



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

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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October 1, 2012

Julie Lineberger, Administrator
Surgery Center of Idaho
2855 East Magic View Drive
Meridian, Idaho 83642

RE: Surgery Center of Idaho, Provider #13C0001060

Dear Ms. Lineberger:

This is to advise you of the findings of the Medicare Fire Life Safety Survey, which was concluded at Surgery Center of Idaho on September 27, 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.

Julie Lineberger, Administrator
October 1, 2012
Page 2 of 2

After you have completed your Plan of Correction, return the original to this office by **October 15, 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,

A handwritten signature in black ink, appearing to read 'M. Grimes', followed by a long horizontal flourish line extending to the right.

MARK P. GRIMES
Supervisor
Facility Fire Safety & Construction Program

MPG/lj

Enclosures

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

Printed: 09/28/2012
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 09/27/2012
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NAME OF PROVIDER OR SUPPLIER SURGERY CENTER OF IDAHO	STREET ADDRESS, CITY, STATE, ZIP CODE 2855 EAST MAGIC VIEW DRIVE MERIDIAN, ID 83642
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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)	(X6) COMPLETION DATE
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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 September 27, 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		
K 029	416.44(b)(1) LIFE SAFETY CODE STANDARD Hazardous areas separated from other parts of the building by fire barriers have at least one hour fire resistance rating or such areas are enclosed	K 029	see attached	10-21-2012 12/12/2012

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OCT 26 2012
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Annabelle TITLE: Administrator (X8) DATE: 10-15-12

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.

5 P. 5987 No. 5987 Idaho Urologic Institute Oct. 26, 2012 12:03PM

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K 029	<p>Continued From page 1</p> <p>with partitions and doors and the area is provided with an automatic sprinkler system. High hazard areas are provided with both fire barriers and sprinkler systems. 38.3.2, 39.3.2</p> <p>This Standard is not met as evidenced by: Based on observation and interview it was determined that the facility did not ensure that hazardous area partitions were smoke resisting. This deficiency can allow smoke and fire gasses to spread beyond the hazardous area in the event of a fire occurring in the room.</p> <p>Findings include:</p> <p>1. During the tour of the facility on September 27, 2012, at 3:05 PM, observation of the wall that separates the ASC from the receiving storage room revealed a hole approximately one inch in size that had cabling running through it and had not been sealed. When questioned about the opening in the wall the Facility Coordinator stated that he was unaware that the penetration existed.</p> <p>2. During the tour of the facility on September 27, 2012, at 3:15 PM, observation of the wall that separates the ASC from the clean supply storage room revealed a hole approximately two inches by five inches in size that had a pipe running through it and had not been sealed. When questioned about the opening in the wall the Facility Coordinator stated that he was unaware that the penetration existed.</p>	K 029	see Attached	10-31-2012
K 048	<p>415.44(b)(1) LIFE SAFETY CODE STANDARD</p> <p>There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 20.7.1.1, 21.7.1.1</p>	K 048	see Attached	11-2-2012

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K 048	<p>Continued From page 2</p> <p>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 fire safety plan included the required eight components. This deficiency can endanger patients and slow an emergency response.</p> <p>Findings include:</p> <p>During record review on September 27, 2012, at 2:30 PM, it was determined that the facility's fire safety plan did <u>not</u> include the transmission of an alarm to the fire department, evacuation of immediate area, evacuation of the smoke compartment, preparation for evacuation and extinguishment of fire. When questioned about the fire safety plan the Administrator stated she was unaware of the required eight components of a fire safety plan.</p> <p>Actual NFPA Standard:</p> <p>20.7.1 Evacuation and Relocation Plan and Fire Drills. 20.7.1.1 The administration of every ambulatory health care facility shall have, in effect and available to all supervisory personnel, written copies of a plan for the protection of all persons in the event of fire, for their evacuation to areas of refuge, and for their evacuation from the building when necessary. All employees shall be periodically instructed and kept informed with respect to their duties under the plan. A copy of the plan shall be readily available at all times in the telephone operator's position or at the security center. The provisions of 20.7.1.2 through 20.7.2.3 shall apply.</p>	K 048	see attached	11-2-2012
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K 048	Continued From page 3 20.7.2.2 A written fire safety plan shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire	K 048	<i>see attached</i>	11-2-2012
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 1 1/2 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 interview it was determined that the facility did not ensure that the facility was separated from other occupancies with a one hour fire rated barrier. This deficiency can let fire and fire gasses into the Ambulatory Surgery Center suite. Findings include: 1. During a tour of the facility on September 27, 2012 at 2:45 PM, observation of the occupancy separation wall in the recovery suite revealed three holes that are approximately one inch in size each in the wall above the exit door from the	K 114	<i>see attached</i>	11-2-2012 10/10/2012

