IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN– 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
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PHONE 208-334-6626
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March 7, 2019

Cindy Clancy, Administrator
Premier Surgical Center
5680 W. Gage Street
Boise, ID 83706

RE: Premier Surgical Center, Provider #13C0001052

Dear Ms. Clancy:

This is to advise you of the findings of the Medicare Fire Life Safety Survey, which was concluded at Premier Surgical Center on February 28, 2019.

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 **March 20, 2019,** 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

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13C0001052	A. BUILDING 01 - ENTIRE BUILDING B. WING _____	02/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER SURGICAL CENTER	5680 W GAGE STREET BOISE, ID 83706

(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 occupies approximately 3,200 square feet of a 6,600 square foot single story wood frame medical office building. The existing building was remodeled in the summer of 2004. The ASC is separated from the remainder of the building (i.e., physician office practice) by a one (1) rated wall that runs from the floor slab to the underside of the roof deck. The building is fully sprinklered and protected in accordance with NFPA 13, light hazard occupancy, which includes an interconnected fire alarm, smoke detection system. There are three (3) exits to grade accessible from the ASC. The facility Emergency Power Supply System (EPSS) is supplied by an on-site diesel powered automatic generator. Piped in oxygen and vacuum are provided in accordance with NFPA 99. The facility is located within a municipal fire district. The following deficiencies were cited during the fire/life safety survey conducted on February 28, 2019. The survey was conducted under applicable provisions set forth in the Life Safety Code, 2012 Edition, Chapter 21, Existing Ambulatory Health Care Occupancies and 42 CFR 416.44(b). The surveyor conducting the survey was: Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction	K 000	RECEIVED MAR 20 2019 FACILITY STANDARDS	
K 345	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm Systems - Testing and Maintenance	K 345		

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

Cindy Clancy | Administrative Director | 3/20/19

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 345	Continued From page 1 A fire alarm system is tested and maintained in accordance with an approved program complying 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 inspected in accordance with NFPA 72. Failure to conduct annual inspections and minimum sensitivity testing has the potential to hinder system response, affecting all occupants during a fire event. Findings include: During review of provided maintenance and inspection records conducted on 2/28/19 from 10:30 AM to 12:00 PM, no records were available for an annual inspection or five-year sensitivity testing inspection for the fire alarm system. Actual NFPA standard: 14.4.5* Testing Frequency. Unless otherwise permitted by other sections of this Code, testing shall be performed in accordance with the schedules in Table 14.4.5, or more often if required by the authority having jurisdiction. 14.4.5.3* In other than one- and two-family dwellings, sensitivity of smoke detectors and single- and multiple-station smoke alarms shall be tested in accordance with 14.4.5.3.1 through 14.4.5.3.7. 14.4.5.3.1 Sensitivity shall be checked within 1 year after installation.	K 345	-OR manager found previous inspection and will continue annual inspections. Corrected on 3/11/19. Adrienne RN → See attached # 1, 2 & 3 Followed and reviewed by Environment of Care and OR manager "EOC" → See attached # 1, 2 & 3 Premier Surgical previously didn't receive annual sensitivity, this will now be in place and implemented by EOC and OR manager.	

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K 345	Continued From page 2 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	→ See attached #1, 2 & 3 EOC and OR manager Corrected from previous page, Asmahw RN 3/11/19	
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 and interview, the facility failed to ensure installed fire suppression systems were maintained in accordance with NFPA 25. Failure to maintain suppression systems has the potential to hinder system response, affecting all	K 353	Corrected on 3/8/19 Asmahw RN → Picture attached #4 Fire Extinguisher. completed and will continue monthly. EOC and OR manager 3/8/19	

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K 353	Continued From page 3 occupants during a fire event. Findings include: During review of provided maintenance and testing records conducted on 2/28/19 from 10:30 AM to 12:00 PM, records failed to reveal quarterly inspections for waterflow alarm had been conducted outside of the annual inspection. Interview of the Safety Coordinator revealed she was not aware of these inspection or tests having been conducted prior to the survey. Actual NFPA standard: 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.	K 353	→ See attached #1 (last page) followed by EOC and OR manager -Corrected by ADonahue RN 3-11-19 and will continue quarterly inspections. → See attached #1 will continue to inspect quarterly EOC and OR manager, -Corrected on 3/11/19 ADonahue RN	
K 511	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 20.5.1, 21.5.1, 21.5.1.2, 9.1.1, 9.1.2 This Standard is not met as evidenced by: Based on observation, the facility failed to maintain safe electrical installations in accordance with NFPA 101 and NFPA 70. Use of	K 511		

