COPY

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
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June 27, 2013

Ron Kack, Administrator
Sawtooth Surgery Center
115 Falls Avenue West
Twin Falls, ID 83303

RE: Sawtooth Surgery Center, Provider #13C0001003

Dear Mr. Kack:

This is to advise you of the findings of the Medicare Fire Life Safety Survey, which was concluded at Sawtooth Surgery Center on June 20, 2013.

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 **July 10, 2013**, 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/pt
Enclosures

SAWTOOTH SURGERY CENTER

July 9, 2013

Idaho Department of Health & Welfare
3232 Elder Street
P.O. Box 83720
Boise Idaho 83720-0009

RECEIVED
JUL 10 2013
FACILITY STANDARDS

Re: Plan of Correction for Sawtooth Surgery Center

Dear Mr. Grimes:

Attached you will find the required written Plan of Correction for the Medicare Life Safety survey as requested addressing deficiencies detailed in the site visit report from June 20, 2013, survey.

If you have any questions or comments, please feel free to contact me at any time.

Sincerely,

Deborah Wensink

Deborah Wensink
Administrator

Email address: Debbie.wensink@amsurg.com

115 Falls Avenue West • Twin Falls, Idaho 83301
(208) 733-1662 • Fax: (208) 734-1023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13C0001003	A. BUILDING 01 - ENTIRE ASC BLDG B. WING _____	06/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The protected wood frame Type V (111) building was built in 1994 and has a basement with a dumbwaiter to service both levels. The ground level is approximately 15,534 square feet and the basement is approximately 6,080 square feet in size. An automatic fire suppression sprinkler system is installed in accordance with NFPA 13. There is a manual fire alarm system with smoke detection throughout. Piped medical gas and a natural gas fueled Essential Electrical System serves the building. Battery backup emergency lighting is provided in the operating rooms and the outdoor generator building. There are seven exits to grade with two interior stairwells for basement access. The following deficiencies were cited during the recertification fire/life safety survey conducted on June 20, 2013. The facility was surveyed under the Life Safety Code, 2000 Edition, Chapter 21, Existing Ambulatory Health Care Occupancy in accordance with 42 CFR 416.44(b). The survey was conducted by: Taylor Barkley Health Facility Surveyor Facility Fire Safety & Construction Program	K 000	RECEIVED JUL 10 2013 FACILITY STANDARDS	
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 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	K 029		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Deborah A Wenrick — TITLE: Administrator — (X6) DATE: 7-9-2013

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 029	Continued From page 1 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 doors were self closing. This deficiency can allow smoke and fire gases to spread beyond the hazardous area in the event of a fire occurring in the room. Findings include: During the tour of the facility on June 20, 2013 at 2:15 PM, observation of the two doors to the medical records storage room revealed that the doors were being held open with door wedges. When questioned about the door wedges the Maintenance Supervisor stated that he was unaware that hazardous area doors are required to be self closing. Actual NFPA Standard: 39.3.2 Protection from Hazards. 39.3.2.1* Hazardous areas including, but not limited to, areas used for general storage, boiler or furnace rooms, and maintenance shops that include woodworking and painting areas shall be protected in accordance with Section 8.4. 8.4.1.3 Doors in barriers required to have a fire resistance rating shall have a 3/4-hour fire protection rating and shall be self-closing or automatic-closing in accordance with 7.2.1.8. 7.2.1.8 Self-Closing Devices. 7.2.1.8.1* A door normally required to be kept closed shall not be secured in the open position at any time and shall be self-closing or automatic-closing in	K 029	416.44(b)(1)LIFE SAFETY CODE STANDARD PLAN OF CORRECTION: The Center will comply with NFPA 38.3.2,39.3.2 related to 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 with partitions and doors. The Center will comply with NFPA 7.2.1.8.1 in that any door will not be wedged open. SYSTEMIC CHANGES: All doors will be maintained for proper closure and will not have devices that prevent proper closure from occurring. Appropriate staff will be educated on the importance of ensuring doors close properly and always remain in proper working order. Inspection of all doors to ensure ongoing function and compliance with requirement not to use obstructive devices will be added to the Environment of Care checklist for routine observation. (Attachment A). RESPONSIBLE PARTY & MONITORING: The Center Director and/or designee will conduct rounds to observe and address placement of devices prohibiting normal door closure. Results of observations, trends noted and actions taken will be reported at the regularly scheduled QAPI meetings for review and reporting to the Governing Body.	7/5/2013

