



C.L. "BUTCH" OTTER - Governor  
RICHARD M. ARMSTRONG - Director

IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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June 18, 2015

Lonna Welch, Administrator  
Surgery Center of Idaho  
2855 East Magic View Drive  
Meridian, ID 83642

RE: Surgery Center of Idaho, Provider #13C0001060

Dear Ms. Welch:

This is to advise you of the findings of the Medicare Fire Life Safety Survey, which was concluded at Surgery Center of Idaho on June 11, 2015.

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.

Lonna Welch, Administrator  
June 18, 2015  
Page 2 of 2

After you have completed your Plan of Correction, return the original to this office by **July 1, 2015**, and keep a copy for your records.

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

Sincerely,



MARK P. GRIMES  
Supervisor  
Facility Fire Safety & Construction Program

MPG/lj

Enclosures

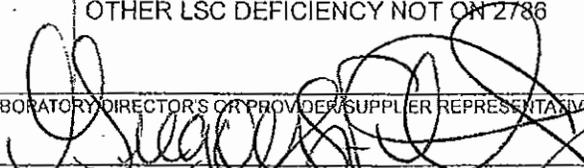
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13C0001060	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING ONE  B. WING _____	(X3) DATE SURVEY COMPLETED  06/11/2015
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NAME OF PROVIDER OR SUPPLIER <b>SURGERY CENTER OF IDAHO</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2855 EAST MAGIC VIEW DRIVE MERIDIAN, ID 83642</b>
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(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
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K 000	<p><b>INITIAL COMMENTS</b></p> <p>The Ambulatory Surgery Center (i.e. ASC) is located on the first floor of a two (2) story, fully sprinklered office occupancy building of Type II Construction. Building construction was finalized on August 16, 2006 with a Certificate of Occupancy, Permit #BP2005-954 City of Meridian. The ASC is one (1) hour separated from the surrounding suites. There is also one (1) hour floor/ceiling assembly between the ASC and the second floor office spaces above. The center is protected throughout by an automatic fire extinguishing system designed/installed per NFPA 13. The center is provided with smoke detection and fire alarm via the building's addressable fire alarm system. Piped in medical gasses are provided and were installed per NFPA Std 99 for a Level I system. Emergency power is provided by an on-site diesel powered generator that complies with NFPA Std 99 for a Type I system. Battery backup emergency lighting is provided within the ASC.</p> <p>The following deficiencies were cited during the certification survey conducted on June 11, 2015. The survey was conducted under applicable provisions set forth in the Life Safety Code, 2000 Edition, Chapter 20, New Ambulatory Health Care Occupancy and 42 CFR 416.44(b).</p> <p>The surveyor conducting the survey was:</p> <p>Sam Burbank          Health Facility Surveyor          Facility Fire Safety &amp; Construction Program</p>	K 000	<p style="text-align: center;">RECEIVED          JUL 15 2015          FACILITY STANDARDS</p>	
K 130	<p><b>MISCELLANEOUS</b></p> <p>OTHER LSC DEFICIENCY NOT ON 2786</p>	K 130	SEE ACTION PLAN	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE CEO	(X6) DATE 15 July 2015
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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.

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

Printed: 06/18/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13C0001060	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING ONE  B. WING _____	(X3) DATE SURVEY COMPLETED  06/11/2015
NAME OF PROVIDER OR SUPPLIER <b>SURGERY CENTER OF IDAHO</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2855 EAST MAGIC VIEW DRIVE MERIDIAN, ID 83842</b>		
(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 130	<p>Continued From page 1</p> <p>This Standard is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to provide readily accessible means of exit access from the shared toilet rooms of the procedure suite. Failure to allow rapid means of exit access has the potential to impede escape in the event of a fire or other emergency. This deficient practice affected patients and staff on the date of survey.</p> <p>Findings include:</p> <p>During the facility tour on June 11, 2015 from 2:00 PM to 3:00 PM/ observation and operational testing of both doors leading from toilet rooms into the procedure rooms found they were equipped with three locking mechanisms: a door knob, along with magnetic locking devices and throw bolts installed on the exterior side. There were no controls or release from the egress side of either the throw bolts or the magnetic locking arrangement and no delayed egress component. When asked why multiple locks had been installed on these doors, the Facility Manager stated the magnetic locks were installed to prevent cross-travel by patients into the adjoining procedure rooms and that the throw bolts were added later as the magnetic locking arrangement was not working properly.</p> <p>Actual NFPA standard:</p> <p>NFPA 101.7.2 MEANS OF EGRESS COMPONENTS</p> <p>7.2.1.5 Locks, Latches, and Alarm Devices. 7.2.1.5.1 Doors shall be arranged to be opened readily from the egress side whenever the building is</p>	K 130		

