



C.L. "BUTCH" OTTER – Governor  
RICHARD M. ARMSTRONG – Director

IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

DEBBY RANSOM, R.N., R.H.I.T. – Chief  
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P.O. Box 83720  
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February 26, 2013

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, which was concluded at Vision Care Center Of Idaho on February 21, 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.

Nancy McHugh, Administrator  
February 26, 2013  
Page 2 of 2

After you have completed your Plan of Correction, return the original to this office by **March 11, 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.

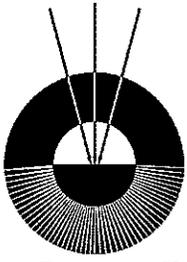
Sincerely,

A handwritten signature in black ink, appearing to read 'M. Grimes', followed by a long horizontal line extending to the right.

MARK P. GRIMES  
Supervisor  
Facility Fire Safety & Construction Program

MPG/nw

Enclosures



**VisionCare**  
CENTER OF IDAHO

3071 E. Franklin Rd. Ste. 101 Meridian, Idaho 83642 Ph: 208.288.1400

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March 8, 2013

Mark P. Grimes  
Supervisor  
Facility Fire Safety & Construction Program  
Idaho Department of Health and Welfare  
3232 Elder St.  
P.O. Box 83720  
Boise, Idaho 83720-0009  
FAX:208-364-1888

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MAR 11 2013

FACILITY STANDARDS

Dear Mr. Grimes,

Enclosed please find the completed and signed form CMS-2567 for Vision Care Center of Idaho. Thank you for affording us the opportunity to reply to and correct the deficiencies found on your inspection of February 21, 2013. If you have any further questions please do not hesitate to contact me.

Sincerely,

Jorge A. Martinez, M.D.  
Medical Director

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

Printed: 02/22/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13C0001034</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - ENTIRE ASC WING</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/21/2013</b>
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NAME OF PROVIDER OR SUPPLIER <b>VISION CARE CENTER OF IDAHO</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3071 EAST FRANKLIN ROAD, SUITE 101 MERIDIAN, ID 83642</b>
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K 000	<p><b>INITIAL COMMENTS</b></p> <p>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 from the Center with one being through the building's main lobby. The second exit is directly 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.</p> <p>The facility was surveyed on February 21, 2013 under the provisions and applicable fire/life safety requirements [i.e., 416.44(b)] set forth under Medicare (i.e., Title XVIII) for certification as an Ambulatory Surgery Center. The following deficiencies were cited during the recertification survey.</p> <p>The survey was conducted by:</p> <p>Taylor Barkley Health Facility Surveyor Facility Fire Safety &amp; Construction Program</p>	K 000		
K 046	<p><b>416.44(b)(1) LIFE SAFETY CODE STANDARD</b></p> <p>Emergency illumination is provided in accordance with section 7.9. 20.2.9.1, 21.2.9.1</p>	K 046		

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MAR 11 2013  
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>DIRECTOR</b>	(X6) DATE <b>3/8/2013</b>
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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	<p>Continued From page 1</p> <p>This Standard is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure that emergency illumination was being tested. Operational testing helps to ensure nonoperational units are discovered and repaired.</p> <p>Findings include:</p> <p>During record review on February 21, 2013 at 10:07 AM, it was revealed that the facility was unable to provide testing records for the emergency lighting units for 30 seconds a month and an annual 90 minute test for the previous twelve month period. When questioned about the emergency light testing the Facility Administrator stated that maintenance and testing was not her responsibility.</p> <p>Actual NFPA Standard:</p> <p>21.2.9 Emergency Lighting and Essential Electrical Systems. 21.2.9.1 Emergency lighting shall be provided in accordance with Section 7.9.</p> <p>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 1 1/2 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.</p>	K 046	<p>Clinical Director will perform visual and functional testing of emergency lighting and document results on a monthly basis per policy. An annual test of battery-powered emergency lighting system with results will also be documented per policy.</p> <p><b>Monitor:</b> Clinical Director will monitor and document results of testing per policy and will report compliance to Governing Body at the quarterly Governing Body meetings for 6 months</p> <p><b>Responsible:</b> Governing Board</p>	3/6/2013
K 050	416.44(b)(1) LIFE SAFETY CODE STANDARD	K 050		

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K 050	Continued From page 2  Fire drills are held at unexpected times under 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 failed to ensure that fire drills were being conducted at least quarterly on each shift. Conducting fire drills helps to ensure that staff are trained in all procedures, including transmission of alarms.  Findings include:  During record review on February 21, 2013 at 11:15 AM, it was revealed that the facility was unable to provide fire drill documentation for the 1st and 3rd quarters for the previous twelve month period. When questioned about the fire drills the Facility Administrator stated that she was not responsible for the fire drills as a different staff member was supposed to keep track of the drills.	K 050	Clinical Director will conduct and maintain documentation of fire drills on a quarterly basis per policy. <b>Monitor:</b> Clinical Director will conduct and document quarterly fire drills per policy and will report compliance to Governing Body at the quarterly Governing Body meetings for 6 months <b>Responsible:</b> Governing Board	3/12/2013
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 observation, operational testing and interview it was determined that the facility did not ensure that portable fire extinguishers were accessible in accordance with NFPA 10. Inaccessible fire extinguishers can slow a response and allow an incipient fire to grow and	K 064		

