



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
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CERTIFIED MAIL: 7000 1670 0011 3315 1620

February 13, 2015

Shane Ricks, Administrator
Millennium Surgery Center
1828 South Millennium Way, Suite 100
Meridian, ID 83642

RE: Millennium Surgery Center, Provider #13C0001011

Dear Mr. Ricks:

Based on the survey completed at Millennium Surgery Center, on February 2, 2015, by our staff, we have determined Millennium Surgery Center is out of compliance with the Medicare ASC Conditions for Coverage of, **Governing Body and Management (42 CFR 416.41)**, **Quality Assessment and Performance (42 CFR 416.43)** and **Infection Control (42 CFR 416.51)**. To participate as a provider of services in the Medicare Program, an ASC must meet all of the Conditions for Coverage established by the Secretary of Health and Human Services.

The deficiencies, which caused these conditions to be unmet, substantially limit the capacity of Millennium Surgery Center, to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567).

You have an opportunity to make corrections of those deficiencies, which led to the finding of non-compliance with the Condition for Coverage referenced above by submitting a written Credible Allegation of Compliance/Plan of Correction.

An acceptable Plan of Correction contains the following elements:

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;

Shane Ricks, Administrator

February 13, 2015

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- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the PoC is effective in bringing the ASC into compliance, and that the ASC remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
- The administrator's signature and the date signed on page 1 of each form.

Such corrections must be achieved and compliance verified by this office, before March 19, 2015. To allow time for a revisit to verify corrections prior to that date, it is important that the completion dates on your Credible Allegation/Plan of Correction show compliance no later than March 9, 2015.

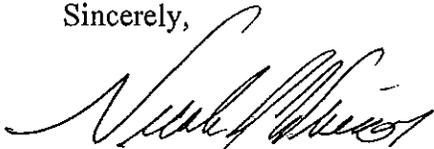
Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **February 26, 2015.**

Failure to correct the deficiencies and achieve compliance will result in our recommending that CMS terminate your approval to participate in the Medicare Program. If you fail to notify us, we will assume you have not corrected.

We urge you to begin correction immediately.

If you have any questions regarding this letter or the enclosed reports, please contact me at (208) 334-6626, option 4.

Sincerely,



DON SYLVESTER
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

DS/pmt
Enclosures

cc: Debra Ransom, R.N., R.H.I.T., Bureau Chief
Gary Keopanya, CMS Region X Office

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

PRINTED: 02/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/02/2015
NAME OF PROVIDER OR SUPPLIER MILLENNIUM SURGERY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1828 SOUTH MILLENNIUM WAY, SUITE 100 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
Q 000	INITIAL COMMENTS The following deficiencies were cited during the Medicare recertification survey of your surgery center conducted from 1/26/15 to 2/02/15. Surveyors conducting the recertification were: Don Sylvester, RN, HFS, Team Leader Gary Gules, RN, HFS Nancy Bax, RN, HFS Acronyms used in this report include: AORN - Association of Perioperative Registered Nurses ASC - Ambulatory Surgery Center CDC - Center for Disease Control CRNA - Certified Registered Nurse Anesthetist CST - Certified Surgical Technician DVT - Deep Vein Thrombosis (blood clot) EGD - Esophagogastroduodenoscopy EMR - Electronic Medical Record H&P - History and Physical Examination HRET - Health Research and Education Trust MSC - Millennium Surgery Center mg - milligrams ml - milliliters NSAID - Non steroidal Antiinflammatory Drug OR - Operating Room PACU - Post Anesthesia Care Unit pt - patient PVC - Premature Ventricular Contraction QAPI - Quality Assessment Performance Improvement RN - Registered Nurse	Q 000		
Q 040	416.41 GOVERNING BODY AND MANAGEMENT	Q 040		

RECEIVED
FEB 27 2015
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Shane P. Richs RN Administrator* TITLE *Administrator* (X6) DATE *3/6/2015*