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K 511	Continued From page 4 non-approved extension cords in designated wet locations such as operating rooms, has the potential to expose patients and staff to the increased risks of electrical shock and arc fires during procedures. Findings include: During the facility tour conducted on 2/28/19 from 1:00 - 3:00 PM, observation of OR2 revealed the use of a 3-1 extension cord. Additional inspection did not demonstrate the extension cord was an approved, wet installation extension cord, but a standard, household utility cord. Actual NFPA standard: NFPA 101 21.5 Building Services. 21.5.1 Utilities. 21.5.1.1 Utilities shall comply with the provisions of Section 9.1. 9.1.2 Electrical Systems. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless such installations are approved existing installations, which shall be permitted to be continued in service. NFPA 70 110.2 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	K 511	We are a dry facility. See attached # 5 -Asonahu and Risk Managment fulfilled requirements and documentation for a dry facility. Corrected 3/11/19 The household utility cord has been removed, 3/11/19. -OR#2 is not used for procedures just for the laser. We also store back up equipment in OR#2. On the laser, no extension cords are on the connections to the outlets. The orange extension cord found on the equipment has been removed from the room. 3/11/19 The surg protectors in OR#1 were inspected by Bio-med and signed off. See attachment #6 Monitored by EOC and OR manager (There are 2 documents for #6 One is a picture, one is a document)	

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K 511	Continued From page 5 Use of Equipment. (A) Examination. In judging equipment, considerations such as the following shall be evaluated: (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 may be marked on the equipment, included in the product instructions, or included in the appropriate listing and labeling 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. II. Installation 310.10 Uses Permitted. The conductors described in	K 511	→ See attachment # 7 and 8 for equipment plan We also use an equipment assessment tool for all the equipment that comes into contact with a patient. See attachment # 8 & 9 - Continued to be followed by EDC and OR manager - Corrected on 3/11/19	

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K 511	Continued From page 6 310.104 shall be permitted for use in any of the wiring methods covered in Chapter 3 and as specified in their respective tables or as permitted elsewhere in this Code. (C) Wet Locations. Insulated conductors and cables used in wet locations shall comply with one of the following: (1) Be moisture-impervious metal-sheathed (2) Be types MTW, RHW, RHW-2, TW, THW, THW-2, THHW, THWN, THWN-2, XHHW, XHHW-2, ZW (3) Be of a type listed for use in wet locations	K 511	→ Our risk manager, Ann Dean, has identified us a dry facility. ↳ Documentation to be maintained by ADON/charge RN ↳ Corrected on 3/11/19	
K 921	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a	K 921		

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K 921	Continued From page 7 period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This Standard is not met as evidenced by: Based on record review and observation, the facility failed to ensure electrical installations in patient care areas for Patient Care Related Electrical Equipment (PCREE), were maintained in accordance with NFPA 70 and NFPA 99. Failure to test relocatable power taps (RPT) and Special Purpose Relocatable Power Taps (SPRPT), has the potential for hindering care during a power loss, exposure to electrical shocks and the increased risk of arc fires to all patients and staff. Findings include: 1) During review of the facility maintenance and inspection records conducted on 2/28/19 from 10:30 AM - 12:00 PM, records did not indicate a program for the maintenance and testing of power strips supplying power to PCREE in patient care areas. 2) During the facility tour conducted on 2/28/19 from 1:00 PM - 3:00 PM, observation of OR1 revealed a UL 1363A power strip was present on the wheeled PCREE. Further observation of OR1 established the power strip was not visibly fixed to the cart and no indication the bio-med testing agency had tested this device. Actual NFPA standard: 10.2.3.6 Multiple Outlet Connection. Two or more	K 921	EOC ↑ OR manager to maintain → See attachment #6 (picture) Biomed has checked the device and the cords are fixed to the cart with zip ties. Corrected 3/1/19 [illegible] RN	

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K 921	Continued From page 8 power receptacles supplied by a flexible cord shall be permitted to be used to supply power to plug-connected components of a movable equipment assembly that is rack-, table-, pedestal-, or cartmounted, provided that all of the following conditions are met: (1) The receptacles are permanently attached to the equipment assembly. (2)*The sum of the ampacity of all appliances connected to the outlets does not exceed 75 percent of the ampacity of the flexible cord supplying the outlets. (3) The ampacity of the flexible cord is in accordance with NFPA 70, National Electrical Code. (4)*The electrical and mechanical integrity of the assembly is regularly verified and documented. (5)*Means are employed to ensure that additional devices or nonmedical equipment cannot be connected to the multiple outlet extension cord after leakage currents have been verified as safe.	K 921		

