IDAHO DEPARTMENT OF
HEALTH & WELFARE

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September 29, 2014

Janet Sartini, Administrator
Pacific Cataract & Laser Institute-- Lewiston
3330 4th Street
Lewiston, ID 83501-4405

RE: Pacific Cataract & Laser Institute - Lewiston, Provider #13C0001043

Dear Ms. Sartini:

This is to advise you of the findings of the Medicare Fire Life Safety Survey, which was concluded at Pacific Cataract & Laser Institute - Lewiston on September 18, 2014.

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 **October 13, 2014,** 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
	13C0001043	A. BUILDING 01 - ENTIRE ASC WING B. WING _____	09/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PACIFIC CATARACT & LASER INSTITUTE - LE	3330 4TH STREET LEWISTON, ID 83501

(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 Surgery Center is located within a single tenant Office Occupancy but is a one (1) hour separated wing/section of less than 2,000 square feet. The entire building, including the ASC portion, is fully sprinklered, of type V(III) construction, and provided with a fire alarm/smoke detection system throughout. The ASC was surveyed in accordance with 42 CFR 416.44 (b) and the provisions of the LIFE SAFETY CODE, Chapter 21, Existing Ambulatory Health Care Occupancies. The following deficiencies were cited during the annual fire/life safety survey conducted on September 18, 2014. The survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	K 000		
K 032	416.44(b)(1) LIFE SAFETY CODE STANDARD At least two exits, located remote from each other, are provided for each floor or fire section of the building. 20.2.4.1, 21.2.4.1, 7.5.1.4 This Standard is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure that exits were free from obstructions or impediments. Failure to keep exits acessible at all times could prevent occupants from safely evacuating during an emergency. This deficient practice affected no patients, all staff and visitors on the date of the	K 032		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Cari E. Taylor	ASC Manager	10/08/2014

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 032	Continued From page 1 survey. Findings include: 1) During the facility tour conducted on September 18, 2014 from 8:15 AM to 11:00 AM, observation and operational testing of the exit door located inside the fire sprinkler riser room found it would not open. Operation of the door found it would only open with a key from the outside of the building. Further investigation found the latch was jammed and would not release when the door latch was activated from the interior side. 2) During the facility tour conducted on September 18, 2014 from 8:15 AM to 11:00 AM, observation and operational testing of the main entry door controlled access found the door would open only six to ten inches and stop. Further attempts to operate the door from the access pad either at the exit or the reception desk would not open the door. The door was found to still be stuck in this condition when the surveyor exited at 11:30 AM. Interview of the ASC Manager found she was not aware either door was not operating prior to the survey. Actual NFPA standard: 21.2.4.1 Not less than two exits of the types described in 39.2.2 that are remotely located from each other shall be provided for each floor or fire section of the building.	K 032-1	WHO is responsible: Cari Taylor, ASC Manager HOW the deficiency was corrected:In-service training was conducted September 23, 2014 to notify all employees that the door was not fully functional @ present & to be aware if they had reason to be working in the sprinkler riser/electrical room. Lock on the fire sprinkler riser room was repaired to allow full functionality of the door. WHEN was it corrected: Repaired October 1, 2014 WHAT will be done to ensure future compliance: Quarterly Facility Inspection. The ASC Manager will ensure the door to the fire sprinkler riser room remains operational during her Quarterly Facility Inspection. This check was added the Building and Equipment Log to begin 1st quarter of 2015. See attached snapshot K032-2 WHO is responsible: Cari Taylor, ASC Manager HOW the deficiency will be corrected: The electric door control system (all four main entry doors) will be replaced to include door control boxes, radio control receivers & push buttons with sealed contacts. A repairman reviewed the job on September 29, 2014. A bid was received & accepted on October 3, 2014. The Nabco System was ordered October 6, 2014 by Clarkston Glass Co. they estimate two weeks for delivery & installation. WHEN will it be corrected: On or before October 24, 2014 WHAT will be done to ensure future compliance: Quarterly Facility Inspection. Once the main entry doors access pad is repaired - the ASC Manager, or representative, will ensure it continues to operate correctly during Quarterly Facility Inspections. Should the door's automatic function fail to operate correctly – a work order will be implemented immediately to restore full functions. This check was added the Building and Equipment Log to begin 1st quarter of 2015. See attached snapshot	Oct 1, 2014
K 130	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786	K 130		