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NAME OF PROVIDER OR SUPPLIER  SURGERY CENTER OF IDAHO		STREET ADDRESS, CITY, STATE, ZIP CODE 2835 EAST MAGIC VIEW DRIVE MERIDIAN, ID 83642		
(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 130	Continued From page 2 occupied. Locks, if provided, shall not require the use of a key, a tool, or special knowledge or effort for operation from the egress side. Exception No. 1: This requirement shall not apply where otherwise provided in Chapters 18 through 23. Exception No. 2: Exterior doors shall be permitted to have key-operated locks from the egress side, provided that the following criteria are met: (a) Permission to use this exception is provided in Chapters 12 through 42 for the specific occupancy. (b) On or adjacent to the door, there is a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high on a contrasting background that reads as follows:  THIS DOOR TO REMAIN UNLOCKED WHEN THE BUILDING IS OCCUPIED  (c) The locking device is of a type that is readily distinguishable as locked. (d) A key is immediately available to any occupant inside the building when it is locked. Exception No. 2 shall be permitted to be revoked by the authority having jurisdiction for cause. Exception No. 3: Where permitted in Chapters 12 through 42, key operation shall be permitted, provided that the key cannot be removed when the door is locked from the side from which egress is to be made.  38.2.2.2.2* Locks complying with Exception No. 2 to 7.2.1.5.1 shall be permitted only on principal entrance/exit doors.  7.2.1.5.4* A latch or other fastening device on a door shall	K 130		

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K 130	Continued From page 3 be provided with a releasing device having an obvious method of operation and that is readily operated under all lighting conditions. The releasing mechanism for any latch shall be located not less than 34 in. (86 cm), and not more than 48 in. (122 cm), above the finished floor. Doors shall be operable with not more than one releasing operation. Exception No. 1*: Egress doors from individual living units and guest rooms of residential occupancies shall be permitted to be provided with devices that require not more than one additional releasing operation, provided that such device is operable from the inside without the use of a key or tool and is mounted at a height not exceeding 48 in. (122 cm) above the finished floor. Existing security devices shall be permitted to have two additional releasing operations. Existing security devices other than automatic latching devices shall not be located more than 60 in. (152 cm) above the finished floor. Automatic latching devices shall not be located more than 48 in. (122 cm) above the finished floor. Exception No. 2: The minimum mounting height for the releasing mechanism shall not be applicable to existing installations.	K 130		

## ACTION PLAN

**Date:** 6.23.2015

**Problem Reference (CMS Section):** Q130

**In-house point-of-contact:** Frank Smith, Facility Manager

**Problem Statement:** Throw Bolts Installed On Doors

**Problem Narrative/Background/Details:** Observation and operational testing of both doors leading from restrooms into the procedure rooms found they were equipped with three locking mechanisms: a door knob, along with magnetic locking devices and throw bolts installed on the exterior side. There were no controls or release from the egress side of either the throw bolts or the magnetic locking arrangement and no delayed egress component.

**Estimated Completion Date (ECD):** 6.24.2015

### **Solution/Action Plan:**

**Task 1:** Removed throw bolts locks from all four rest room doors on 6.24.2015. Will use original installed manual locks on all four doors. This will allow personnel to egress restrooms with no delay lock components.

**Actual Completion Date (ACD):** 6.24.2015

**Monitoring/tracking:** Mechanical solution used; staff will notify Facility Manager as needed when a facility issue arises

**ACD Validated by:** Lonna Welch, Administrator & Greg Feltenberger, CEO