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K 114	Continued From page 4 suite. When questioned about the penetrations the Facility Coordinator stated that they were created for pneumatic door control tubing to pass through. 2. During a tour of the facility on September 27, 2012 at 3:02 PM, observation of the occupancy separation wall to the therapy department revealed a hole approximately five inches by five inches in size. When questioned about the penetration the Facility Coordinator stated that he did not know why the penetration had been created as there was no piping or cabling running through it.	K 114	<i>see Attached</i>	11-2-2012
K 130	MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This Standard is not met as evidenced by: Finding #1: §416.41(c) Standard: Disaster Preparedness Plan Based upon interview and record review the facility/governing body failed to ensure a written emergency preparedness plan was in place to effectively deal with the care, health and safety of patients, staff and other individuals when a major disruptive event occurs. This deficient practice affects all patients, staff and visitors to the facility. Findings include: Record review of the facility's disaster plan on September 27, 2012 at 2:10 PM, revealed the disaster plan did not include hazard mitigation for patients, staff and visitors, facility preparedness or disaster response and recovery. Interview with the Administrator revealed that the facility did not conduct an annual disaster drill or attempt to	K 130	<i>see Attached</i>	12-1-2012

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K 130	<p>Continued From page 5 coordinate the disaster plan with local and or State authorities.</p> <p>Finding #2:</p> <p>Based on record review and interview it was determined that the facility did not ensure that the automatic fire sprinkler system was being maintained in accordance NFPA 25. Properly maintaining the fire sprinkler system helps to ensure system reliability.</p> <p>Findings include:</p> <p>During record review on September 27, 2012 at 2:40 PM, the facility was <u>unable to provide documented quarterly automatic fire sprinkler system inspections</u> for the previous twelve month period. When questioned about the quarterly inspections the Facility Coordinator stated that he was unaware of the required quarterly inspections.</p> <p>Actual CFR Standard:</p> <p>Finding #1:</p> <p>§416.41(c) Standard: Disaster Preparedness Plan</p> <p>(1) The ASC must maintain a written disaster preparedness plan that provides for the emergency care of patients, staff and others in the facility in the event of fire, natural disaster, functional failure of equipment, or other unexpected events or circumstances that are likely to threaten the health and safety of those in the ASC.</p> <p>(2) The ASC coordinates the plan with State and local authorities, as appropriate.</p>	K 130	<p>Attached</p> <p>Attached</p>	<p>12-1-2012</p> <p>11-10-2012</p>
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K 130	<p>Continued From page 6</p> <p>(3) The ASC conducts drills, at least annually, to test the plan's effectiveness. The ASC must complete a written evaluation of each drill and promptly implement any corrections to the plan.</p> <p>Finding #2:</p> <p>Actual NFPA Standard:</p> <p>NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems 1998 Edition</p> <p>2-2.6 Alarm Devices. Alarm devices shall be inspected quarterly to verify that they are free of physical damage.</p> <p>2-3.3* Alarm Devices. Waterflow alarm devices including, but not limited to, mechanical water motor gongs, vane-type waterflow devices, and pressure switches that provide audible or visual signals shall be tested quarterly.</p>	K 130	See Attached	
K 144	<p>416.44(b)(1) LIFE SAFETY CODE STANDARD</p> <p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1, NFPA 110</p> <p>This Standard is not met as evidenced by: Based on observation, record review and interview 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.</p>	K 144	See Attached	10-15-2012

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K 144	<p>Continued From page 7</p> <p>Findings Include:</p> <p>During record review on September 27, 2012 at 1:50 PM, the facility was unable to provide documented weekly emergency generator inspections for the previous twelve months. When questioned about the weekly inspections the Facility Coordinator stated that he was unaware of the weekly inspection requirement.</p> <p>Observation of the emergency generator battery on September 27, 2012 at 4:00 PM revealed that it was the maintenance free type of battery.</p> <p>Actual NFPA Standard:</p> <p>NFPA 110 Standard for Emergency and Standby Power Systems 1999 Edition</p> <p>6-4.1* Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly.</p> <p>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:</p> <ul style="list-style-type: none"> (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	<i>See Attached</i>	

CMS Conditions of Coverage Summary Statement of Deficiencies

Pg. 1

K000 – Introduction

K029 - 416.44 Life Safety Code Standards

Findings: #1; There is a hole in the firewall that separates the ASC from the receiving storage supply room

Findings: #2; There is a hole in the firewall that separates the ASC from the clean supply storage room.

Resolution: The facility will ensure that hazardous area partitions will be smoke and fire gasses resistant. The Facility Coordinator will inspect and seal all holes found during the CMS inspection in the ASC firewalls. This will be accomplished by sealing, #1, the hole in the firewall that separates the ASC from the receiving storage supply room in the ASC facility, and #2, the hole in the firewall that separates the ASC from the clean supply storage room, with Dap Blockade High Performing Latex sealant. Any future construction or work that could potentially cause a breach in the fire walls within the ASC will be inspected at completion of the work by the Facility Coordinator. He will then documents any new breaches in the fire walls, repair these breaches and document the date of sealing of these holes. This report will be reviewed by the ASC Administrator and Medical Officer quarterly.

Completion: This deficiency will be completed by the end of the day on October 31th, 2012 by the Facility Coordinator.