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March 7, 2019

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Boise, ID 83706

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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 **March 20, 2019,** 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

Enclosure

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

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E 000	Initial Comments The Ambulatory Surgery Center occupies approximately 3,200 square feet of a 6,600 square foot single story wood frame medical office building. The existing building was remodeled in the summer of 2004. The ASC is separated from the remainder of the building (i.e., physician office practice) by a one (1) rated wall that runs from the floor slab to the underside of the roof deck. The building is fully sprinklered and protected in accordance with NFPA 13, light hazard occupancy, which includes an interconnected fire alarm, smoke detection system. There are three (3) exits to grade accessible from the ASC. The facility Emergency Power Supply System (EPSS) is supplied by an on-site diesel powered automatic generator. Piped in oxygen and vacuum are provided in accordance with NFPA 99. The facility is located within a municipal fire district. The following deficiencies were cited during the Emergency Preparedness survey conducted on February 28, 2019. 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/Life Safety & Construction	E 000	RECEIVED MAR 20 2019 FACILITY STANDARDS -Emergency Plan in place, all documentation up to date as of 3/18/19. Continued to be monitored by OR Manager.	
E 006	Plan Based on All Hazards Risk Assessment CFR(s): 416.54(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan	E 006	See attachments: 10, 11, 12 & 13, 14 → See policy/procedures attachment	

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

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E 006	Continued From page 1 that must be reviewed, and updated at least annually. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* *[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. *[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. This Standard is not met as evidenced by: Based on record review and interview, the facility failed to ensure that a hazard vulnerability analysis (HVA) included a community based component in the risk assessment. Failure to consider community risks in the development of the plan, has the potential to hinder planning, training and response during an emergency. Findings include: During review of the provided Emergency	E 006	→ See attachment #15 All-hazards approach assessment -Continued to be followed by EOC and OR manager -Hazards assessment completed 3/18/19 and continues to be monitored by EOC and OR manager. → See attachment #16	

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	13C0001052	A. BUILDING _____ B. WING _____	02/28/2019

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E 006	Continued From page 2 Operations Plan (EOP) conducted on 2/28/19 from 9:00 - 10:30 AM, records failed to demonstrate community relevant events as associated with the county all-hazards risk assessment, had been evaluated during development of the HVA. Interview of staff present substantiated the HVA had used risk data from internal facility discussions and did not use county or other outside agency available information. Reference: 42 CFR 416.54(a) 1-2	E 006		
E 013	Development of EP Policies and Procedures CFR(s): 416.54(b) (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or	E 013	All policies and procedures up to date to implement a successful emergency response plan - ADonahue KW 3-19-19 → See attachment #11 & 12 ↳ Emergency Response Program ↳ All applicable individuals - part of the Emergency Response Program - OR manager to continue and maintain 3/18/19. → See attachment #14 System Failure & Staff Response Plan	

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E 013	Continued From page 3 water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least annually. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This Standard is not met as evidenced by: Based on record review and interview, the facility failed to ensure that a hazard vulnerability analysis (HVA) included a community based component in the risk assessment. Failure to consider community risks in the development of the plan, hinders the ability of the facility to develop relevant policies and procedures that align to identified risks. Findings include: During review of the provided Emergency Operations Plan (EOP) conducted on 2/28/19 from 9:00 - 10:30 AM, records failed to demonstrate community relevant events as associated with the county all-hazards risk assessment, had been evaluated during development of the HVA. Interview of staff present substantiated the HVA had used risk data	E 013		

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E 013	Continued From page 4 from internal facility discussions and did not use county or other outside agency available information. (See also: E-0006) Reference: 42 CFR 416.54(b)	E 013		
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 waiver, has the potential to limit facility continuity of operations during an emergency that affects an	E 026		

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E 026	Continued From page 5 area or region. Findings include: During review of the provided EOP conducted on 2/28/19 from 9:00 - 10:30 AM, documentation provided revealed the facility did not have a policy or procedure in place addressing their role under an 1135 waiver during a declaration of disaster. Reference: 42 CFR 416.54 (b) (8)	E 026		