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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Q 040	<p>Continued From page 1</p> <p>The ASC must have a governing body that assumes full legal responsibility for determining, implementing, and monitoring policies governing the ASC's total operation. The governing body has oversight and accountability for the quality assessment and performance improvement program, ensures that facility policies and programs are administered so as to provide quality health care in a safe environment, and develops and maintains a disaster preparedness plan.</p> <p>This CONDITION is not met as evidenced by: Based on staff interview and review of medical records, policies, meeting minutes and quality documents, it was determined the ASC's Governing Body failed to assume responsibility for determining, implementing, and monitoring policies and failed to oversee the ASC's QAPI program. This resulted in a lack of guidance and direction to staff and the failure to sustain regulatory compliance. Findings include:</p> <ol style="list-style-type: none"> 1. Refer to Q43 as it relates to the failure of the Governing Body to develop an emergency preparedness plan that was coordinated with State and local authorities and that an emergency preparedness drill was conducted at least annually to test the plan's effectiveness. 2. Refer to Q80 Condition for Coverage: Quality Assessment and Performance Improvement as it relates to the Governing Body's failure to ensure the ASC's quality program was developed, implemented and maintained. 3. Refer to Q240 Condition for Coverage: Infection Control as it relates to the Governing 	Q 040	<p>MSC will meet QHO condition by complying to all deficiencies noted in this statement evidence of compliance will be proven by meeting each requirement.</p> <p>Shane Ricks will supervise completion of the Plans of Correction the Governing Board will meet on March 6 to review and approve all Plans of Correction. During the period of time prior to the G.B. meeting plans will be reviewed by Shane Ricks and the Medical Director Bret Rodgers M.D.</p>

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Q 040	Continued From page 2 Body's failure to ensure a comprehensive infection control program was developed, implemented and monitored. The cumulative effect of these systemic deficient practices resulted in the lack of clear processes to guide staff in the provision of care and to evaluate its services.	Q 040			
Q 043	416.41(c) DISASTER PREPAREDNESS PLAN (1) The ASC must maintain a written disaster preparedness plan that provides for the emergency care of patients, staff and others in the facility in the event of fire, natural disaster, <u>functional failure</u> of equipment, or other unexpected events or circumstances that are likely to threaten the health and safety of those in the ASC. (2) The ASC coordinates the plan with State and local authorities, as appropriate. (3) The ASC conducts drills, at least annually, to test the plan's effectiveness. The ASC must complete a written evaluation of each drill and promptly implement any corrections to the plan. This STANDARD is not met as evidenced by: Based on interview and administrative document review, it was determined the facility failed to ensure the Governing Body developed an emergency preparedness plan that addressed all hazards, was coordinated with State and local authorities, and that an emergency preparedness drill was conducted at least annually to test the plan's effectiveness for all patients, staff and visitors. This resulted in the potential for the facility's inability to effectively deal with the care,	Q 043	Emergency Preparedness Disaster Plan. Updated to include Functional Failure of Equipment. To be reviewed and approved prior to 3/6/15 Plan will be reviewed by staff and Governing board prior to 3/6/15 Updated policy / addition of Functional Failure of equipment will be covered in the next Disaster Drill to be done prior to 3/13/14. <i>[Signature]</i>		

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Q 043	Continued From page 3 health and safety of patients, staff and other individuals when a major disruptive event occurred. Findings include: During an interview on 2/02/15 beginning at 1:00 PM, the Administrator provided a binder containing the ASC's disaster plan. He stated the ASC had not conducted an analysis of hazard vulnerability or staff training specific to hazards other than fire. The Administrator provided documentation of annual fire drills. However, he stated the ASC did not conduct drills to test emergency preparedness for hazards other than fire. - The Administrator was asked how the ASC coordinated emergency preparedness with State and local authorities. He presented a letter he had written to the county emergency management agency, offering assistance at the state and local level. The letter was dated 8/10/11. The Administrator stated he did not receive a response and he did not contact the agency again. The ASC failed to ensure an emergency preparedness plan that addressed all hazards was developed, coordinated with State and local authorities, and that an emergency preparedness drill was conducted at least annually to test the plan's effectiveness.	Q 043	This information is incorrect. MSC completed 3 disaster drills in 2014. These drills were not reviewed by the surveyors 7/15/14 Earthquake drill 10/16/14 Ebola infection Suspected. 12/15/14 Snowed in with patients. MSC will conduct a hazard analysis prior to 3/1/15. It will be placed in the Emergency Response binder. The hazard analysis will be reviewed by the Staff and the Governing Board for Education and review for completeness. Evidence of these actions will be recorded in the Governing board and Staff meeting notes dated 3/6	
Q 080	416.43 QUALITY ASSESSMENT AND PERFORMANCE The ASC must develop, implement and maintain an on-going, data-driven quality assessment and performance improvement (QAPI) program. This CONDITION is not met as evidenced by:	Q 080		

2/20/15 [redacted] was contacted the Ada County Emergency management Director. He stated that Surgery Centers are currently not part of the response plan. He will keep our Disaster management plan on file and will contact us if needs change. MSC will send updates to Mr. Hardman when MSC updates our policies.

