Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	55C0001059	05/12/2026
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)
K0211	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full instant use in case of emergency, unless modified by 20/21.2.2 through 20/21.2.11. 20.2.1, 21.2.1, 7.1.10.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the means of egress from obstruction. This was evidenced by obstructed paths of egress. This affected all patients and could result in delayed evacuation in the event of an emergency. NFPA 101 Life Safety Code, 2012 edition 21.2 Means of Egress Requirements. 21.2.3.2 The clear width of any corridor or passageway required for exit access shall be not less than 44 in. (1120 mm). Findings: During a tour of the facility and interview with Staff on 5/12/26, the corridors were observed.

	1. At 10:23 a.m., the corridor in front of Fire Door 6 near the clean work room was observed. The corridor was approximately 60 inches wide, and a wheeled crib was stored along the corridor wall. The crib obstructed the clear path of egress down to approximately 40 inches. Directional exit signage on the ceiling in front of Fire Door six indicated that the exit access was along the corridor where the crib was stored. Upon interview, the Administrator stated that the corridor was used by staff and that patients did not use the corridor. 2. At 10:35 a.m., the sterile corridor on the backside of Operating Rooms (OR) 2 through 5 was observed. The corridor was approximately 72 inches wide and was lined with metal rolling shelves on both sides of the corridor. In one area of the corridor, the metal shelves obstructed the clear path of egress down to approximately 18 inches. Directional exit signs were observed on the ceiling at each end of the corridor. Upon interview, the Administrator stated that the shelves stored OR supplies for the day and stated that patients did not use the corridor.