IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK– ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
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August 2, 2016

Deborah Wensink, Administrator
Sawtooth Surgery Center
115 Falls Avenue West
Twin Falls, ID 83303

RE: Sawtooth Surgery Center, Provider #13C0001003

Dear Ms. Wensink:

This is to advise you of the findings of the Medicare Fire Life Safety Survey, which was concluded at Sawtooth Surgery Center on July 19, 2016.

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 **August 15, 2016,** 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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13C0001003	A. BUILDING 01 - ENTIRE ASC BLDG B. WING ______	07/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAWTOOTH SURGERY CENTER	115 FALLS AVENUE WEST TWIN FALLS, ID 83303

(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 protected wood frame Type V (111) building was built in 1994 and has a basement with a dumbwaiter to service both levels. The ground level is approximately 15,534 square feet and the basement is approximately 6,080 square feet in size. An automatic fire suppression sprinkler system is installed in accordance with NFPA 13. There is a manual fire alarm system with smoke detection throughout. Piped medical gas and a natural gas fueled. Essential Electrical System serves the building. Battery backup emergency lighting is provided in the operating rooms and the outdoor generator building. There are seven exits to grade with two interior stairwells for basement access. The following deficiencies were cited during the recertification fire/life safety survey conducted on July 19, 2016. The facility was surveyed under the Life Safety Code, 2000 Edition, Chapter 21, Existing Ambulatory Health Care Occupancy in accordance with 42 CFR 416.44(b). The survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction	K 000	RECEIVED AUG 12 2016 FACILITY STANDARDS	
K 012	416.44(b)(1) LIFE SAFETY CODE STANDARD Buildings two or more stories in height and of Type II(000),III (200) V (000) construction are equipped throughout with a supervised approved automatic sprinkler system in accordance with section 9.7, 20.1.6.3, 21.1.6.3 This Standard is not met as evidenced by: Based on record review, observation and interview the facility failed to maintain fire suppression systems in accordance with NFPA	K 012	K012 416.44(b) LIFE SAFETY CODE STANDARD PLAN OF CORRECTION: The automatic sprinkler system will be maintained according to NFPA 25. SYSTEMIC CHANGES: The Center Director revised the agreement (Attachment A) with the fire system vendor, adding the requirement for quarterly inspections of the sprinkler system. An annual inspection of the sprinkler system was conducted on 7/23/2016 (Attachment B) and the next quarterly inspection has been scheduled for October.	7/23/2016

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Deborah A. [illegible] — TITLE: Administrator — (X6) DATE: 8-10-2016

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 012	Continued From page 1 25. Failure to maintain fire suppression sprinkler systems could hinder system response during a fire event. This deficient practice affected all patients, staff and visitors on the date of the survey. Findings Include: 1) During review of provided annual fire suppression system inspection records conducted on July 19, 2016 from approximately 1:30 PM to 2:00 PM, no record was provided demonstrating quarterly sprinkler inspections had been conducted. When asked, the Maintenance Manager stated he was not aware that quarterly sprinkler inspections were required. 2) During the facility tour conducted on July 19, 2016 from approximately 2:00 PM to 4:30 PM, observation of sprinkler inspection tags attached to the main fire suppression system riser did not indicate quarterly sprinkler inspections had been performed. Actual NFPA Standard: NFPA 101 9.7 AUTOMATIC SPRINKLERS AND OTHER EXTINGUISHING EQUIPMENT 9.7.5 Maintenance and Testing. All automatic sprinkler and standpipe systems required by this Code shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25 2-2.6 Alarm Devices.	K 012	RESPONSIBLE PARTY AND MONITORING: The Center Director is responsible for ensuring quarterly inspections of the sprinkler system. Quarterly inspections will be tracked via the facility's Environment of Care Rounds checklist (Attachment C) The Center Director will provide results from the Environment of Care Rounds checklist to the QAPI Committee quarterly for review and recommendation. Recommendations will be submitted to the Governing Body for review and approval.	

