IDAHO DEPARTMENT OF
HEALTH & WELFARE

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BUREAU OF FACILITY STANDARDS
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September 6, 2013

Bruce Tolman, Administrator
Idaho Foot Surgery Center
1540 Elk Creek Drive
Idaho Falls, ID 83404-8322

RE: Idaho Foot Surgery Center, Provider #13C0001008

Dear Mr. Tolman:

This is to advise you of the findings of the Medicare Fire Life Safety Survey, which was concluded at Idaho Foot Surgery Center on August 28, 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.

FILE COPY

After you have completed your Plan of Correction, return the original to this office by **September 19, 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/lj

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13C0001008	A. BUILDING 02 - **ENTIRE ASC BUILDING** B. WING ________	**08/28/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FOOT SURGERY CENTER	**1540 ELK CREEK DRIVE IDAHO FALLS, ID 83403**

(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 Center is located in the free standing building containing the general office practice of the Physician. The building is a single story structure, with a basement that contains an employee break room, residential laundry and storage spaces. The certificate of occupancy is dated July 18, 2006. Services provided within the ASC are limited to procedures not requiring general anesthesia nor are services provided that require the use of life support equipment. The building is provided with a manual fire alarm system with limited smoke detection and the system is off-site monitored. Emergency power is supplied by a 15K on site natural gas generator. Emergency lighting, exit signage and portable fire extinguishers are provided in the building. The following deficiencies were cited during the certification survey conducted on August 28, 2013. The survey was conducted under applicable provisions set forth in the Life Safety Code, 2000 Edition, Chapter 20, New Ambulatory Health Care Occupancy and 42 CFR 416.44(b). The surveyor conducting the survey was: Taylor Barkley Health Facility Surveyor Facility Fire Safety & Construction Program	K 000	RECEIVED SEP 18 2013 FACILITY STANDARDS	
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 and interview it was	K 046	Emergency Light Testing: On September 16, 2013, the required emergency light testing and visual inspections were performed on all three units located within	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Owner

(X6) DATE: 9/16/2013

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 046	Continued From page 1 revealed that the facility did not ensure that emergency light testing for 90 minutes once a year and 30 seconds per month was being completed and documented. Failure to test the emergency lights can result in nonoperational units not being discovered and repaired. Findings include: During record review on August 28, 2013 at 9:40 AM, the facility was unable to provide testing records for the emergency lights for 90 minutes once a year and 30 seconds per month for the previous 12 month period. When this deficient practice was discussed with the facility consultant she stated that the facility had not conducted emergency light testing. Actual NFPA Standard: Chapter 20 NEW AMBULATORY HEALTH CARE OCCUPANCIES 20.2.9.1 Emergency lighting shall be provided in accordance with Section 7.9. 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	Continued From page 1 the facility and results have been logged into the 'Emergency Light Test Log' (refer to Appendix A). The 30 second testing will be completed on a monthly basis by the facility administrator, and the 90 minute annual testing will be completed by an Omni Security Systems INC. representative. This will provide our facility a timely opportunity to perform repairs/replacements, if needed; thus, ensuring proper functionality during emergency situations and resulting in improved patient care.	
K 050	416.44(b)(1) LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under	K 050	Fire Drills: Fire drills have been scheduled, by the facility administrator, to	

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

FORM APPROVED
OMB NO. 0938-0391

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K 050	Continued From page 2 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 did not conduct one fire drill per shift per quarter. Failure to adequately conduct drills for all shifts can result in staff not being trained to react appropriately in an emergency. Findings include: During record review on August 28, 2013 at 9:55 AM, the facility was unable to provide documentation for conducting drills for the previous twelve month period. When questioned about the documentation for the drills the facility consultant stated that the facility did not conduct any fire drills during the previous twelve month period.	K 050	Continued From page 2 occur at the facility on a quarterly basis starting with the first on September 19, 2013. A 'Fire Drill Log', indicating the scheduled months of each fire drill, has been created (refer to Appendix B). Along with the log, we have developed an 'Emergency Drill Report Form' that will be completed by the facility administrator after every drill (refer to Appendix C). These measures will allow for the adequate preparedness of our employees in unexpected fire emergencies.	
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 was being maintained in accordance with NFPA 72. Failure to conduct sensitivity testing could result in the fire alarm	K 051	Smoke Detector Testing: Sensitivity testing of the facility's system was performed on August 28, 2013 by [redacted] INC. (refer to Appendix D). This test has been considered the first required (after 1 yr. of installation) due to us being unaware of previous testing and therefore, the facility administrator will plan to schedule the next required testing with [redacted] INC. in September of 2015. Subsequent testing will be scheduled based on the results of the first two. A 'Smoke Detector Sensitivity Test Log' (refer to Appendix E) has been created to document results and serves as a means of monitoring. Our	

