IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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January 24, 2017

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 January 12, 2017.

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 **February 6, 2017**, 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,

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
	13C0001060	A. BUILDING **01 - BUILDING ONE** B. WING _____	**01/12/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURGERY CENTER OF IDAHO	**2855 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 000	INITIAL COMMENTS 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. The following deficiencies were cited during the certification survey conducted on January 12, 2017. The survey was conducted under applicable provisions set forth in the Life Safety Code, 2012 Edition, Chapter 21, Existing Ambulatory Health Care Occupancy and 42 CFR 416.44(b). The surveyors conducting the survey were: Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction Program Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction Program	K 000	FEB 06 2017	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	CEO	3 FEB 2017

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 100	Continued From page 1	K 100		
K 100	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section, any LSC Section 20.1 and 20.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure fire and smoke resistive properties of the structure were maintained. Failure to seal penetrations from conduits and cabling which pass through walls and ceilings, could allow fires, smoke and dangerous gases to pass between compartments. This deficient practice affected patients, staff and visitors on the date of the survey. Findings include: During the facility tour conducted on January 12, 2017 from approximately 12:30 PM to 3:45 PM, above the ceiling inspections of the OR suite and the fire barrier separating the OR suite to reception, revealed the following: An approximately two (2) inch conduit containing data cabling, from the janitorial storage closet into the ceiling above, was not sealed. The wall separating the reception from the OR suite revealed four (4) unsealed approximately 3/4" inch conduits; one (1) unsealed approximately 2-1/2" conduit; one (1) unsealed approximately 1-1/2" conduit. When asked about the penetrations, the Facility Manager stated he was not aware of these penetrations prior to the date of the survey.	K 100		

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K 100	Continued From page 2 Based on the extent and the number of findings, the condition was deemed widespread and no further documentation was required. Actual NFPA standard: 21.1.6 Minimum Construction Requirements. 21.1.6.1 Ambulatory health care occupancies shall be limited to the building construction types specified in Table 21.1.6.1, unless otherwise permitted by 21.1.6.6. (See 8.2.1.) 8.2 Construction and Compartmentation. 8.2.1 Construction. 8.2.2.2 Fire compartments shall be formed with fire barriers that comply with Section 8.3. 8.3.5.1* Firestop Systems and Devices Required. Penetrations for cables, cable trays, conduits, pipes, tubes, combustion vents and exhaust vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a fire barrier shall be protected by a firestop system or device. The firestop system or device shall be tested in accordance with ASTM E 814, Standard Test Method for Fire Tests of Through Penetration Fire Stops, or ANSI/UL 1479, Standard for Fire Tests of Through- Penetration Firestops, at a minimum positive pressure differential of 0.01 in. water column (2.5 N/m2) between the exposed and the unexposed surface of the test assembly.	K 100		
K 500	NFPA 101 Building Services - Other Building Services - Other List in the REMARKS section any LSC Section 20.5 and 21.5 Building Services requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the	K 500		

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K 500	Continued From page 3 applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This Standard is not met as evidenced by: Based on record review and interview, the facility failed to ensure the relative humidity in the operating rooms were maintained in accordance with CMS guidelines under nationally recognized standards. Failure to maintain relative humidity levels above twenty percent, could result in arc fires in the presence of increased static discharge. This deficient practice affected patients, staff and visitors on the date of the survey. Findings include: During review of operating room temperature and relative humidity records conducted on January 12, 2017 from approximately 9:30 AM to 12:00 PM, records indicated relative humidity in OR 1 and 2 dropped below 20% on ten (10) occasions in twelve months, with no corrective actions documented correcting the deficiency. When asked, the Facility Manager stated he was not aware of the amount of times the condition occurred, but the reason for the lower humidity was the colder weather. Reference: CMS S&C 13-25 ASHRAE 170-2013	K 500		
K 920	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and	K 920		

