IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

March 15, 2012

Crystal Baisch, Administrator
Sinus Surgery Center Idaho PA
727 East River Park Lane Suite 200
Boise, Idaho 83706

RE: Sinus Surgery Center Idaho PA, Provider #13C0001062

Dear Ms. Baisch:

This is to advise you of the findings of the Medicare Fire Life Safety Survey, which was concluded at Sinus Surgery Center Idaho PA on March 9, 2012.

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 28, 2012**, 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

PRINTED: 03/14/2012
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
	13C0001062	A. BUILDING 01 - ASC IN PHYSICIAN OFFIC B. WING _____	03/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SINUS SURGERY CENTER IDAHO PA	727 EAST RIVER PARK LANE SUITE 200 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 is located in a single story, single tenant structure of Type V III construction. The portion of the building housing the ASC and attached physician clinic was renovated in the fall of 2000 and occupied as an ASC (River Run Surgical Center) in March of 2001. The ASC occupies approximately 2,000 square feet of the approximately 4,500 square feet of the combined space. The ASC is separated from the attached clinic by a (1) one hour rated wall assembly. There is (1) one exit directly to the exterior from the ASC with (2) two additional exits to the exterior available through the attached clinic. The ASC and the attached clinic are provided with a complete fire alarm/smoke detection system with off-site monitoring. Emergency power for the ASC is provided by a Type I system with on-site diesel powered automatic generator. Piped in medical gas is provided as well as a central vacuum system. There are portable fire extinguishers provided throughout. The following deficiencies were cited during the survey conducted on March 9, 2012. 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). The surveyor conducting the survey was: Taylor Barkley Health Facility Surveyor Facility Fire Safety & Construction Program	K 000	RECEIVED MAR 28 2012 FACILITY STANDARDS	
K 046	416.44(b)(1) LIFE SAFETY CODE STANDARD	K 046		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: L Baisch | TITLE: adm | (X6) DATE: 3/27/2012