Updated Policy: Chapter 7 Policy 7.08 - Building Maintenance

EMERGENCY SERVICES – ACTS OF NATURE • POLICY 7.08

Building Maintenance

Purpose: Construction or repair work in the SCI

Procedure:

The SCI Facility Coordinator will monitor all types of work and construction that is performed within the facility. This includes but not limited to any type of change to the structure that could result in a breach of the SCI firewalls.

Definitions:

Breach: An opening, tear, gap or rupture especially in a solid structure. To make a hole or gap in; break through of a solid structure

The Facility Coordinator will review, make changes, and document any breaches that may have taken place upon construction or any type of work being done in SCI. Example: Changes being made to the SCI firewall that includes but not limited to a hole in the wall, the Facilities Coordinator will patch and repair the hole and document the following:

1. what is the breach
2. how it was repaired
3. date and time

Once this has been completed the report will be reviewed by the SCI Administrator, President and Medical Director.

All maintenance, breaches or requested changes will be reviewed monthly at the Board meeting if necessary.

Pg. 2, 3, 4

K048 – 416.44 Life Safety Code Standard

20.7.1 , 20.7.2.2

Findings: Fire and Safety Plan did not include the transmission of an alarm to the fire department, evacuation of immediate area, evacuation of the smoke compartment, preparation for evacuation and extinguishment of fire.

8 Components are missing: Use of Alarm, Transmission of alarm to fire department, response to alarms, isolation of fire, evacuation of smoke compartment, preparation of floors and building for evacuation, extinguishment of fire.

Resolution: The SCI ASC fire safety plan will be revised to include all eight of the required components. All employees will be periodically instructed and kept informed with respect to their duties under the revised plan to include the use of alarm, transmission of alarm to fire department, response to alarms, isolation of fire, evacuation of smoke compartment, preparation of floors and building for evacuation, and extinguishment of fire. A copy of this plan will be readily available at the SCI front desk, pre-op work station, and post-op work station.

Fire drill and the fire plan training will be conducted quarterly and documented in the Employee Training binder. A copy of this plan will be readily available at all times in the PACU work station. The fire safety plan will be revised to meet NFPA Standard by the Administrator of SCI. This revised plan will be reviewed by the Medical Officer.

Completion: This deficiency will be corrected and completed by November 2, 2012.

Updated Policy: Chapter 7, Policy 7.01 – Fire

EMERGENCY SERVICES – ACTS OF NATURE • POLICY 7.01

Fire

Purpose: To assure appropriate emergency response

Fire alarm system:

The activation of this system will notify all persons in the building of the emergency.

When activated, it will notify the Fire Department directly or indirectly through a monitoring agency.
Staff must notify by calling 911 – when there is a fire in the facility even if the alarm has been activated.
After an actual alarm, the monitoring agency must be notified to alert them of a meaningful alarm.
Knox Box key is held by the Fire Department. The Fire Department will be notified whenever building key changes and new keys will be provided.

Fire and smoke barrier doors and walls

These doors/walls divide the facility into sections to prevent the spread of fire and or smoke. The barrier doors close automatically when the alarm system is activated.
These doors will never be obstructed and will be inspected and maintained on a regular basis.

Smoke and heat detectors

Smoke Detector: A device which detects the visible or invisible particles of combustion.
Heat Detector: A device which detects abnormally high temperatures or Rate of Rise of temperature.

Emergency lighting and power systems

An emergency generator is to provide automatic restoration of electrical power for emergency circuits within TEN (10) SECONDS of power failure. The following services are connected to emergency power system:

- Exit lights
- Emergency Call System
- Fire Alarm System
- Fire and /or Smoke Barrier Doors
- Hallway lights (every third fixture)
- Refrigerator for medication storage.

Fire Plan

Purpose: To assure safety and a prompt response to a fire

Procedure:

The first person to see a fire removes anyone from immediate area closes door and activates nearest FIRE PULL. This activation it will notify the Fire Department directly or indirectly through a monitoring agency

Call 911, state "fire" and give address clearly.

Pick up phone and page – "CODE RED" – GIVE LOCATION. Repeat this 3 times.

When a fire is discovered, Staff will procure the fire extinguisher and follow fire extinguisher training and use the method of extinguishing if appropriate to the size of the fire.

Staff will assist with the removal of all patients, visitors and staff in accordance with evacuation plan. Pre-op, Post-op, waiting room patients and staff will exit the building via the lobby or the exit located in the waiting room. All staff and patients will meet at the North East corner of the parking lot. The receptionist will have a schedule of patients to make sure everyone is accounted for. Administrator will have staffing schedule to account for staff and physicians.

Pre and post-op staff will close all doors in facility.

O.R. staff turns off medical gases (in O.R., first consult with surgeon and anesthesiologist).

The receptionist will wait outside to direct the fire department to the location of the fire.

Always exit the building quickly and in an orderly manner. Use the exit closest to you and away from the fire.

If surgery is in progress, it should be brought to an interim conclusion as soon as possible. A sterile dressing should be placed over the wound and the patient is exited through the OR door located at the South end of the OR hallway. Staff, patients, and physicians will meet at the South West corner to be accounted for and wait for further direction. If a surgery is in progress and the fire is not in the OR the staff, physician will be put on notice. The surgery will continue until complete or an order to evacuate is given.