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K 064	<p>Continued From page 3 spread.</p> <p>Findings include:</p> <p>During the tour of the facility on February 21, 2013 at 12:12 PM, observation of the LASIK operating room revealed an extinguisher installed in a wall mounted cabinet. When the cabinet was attempted to be opened in order to inspect the extinguisher it was revealed that the cabinet was locked and was unable to be opened. When questioned about the locked extinguisher cabinet the Facility Administrator stated that she did not know why the cabinet was locked.</p> <p>Actual NFPA Standard:</p> <p>NFPA 10 Standard for Portable Fire Extinguishers 1998 Edition 1-6.5 Cabinets housing fire extinguishers shall not be locked.</p>	K 064	<p>All fire extinguishers are accessible.</p> <p><b>Monitor:</b> Clinical Director will ensure all fire extinguishers are accessible by conducting visual inspections on a monthly basis. Documentation of findings will be presented to Governing Body at quarterly Governing Body meetings for 6 months.</p> <p><b>Responsible:</b> Governing Body</p>	2/28/2013
K 070	<p>416.44(b)(1) LIFE SAFETY CODE STANDARD</p> <p>Portable space heating devices are prohibited except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F (100 degrees C). 20.7.8, 21.7.8</p> <p>This Standard is not met as evidenced by: Based on observation and interview it was determined that the facility did not ensure that the use of portable space heaters was prohibited or tested to ensure that the heating element did not exceed 212 degrees Fahrenheit in nonsleeping staff and employee areas. The use of portable heating devices have historically been the cause of fires.</p>	K 070		

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K 070	Continued From page 4  Findings include:  During the tour of the facility on February 21, 2013 at 12:01 PM, observation of the rear storage room in the pre op / post op area revealed a portable space heater that was plugged into a duplex electrical outlet. When questioned about the heater the Facility Administrator stated that she did not test the temperature of the heating element to ensure that it did not exceed 212 degrees Fahrenheit.	K 070	Portable space heater removed from facility. <b>Monitor:</b> Clinical Director will conduct random inspections on a monthly basis to ensure there is no use of prohibited equipment. Compliance will be reported to the Governing Body at the quarterly Governing Body meetings for 6 months. <b>Responsible:</b> Governing Body	2/28/2013	
K 076	416.44(b)(1) LIFE SAFETY CODE STANDARD  Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities, and NFPA 101.  (a) Oxygen storage locations of greater than 3,000 cu. ft. are enclosed by a one hour separation.  (b) Locations for supply systems of greater than 3,000 cu. ft. are vented to the outside.  4.3.1.1.2, 20.3.2.4, 21.3.2.4  This Standard is not met as evidenced by: Based on observation, record review and interview it was determined that the facility failed to ensure that compressed oxygen gas cylinders were individually secured. This deficiency has the potential to possibly damage or rupture a compressed gas cylinder valve.  Findings include:  During a tour of the facility on February 21, 2013 at 12:10 PM, observation of the rear storage	K 076	Individual compressed oxygen cylinders are stored upright and secured individually. <b>Monitor:</b> Clinical Director will visualize oxygen cylinders to ensure proper storage on a monthly basis. Monthly inspection log will be presented to Governing Body at quarterly Governing Body meeting for 6 months. <b>Responsible:</b> Governing Body	2/27/2013	

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K 076	Continued From page 5 room in the pre op / post op area revealed four E sized oxygen cylinders lying on their sides on the floor with the valves against the wall. When questioned about the cylinders on the floor the Facility Administrator stated that the facility did not have a place to store them.  Review of the facility's Fire Plan Policy #1, with an approved date of November 16, 2009 notes in section USE/STORAGE OF OXYGEN, sentence #3 that oxygen cylinders will be stored upright, secured to prevent falling or laying securely on the stretchers, separate from any other flammable gasses or liquids.  Actual NFPA Standard: 3 NFPA 99 Standard for Health Care Facilities 1999 Edition 4-3.1.1.1 Cylinder and Container Management. Cylinders in service and in storage shall be individually secured and located to prevent falling or being knocked over.	K 076		
K 130	NFPA 101 MISCELLANEOUS  OTHER LSC DEFICIENCY NOT ON 2786  This Standard is not met as evidenced by: Based on record review and interview it was determined that the facility did not ensure that the sprinkler system was being maintained in accordance NFPA 25. Properly maintaining the sprinkler system helps to ensure system reliability.  Findings include:  During record review, on February 21, 2013 at	K 130		