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ASC IN PHYSICIAN OFFIC B. WING	(X3) DATE SURVEY COMPLETED
	13C0001062		03/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SINUS SURGERY CENTER IDAHO PA	727 EAST RIVER PARK LANE SUITE 200 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 046	Continued From page 1 Emergency illumination is provided in accordance with section 7.9. 20.2.9.1, 21.2.9.1 This STANDARD is not met as evidenced by: Based on record review and interview it was revealed that the facility did not ensure that emergency light testing for 90 minutes once a year and 30 seconds per month was being completed and documented. Failure to test the emergency lights can result in nonoperational units not being discovered and repaired. The facility had two patients in the facility during the survey. This deficiency affected all patients, staff and visitors present on the day of the survey. Findings include: During record review on March 9, 2012 at 10:50 AM, the facility was unable to provide testing records for the emergency lights for 90 minutes once a year and 30 seconds per month for the previous 12 month period. When this deficient practice was discussed with the facility staff member responsible for maintenance he stated that he was unaware of the emergency light testing requirements. This deficiency was acknowledged during the exit conference with the Administrator and Surveyor. Actual NFPA Standard: Chapter 20 NEW AMBULATORY HEALTH CARE OCCUPANCIES 20.2.9.1 Emergency lighting shall be provided in accordance with Section 7.9.	K 046	**Corrective Action for K046:** Policy and Procedure developed on 03/12/ 2012. Spreadsheet to document emergency light testing developed on 03/12/ 2012. Staff training completed on 03/12/ 2012. Training on new Policy and Procedure for emergency light testing requirements Responsibility for testing assigned to the OR Manager. Ray Griewe, RN will test the emergency lights monthly and annually. Testing will be documented. Administrator, Crystal Baisch will monitor monthly and annually that the testing is completed and documented by: Added to OR Managers annual review Added to QA/Governing Body minute notes Added to facilities calendar Checklist of things that must be done monthly, quarterly and annually.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ASC IN PHYSICIAN OFFIC B. WING	(X3) DATE SURVEY COMPLETED
	13C0001062		03/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SINUS SURGERY CENTER IDAHO PA	727 EAST RIVER PARK LANE SUITE 200 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 046	Continued From page 2 7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 11/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction.	K 046		
K 051	416.44(b)(1) LIFE SAFETY CODE STANDARD A manual fire alarm system, not a pre-signal type, is provided to automatically warn the building occupants. Fire alarm system has initiation notification and control function. The fire alarm system is arranged to automatically transmit an alarm to summon the fire department. 20.3.4.1, 21.3.4.1 This STANDARD is not met as evidenced by: Based on record review and interview it was revealed that the facility did not ensure that the fire alarm system and all components were being maintained in a fully functional status in accordance with NFPA 72. Properly maintaining a fire alarm system and all components help to ensure system reliability. The facility had two patients in the facility during the survey. This deficiency affected all patients, staff and visitors present on the day of the survey. Findings include: During record review on March 9, 2012 at 10:15	K 051	**Corrective Action For K051:** The pull station in the main lobby was replaced on March 16, 2012 by Audio Electronics Inc. AEI replaced 3 pull stations and tested each for correct operation. Future Fire Alarm Inspection Reports will be read more carefully and necessary action completed by Crystal Baisch, Administrator.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ASC IN PHYSICIAN OFFIC B. WING	(X3) DATE SURVEY COMPLETED
	13C0001062		03/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SINUS SURGERY CENTER IDAHO PA	727 EAST RIVER PARK LANE SUITE 200 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 051	Continued From page 3 AM, review of the annual Fire Alarm inspection report dated August 3, 2011 indicated that the main lobby pull stations needed to be replaced due to reset keys being stripped. When questioned about the pull stations the Administrator stated that she was made aware of the problem during the annual inspection and the pull station have not been replaced as of the date of the survey. Actual NFPA Standard: Chapter 20 NEW AMBULATORY HEALTH CARE OCCUPANCIES 20.3.4.1 General. Ambulatory health care facilities shall be provided with fire alarm systems in accordance with Section 9.6, except as modified by 20.3.4.2 through 20.3.4.5. 9.6.1.4 A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm Code, unless an existing installation, which shall be permitted to be continued in use, subject to the approval of the authority having jurisdiction. NFPA 72 National Fire Alarm Code ® 1999 Edition 7-1.1.2 System defects and malfunctions shall be corrected. If a defect or malfunction is not corrected at the conclusion of system inspection, testing, or maintenance, the system owner or the owner ' s designated representative shall be informed of the impairment in writing within 24	K 051		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ASC IN PHYSICIAN OFFIC B. WING	(X3) DATE SURVEY COMPLETED
	13C0001062		03/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SINUS SURGERY CENTER IDAHO PA	727 EAST RIVER PARK LANE SUITE 200 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 051	Continued From page 4 hours.	K 051		
