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)
K0908	Gas and Vacuum Piped Systems Central Supply System Alarms CFR(s): NFPA 101 Gas and Vacuum Piped Systems - Inspection and Testing Operations The gas and vacuum systems are inspected and tested as part of a maintenance program and include the required elements. Records of the inspections and testing are maintained as required. 5.1.14.2.3, B.5.2, 5.2.13, 5.3.13, 5.3.13.4 (NFPA 99) This STANDARD is not met as evidenced by: Based on document review, observation, and interview, the facility failed to maintain the piped in medical gas system. This was evidenced by the failure to correct discrepancies noted on the medical gas inspection report and the absence of labels for the shutoff valves. This affected all patients and could result in an oxygen manifold malfunction. NFPA 99, Health Care Facilities Code, 2012 Edition 5.1.4.2 Accessibility. All valves, except valves in zone valve box assemblies, shall be located in secured areas such as locked piped chases, or be locked or latched in their operating position, and be labeled as to gas supplied and the area(s) controlled. 5.1.11.2 Shutoff Valves. 5.1.11.2.1 Shutoff valves shall be identified with the following:

(1) Name or chemical symbol for the specific medical gas or vacuum system

(2) Room or areas served

(3) Caution to not close or open the valve except in emergency

Findings:

During document review, a tour of the facility, and interview with the Administrator on 4/30/18, the piped in medical gas system was observed and records were requested.

1. At 2:00 p.m., a maintenance and testing report dated 12/26/17 was provided and reviewed

-Page 3-12 of the report indicated that there were three discrepancies found on the Master Panel.

-Page 3-13 of the report indicated that there were discrepancies in the Configuration of the Oxygen Manifold.

-Page 3-13 also indicated that there were discrepancies in the System Configuration & Performance, CO Monitor, and Dew Point Monitor of the Medical Air Compressor.

-Page 3-14 of the report indicated that there were medical gas outlet discrepancies found in the Central Sterile Room, the Decontamination Room, and the Recovery Room.

-Page 3-15 of the report indicated that there were medical gas zone valve box discrepancies due to lack of labels on the boxes located in Recovery Room, outside OR 2, outside Central Sterile, and by the Waiting Room door.

-Page 3-16 of the report indicated there were discrepancies with the area alarm panel in the Recovery Room and outside OR 2.

Upon interview, the Administrator confirmed these findings and stated they had received a quote for the repairs, but had not set a date to have the vendor start the repairs.

2. At 2:20 p.m., the medical gas zone valve boxes inside the Surgery Suite were not labeled.