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K 012	Continued From page 2 Alarm devices shall be inspected quarterly to verify that they are free of physical damage.	K 012		
K 013	416.44(b)(1) LIFE SAFETY CODE STANDARD Existing ambulatory health care occupancies shall be limited to the building construction specified in Section 21.1.6 of the LSC. 21.1.6 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure the smoke and fire resistive properties of the structure. Failure to maintain the smoke and fire resistive properties of the structure could allow fire, and its byproducts to communicate into open spaces between floors or attics. This deficient practice affected all patients, staff and visitors on the date of the survey. Findings Include: 1) During the facility tour conducted on July 19, 2016 from approximately 1:30 PM to 4:30 PM, an above the ceiling inspection of the Medical Records area revealed a hole in the one-hour separation, exposing the attic space above, which measured approximately twelve inches in diameter. When asked, the Maintenance Manager stated he was not aware of this hole prior to the date of the survey. 2) During the facility tour conducted on July 19, 2016 from approximately 1:30 PM to 4:30 PM, observation of the basement ceiling area adjacent to the Mechanical Room, revealed two pipes entering the ceiling through an unsealed penetration of approximately twelve inches by twelve inches in size. 21.1.6.3 Buildings of two or more stories in height housing ambulatory health care facilities shall be of Type	K 013	K013 416.44(b) LIFE SAFETY CODE STANDARD PLAN OF CORRECTION: Penetrations in smoke/fire barriers will be enclosed in accordance with the current NFPA Life Safety Code. SYSTEMIC CHANGES: The Center Director contacted a fire stopping vendor to schedule sealing the fire wall penetrations with the appropriate fire rated material in the following: 1. Medical records room, above the ceiling tile, the hole exposing the attic space above. 2. Basement ceiling area adjacent to the Mechanical room, where two pipes enter the ceiling. Attachment E: Firestopping proposal RESPONSIBLE PARTY AND MONITORING: The Center Director is responsible for ensuring facility compliance with Life Safety Code Standards. The Center Director will confirm the appropriate sealing of the penetrations upon completion. The Center Director or designee will visually inspect for penetrations in the fire barriers after workmen have completed work in the building to ensure that penetrations are sealed. These inspections will be tracked on the Environment of Care Rounds checklist (Attachment C). The Center Director will report the results from inspections to the QAPI Committee quarterly for review and recommendation. Recommendations will be submitted to the Governing Body for review and approval.	8/19/2016

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K 013	Continued From page 3 I(443), Type I(332), Type II(222), Type II(111), Type III(211), Type IV(2HH), or Type V(111) construction. (See 8.2.1.) Exception: Buildings constructed of Type II(000), Type III(200), or Type V(000), if protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. 8.2.1* Construction. Buildings or structures occupied or used in accordance with the individual occupancy chapters (Chapters 12 through 42) shall meet the minimum construction requirements of those chapters. NFPA 220, Standard on Types of Building Construction, shall be used to determine the requirements for the construction classification. Where the building or facility includes additions or connected structures of different construction types, the rating and classification of the structure shall be based on either of the following: (1) Separate buildings if a 2-hour or greater vertically-aligned fire barrier wall in accordance with NFPA 221, Standard for Fire Walls and Fire Barrier Walls, exists between the portions of the building Exception: The requirement of 8.2.1(1) shall not apply to previously approved separations between buildings. (2) The least fire-resistive type of construction of the connected portions, if no such separation is provided. 8.2.3.2.3* Opening Protectives. 8.2.3.2.3.1 Every opening in a fire barrier shall be protected to limit the spread of fire and restrict the movement of smoke from one side of the fire barrier to the other. The fire protection rating for opening protectives shall be as follows:	K 013		

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K 013	Continued From page 4 (1) 2-hour fire barrier - 11/2-hour fire protection rating	K 013		
	(2) 1-hour fire barrier - 1-hour fire protection rating where used for vertical openings or exit enclosures, or 3/4-hour fire protection rating where used for other than vertical openings or exit enclosures, unless a lesser fire protection rating is specified by Chapter 7 or Chapters 11 through 42 Exception No. 1: Where the fire barrier specified in 8.2.3.2.3.1(2) is provided as a result of a requirement that corridor walls or smoke barriers be of 1-hour fire resistance-rated construction, the opening protectives shall be permitted to have not less than a 20-minute fire protection rating when tested in accordance with NFPA 252, Standard Methods of Fire Tests of Door Assemblies, without the hose stream test. Exception No. 2: The requirement of 8.2.3.2.3.1(2) shall not apply where special requirements for doors in 1-hour fire resistance-rated corridor walls and 1-hour fire resistance-rated smoke barriers are specified in Chapters 18 through 21. Exception No. 3: Existing doors having a 3/4-hour fire protection rating shall be permitted to continue to be used in vertical openings and in exit enclosures in lieu of the 1-hour rating required by 8.2.3.2.3.1(2). (3) 1/2-hour fire barrier - 20-minute fire protection rating Exception: Twenty-minute fire protection-rated doors shall be exempt from the hose stream test of NFPA 252, Standard Methods of Fire Tests of Door Assemblies.			
K 115	416.44(b)(1) LIFE SAFETY CODE STANDARD Ambulatory health care facilities are divided into at least two smoke compartments with smoke barriers having at least 1 hour fire resistance	K 115		