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K 920	Continued From page 4 Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This Standard is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure safe electrical installations in operating rooms in accordance with NFPA 99. Failure to provide safe electrical installations in a patient care room could result in electrocution or fires by arcing. This deficient practice affected patients, staff and visitors on the date of the survey. Findings include: 1) During review of the facility systems inspection and testing documentation conducted on January 12, 2017 from approximately 10:00 AM to 12:00 PM, no records were provided indicating a ongoing maintenance program for the inspection	K 920		

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K 920	Continued From page 5 and testing of relocatable power taps in the operating rooms. 2) During the facility tour conducted on January 12, 2017 from approximately 12:30 PM to 3:00 PM, observation of OR 2 revealed a relocatable power tap which was plugged into 1 of 2 emergency outlets under the desk. Further observation of the workstation revealed the RPT supplied power to the computer and monitor at the desk and was a standard UL 1363 rated connection with three (3) open/unused outlets. When asked, the Facility Manager stated he was not aware of the standards for relocatable power taps in operating rooms. Actual NFPA standard: NFPA 99 Chapter 10 10.2.3.6 Multiple Outlet Connection. Two or more 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.	K 920		

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K 920	Continued From page 6 (5)*Means are employed to ensure that additional devices or nonmedical equipment cannot be connected to the multiple outlet extension	K 920		
K 923	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage *Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. *Greater than 300 but less than 3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hour fire protection rating. *Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored	K 923		

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K 923	Continued From page 7 in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure medical gas storage was in accordance with NFPA 99. Failure to segregate, identify and secure medical gases could result in accidental damage and explosions from unsecured cylinders and/or using the incorrect cylinder in an emergency. This deficient practice affected patients, staff and visitors on the date of the survey. Findings include: During the facility tour conducted on January 12, 2017 from approximately 12:30 PM to 3:00 PM, observation of the medical gas storage area revealed one (1) unsecured carbon dioxide cylinder and empty oxygen cylinders stored in racks with full cylinders, without clear separation. When asked, the Facility Manager stated he was aware of the requirements regarding medical gas storage and the risks associated. Actual NFPA standard: 5.1.3.3.2* Design and Construction. Locations for central supply systems and the storage of positive-pressure gases shall meet the following requirements: (1) They shall be constructed with access to move cylinders, equipment, and so forth, in and out of the location on hand trucks complying with 11.4.3.1.1. (2) They shall be secured with lockable doors or gates or otherwise secured. (3) If outdoors, they shall be provided with an enclosure (wall or fencing) constructed of noncombustible materials with a minimum of two	K 923		

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K 923	Continued From page 8 entry/exits. (4) If indoors, they shall be constructed and use interior finishes of noncombustible or limited-combustible materials such that all walls, floors, ceilings, and doors are of a minimum 1-hour fire resistance rating. (5)*They shall be compliant with NFPA 70, National Electrical Code, for ordinary locations. (6) They shall be heated by indirect means (e.g., steam, hot water) if heat is required. (7) They shall be provided with racks, chains, or other fastenings to secure all cylinders from falling, whether connected, unconnected, full, or empty. (8)*They shall be supplied with electrical power compliant with the requirements for essential electrical systems as described in Chapter 6. (9) They shall have racks, shelves, and supports, where provided, constructed of noncombustible materials or limited-combustible materials. (10) They shall protect electrical devices from physical damage. 11.6.5 Special Precautions - Storage of Cylinders and Containers. 11.6.5.1 Storage shall be planned so that cylinders can be used in the order in which they are received from the supplier. 11.6.5.2 If empty and full cylinders are stored within the same enclosure, empty cylinders shall be segregated from full cylinders. 11.6.5.3 Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed in a rapid manner.	K 923		

ACTION PLAN

Date: 02.03.17

Problem Reference (CMS Section): K 100

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

Problem Statement: Failure to seal penetration from conduits and cabling which pass through walls and ceilings.

Problem Narrative/Background/Details: 1. Ceiling inspection of the OR suite and the fire barrier separating the OR suite to reception, revealing an approximately two-inch conduit containing data cabling from the janitorial storage closet into the ceiling above was not sealed.
2. The wall separating the reception from the OR suite revealed four unsealed approximately ¾" inch conduits; one unsealed approximately 2-1/2" conduit; one unsealed approximately 1-1/2" conduit.

