Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	55C0001059	05/07/2026
Name of Provider or Supplier	**Street Address, City, State**	
Fort Sutter Surgery Center, A Ca Limited Partnership	2801 K Street, Suite 525, Sacramento, CA	

For information on the provider's plan to correct this deficiency, please contact the provider or the state survey agency.

(X4) ID Prefix Tag	**Summary Statement of Deficiencies** (Each deficiency should be preceded by full regulatory or LSC identifying information)
Q0101	PHYSICAL ENVIRONMENT CFR(s): 416.44(a)(1) The ASC must provide a functional and sanitary environment for the provision of surgical services. Each operating room must be designed and equipped so that the types of surgery conducted can be performed in a manner that protects the lives and assures the physical safety of all individuals in the area. This STANDARD is not met as evidenced by: Based on observation, interview and document review the Ambulatory Surgery Center (ASC) failed to ensure a safe, functioning environment for 62 of 62 surgical patients when staff in the operating room (OR) did not have immediate access to the video laryngoscopes (VL- specialized equipment used by healthcare professionals to access patients airways, especially in difficult airway situations) that were being stored at the end of a long hallway located on the back side of five ORs that on one side contained large metal racks used for storing supplies and on the other side contained case carts (large rolling carts that contain items needed for surgical cases) and additional storage racks. This failure had the potential to put all 62 surgical patients at risk for complications related to restricted or difficult airway access. Findings: During a concurrent observation and interview on 5/6/26 at 10:17 a.m. with the Operating Room Manager (ORM) in the hallway located behind ORs, the ORM confirmed 5 active ORs opened into the hallway which was lined on one side with

	large metal racks containing supplies and on the other side [where the OR doors were located] was lined with additional storage racks and case carts and this created very little space to maneuver any type of equipment or walk through. The ORM further confirmed there were two VLs being stored in the back corner of the hallway and if they were needed emergently in any of the ORs, staff would not be able to roll the VLs down the hallway as there was not enough space. The ORM stated the VLs were used for difficult airway intubation (a healthcare professional inserts a tube into the windpipe to open the airway and facilitate breathing) by the anesthesiologist and are considered an emergency piece of equipment that should be available for immediate use if necessary. The ORM further stated storing the VLs in the hallway was a patient safety issue and they should be moved to a more appropriate location so they could be retrieved quickly. During a review of the facilitys policy and procedure (P&P) titled, General Safety Rules Policy, dated 12/8/25, the P&P indicated, All workforce members are expected to maintain general awareness of their work areaadhere to general safety practicesreport environmental conditions that may present a safety hazardGeneral Areas and Hallwaysgive right of way to wheeled equipmentkeep equipment in hallways stored on one sidekeep all storage areas neat and hazard freeMitigation Measuresmaintain hallways free from obstacles.