IDAHO DEPARTMENT OF
HEALTH & WELFARE

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August 4, 2014

Mark Hollingshead, Administrator
Surgicare Center of Idaho
360 East Mallard Drive, Suite 125
Boise, ID 83706

RE: Surgicare Center of Idaho, Provider #13C0001014

Dear Dr. Hollingshead:

This is to advise you of the findings of the Medicare Fire Life Safety Survey, which was concluded at Surgicare Center Of Idaho on August 1, 2014.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicare deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. It is important that your Plan of Correction address each deficiency in the following manner:

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.

2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.

3. Identify the date each deficiency has been, or will be, corrected.

4. Sign and date the form(s) in the space provided at the bottom of the first page

After you have completed your Plan of Correction, return the original to this office by **August 18, 2014**, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13C0001014	A. BUILDING 01 - ENTIRE ASC WING B. WING _____	08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURGICARE CENTER OF IDAHO	360 EAST MALLARD DRIVE. SUITE 125 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	K 000		

The Ambulatory Surgery Center (ASC) is located on the first floor of a two story Type II (111) structure. Portable fire extinguishers, emergency lighting and exit signs are provided. The building has an automatic sprinkler system installed throughout. There are two (2) remotely located exit doors leading to the exterior. A one (1) hour rated wall assembly separates the ASC from other occupancies and the OR is classified as a suite. Procedures performed in the ASC are limited to local anesthesia.

The following deficiencies were cited during the annual fire/life safety survey conducted on August 1, 201. The facility was surveyed under the 2000 Edition of the Life Safety Code 101, Chapter 21 Existing Ambulatory Health Care Occupancies and 42 CFR 416.44(b).

The survey was conducted by:
Sam Burbank
Health Facility Surveyor
Facility Fire Safety and Construction

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K 115	416.44(b)(1) LIFE SAFETY CODE STANDARD	K 115		

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, the facility

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 8-5-14

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.

Medical Director 8-11-14

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 115	Continued From page 1 failed to ensure that smoke barriers were maintained. Failure to ensure smoke barriers prevent the passage of smoke would allow smoke and dangerous gases to pass freely hindering safe evacuation of occupants. This deficient practice affected no patients, staff and visitors on the date of the survey. Findings include: 1) During the facility tour conducted on August 1, 2014 from 11:15 AM to 12:30 PM observation of the ceiling in Exam Rm 2 found that the beauty ring for (1) of the recessed lights was missing leaving an approximately 1/2 inch gap between the fixture and surrounding ceiling tile. Interview of the Coordinator indicated she was unaware this component was gone. 2) During the facility tour conducted on August 1, 2014 from 11:15 AM to 12:30 PM observation of the ceiling in the Medical Records room found that (2) ceiling tiles were removed. Further investigation showed (2) penetrations of the 1-hour wall from what appeared to be computer wiring were found to be unsealed. When asked, the Coordinator stated that the ceiling was opened to accommodate a new computer installation. 3) During the facility tour conducted on August 1, 2014 from 11:15 AM to 12:30 PM observation of the ceiling in Operating room #1 ("RK" room) found that (2) ceiling tiles were raised approximately one inch. Further investigation found a ceiling tile above the computer with an approximate 3/4 inch by 3/4 inch square hole cut out of the edge. Interview of the Coordinator indicated that she was not aware of these penetrations.	K 115	1) Fixture was replaced & gap no longer present. There will be a weekly inspection of light fixtures by Administrator. 2) Ceiling tiles put back in proper position. No longer Unsealed. 3) New ceiling tiles installed. Raised ceiling tiles recentered.	8-5-14 8-5-14 8-11-14

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K 115	Continued From page 2 Actual NFPA standard: 21.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1 hour. Exception: Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems for buildings protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. 8.3.2* Continuity. Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces. Exception: A smoke barrier required for an occupied space below an interstitial space shall not be required to extend through the interstitial space, provided that the construction assembly forming the bottom of the interstitial space provides resistance to the passage of smoke equal to that provided by the smoke barrier.	K 115		
K 130	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This Standard is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure that self-closing doors would close completely. Failure	K 130		

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K 130	Continued From page 3 to maintain self-closing doors would allow smoke to pass freely during a fire event hindering safe egress. This deficient practice affected no patients, staff and visitors on the date of the survey. Findings include: During the facility tour conducted on August 1, 2014 from 10:45 AM to 12:00 PM, observation of the door separating the (1) exam rooms to pre-op hallway; (2) pre-op hallway to the reception area; (3) waiting/teaching area to the main waiting room would not self-close when activated. Interview of the Coordinator indicated she was not aware these doors would not self-close. Actual NFPA standard: 21.1.1.3 Total Concept. All ambulatory health care facilities shall be designed, constructed, maintained, and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. Because the safety of ambulatory health care occupants cannot be ensured adequately by dependence on evacuation of the building, their protection from fire shall be provided by appropriate arrangement of facilities, adequate, trained staff, and development of operating and maintenance procedures composed of the following: (1) Design, construction, and compartmentation (2) Provision for detection, alarm, and extinguishment (3) Fire prevention and the planning, training, and drilling programs for the isolation of fire, transfer of occupants to areas of refuge, or evacuation of the building	K 130	Doors were fixed by [redacted] commercial technician from Minuteman AM three doors now self close completely.	8-4-14