Estimated Completion Date (ECD): 02.11.17

Solution/Action Plan:

Task 1 and ECD: 01.12.17 we ordered Fire Barrier Putty (See attachment 1).

Task 2 and ECD: 02.11.17 We will inspect and seal all conduits penetrating the walls (particularly areas referenced above) and ceiling in fire compartments with Fire Barrier Putty

Actual Completion Date (ACD):

Monitoring/Tracking: Facility Manager will inspect fire wall penetrations whenever maintenance occurs in effective fire compartments.

ACD Validated by: Lonna Welch, Administrator and Greg Feltenberger, CEO

ACTION PLAN

Date: 02.03.17

Problem Reference (CMS Section): K 500

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

Problem Statement: Failed to ensure the relative humidity in the in the operating rooms were maintained.

Problem Narrative/Background/Details: During review of the operating room temperature and relative humidity records conducted on January 12. 2017 from approximately 9:30 AM to 12:00 PM, records indicated relative humidity in OR 1 and 2 dropped below 20% on ten occasions in twelve months, with no corrective actions documented correcting the deficiency.

Estimated Completion Date (ECD): 02.03.17

Solution/Action Plan:

Task 1 and ECD: 01.16.17 we had R.M. Mechanical technician (See attachment 1) went over our humidifier issues like the lack of proper humidity output to maintain the 20 to 60% humidity output for all OR's. Technician then adjusted output for OR 1 and 2.

Task 2 and ECD: 02.03.17 R.M. Mechanical will start a Preventive Maintenance program for humidifiers.

Actual Completion Date (ACD): 02.03.17

Monitoring/Tracking: Staff have been trained to monitor and log humidity daily and will notify Facility Manager as needed when humidity deviates from appropriate range.

ACD Validated by: Lonna Welch, Administrator and Greg Feltenberger, CEO

ACTION PLAN

Date: 02.03.17

Problem Reference (CMS Section): K 920

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

Problem Statement: Power strips in the patient care vicinity failed to ensure safe electrical installation in operating rooms.

Problem Narrative/Background/Details: 1. No records were provided indicating on-going maintenance program for the inspection and testing of relocatable power taps in the operating rooms. 2. Observation of OR 2 revealed a relocatable power tap was plugged into 1 of 2 emergency outlets under the desk. Further observation of the workstation revealed the RPT supplied power to the computer and monitor at the desk and was a standard UL 1363 rated connection with three open/unused outlets.

Estimated Completion Date (ECD): 02.03.17

Solution/Action Plan:

Task 1 and ECD: 02.03.17 Removed all relocatable power taps from operating rooms.

Actual Completion Date (ACD): 02.03.17

Monitoring/Tracking: Staff will notify Facility Manager prior to the use of relocatable power taps in operating rooms.

ACD Validated by: Lonna Welch, Administrator and Greg Feltenberger, CEO

ACTION PLAN

Date: 02.03.17

Problem Reference (CMS Section): K 923

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

Problem Statement: Facility failed to ensure medical gas storage was in accordance with NFPA 99.

Problem Narrative/Background/Details: Observation of the medical gas storage area revealed one unsecured carbon dioxide cylinder stored in racks with full cylinders without clear separation.

Estimated Completion Date (ECD): 02.10.17

Solution/Action Plan:

Task 1 and ECD: 01.12.17 We secured the carbon dioxide gas cylinders in a storage rack.

Task 2 and ECD: 01.12.17 called [redacted] remove excess empty gas cylinders.

Task 3 and ECD: 02.10.17 Process will be created and staff will be educated on the new process of organization of oxygen and carbon dioxide cylinders.

Actual Completion Date (ACD):

Monitoring/Tracking: Staff will notify Facility Manager as needed when gas cylinder storage racks (for empties) are nearly full so an order can be placed for [redacted] to remove empty cylinders.

ACD Validated by: Lonna Welch, Administrator and Greg Feltenberger, CEO