All smoke compartments will be evacuated by as follows:

1. Patients and staff will be evacuated from the effected smoke compartment immediately
2. Staff will be sure that all smoke compartments are cleared of patients and staff
3. Staff will ensure all doors to the effected smoke compartment are closed upon exit
4. Staff and patients will report to designated areas per evacuation policy

The Administrator /designee will oversee the evacuation of the building and be the last one to leave the building. Never leave a patient unattended.

Fire and Disaster Guidelines

Purpose: To assure the implementation of appropriate measures to maintain a safe environment

Procedure:

All staff will participate in the following:

Fire and other internal disaster drills will be conducted on a quarterly basis (4), including testing the fire alarm system, and keeping a record of the results; one of these must include documented cardiopulmonary resuscitation technique drill.

Ongoing In-service programs concerning aspects of fire safety and the disaster plan as appropriate.

All staff will receive orientation to the following within 15 days of hire. This orientation will include information as to the location and use of:

- Exits
- Fire alarm pulls
- Fire extinguishers
- Fire and/or smoke barrier doors
- Utility shut offs – gas, electrical and water
- Medical gas storage and manifold shut – offs
- Air circulating systems
- Auxiliary power source

All staff will observe Fire Prevention and Life Safety practices by:

- Promptly reporting any known fire or life hazard
- Maintaining clear hallways and exits
- Enforcing the No Smoking Policy
- The proper disposal of trash

Fire escape plan (drawing goes here) emergency phone list

Purpose: To enable a rapid response to any emergency

Procedure: Staff will;

Consult fire escape plan for nearest exit. The fire escape plans are located in each work area and break room door.

This list of emergency phone numbers will be posted by all phones in the facility.

Fire Department: 911

Police Department: 911

Ambulance: 911

Emergency Room:

[REDACTED]

Poison Control Center:

[REDACTED]

This list will be maintained and updated as needed by the Surgery Center Administrator.

Location of emergency shut – offs

SERVICE

SHUT-OFF LOCATION

Natural Gas Shut – off

MAIN at the Meter

LOCAL shut offs can be found at location of southwest corner of the building.

Individual pieces of equipment; crescent wrench can be located next to the gas meter.

Water Shut – off

MAIN in the Fire Riser Room located in the front of the building. Located on the west wall to the right of the door. Valve is labeled and painted blue.

LOCAL shut offs can be found at locations of individual pieces of equipment

Electrical Shut – off

MAIN in the Electrical Room

Electrical room is on the rear of the building right of employee entrance, labeled Electrical Room – door entrance is on the exterior of the building

Medical Gas Shut – off

MAIN at the Medical Gas Manifold in the Med Gas Room.

On the left wall upon entering, labeled Medical Gas Room.

Local shut offs can be found outside of rooms in the OR hallway and cysto suites.

CMS Conditions of Coverage Summary Statement of Deficiencies

Pg. 3

20.7.1.1

Findings: Copy of the evacuation plan shall be readily available at all times in the telephone operator's position or at the security center.

Resolution: A copy of evacuation plan will be distributed and placed in the Pre-op work station, Post-op work station, and the Receptionist front desk.

Completion: This process was completed 10.22.2012

Chapter 7, Policy 7.01, – Fire

The policy will be readily available at the receptionist desk and pre and post op counters.

All staff will participate in the following:

Fire and other internal disaster drills will be conducted on a quarterly basis (4), including testing the fire alarm system, and keeping a record of the results; one of these must include documented cardiopulmonary resuscitation technique drill.

Ongoing In-service programs concerning aspects of fire safety and the disaster plan as appropriate.

Pg. 4-5

K114 – 416.44 – Life Safety Code Standard

1. Findings: #1 Observation of the occupancy separation wall in the recovery suite revealed three holes that are approximately one inch in size each in the wall above the exit door from the suite.

2. Findings: #2 Observation of the occupancy separation wall to the therapy department revealed a hole, 5 inches by 5 inches in the fire wall.

Resolution: The facility will ensure that hazardous area partitions will be smoke and fire gasses resistant. The Facility Coordinator will inspect and seal all holes found during the CMS inspection in the ASC firewalls. This will be accomplished by sealing, #1, the three holes that are approximately one inch in size, each in the wall above the exit door from the recovery suite, and #2, the hole, 5 inches by 5 inches in the separation wall to the therapy department with Dap Blockade High Performing Latex sealant. Any future construction or remodeling work that could potentially cause a breach in the fire walls within the ASC will be inspected at completion of the work by the Facility Coordinator. He will then documents any new breaches in the fire walls, repair these breaches and document the date of sealing of these holes. This report will be reviewed by the ASC Administrator and Medical Officer quarterly.

Completion: These deficiency were completed by the Facility Coordinator on 10/31/2012

Building Maintenance

Purpose: Construction or repair work in the SCI

Procedure:

The SCI Facility Coordinator will monitor all types of work and construction that is performed within the facility. This includes but not limited to any type of change to the structure that could result in a breach of the SCI firewalls.