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Q 080	Continued From page 4 Based on staff interview and review of policies, meeting minutes, medical records, and quality program documents, it was determined the ASC failed to ensure a quality program was developed, implemented and maintained. This prevented the ASC from developing a comprehensive QAPI program and evaluating its practices. Findings include: 1. Refer to Q84 as it relates to the ASC's failure to ensure the Governing Body defined, implemented and maintained the QAPI program.	Q 080	A data driven QAPI program will be in place and functioning and pending review and approval of the Governing Board meeting on March 6, 2015. Sharee Ricks will champion this program	
Q 081	416.43(a), 416.43(c)(1) PROGRAM SCOPE; PROGRAM ACTIVITIES (a)(1) The program must include, but not be limited to, an ongoing program that demonstrates measurable improvement in patient health outcomes, and improves patient safety by using quality indicators or performance measures associated with improved health outcomes and by the identification and reduction of medical errors. (a)(2) The ASC must measure, analyze, and track quality indicators, adverse patient events, infection control and other aspects of performance that includes care and services furnished in the ASC. (c)(1) The ASC must set priorities for its performance improvement activities that - (i) Focus on high risk, high volume, and problem-prone areas. (ii) Consider incidence, prevalence, and severity of problems in those areas. (iii) Affect health outcomes, patient safety, and quality of care.	Q 081	MSE will better compile quality data to assist MSE in providing quality care as evidence of quality data in critical areas of care. If there are areas of improvement the data will assist in identifying problem issues. The plan will be carried out by the Quality and Performance Improvement Committee which will meet on 3/3/15. The findings from this meeting will be presented to the governing board.	

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Q 081	Continued From page 5 This STANDARD is not met as evidenced by: Based on staff interview and review of policies, meeting minutes and QAPI documents, it was determined the ASC failed to ensure its quality program was comprehensively defined, developed and implemented. This prevented the ASC from analyzing its processes in order to improve them. Findings include: 1. A specific QAPI plan, including quality indicators, priorities, and time frames, was not documented between 1/01/14 and 1/26/15. The Administrator was interviewed on 1/26/15 beginning at 3:00 PM. He stated the ASC had been ongoing quality activities but a plan had not been developed that defined the overall QAPI program and directed staff as to how to carry out those activities. The facility's undated "Quality Improvement Policies and Procedures" were reviewed. The policy stated in the "Program" section that program activities were to be completed as follows: a. Chart reviews for quality of care standards/criteria were to be reviewed quarterly by randomly selecting 5% or a minimum of 2 patient medical records. The review was to be completed by a peer review trained staff member who was to assess the following areas: - Record keeping. - Proper utilization of the facility. - Appropriateness of care and medical necessity.	Q 081	QAPI Programs activities The program will collect and analyze data from all disciplines of care specifically PEER Review, Dr. Anesthesia, and Clinical Staff Chart Reviews Satisfaction Surveys Active Surveillance of Hand Hygiene Cleanliness of the Environment Sterilization of instruments (Including Cidex test strip Immediate use Sterilization Biological Indicators RN and CST QA Logs Drills complete in a timely manner and high quality Annual Education of staff Policy review ESP OSTA Education annually Pathology Records Etc Data will be collected and will be part of the QAPI		

Annual Review. The data will be presented to the governing body on 3/6/15. The QAPI committee will review all data and propose a plan for 2015 to the governing body. The QAPI committee will meet on 3/3/15. Shane Triets and Brent Rodgers MD will supervise the completion of this plan of action.