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K 115	Continued From page 5 rating. Doors in smoke barriers are equipped with positive latcher. Doors shall be constructed of not less than 1 3/4 inch thick solid bonded core wood or equivalent. Vision panels are provided and are of fixed wire glass limited to 1,296 sq. inch per panel. (Indicate N/A for facilities of less than 5,000 sq. ft. with an approved smoke detection system, and less than 10,000 sq. ft. with an approved supervicsed sprinkler system in accordance with 9.7.) 20.3.7.2, 20.3.7.3, 20.3.7.4, 20.3.7.6, 21.3.7.3, 21.3.7.2, 21.3.7.4, 21.3.7.6 This Standard is not met as evidenced by: Based upon observation, operational testing and interview, the facility failed to ensure smoke barrier doors would self-close. Failure to ensure doors entering stairwells would self-close could allow smoke and dangerous gases to pass between floors during a fire event affecting the safe egress of patients.This deficient practice affected all patients, staff and visitors on the date of the survey. Findings Include: 1) During the facility tour conducted on July 19, 2016 from approximately 1:30 PM to 4:30 PM, observation and operational testing of the door separating the rear exit of PACU and entering the basement stairwell, revealed the door was equipped with a self-closing device, but would not self-close when activated. When asked, the Maintenance Manager stated he was unaware this door was not self-closing as designed. 2) During the facility tour conducted on July 19, 2016 from approximately 1:30 PM to 4:30 PM, observation and operational testing of the door which entered the basement from CCP (Clean Central Sterile Processing) above, revealed the door was equipped with a self-closing device, but	K 115	K115 416.44(b) LIFE SAFETY CODE STANDARD PLAN OF CORRECTION: Smoke barrier doors will self-close when activated. SYSTEMIC CHANGES: A door company vendor repaired the deficient smoke barrier doors to self-close when activated. Repair has been completed for the non-functioning doors: door separating the rear exit of the PACU entering the basement stairwell and the door entering the basement from the Clean Central Processing area. RESPONSIBLE PARTY AND MONITORING: The Center Director is responsible for ensuring the automatic closing of the smoke barrier doors. The non-functioning doors were inspected for appropriate functioning upon completion of the repair and will undergo formal inspection annually. Annual inspections will be documented on the Fire Door Inspection Form (Attachment D). Appropriate clearance and latching of fire doors will be tracked monthly and documented on the Environment of Care Rounds Checklist (Attachment C). The Center Director will report the results from the fire door inspections and activities on the Environment of Care Rounds Checklist to the QAPI Committee quarterly for review and recommendation. Recommendations will be submitted to the Governing Body for review and approval.	8/5/2016

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K 115	Continued From page 6 would not self-close. When asked the Maintenance Manager stated that he was unaware that the door was not self-closing. Actual NFPA Standard: 21.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1 hour. Exception: Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems for buildings protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. 8.3.4.3* Doors in smoke barriers shall be self-closing or automatic-closing in accordance with 7.2.1.8 and shall comply with the provisions of 7.2.1.	K 115		
K 130	416.44(b)(1) MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This Standard is not met as evidenced by: Based on record review and interview, the facility failed to ensure the maintenance and testing of fire-rated dumbwaiter doors was conducted annually in accordance with NFPA 80. Failure to maintain and inspect dumbwaiter doors annually could fail to detect system malfunctions and allow fires, smoke and dangerous gases to communicate between floors. This deficient practice affected all patients, staff and visitors on the date of the survey. Findings include: During review of the facility annual fire protection systems inspection records, no record was available demonstrating the dumbwaiter doors	K 130	K130 416.44(b) LIFE SAFETY CODE PLAN OF CORRECTION: All horizontal or vertical sliding and rolling fire doors will be inspected and tested annually to check for proper operation and full closure. SYSTEMIC CHANGES: The Center Director contacted an overhead door company who provided inspection and testing of the dumbwaiter doors. Dumbwaiter door was adjusted and shown to release as designed with smoke detector activation. RESPONSIBLE PARTY AND MONITORING: The Center Director is responsible for ensuring annual testing of the dumbwaiter door. Annual inspections will be documented on the Fire Door Inspection Form (Attachment D). Annual testing of the dumbwaiter door will be tracked via the facility's Environment of Care Rounds checklist (Attachment C). The Center Director will provide results from the Environment of Care Rounds checklist to the QAPI Committee quarterly for review and recommendation. Recommendations will be submitted to the Governing Body for review and approval.	7/29/2016

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K 130	Continued From page 7 connecting the basement to the CCP (Clean Central Processing) had been tested on an annual basis. When asked about the lack of documentation for the annual testing, the Maintenance Manager stated he was not aware these doors were required to be inspected annually. Actual NFPA standard: NFPA 80 Standard for Fire Doors and Fire Windows 1999 Edition Chapter 15 Care and Maintenance 15-2.4 Maintenance of Closing Mechanisms. 15-3.4.3 All horizontal or vertical sliding and rolling fire doors shall be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer ' s instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction.	K 130		