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K 130	Continued From page 2 This Standard is not met as evidenced by: Based on record review, observation and interview, the facility failed to perform quarterly sprinkler testing as required under NFPA 25. Failure to perform quarterly testing on sprinklers could result in the system failing to operate during a fire event. This deficient practice affected no patients, all staff and visitors on the date of the survey. Findings include: 1) During record review of the facility conducted on September 18, 2014 from 8:15 AM to 10:00 AM, the facility failed to provide and quarterly sprinkler testing report. Interview of the ASC Manager revealed she was not aware this testing was required. 2) During the facility tour conducted on September 18, 2014 from 10:00 AM to 11:00 AM, observation of the sprinkler riser found the system to be installed in accordance with NFPA 13, requiring a quarterly sprinkler inspection. Actual NFPA standard: NFPA 13 12-1* General. A sprinkler system installed in accordance with this standard shall be properly inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, to provide at least the same level of performance and protection as designed.	K 130	K130-1&2 WHO is responsible: Cari Taylor, ASC Manager HOW the deficiency will be corrected: Simplex-Grinnell contacted with request to amend existing contract to include Quarterly Testing of the facility's Sprinkler System WHEN will it be corrected: Amended contract received & sent to corporate director for the Buildings & Equipment Dept. October 6, 2014. First quarterly inspection will coincide with annual inspection in December 2014. WHAT will be done to ensure future compliance: ASC Manger has implemented three methods for ensuring compliance. 1. Contracted with local company to perform quarterly sprinkler testing 2. ASC Manager added a quarterly reminder on her Microsoft Outlook Calendar 3. Added quarterly check to the Building and Equipment Log to begin December of 2014. See attached snap shot.	

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K 130	Continued From page 3 NFPA 25 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.	K 130		
K 147	416.44(b)(1) LIFE SAFETY CODE STANDARD Electrical wiring and equipment are in accordance with NFPA 70, National Electrical Code 9.1.2, 20.5.1 This Standard is not met as evidenced by: Based on record review and interview, the facility failed to provide documentation for 90 minute annual testing for emergency lighting. Failure to test emergency lighting for 90 minutes annually could result in an emergency lighting system failure during an extended loss of power. This deficient practice affected no patients, all staff and visitors on the date of the survey. Findings include: During record review of the facility conducted on September 18, 2014 from 8:15 AM to 11:00 AM, the facility was unable to provide a record of 90 minute annual test being conducted on the emergency lighting. When asked, the ASC Manager and responsible staff member stated they were aware this test was necessary, but were unaware of it ever having been performed. Actual NFPA standard: 4.6.12 Maintenance and Testing. 4.6.12.1 Whenever or wherever any device, equipment,	K 147	WHO is responsible: Cari Taylor, ASC Manager HOW the deficiency will be corrected: Perform an annual check of the emergency lighting in the ASC. WHEN will it be corrected: Test will be conducted on or before October 10, 2014 with instruction/assistance from Buildings & Equipment personnel. WHAT will be done to ensure future compliance: ASC Manager will ensure that the annual emergency lights will be tested on an annual basis. This annual check was added to the Building and Equipment Log. ASC Manager will also set up a revolving Microsoft Outlook reminder on her calendar. See attached snapshot	

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K 147	Continued From page 4 system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be continuously maintained in accordance with applicable NFPA requirements or as directed by the authority having jurisdiction. 4.6.12.3 Equipment requiring periodic testing or operation to ensure its maintenance shall be tested or operated as specified elsewhere in this Code or as directed by the authority having jurisdiction. 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. Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment that automatically performs a test for not less than 30 seconds and diagnostic routine not less than once every 30 days and indicates failures by a status indicator shall be exempt from the 30-day functional test, provided that a visual inspection is performed at 30-day intervals.	K 147		