. See attached critique of internal disaster as well as calendar for 2019. Current Director in Training will become active Director in Jan. 2019 and has requested to be involved in North Central Healthcare Coalition Meeting in order to receive additional training and participation with outside/external disaster preparation.

Emergency Preparedness Survey 2018

Syringa Surgery Center, Lewiston, ID

Prepared by M. Moree RN, Director in Training

11/21/18

11/21/18 1145