IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN– Director

TAMARA PRISOCK-- ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
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April 1, 2019

Nancy McHugh, Administrator
Vision Care Center of Idaho
3071 East Franklin Road, Suite 101
Meridian, ID 83642

RE: Vision Care Center Of Idaho, Provider #13C0001034

Dear Ms. McHugh:

This is to advise you of the findings of the Emergency Preparedness Survey, which was concluded at Vision Care Center of Idaho on March 28, 2019.

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 **April 15, 2019,** 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, option 3.

Sincerely,

Nate Elkins
Supervisor
Facility Fire Safety & Construction Program

NE/lj

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13C0001034	A. BUILDING _____ B. WING _____	03/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISION CARE CENTER OF IDAHO	3071 EAST FRANKLIN ROAD, SUITE 101 MERIDIAN, ID 83642

(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
E 000	Initial Comments The Center is located on the ground floor of a two (2) story building of Type II (000) construction. The Center is approximately 3,800 s.f. and was completed in August of 2000. The building is protected throughout by an automatic fire extinguishing system designed per NFPA Std 13 for a light hazard occupancy. The building is also provided with a complete fire alarm system with smoke detection in the Center and off-site monitoring of the system. The Center is separated from the entry lobby by a two (2) hour rated wall assembly and from the upper floor by a concrete slab on metal decking supported on metal trusses. There are two (2) exits to grade from the Center. Emergency power/lighting is provided by an on-site automatic 40K generator and wall mounted battery back lights in the Center and the two (2) operating rooms. The following deficiencies were found during the Emergency Preparedness recertification survey on March 28, 2019. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 416.54. The survey was conducted by: Nate Elkins, Supervisor Facility Fire Safety & Construction Program	E 000	RECEIVED APR - 8 2019 FACILITY STANDARDS	
E 026	Roles Under a Waiver Declared by Secretary CFR(s): 416.54(b)(6) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk	E 026		

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

Pamela Bitzer, RN | Clinical Director | 4/5/2019

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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E 026	Continued From page 1 assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to provide policies and procedures that specifically addresses the facility's role in emergencies where the President declares a major disaster or emergency under the Stafford Act or an emergency under the National Emergencies Act, and the HHS Secretary declares a public health emergency. Failure to provide policies and procedures that address what coordination efforts are required during a declared emergency in which a waiver of federal requirements under section 1135 of the Act has been granted has the potential to affect continuity of operations and reimbursement after an emergency Findings include:	E 026	Our facility may be called upon to provide personnel to the local hospital in the event of a national emergency declared by the President. In light of this, the procedure for application of the 1135 waiver was included into our Emergency Preparedness policy and procedure manual. The Clinical Director will be responsible for monitoring any updates to this requirement annually. 4/5/2019	

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E 026	Continued From page 2 During review of the provided Emergency Preparedness Plan on March 28, 2019 from 1:00 p.m. to 2:00 p.m. no documentation could be provided that showed a policy or procedure in place addressing the facility's role under an 1135 waiver during a declaration of disaster. When asked, the Administrator stated the facility was unaware of the requirement. Reference: 42 CFR 416.54 (b) (8)	E 026		
E 039	EP Testing Requirements CFR(s): 416.54(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event.	E 039		

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E 039	Continued From page 3 (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This STANDARD is not met as evidenced by: Based on record review, it was determined the facility failed to participate in a full-scale exercise that is community-based or document that a community-based exercise was not accessible. Failure to conduct full scale community-based exercise has the potential to hinder staff	E 039		

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E 039	Continued From page 4 emergency response during actual disasters and integrate into the broader community ' s response during an emergency. Findings Include: During review of the provided Emergency Preparedness Plan on March 28, 2019 from 1:00 p.m. to 2:00 p.m. no documentation could be provided that showed participation in a full-scale exercise that is community-based or documentation that a community-based exercise was not accessible. Reference: 42 CFR 416.54 (d) (2)	E 039	The Clinical Director will communicate, annually, with the Central District Health coordinator for the Public Health Preparedness Program to apprise him of the resources we have available and see if there are any community based emergency exercises appropriate for us to participate in. His response to this query will be kept on file in our policy and procedure manual. 4/5/2019	

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April 1, 2019

Nancy McHugh, Administrator
Vision Care Center of Idaho
3071 East Franklin Road, Suite 101
Meridian, ID 83642

RE: Vision Care Center Of Idaho, Provider #13C0001034

Dear Ms. McHugh:

This is to advise you of the findings of the Medicare Fire Life Safety Survey conducted at Vision Care Center of Idaho on March 28, 2019.

Based on the results of this survey, Vision Care Center Of Idaho was found to be in substantial compliance with the fire/life safety requirements set forth in the Life Safety Code, 2012 Edition, for Ambulatory Surgery Centers.

Thank you for the courtesies extended to us during our visit. If we can be of help to you, please call our office at (208)334-6626, option 3.

Sincerely,

Nate Elkins
Supervisor
Facility Fire Safety and Construction Program

NE/lj

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	13C0001034	A. BUILDING **01 - ENTIRE ASC WING** B. WING _____	**03/28/2019**

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VISION CARE CENTER OF IDAHO	**3071 EAST FRANKLIN ROAD, SUITE 101** **MERIDIAN, ID 83642**

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K 000	INITIAL COMMENTS The Center is located on the ground floor of a two (2) story building of Type II (000) construction. The Center is approximately 3,800 s.f. and was completed in August of 2000. The building is protected throughout by an automatic fire extinguishing system designed per NFPA Std 13 for a light hazard occupancy. The building is also provided with a complete fire alarm system with smoke detection in the Center and off-site monitoring of the system. The Center is separated from the entry lobby by a two (2) hour rated wall assembly and from the upper floor by a concrete slab on metal decking supported on metal trusses. There are two (2) exits to grade from the Center. Emergency power/lighting is provided by an on-site automatic 40K generator and wall mounted battery back lights in the Center and the two (2) operating rooms. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Chapter 21, Existing Ambulatory Health Care Occupancies, in accordance with 42 CFR 416.44. The facility was found to be in substantial compliance during the recertification survey conducted on March 28, 2019. The survey was conducted by: Nate Elkins, Supervisor Facility Fire Safety & Construction Program	K 000		

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

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