Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	55C0001062	04/30/2018
Name of Provider or Supplier	**Street Address, City, State**	
Sacramento Eye Surgicenter	3150 J Street, 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)
E0013	Development of EP Policies and Procedures CFR(s): 416.54(b) 403.748(b), 416.54(b), 418.113(b), 441.184(b), 460.84(b), 482.15(b), 483.73(b), 483.475(b), 484.102(b), 485.68(b), 485.625(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk 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 every 2 years. *[For LTC facilities at 483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk 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. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at 460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at 494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk 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 every 2 years. These emergencies include, but are not limited to, fire, equipment or power

failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area.

This STANDARD is not met as evidenced by:
Based on document review and interview, the facility failed to provide the required emergency policies and procedures. This was evidenced by an emergency plan that did not address a policy and procedure for medical record preservation, the use of volunteers during an emergency, and by the absence of a policy and procedure indicating the facility's role in providing treatment and care under an 1135 waiver at an alternate care site during an emergency. This affected all patients and could result in the facility being unprepared to facilitate volunteer support and/or being inadequately prepared to provide care at an alternate location during an emergency situation.

Findings:

During document review and interview with the Administrator on 4/30/18, the emergency preparedness policies and procedures were requested.

1. At 2:06 p.m., there were no policies and procedures provided that addressed storage, use, and maintenance of medical records during an emergency. Upon interview, the Administrator confirmed the finding.

2. At 2:07 p.m., there was no policy and procedure for the use of volunteers or other staffing strategies during an emergency. Upon interview, the Administrator confirmed the finding.

3. At 2:08 p.m., the policy and procedure provided did not include a process for an 1135 waiver for providing care and treatment at an alternate location during a declared emergency. Upon interview, the Administrator confirmed the finding and stated that they were not aware of the requirement.