



IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
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P.O. Box 83720
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PHONE 208-334-6626
FAX 208-364-1888

August 10, 2006

FILE COPY

Charlene Barnard, Administrator
Idaho Surgicenter of Idaho Falls
2025 East 17th Street NORTH
Idaho Falls, ID 83404

Dear Ms. Charlene:

This is to advise you of the findings of the Medicare/State Licensure fire safety survey conducted at Idaho Surgicenter of Idaho Falls on July 27, 2006.

Enclosed is the Statement of Deficiencies/Plan of Correction, form CMS-2567, listing fire/life safety deficiencies. In the space provided on the right hand side of each form, answer the deficiencies and give the date that it will be completed. Include in your plan of correction necessary corrective measures taken, provisions implemented to prevent re-occurrence, and department head/person responsible to monitor/assure that the deficiencies do not re-occur.

After you have answered and dated each deficiency, please sign and date each cover page in the spaces provided. Retain one (1) copy of each page and return the originals to this office by **August 23, 2006**.

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

Sincerely,

Mark Grimes
Supervisor
Facility Fire Safety & Construction

MG/mlw

Enclosures



IDAHO EYE CENTER

2025 East 17th Street
Idaho Falls, ID 83404
(208) 524-2025
(208) 529-1924 (fax)

FAX

To: Mark Grimes Fax: 1-208 364-1888
 From: Marilyn Shelton Date: 9/27/06
 Re: Deficiency Pages: 5
 CC:

- Urgent For Review Please Comment Please Reply Please Recycle

Dear Mark

Notes:

I have faxed the 2507 form with our plan of action. Craig Bates will email the before and after photos to you with proof of correction. Charlene Barnard has written in their plan of action. If you need anything else please call Marilyn @ 5242025.

Thank-you Marilyn Shelton

The PHI (Protected Health Information) contained in this FAX is HIGHLY CONFIDENTIAL. It is intended for the exclusive use of the addressee. It is to be used only to aid in providing specific healthcare services to the patient. Any other use is a violation of Federal Law (HIPAA) and will be reported as such. If you have received this telecopy in error, please notify us immediately by telephone at the above number to arrange for return of the document to us. Thank you.

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

Printed: 08/08/2006
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001035	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE ASC BLDG B. WING _____	(X3) DATE SURVEY COMPLETED 07/27/2006
NAME OF PROVIDER OR SUPPLIER IDAHO SURGICENTER OF IDAHO FALLS		STREET ADDRESS, CITY, STATE, ZIP CODE 2025 E. 17TH STREET IDAHO FALLS, ID 83404		
(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	<p>INITIAL COMMENTS</p> <p>A Fire / Life Safety survey was conducted at Idaho Surgical Center North on 7/27/06. The 2000 Existing Edition of the Life Safety Code was utilized for this survey, in accordance with 42 CFR 416.44(b)</p> <p>The facility is a two story Type V (111) construction with a basement. It has a composite pitched roof with brick veneer on the exterior. The building does not have automatic sprinkler protection in place. Emergency power is provided by batteries that are located in the basement. The ASC portion has a one hour separation from the rest of the facility. Its original construction was February 1986.</p> <p>The deficiencies identified during this survey are listed below.</p> <p>The surveyors conducting the survey were:</p> <p>Debby Ransom, RN, RHIT Bureau Chief Facility Standards</p> <p>Mark Grimes, Supervisor Facility Standards, Fire / Life Safety Program</p> <p>Taylor Barkley Health Facility Surveyor</p>	K 000		
K 050	<p>416.44(b)(1) LIFE SAFETY CODE STANDARD</p> <p>Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. 20.7.1.2, 21.7.1.2</p>	K 050		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 050	Continued From page 1 This Standard is not met as evidenced by: Based upon staff interview, and record review, the facility did not ensure that fire drills are held at least quarterly on each shift. Based upon a single shift during hours of operation, at least one (1) fire drill is required every three (3) months. Findings included: Record review revealed (2) fire drills were recorded during the last nine months. Drills were recorded for the dates of 07/07/06 and 10/14/05. Staff interview at approximately 3:45 p.m. on 7/27/06 confirmed the records were correct.	K 050	<i>our policy of quarterly fire drills. We began by holding a fire drill on 9-8-06 to satisfy one date. This policy is recorded in our Policy & Procedure manuals.</i> <i>C. Barnard Practice Administrator ICN mth. 9-26-06</i>	
K 114	416.44(b)(1) LIFE SAFETY CODE STANDARD Ambulatory health care occupancies are separated from other tenants and occupancies by fire barriers with at least a 1 hour fire resistance rating. Doors in such barriers are solid bonded core wood of 1½ inches or equivalent and are equipped with a positive latch and closing device. Vision panels, if provided in fire barriers or doors, are fixed fire window assemblies in accordance with 8.2.3.2.2. This Standard is not met as evidenced by: Based on observation on 07/27/06, it was determined that the facility had failed to maintain the one hour required separation for the ASC.	K 114		

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K 114	Continued From page 2 Findings include: Observation on 7/27/06 at approximately 3:15 p.m. with the Facility Director of the ASC separation wall in the attic space revealed an opening approximately 24 inches by 12 inches near the top of the wall. The sheetrock had been removed from the wall in order for IT cables to pass through. The observation was acknowledged by the Facility Director upon the surveyor's exiting of the attic space, as well as during the exit interview.	K 114	The cable was moved The opening was closed with fire graded sheetrock see photo. Completed on 9/25/06	
K 130	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This Standard is not met as evidenced by: Based upon observation the facility failed to ensure that exposing occupancies and materials of construction present no threat of fire penetration from such occupancy or to the collapse of the structure. Section 21.1.6.5 Minimum Construction Requirements Findings include: On 07/27/06 surveyor observation of the facility's roof truss system in the attic revealed a truss had been altered, thereby weakening the truss. Support for the truss is now electrical conduit with energized wire running through it. This places occupants at a greater risk to possible truss	K 130	Before and after photos e-mailed. Plan of action: Support beam was placed below stud and electrical box. Additional support beam was added to the top of the stud and screwed into place. Metal bracket added to joints for additional support.	

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K 130	Continued From page 3 failure, and an electrically created fire hazard. During inspection of the ASC's separation wall in the attic space, the surveyor discovered a truss that had a vertical web member cut free from the bottom chord. The member was cut approximately 24 inches up from the bottom chord so a HVAC duct could pass through. Electrical conduit running the length of the attic has a junction box fastened to this truss member, and the conduit junction box is now acting as the support for the top chord. The truss member had pulled loose from the top chord, so it's only support is the electrical conduit junction box, that is fastened to it. The weight of the vertical web member is bending the conduit where it enters and exits both sides of the junction box. This was witnessed and acknowledged by Facility Director who was able to see this from the attic access door.	K 130	<i>This was completed on 9/25/06. Marybeth Shuck ASC Director</i>	

IDAHO SURGICENTER
FIRE MANUAL

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June 2006

B. Fire Drill

1. PURPOSE

To review at specified intervals policies and procedures, equipment and systems for appropriate activities in the event of fire or internal disaster requiring evacuation.

2. SCOPE

Surgery Center personnel

3. POLICY

A fire drill will be held and documented quarterly. When possible, a member of the Fire Department will be requested to be present for drills and to critique performance.

A representative from ADT will conduct a yearly inspection of fire alarm system and smoke detectors.