Definitions:

Breach: An opening, tear, gap or rupture especially in a solid structure. To make a hole or gap in; break through of a solid structure

The Facility Coordinator will review, make changes, and document any breaches that may have taken place upon construction or any type of work being done in SCI.

Example: Changes being made to the SCI firewall that includes but not limited to a hole in the wall, the Facilities Coordinator will patch and repair the hole and document the following:

1. what is the breach
2. how it was repaired
3. date and time

Once this has been completed the report will be reviewed by the SCI Administrator, President and Medical Director.

All maintenance, breaches or requested changes will be reviewed monthly at the Board meeting if necessary.

Pg. 5,6,7,8

K130 – 416.41, 2-2.6, 2-3.3 - Miscellaneous

Other LSC Deficiency not on 2786

Findings #1: Standard Disaster Preparedness Plan

The facility /governing body failed to ensure a written emergency preparedness plan was in place to effectively deal with the care, health and safety of patients, staff and other individuals when a major disruptive event occurs.

Resolution: The SCI ASC disaster preparedness plan will be revised to include hazard mitigation for patients, staff, and visitors, facility preparedness, and disaster response and recovery. An annual disaster

drill will be scheduled after completion of the revised plan and the local and/or state authorities will be contacted to try to coordinate the disaster plan. The SCI administrator will revise the disaster preparedness plan, schedule a disaster drill, and contact the local and/or state authorities to coordinate our drill and plan on an annual basis. The administrator will complete a written evaluation and promptly implement any corrections to the plan. This written evaluation will be reviewed by the administrator and Medical Officer on an annual basis.

Completion: This deficiency will be completed and in place by December 1, 2012.

Findings #2: The facility does not ensure that the automatic sprinkler system was being maintained in accordance NFPA 25.

Resolution: The Facility Coordinator has contracted with [REDACTED] for quarterly inspection, testing, and maintenance of the water -based sprinkler system. These inspections will include verification that all alarm devices are free of physical damage and mechanically sound. This will include documentation to be reviewed by the facilities coordinator and SCI Administrator. This inspection will be kept in the Facilities binder. The Facilities Coordinator will schedule and maintain documentation of the sprinkler system inspection in the Facilities binder for the Administrator and Medical Director to review quarterly.

Simplex Grinnell's contacted first inspection is scheduled for November 1, 2012. [REDACTED] will at that time provide us with documentation that the sprinkler system has been tested.

Completion: This deficiency will be completed and in place by November 10, 2012

EMERGENCY SERVICES – ACTS OF NATURE • POLICY 7.02

Disruption of Services Due to Natural Disaster

Purpose: Safe and effective management of patient care with restricted resources

Procedure: Staff will;
Train annually
Contact Local State Authority to attend the annual training

WATER:

Notify the Medical Director and Administrator.

Facilities Coordinator will Notify Water Company at [REDACTED] or [REDACTED] after regular business hours

Immediately restrict use of water. If there is a possibility of contamination, turn off Main Water Valve.

Deliver adequate drinking water to all areas by utilizing bottled water.

Consider the possibility of recovering and storing water from water heaters and boilers.

Administrator will inform personnel to be prepared to line toilets with plastic bags for the collection of human waste. These bags are then treated as infectious waste.

NATURAL GAS:

Notify the Medical Director and Administrator.

Facilities Coordinator will notify the Gas Company at [REDACTED].

If a gas leak is evident Facilities Coordinator will notify Fire Department. Staff will remove all persons from building and open doors to ventilate.

Facilities Coordinator will shut off Main Valve at meter.

Do not use matches, or any open flame, or activate light switches or other electrical appliances.

ELECTRICITY:

Notify the Medical Director and Administrator.

Facilities Coordinator will notify the Power Company at [REDACTED].

Facilities Coordinator will shut down Main Power if necessary which is located in the Electrical room

Emergency Power Source

Purpose: To Assure continuous and safe care to patients

Procedure: Facility Coordinator will insure the following;

The facility will have available an emergency generator to take over the supplying of power in the event of a commercial power failure.

The following will be connected to emergency generator source:

- Selected overhead lights
- Exit lights
- Fire alarm system
- Refrigerator for medication storage
- Emergency call system
- Fire and/or Smoke Barrier Doors
- Critical patient care equipment in the Pre-op, OR, and Post-op areas

The emergency generator will be exercised biweekly. Logs of this will be kept by assigned facility personnel.

The emergency generator must provide automatic restoration of power to emergency circuits within TEN SECONDS of power failure.

Emergency lights are located throughout the SCI and automatically activate in the case of a power failure.

Flashlights will be kept in all patient care areas. The operation of these should be routinely monitored by personnel in each area.

In the event of a power outage within the facility, surgery cases will not be started while operating on emergency generator power. In addition, cases that are in process within the operating room(s) will be finished as soon as possible under the operating room physicians' guidance.

Surgery cases may resume once complete power has been restored to the facility and the generator is no longer required as the primary power source.

Isolated Power Panel - Information

Isolated power panels provide a safe power system for Surgery Center operating rooms. It provides those entities a very high level of protection from electrical shock / harm and explosions due to volatile gases for their doctors, nurses, & patients. This allows a superior protection from liability issues than any other electrical system. It therefore allows their insurance carriers to have a higher degree of assurance that they have provided the best electrical protection available in the industry.