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K 029	Continued From page 2 accordance with 7.2.1.8.2.	K 029		
K 046	416.44(b)(1) LIFE SAFETY CODE STANDARD 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, interview and observation of operational testing it was determined that the facility failed to ensure that emergency lighting was being tested for thirty seconds a month or for 90 minutes once annually. Operational testing helps to ensure nonoperational units are discovered and repaired. Findings include: 1. During record review on June 20, 2013 at 11:04 AM, it was revealed that the facility was unable to provide testing records for the emergency lighting units for 30 seconds a month and an annual 90 minute test for the previous twelve month period. When questioned about the emergency light testing the Maintenance Supervisor stated he was unaware of the emergency lighting testing requirements. 2. During a tour of the facility on June 20, 2013 at 10:20 AM, it was revealed that the emergency lighting unit in the generator room would not illuminate upon pressing of the test button. This was observed and noted by the Surveyor and Maintenance Supervisor. Actual NFPA Standard: 21.2.9 Emergency Lighting and Essential Electrical Systems. 21.2.9.1	K 046	416.44(b)(1) LIFE SAFETY CODE - Emergency Illumination Section 7.9.20..2.9.1,21.2.9.1 PLAN OF CORRECTION: The Center will perform monthly 30 second and annual 90 minute testing of all battery powered emergency lights. The Center Director will ensure all battery back up lights are tested monthly for 30 seconds and annually for at least 90 minutes to ensure proper operation and that results of all tests are recorded appropriately on the maintenance record. Any nonoperational units that are discovered during testing will be repaired promptly. SYSTEMATIC CHANGES: Appropriate staff have been provided education on the importance of performing 30 second and 90 minute tests on back up battery powered lights. (Attachment B) This task has been added to the facility EOC Checklist. (Attachment A). RESPONSIBLE PARTY/MONITORING: The Center Director will monitor maintenance logs for evidence of tests being performed appropriately. Actions taken and results of all monitors will be reported to the QAPI Committee at regularly scheduled meetings for review and reporting to the Governing Body.	7/6/2013

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K 046	Continued From page 3 Emergency lighting shall be provided in accordance with Section 7.9. 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 050	416.44(b)(1) LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. 20.7.1.2, 21.7.1.2 This Standard is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure that fire drills were being conducted at least quarterly on each shift. Conducting fire drills helps to ensure that staff are trained in all procedures, including transmission of alarms. Findings include: During record review on June 20, 2013 at 2:20 PM, it was revealed that the facility was unable to provide fire drill documentation for the 1st and 2nd quarters for the previous twelve month period. When questioned about the fire drills the Facility Administrator stated that she was	K 050	416.44(b)(1) LIFE SAFETY CODE STANDARD PLAN OF CORRECTION: The Center will hold quarterly fire drills at unexpected times during hours of operation under varying conditions at least quarterly on each shift. SYSTEMIC CHANGES: On a quarterly basis the center will hold fire drills at various unexpeeted times of operations of the Center. These drills will include transmission of the fire alarm and simulation of emergency fire conditions. These drills will be documented on the "Fire Drill Report" (Attachment C) and evaluation completed by the safety committee to determine if any changes in the procedure are needed. The fire drill evaluation will be reported to the QAPI committee and Governing Body on a quarterly basis. MONITORING AND RESPONSIBILITY: The Center Director will be responsible for the quarterly fire drill and follow up. Reports will be provided to the QAPI committee and Governing Body on a quarterly basis.	7/8/2013

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K 050	Continued From page 4 unaware that the fire drills were not conducted and documented.	K 050		
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 determined that the facility failed to ensure that the fire alarm system was being maintained in accordance with NFPA 72. Inspections and testing helps to ensure fire alarm system reliability in the event of a fire. Findings include: During record review on June 20, 2013 at 10:50 AM, it was revealed that the facility was unable to provide smoke detector sensitivity testing records. When questioned the Maintenance Supervisor stated that he was unaware of the requirement for smoke detector sensitivity testing. Actual NFPA Standard: NFPA 101 ® Life Safety Code ® 2000 Edition 21.3.4.1 General. Ambulatory health care facilities shall be provided with fire alarm systems in accordance with Section 9.6, except as modified by 21.3.4.2 through 21.3.4.5. 9.6.1.4 A fire alarm system required for life safety shall be installed, tested, and maintained in	K 051	416.44(b)(1) LIFE SAFETY CODE STANDARD PLAN OF CORRECTION: The Center will ensure that the fire alarm systems smoke detector sensitivity testing is performed every other year in accordance with NFPA 72, 10.4.4.2. SYSTEMIC CHANGES: The smoke detectors were replaced and sensitivity testing was conducted. (Attachment D) RESPONSIBILITY AND MONITORING: The Center Director is responsible to ensure that all fire alarm systems smoke detector sensitivity testing is performed correctly and according to code. Results of testing will be reviewed with the QAPI Committee and the Governing Body.	7/13/2013