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K 051	Continued From page 3 system not functioning as designed. Findings include: During record review on August 28, 2013 at 10:45 AM, it was revealed that the facility could not produce a documented record of smoke detector sensitivity testing. When questioned about the sensitivity testing the facility consultant stated that she was unaware of the requirement for smoke detector sensitivity testing. Actual NFPA Standard: Chapter 20 NEW AMBULATORY HEALTH CARE OCCUPANCIES 20.3.4.1 General. Ambulatory health care facilities shall be provided with fire alarm systems in accordance with Section 9.6, except as modified by 20.3.4.2 through 20.3.4.5. 9.6.1.4 A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm Code, unless an existing installation, which shall be permitted to be continued in use, subject to the approval of the authority having jurisdiction. NFPA 72 National Fire Alarm Code®1999 Edition 7-3.2.1 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	K 051	Continued From page 3 continuous sensitivity testing will help maintain the system accuracy and provide patients with improved safety.	

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Printed: 09/04/2013
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K 051	Continued From page 4 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 064	416.44(b)(1) LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided. 20.3.5.2, 21.3.5.2 This Standard is not met as evidenced by: Based on record review and interview it was determined that the facility did not ensure that portable fire extinguishers were being inspected in accordance with NFPA 10. Monthly inspections help to ensure extinguisher reliability in the event of a fire requiring the use of an extinguisher. Findings include: During a tour of the facility on August 28, 2013 between 9:30 AM and 9:45 AM, observation of the inspection tags on the portable fire extinguishers revealed that the annual inspection was completed in June of 2013 with no monthly inspections initialed and dated. When questioned about the monthly inspections the facility consultant stated that she did not know why the facility did not document monthly inspections on the inspection tags. Actual NFPA Standard: Chapter 20 NEW AMBULATORY HEALTH CARE OCCUPANCIES	K 064	Fire Extinguisher Inspections: Beginning September 16, 2013, fire extinguishers will be inspected monthly by the facility administrator for any visual and functional defects. This inspection will be recorded on the tag of each extinguisher by the initials of the person performing the inspection. Annual inspections will also continue to be performed by an outside fire services company. This will ensure proper functioning of the fire extinguishers in the event of an emergency. RECEIVED SEP 20 2013 FACILITY STANDARDS	

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K 064	Continued From page 5 20.3.5.2 Portable fire extinguishers shall be provided in ambulatory health care facilities in accordance with 9.7.4.1. 9.7.4.1* Where required by the provisions of another section of this Code, portable fire extinguishers shall be installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. NFPA 10 Standard for Portable Fire Extinguishers 1998 Edition 4-3 Inspection. 4-3.1* Frequency. Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require. 4-4.4* Maintenance Record keeping. Each fire extinguisher shall have a tag or label securely attached that indicates the month and year the maintenance was performed and that identifies the person performing the service.	K 064		
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 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	K 114	Repair of Fire Wall Doors: As of September 16, 2013 the spring loaded door hinges, on the two noted horizontal doors along the fire wall separating the Surgery Center from the adjoining facility, were tightened. Testing of the doors from an open position revealed that they now close and latch on their own. This change will continue to ensure a safe environment for patients in the event of an emergency.	

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K 114	Continued From page 6 This Standard is not met as evidenced by: Based on observation, operational testing 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 and self closing doors. This deficiency can let fire and fire gasses into the Ambulatory Surgery Center suite. Findings include: During a tour of the facility on August 28, 2013 at 11:30 AM, observation of operational testing of the two doors to the physician clinic revealed that they would not self close and latch when released from the open position. When questioned about the two doors the facility consultant stated that she was unaware that doors in the occupancy separation were required to self close and latch.	K 114		
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 This Standard is not met as evidenced by: Based on record review and interview the facility did not ensure that the emergency generator was being inspected on a weekly basis or being load tested on a monthly basis in accordance with NFPA 110. Failure to inspect and load test the emergency generator could result in the generator not starting or functioning properly in the event of a power outage. Findings include: During record review on August 28, 2013 at 9:35 AM, the facility was unable to provide	K 144	Updated Emergency Generator Testing Policy: Beginning September 16, 2013, the facility has updated the Generator Maintenance Procedure Policy to include weekly emergency generator testing and monthly load testing. This testing will be the responsibility of the facility administrator, and will be documented on the new generator logs included herein (Refer to Appendix F). Any malfunctions of the generator can thus be addressed on a timely basis. This testing will ensure proper functionality of the generator in emergency situations.	

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K 144	Continued From page 7 documented weekly emergency generator inspections or monthly load tests for the previous twelve months. When questioned about the generator inspections and load tests the facility consultant stated that the facility had not been maintaining the emergency generator. Actual NFPA Standard: NFPA 110 Standard for Emergency and Standby Power Systems 1999 Edition 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. 6-3.4 A written record of the EPSS inspections, tests, exercising, operation, and repairs shall be maintained on the premises. The written record shall include the following: (a) The date of the maintenance report (b) Identification of the servicing personnel (c) Notation of any unsatisfactory condition and the corrective action taken, including parts replaced (d) Testing of any repair for the appropriate time as recommended by the manufacturer	K 144		