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 1¾ 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 and operational testing it was determined that the facility did not ensure that a door in the fire barrier was self closing. An open door in a fire barrier can let fire and fire gasses into the rest of the building outside of the Ambulatory Surgical Center's rated fire wall. The facility had two patients in the facility during the survey. This deficiency affected all patients, staff and visitors present on the day of the survey. Findings include: During a tour of the facility on March 9, 2012 at 12:38 PM, observation of operational testing of the door to the Ambulatory Surgical Center entrance from the waiting room revealed that the bottom of the door was dragging on the floor carpeting and would not self close when released from the open position. This was observed and noted by the Administrator and Surveyor.	K 114	**Corrective Action For K114:** The door to the ASC's waiting room will be fixed on March 30th 2012 to ensure that it will self close and NOT lodge itself open. All employees of the surgery center and the medical practice were educated on the Life Safety Code Standards. All employees will ensure that doors will close automatically in the future and if not, will report the issue to the administrator. It was also made clear that doors must be able to self close and cannot be propped open with door wedges or anything else. This will ensure safety of all employees and patients inside the building in case of a fire.	
K 144	416.44(b)(1) LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised	K 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ASC IN PHYSICIAN OFFIC B. WING	(X3) DATE SURVEY COMPLETED
	13C0001062		03/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SINUS SURGERY CENTER IDAHO PA	727 EAST RIVER PARK LANE SUITE 200 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 144	Continued From page 5 under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1, NFPA 110 This STANDARD is not met as evidenced by: Based on record review and interview it was determined that the facility did not ensure that the emergency generator was being inspected on a weekly basis in accordance with NFPA 110. Failure to inspect the generator on a weekly basis could result in the generator not starting or functioning properly in the event of a power outage. The facility had two patients in the facility during the survey. This deficiency affected all patients, staff and visitors present on the day of the survey. Findings include: During record review on March 9, 2012 at 11:00 AM, the facility was unable to provide documented weekly inspections for the generator. When this deficient practice was discussed with the facility staff member responsible for maintenance he stated that he was unaware of the weekly generator inspection requirements. This deficiency was acknowledged during the exit conference with the Administrator and Surveyor. Actual NFPA Standard: NFPA 110 Standard for Emergency and Standby Power Systems 1999 Edition 6-4 Operational Inspection and Testing. 6-4.1* Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected	K 144	**Corrective Action For K144:** The Generator Check Policy and Procedure has been reviewed and updated to ensure the NFPA Standard 1999 Edition standards are being met. New Generator Log forms are being developed. Western States was contacted and asked to do an in-service regarding maintenance of the generator and how to check the generator. The training is scheduled for April 4, 2012. The log forms will be developed based on the recommended items that should be checked weekly that actually reflect our generator. Staff training on the new policy and procedure and new log forms will be done after the Western States in-service. Until then, the generator will be opened and inspected by Jon Stull, employee. He will check and document the things that are obvious – general condition of generator inside and out, oil and fuel level, load, and transfer time. Our current policy requires the generator to be tested weekly – power is shut off and the generator kicks on. Per Western States our generator is a single phase generator – when the power is killed and the lights come on – this verifies that	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13C0001062	A. BUILDING 01 - ASC IN PHYSICIAN OFFIC B. WING	03/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SINUS SURGERY CENTER IDAHO PA	727 EAST RIVER PARK LANE SUITE 200 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 144	Continued From page 6 weekly and shall be exercised under load at least monthly. 6-3.4 A written record of the EPSS inspections, tests, exercising, operation, and repairs shall be maintained on the premises. The written record shall include the following: (a) The date of the maintenance report (b) Identification of the servicing personnel (c) Notation of any unsatisfactory condition and the corrective action taken, including parts replaced (d) Testing of any repair for the appropriate time as recommended by the manufacturer	K 144	**Continued From page 6 K144** the transfer switch is working properly. Western States does check the transfer switch yearly. The battery is a self contained battery.	
K 211	416.44(b)(1) LIFE SAFETY CODE STANDARD o Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor, the corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 18.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623 This STANDARD is not met as evidenced by: Based on observation it was determined that the facility did not ensure that alcohol based hand rub	K 211	**Corrective Action For K211:** The Alcohol Based Hand Rub dispenser that was installed close to an ignition source was removed immediately when pointed out. It has not been remounted. If and when it is remounted, it will be mounted according to Life Safety Code – not close to an ignition source. ☺ When the Alcohol Base Rub was installed, Ray Griewe, RN tried very hard to make sure he had interpreted the install guidelines correctly. We are very sorry that we did not and very thankful to Taylor for being so kind regarding this error. 3-9-12 TB	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ASC IN PHYSICIAN OFFIC B. WING	(X3) DATE SURVEY COMPLETED
	13C0001062		03/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SINUS SURGERY CENTER IDAHO PA	727 EAST RIVER PARK LANE SUITE 200 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 211	Continued From page 7 dispensers were not installed above an ignition source. This deficiency could start a fire in the event of container leakage. The facility had two patients in the facility during the survey. This deficiency affected all patients, staff and visitors present on the day of the survey. Findings include: During a tour of the facility on March 9, 2012 at 12:20 PM, observation of Operating Room #1 revealed an alcohol based hand rub dispenser installed above a light switch. When this deficient practice was discussed with the facility staff member responsible for maintenance he stated that he was unaware that the dispenser had been installed above the light switch. This deficiency was corrected during the survey and was acknowledged during the exit conference with the Administrator and Surveyor.	K 211		