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K 130	<p>Continued From page 6</p> <p>10:31 AM, the facility was unable to provide documented quarterly sprinkler system inspections for the previous twelve month period. When questioned about the quarterly sprinkler system inspections the Facility Administrator stated that maintenance and testing was not her responsibility.</p> <p><b>Actual NFPA Standard:</b></p> <p>NFPA 101® Life Safety Code ® 2000 Edition 9.7.5 Maintenance and Testing. All automatic sprinkler and standpipe systems required by this Code shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems.</p> <p>NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems 1998 Edition</p> <p>2-2 Inspection.</p> <p>2-2.6 Alarm Devices: Alarm devices shall be inspected quarterly to verify that they are free of physical damage.</p> <p>2-3.3* Alarm Devices. Waterflow alarm devices including, but not limited to, mechanical water motor gongs, vane-type waterflow devices, and pressure switches that provide audible or visual signals shall be tested quarterly.</p>	K 130	<p style="text-align: right;">3/8/2013</p> <p>Sprinkler system and alarm devices scheduled for inspection 3/22/2013. Contract secured with [REDACTED] to include quarterly inspections, testing and maintenance of the sprinkler and standpipe system. Contract secured with [REDACTED] to include quarterly inspection and testing of alarm devices.</p> <p><b>Monitor:</b> Clinical Director will communicate with building manager to ensure inspections are conducted on a quarterly basis. Quarterly maintenance and service records will be maintained. Compliance will be presented to Governing Body at quarterly Governing Body meetings for 6 months.</p> <p><b>Responsible:</b> Governing Body</p>	
K 144	<p>416.44(b)(1) LIFE SAFETY CODE STANDARD</p> <p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1, NFPA 110,</p>	K 144		

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K 144	<p>Continued From page 7 8.4.2</p> <p>This Standard is not met as evidenced by: Based on record review, interview and observation it was determined that the facility did not ensure that the emergency generator was being load tested monthly or inspected on a weekly basis in accordance with NFPA 110. Failure to conduct monthly load tests or inspect the generator on a weekly basis could result in the generator not starting or functioning properly in the event of a power outage.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. During record review on February 21, 2013 at 10:15 AM, the facility was unable to provide documented 30 minute monthly load tests or weekly inspections for the previous twelve month period. When this deficient practice was discussed with the Facility Administrator she stated that she was unaware of the emergency generator testing and inspection requirements.</li> <li>2. During the tour of the facility on February 21, 2013 at 10:48 AM, observation of the emergency generator battery revealed that the battery was not the maintenance free type.</li> </ol> <p>Actual NFPA Standard:</p> <p>NFPA 110 Standard for Emergency and Standby Power Systems 1999 Edition 6-4 Operational Inspection and Testing. 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.</p>	K 144	<p>Weekly visual inspection and monthly load test to be conducted by Clinical Director. Contract secured with [REDACTED] to perform annual maintenance and 30 minute load-bank test is scheduled for 3/18/2013. Weekly inspection of storage batteries process initiated and will be conducted by Clinical Director. Inspection and service records will be maintained per protocol. <b>Monitor:</b> Clinical Director will conduct weekly and monthly inspections per policy. Annual maintenance and service records will be maintained. Compliance will be presented to Governing Body at quarterly Governing Body meetings for 6 months. <b>Responsible:</b> Governing Body</p>	3/8/2013
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K 144	Continued From page 8  6-4.2* Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (a) Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating (b) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer The date and time of day for required testing shall be decided by the owner, based on facility operations.  6-3.6* Storage batteries, including electrolyte levels, used in connection with Level 1 and Level 2 systems shall be inspected at intervals of not more than 7 days and shall be maintained in full compliance with manufacturer's specifications. Defective batteries shall be repaired or replaced immediately upon discovery of defects.  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		
K 147	416.44(b)(1) LIFE SAFETY CODE STANDARD  Electrical wiring and equipment are in accordance	K 147		

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13C0001034	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE ASC WING B. WING _____	(X3) DATE SURVEY COMPLETED  02/21/2013
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NAME OF PROVIDER OR SUPPLIER VISION CARE CENTER OF IDAHO	STREET ADDRESS, CITY, STATE, ZIP CODE 3071 EAST FRANKLIN ROAD, SUITE 101 MERIDIAN, ID 83642
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(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
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K 147	<p>Continued From page 9 with NFPA 70, National Electrical Code 9.1.2, 20.5.1</p> <p>This Standard is not met as evidenced by: Based on observation and interview the facility did not ensure that electrical wiring and equipment usage was in accordance with NFPA 70. Utilizing extension cords can lead to overloaded wiring and start a fire.</p> <p>Findings include:</p> <p>During the tour of the facility on February 21, 2013 at 12:15 PM, observation of the main operating room revealed an extension cord powering a stereo system. When questioned about the extension cord usage the Facility Administrator stated that she was unaware of the usage in the room.</p> <p>Actual NFPA Standard:</p> <p>NFPA 70 National Electrical Code 1999 Edition 400.6 Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following:</p> <ul style="list-style-type: none"> <li>(1) As a substitute for the fixed wiring of a structure</li> <li>(2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors</li> <li>(3) Where run through doorways, windows, or similar openings</li> <li>(4) Where attached to building surfaces</li> </ul>	K 147	<p>The extension cord was removed.</p> <p><b>Monitor:</b> Clinical Director will conduct random inspections on a monthly basis to ensure there is no inappropriate use of extension cords. Compliance will be reported to the Governing Body at the quarterly Governing Body meetings for 6 months.</p> <p><b>Responsible:</b> Governing Body</p>	2/28/2013
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