Isolated power is an ungrounded power system / service that is required for many varieties of hospital and medical center applications.

These panels supply uninterrupted power in the event of a line-to-ground fault, while eliminating the danger of electrical shock and explosion due to electrical arcing. If a fault should occur, an alarm is activated but lives are not endangered when the 1st alarm is activated and power to life sustaining equipment is NOT interrupted.

Therefore, alarm condition does not mean there is imminent danger to the patient. It simply means that the system has reverted to a grounded condition (the same as in the rest of building). The Bi-Med, Engineering or Facilities organization (whichever one has been designated with Isolated Power responsibility) should be notified immediately to correct the problem as soon as possible.

These systems are required by the National Fire Protection Agency code NFPA-99. In addition, Hospital, Surgery Centers & Medical regulatory bodies, such as the State Departments of Health, JCAHO (Joint Commission on Accreditation of Healthcare Organizations), and other regulatory commissions overseeing medical facilities.

Operating Room Isolated Panels

This isolated power panel contains all the basic elements of an isolated power system – using a shielded isolation transformer, line isolation monitor, circuit breaker panel and ground bus. The unit is commonly installed in the hallway outside the operating room with remote receptacles inside the operating room or today most often inside the operating room itself. In the case of a hallway installation a remote Enunciators / alarm indicator panel must be installed inside the room in accordance with the NEC (National Electrical Code).

Although the Isolated Power System is most often used to deliver 120 volt service to receptacles in the operating room, it is recommended in all flammable anesthesia and "wet" locations, and any area where the interruption of power cannot be tolerated.

Isolated Power Panels / Systems are made up of a shielded isolation transformer, line isolation monitor, circuit breaker panel, circuit breakers, ground bus and LIM (Line Isolation Monitor)

Isolation Power Panel / Systems

The Isolated Power Panel / System provide receptacles and ground jacks for intensive care and coronary units. This panel / system are also used in operating rooms, cardiac catheterization labs, emergency rooms, and critical care and recovery areas, in addition to anesthetizing locations.

This power system contains all the basic elements of an isolated power system - shielded isolation transformer, line isolation monitor, circuit breaker panel, ground bus and LIM (Line Isolation Monitor). It also includes a maximum of 6 to 8 120 volt, UL listed twist-lock, duplex or parallel blade receptacles and up to seven ground jacks for additional grounding points. This depends on the KVA size of the panel. This Isolated Power Panel can feed remote and panel-mounted receptacles.

Line Isolation Monitors

Because an isolated system can easily become unintentionally grounded without giving any indication to the user, a monitor must automatically check the integrity of the isolation of the system and activate an alarm without interrupting the electrical service. Therefore the LIM (Line Isolation Monitor) are standard features of Isolated Power Panels.

Compliance Maintenance Testing

Hospital electrical equipment receives a lot of physical abuse; therefore, it must be properly maintained to provide electrical safety for patients and staff. Compliance test are required by NFPA (National Fire Protection), DOH (Department of Health) & JCAHO (Joint Commission on Accreditation of Healthcare Organizations) along with other health regulatory commissions. The correct intervals are 6 months for Isolated Power Panels with analog LIMs (Line Isolated Monitors) and 12-month interval for Isolated Power Panels with digital LIMs. Not properly having test made and needed repairs completed & documented at correct intervals can cause a safety issue and have a major negative impact on liability insurance.

History

During the 1920s and '30s, the number of fires and explosions in operating rooms grew at an alarming rate. Authorities determined that the major causes of these accidents fell into two categories:

- Man-made electricity
- Static electricity

In 1939, experts began studying these conditions in an attempt to produce a safety standard. The advent of World War II delayed the study's results until 1944. At that time, the National Fire Protection Agency (NFPA) published "Safe Practices in Hospital Operating Rooms." The early standards were not generally adopted in new hospital construction until 1947. It soon became apparent that these initial standards fell short of providing the necessary guidelines for construction of rooms in which combustible agents would be used. NFPA appointed a committee to revise the 1944 standards. In 1949, this committee published a new standard, NFPA No. 56, the basis for our current standards. The National Electrical Code (NEC) of 1959 firmly established the need for ungrounded isolated distribution systems in areas where combustible gases are used. In the same year, the NEC incorporated the NFPA standards into the code.

The increased use of electronic diagnostic and treatment equipment, and the corresponding increase in electrical hazards, has resulted in the use of isolated ungrounded systems in new areas of the hospital since 1971. These new hazards were first recognized in NFPA bulletin No. 76BM, published in 1971. Isolating systems are now commonly used for protection against electrical shock in many areas. Those areas include:

- Intensive care units (ICUs)
- Operating Rooms (ORs)
- Coronary care units (CCUs)
- Emergency departments
- Special procedure rooms
- Cardiovascular laboratories
- Dialysis units
- Various wet locations

Electrical Leakage Hazard

Electric equipment operating in the patient vicinity, even though operating perfectly, may still be hazardous to the patient. This is because every piece of electrical equipment produces a leakage current. The leakage consists of any current, including capacitive coupled current, not intended to be applied to a patient, but which may pass from exposed metal parts of an appliance to ground or to other accessible parts of an appliance. Normally, this current is shunted around the patient via the ground conductor in the power cord. However, as this current increase, it can become a hazard to the patient.