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K 051	Continued From page 5 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 7-3.2.1* Detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector-caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed.	K 051		
K 115	416.44(b)(1) LIFE SAFETY CODE STANDARD Ambulatory health care facilities are divided into at least two smoke compartments with smoke barriers having at least 1 hour fire resistance rating. Doors in smoke barriers are equipped with positive latcher. Doors are constructed of not less than 1□ inch thick solid bonded core wood or equivalent. Vision panels are provided and are of fixed wire glass limited to 1,296 sq. inch per panel. 20.3.7.1, 20.3.7.2, 20.3.7.3, 21.3.7.1, 21.3.7.2, 21.3.7.3 This Standard is not met as evidenced by: Based on observation and interview it was	K 115		

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K 115	Continued From page 6 determined that the facility did not ensure that the facility was separated into at least two smoke compartments with smoke barriers having at least 1 hour fire resisting rating. This deficiency can allow fire and fire gasses into the other smoke compartment. Findings include: During a tour of the facility on June 20, 2013 at 1:00 PM observation of the smoke barrier wall above the cross corridor doors by operating room #5 revealed multiple penetrations from conduit, wiring, piping, and areas of the wall that did not meet the roof deck. When questioned about the lack of a fire rated smoke barrier the Maintenance Supervisor stated that he was unaware of the fire rated smoke barrier requirements.	K 115	416.44(b)(1)LIFE SAFETY CODE STANDARD PLAN OF CORRECTION: The Center will comply with NFPA 20.3.7.1., 20.3.7.2, 20.3.7.3, 21.3.7.1., 21, 3.7.2, related to health care occupancies separated from other tenants and occupancies by fire barriers have at least one hour fire resistance rating. SYSTEMIC CHANGES: The unsealed penetrations in the smoke barrier wall above the cross corridor doors by operating room #5 have been sealed with fire rated material. (F1 Fire Caulk) (Attachment E). RESPONSIBLE PARTY & MONITORING: The Center Director or designee will visually inspect for fire wall penetrations . The Center Director will report the results to the QAPI Committee for review and recommendation. Recommendations will be submitted to the Governing Body for review and approval.	7/5/2013
K 130	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 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 sprinkler system was being maintained in accordance NFPA 25. Properly maintaining the sprinkler system helps to ensure system reliability. Findings include: 1. During record review on June 20, 2013 at 11:02 AM, the facility was unable to provide documented quarterly sprinkler system inspections for the previous twelve month period. When questioned about the quarterly sprinkler system inspections the Maintenance Supervisor	K 130	LIFE SAFETY CODE STANDARD PLAN OF CORRECTION: The Center will ensure that the automatic sprinkler system is maintained, tested, and inspected quarterly in accordance with NFPA 25, Section 2.1. Additionally, the Center will ensure that the five year inspection of the automatic sprinkler system is conducted including testing of the gauges and valves. SYSTEMIC CHANGES: 1) The Center contracted with Delta Fire Systems (Attachment F) to ensure that the automatic sprinkler system is maintained, tested and inspected quarterly, annually and at five year intervals . The report of the fire sprinkler inspection performed is attached. This task has been added to the facility EOC Checklist. (Attachment A).	7/8/2013

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K 130	Continued From page 7 stated that he was unaware of the quarterly testing requirement. 2. During record review on June 20, 2013 at 11:00 AM, it was revealed that the annual sprinkler system inspection report dated January 12, 2013, documented that a date for a five year inspection was not known and that the system was due for a five year inspection. When questioned about the five year inspection the Maintenance Supervisor stated that he was unaware of a five year inspection requirement. Actual NFPA Standard: NFPA 101® Life Safety Code ® 2000 Edition 9.7.5 Maintenance and Testing. All automatic sprinkler and standpipe systems required by this Code shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems 1998 Edition Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance Obstruction investigation Maintenance 5 years or as needed 2-2.6 Alarm Devices. Alarm devices shall be inspected quarterly to verify that they are free of physical damage. 2-3.3* Alarm Devices. Waterflow alarm devices including, but not limited to, mechanical water motor gongs, vane-type	K 130	Continued from page 7 RESPONSIBLE PARTY & MONITORING: The Center Director, or designee, will be responsible to ensure the automatic sprinkler system is maintained, tested and inspected as per NFPA 25. Test results will be reported to the QAPI Committee and Governing Body no less than annually.	