Without proper use of grounding, which is critical to safety, leakage currents could reach values of 1,000 μA before the problem is perceived. A leakage current of 10 to 180 μA can injure the patient. Ventricular fibrillation can occur from exposure to this leakage current.

EMERGENCY SERVICES – ACTS OF NATURE • POLICY 7.03

Flooding

Purpose: Assure appropriate response

Procedure: Patients and staff will be evacuating from the first floor to the second floor of the building.

CAUSES:

- Broken water pipes or main line
- Excessive rain
- Broken dam or reservoir

RESPONSE: Staff will;

- Shut OFF all utilities
- Toilets can be lifted from floor to create a readily available drain
- Create dams to direct water to drains
- Notify Administrator, Fire Department, Police Department and Civil Defense
- Make every effort to provide for needs of patients and staff. Snacks, blankets, safe drinking water and shelter may be provided.

EVACUATION:

- The Administrator /designee or emergency personal will make the decision to evacuate. Be sure the area you are evacuating too, is safer than the area you are leaving.
- Provide safe and efficient means of transportation.
- Secure the facility if it becomes necessary to evacuate.
- Follow evacuation procedures per facility policy.

Windstorm

Purpose: To assure safe response

Procedure: Staff will;

Move all persons to a safe location within the interior of the building. Interior corridors and bathrooms without window are the safest areas in a facility.

Secure all outdoor furniture, trashcans, etc.

Keep staff and patients away from all windows.

Board up windows if time permits.

Keep radio or television on for weather advisories.

Provide snacks and water as needed.

Bring flashlights to areas persons are occupying.

Evacuation during a windstorm should not usually be attempted.

The Administrator /designee or emergency personal will make the final decision whether to evacuate. This should only be attempted when you are certain the chosen area for the evacuation is safer than the area you are leaving. Follow facility evacuation procedure.

Remember, fires are extremely dangerous during a windstorm.

Administrator will make sure all staff and visitors are accounted for by utilizing the daily schedule.

Earthquake

Purpose: Assure appropriate response to emergency

Procedure: Staff will;

Drop Cover Hold

Personnel should protect themselves from falling objects.

It is best to lie face down under a desk, in a doorway or on the floor next to an INTERIOR WALL.

Hold onto a solid source if available.

Place your hands over your head for protection.

DO NOT RUN OUTSIDE! You may be hit by falling debris.

Following earthquake, personnel should make an immediate check of all persons and report any injuries or damage to the Medical Director and Administrator. Administrator will review schedules being accountable for staff and patients.

Administer first aid as needed.

If necessary, remove injured persons or those in a danger area.

Make a check of the facility for the following:

- Fire
- Door not able to open
- Weakness in ceilings or walls
- Broken glass or spilled liquids
- Electrical shorts and power failure
- Ruptured gas or water lines

Close all drapes or curtains. This will protect room occupants from the danger of falling glass during any aftershock. Leave all undamaged doors open unless there is a fire.

Make every effort to calm people's fear. Keep people away from windows, skylights and overhead lighting fixtures.

Access battery powered radio for emergency information.

Have flashlights available in all areas.

Notify Fire, Police or any other agency if you are in need of assistance.

Make every effort to return facility to normal operation.

Should the facility be damaged severely enough to require evacuation, this decision will be made by the Administrator / designee or emergency personnel. Evacuation should only be attempted when you are certain the area chosen for the evacuation is safer than the area you are leaving. If evacuation is necessary, staff / patients will meet at the northeast corner of the parking lot.

BE PREPARED FOR AFTER SHOCKS. They can be strong enough to cause further damage to an already weakened structure.

Bomb Threat

Purpose: To Identify Source

Procedure:

Staff will;

Initiate Bomb Threat Record

What to do:

Keep the caller on the line as long as possible.

Attract the attention of nearby persons to call the Police Department.

Complete bomb threat record.

Listen for background noise, speech patterns, and any accent.

Notify Surgery Center Administrator or designee (who will notify the Medical Director.)

Secure facility from unauthorized personnel.

INITIATE SEARCH OF FACILITY:

Check all closets, cupboards, toilet tanks, lockers, and storage rooms.

Check all rooms accessible to the public. Check under furniture, public rest rooms and all common areas.

Search outside of facility, patios, shrubbery, adjacent structures and roof.

If a suspicious object is located, **DO NOT TOUCH**. Report location to police when they arrive.

Move all persons, patients, family and staff to a safe area if a suspicious object is found. A minimum of three walls from the object is advised.

The decision to evacuate the building will be made by the Administrator /designee or Emergency Personnel.

Prior to evacuation, close all doors to all rooms and closets. Close all Fire Doors.

Do not reenter the facility until authorized by the Administrator /designee or Emergency Personnel.