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K 130	Continued From page 8 waterflow devices, and pressure switches that provide audible or visual signals shall be tested quarterly.	K 130		
K 144	416.44(b)(1) LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1, NFPA 110, 8.4.2 This Standard is not met as evidenced by: Based on record review, interview and observation it was determined that the facility did not ensure that the emergency generator was being load tested monthly or inspected on a weekly basis in accordance with NFPA 110. Failure to conduct monthly load tests or inspect the generator on a weekly basis could result in the generator not starting or functioning properly in the event of a power outage. Findings include: 1. During record review on June 20, 2013 at 10:07 AM, the facility was unable to provide documented 30 minute monthly load tests or weekly inspections for the previous twelve month period. When this deficient practice was discussed with the Maintenance Supervisor he stated that he was unaware of the emergency generator testing and inspection requirements. 2. During the tour of the facility on June 20, 2013 at 10:18 AM, observation of the emergency generator battery revealed that the battery was not the maintenance free type. Actual NFPA Standard:	K 144	416.44(b)(1) LIFE SAFETY CODE STANDARD PLAN OF CORRECTION: The center will perform generator inspections weekly and exercised under load for 30 minutes per month in accordance with NFPA99. 3.4.4.1, NFPA 110. SYSTEMIC CHANGES: 1. There will be weekly, monthly, and quarterly visual inspections and documentation of the emergency generator system. (Attachment G - Emergency Generator Log) 2. Competency training for the Building Maintenance has been completed for inspecting the generator. (Attachment H) MONITORING AND RESPONSIBILITY: Weekly and monthly monitoring of the generator system (visual inspection and weekly generator exercise) will be performed by the Center Director/designee. Accurate reports will be maintained by the Center Director. Generator testing will be reported to the QAPI committee and Governing Body quarterly.	7/3/2013

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K 144	Continued From page 9 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 weekly and shall be exercised under load at least monthly. 6-4.2* Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (a) Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating (b) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer The date and time of day for required testing shall be decided by the owner, based on facility operations. 6-3.6* Storage batteries, including electrolyte levels, used in connection with Level 1 and Level 2 systems shall be inspected at intervals of not more than 7 days and shall be maintained in full compliance with manufacturer ' s specifications. Defective batteries shall be repaired or replaced immediately upon discovery of defects. 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	K 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13C0001003	A. BUILDING 01 - ENTIRE ASC BLDG B. WING _____	06/20/2013

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K 144	Continued From page 10 (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		
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. 19.3.2.7, 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 and interview it was determined that the facility did not ensure that Alcohol Based Hand Rub (ABHR) dispensers were not installed above an ignition source. This deficiency can accelerate and increase the intensity of a fire in the event a fire were to occur in the room. Findings include: 1. During the tour of the facility on June 20, 2013 at 1:55 PM, observation of operating room #3 revealed an alcohol based hand rub dispenser installed on the wall above a light switch and an	K 211	416.44 (b)(1) LIFE SAFETY CODE PLAN OF CORRECTION: The Center will abide with Life Safety Code 416.44 (b)(1), 19.3.2.7, CFR 403.744, 418.100, 406.72, 482.70, 483.623, 485.623 by properly installing alcohol based hand rub (ABHR) dispensers. SYSTEMATIC CHANGES: The Center has removed all alcohol based hand rub dispensers that are mounted above a light switch or receptacle. (Attachment I) RESPONSIBLE PARTY & MONITORING It is the responsibility of the Center Director to ensure the facility is in compliance with the Life Safety Code Standards. The Center Director or designee, is responsible for monitoring and assuring that no alcohol hand rub dispensers are mounted above electrical receptacles or light switches. This will be documented on the Environment of Care checklist on a monthly basis. The Center Director will report the results to the QAPI Committee quarterly for review and recommendation. Recommendations will be submitted to the Governing Body for review and approval.	7/3/2013

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K 211	Continued From page 11 electrical outlet. When questioned about the dispenser the Maintenance Supervisor stated that he was unaware that dispensers can not be installed over an ignition source. 2. During the tour of the facility on June 20, 2013 at 2:10 PM, observation of the eye recovery room revealed an alcohol based hand rub dispenser installed on the wall above an electrical outlet. When questioned about the dispenser the Maintenance Supervisor stated that he was unaware that dispensers can not be installed over an ignition source.	K 211		