A supply of Bomb Threat Records will be kept at the Reception Desk and the Nurse's Station.

BOMB THREAT RECORD

Any person receiving a bomb threat should attempt to obtain and record the following information:

WHO is calling please? _____

WHERE is the bomb right now? _____

WHAT does the bomb look like? _____

WHEN is the bomb going to explode? _____

WHY are you trying to harm others? _____

Date of Call _____ Time _____ A.M. P.M.

Origin of Call: _____ Long Distance _____ Phone Booth _____ Cell phone _____

Identity of caller: Sex _____ Age _____

What did caller say: _____

VOICE:

Loud _____ Soft _____

High _____ Low _____

Raspy _____ Pleasant _____

Other _____

SPEECH:

Nasal _____ Stutter _____

Distinct _____ Garbled _____

LANGUAGE:

Good _____ Poor _____

Obscene _____

ACCENT:

Racial _____ Foreign _____

Regional _____ Local _____

MANNER:

Calm _____ Angry _____

Emotional _____ Nervous _____

Incoherent _____

BACKGROUND NOISES:

Music _____ Traffic _____

Voices _____ Quiet _____

Other _____

Remarks: _____

Immediately Report Call to 911 and Administration

Signature of person taking call : _____

Evacuation

Purpose: To move all persons to a safe area

Procedure:

DEFINITION

Evacuation is the removal of persons from a dangerous or potentially dangerous area to an area of safety. The need to move persons to an outside area is determined by the seriousness of the emergency. In most cases, areas of safety within the facility can be created by closing all doors into hallways and all Fire/Smoke barrier doors.

PARTIAL

This is the removal of persons (where Fire or other Emergency can be confined to one room) to a safe location within the facility. Be prepared to move persons from adjoining areas.

HORIZONTAL

This is the removal of persons on a horizontal plane (same floor level as emergency). Be prepared to move persons to another area of the facility or outside.

COMPLETE

This is the evacuation of all persons to a place of safety outside the facility.

WHY EVACUATE?

To move people from unsafe to safe areas. Evacuate only when you are certain that the area chosen is safer than the area you are leaving.

To free the use of the facility for the care of incoming casualties or displaced persons.

The Administrator /designee or emergency personnel will make the decision to evacuate.

WHEN EVACUATION IS NECESSARY

Priority of evacuation is based on the exposure to danger.

Notify the receptionist that evacuation is taking place.

Lead ambulatory patients and visitors from the area to the nearest, safest exit. Other patients will be moved by wheelchair or stretcher.

The surgeon is responsible for the safety of the patient in the O.R. The surgical team will remain under his control. PACU patients are the responsibility of the RN staff / designee. Patients in the Preoperative area will be the responsibility of the Preoperative Nurse.

Try not to exit the same way Emergency Personnel will be arriving.

The Administrator will conduct a final search to assure all persons have been removed from the facility.

WHERE TO EVACUATE

To an area outside the facility: all staff and patients will evacuate to the northeast corner of the parking lot where the Administrator will have daily schedule to make sure all parties are accounted for.

PRIORITY

1. Those in area of immediate danger.
2. Ambulatory (A person who is able to leave a building unassisted under emergency conditions.)
3. Non ambulatory (A person who is unable to leave a building unassisted under emergency conditions).

Involvement in Community Disaster

In the event of a community disaster, Surgery Center of Idaho will offer available disposable medical supplies limited to the amount on hand at the time of disaster.

Surgery Center of Idaho will make preparations to close immediately upon notification of a community disaster.

RECOVERY OF A FIRE OR NATURAL DISASTER

Immediately after any fire or natural disaster, the fire department or local EMS will be notified by the Administrator or designated appointee to coordinate plan of response and recovery.

The SCI facility will remain closed after a fire or other natural disaster until such time that there is a evaluation of adequate clean up, ventilation, repair, and or reconstruction of damaged or affected areas of the facility. This process will be coordinated by the Administrator and governing board.

Pg. 7 and 8

K144 – 416.44, 6-4.1, 6-3.4 - Life Safety Code Standard

Generator

Findings #1: 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 even of a power outage.

Resolution: An SCI weekly and a separate SCI Monthly Emergency Generator Inspection Log has been developed in accordance with NFPA 110 by the Facility Coordinator. The Facility Coordinator will document a weekly inspection of the emergency generator, including all appurtenant components, in accordance with NFPA 110, in the Weekly Emergency Generator log. The generator will be tested under load on a monthly basis and parameters documented in the Monthly Emergency Generator log. Any abnormal emergency generator functions or findings will be documented and reported to the SCI Administrator ASAP. The Weekly and Monthly Generator logs will be maintained on the premises of the SCI.

NFPA 110 Standards will be followed pertinent to any repairs and follow-up testing.

The documentation will include:

1. Date of maintenance report
2. Identification of the servicing personnel
3. Notation of any unsatisfactory condition and the corrective action taken, including parts replaced.
4. Testing of any repair for the appropriate time as recommended by the manufacturer

The documentation will be reviewed by the SCI Administrator and Medical Director on a quarterly basis.

See attached log.

Completion: This deficiency will be completed by October 15, 2012