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Q 081	<p>Continued From page 6</p> <ul style="list-style-type: none"> - Post-operative pathological diagnosis to determine justification of procedures done. - Medication and lab review. <p>The policy did not include documentation of measurable baseline data or a measurable goal the facility was striving to maintain or attain.</p> <p>Medical Staff meeting minutes dated 3/4/14, 7/8/14, 10/14/14 and 12/9/14 were reviewed. The meeting minutes did not include quantifiable data which allowed the facility to measure compliance (e.g. percentage or how many records included errors out of how many total records reviewed).</p> <p>The Administrator was interviewed on 1/26/15 beginning at 3:00 PM. He confirmed the minutes did not include quantifiable data.</p> <p>b. Patient Satisfaction was to be monitored through post-operative patient questionnaires, with data being reviewed quarterly.</p> <p>The policy did not include documentation of measurable baseline data or a measurable goal the facility was striving to maintain or attain.</p> <p>Medical Staff meeting minutes date 3/4/14, 7/8/14, 10/14/14 and 12/9/14 were reviewed. The meeting minutes did not include quantifiable data which allowed the facility to measure compliance (e.g. percentage or how many surveys documented satisfaction out of how many total records reviewed) or discussion regarding what information the surveys provided.</p> <p>The Administrator was interviewed on 1/26/15 beginning at 3:00 PM. He confirmed the meeting minutes did not include quantifiable data.</p>	Q 081	<p><i>This Plan will include quantifiable data and measurable goals. This will be part of the QAPI meeting on 3/3/15.</i></p>		

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Q 081	<p>Continued From page 7</p> <p>c. All cases of post-operative infections were to be reviewed via post-operative telephone interviews, unplanned admissions, and returned infection control reports.</p> <p>The policy did not include documentation of measurable baseline data or a measurable goal the facility was striving to maintain or attain.</p> <p>Medical Staff meeting minutes date 3/4/14, 7/8/14, 10/14/14 and 12/9/14 were reviewed. The meeting minutes did not include quantifiable data which allowed the facility to measure compliance (e.g. number of post-operative infections or unplanned admissions reported out of total number of procedures performed, and/or number of infection control reports indicating infection out of total number of reports returned, etc.).</p> <p>The Administrator was interviewed on 1/26/15 beginning at 3:00 PM. He confirmed the meeting minutes did not include quantifiable data.</p> <p>d. Medical/surgical equipment currently used or proposed for use at the facility was to be reviewed via the facility's equipment management program and biomedical checks.</p> <p>The policy did not include documentation of measurable baseline data or a measurable goal the facility was striving to maintain or attain.</p> <p>Medical Staff meeting minutes date 3/4/14, 7/8/14, 10/14/14 and 12/9/14 were reviewed. The meeting minutes documented equipment, such as C-arms, a large autoclave, etc. that were under review for purchase. However, quantifiable data related to equipment maintenance and</p>	Q 081			

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Q 081	<p>Continued From page 8 biomedical checks was not present.</p> <p>The Administrator was interviewed on 1/26/15 beginning at 3:00 PM. He confirmed the meeting minutes did not include quantifiable data.</p> <p>e. Quality indicator findings were to be reviewed, with focus on at least one indicator per department until the expected outcome was reached and to determine if corrective action of recurrent problems was adequate. The corresponding "Policy of Quality Indicators" section of the policy stated the "Quality Indicator Sheet (Incident Report Form)" was to be completed to "...track the frequency of deviation from the standards of care, therefore, allowing corrective actions to be taken when deemed necessary."</p> <p>The policy did not include documentation of measurable baseline data or a measurable goal the facility was striving to maintain or attain.</p> <p>The Administrator was interviewed on 1/26/15 beginning at 3:00 PM. He confirmed the policy did not include documentation of measurable baseline data or a measurable goal.</p> <p>f. The policy stated incident report forms were to be "...filled out in the appropriate area of the occurrence. At the end of the day, during the daily chart reviews, the QI forms are to be collected and given to the Administrator. The indicators are tallied and entered into a log." The policy did not include a process to investigate the incidents to identify causes and potential actions to prevent future incidents.</p> <p>The Administrator was interviewed on 1/26/15</p>	Q 081			

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Q 081	Continued From page 9 beginning at 3:00 PM. He confirmed information including a causal analysis or additional information. 2. Refer to Q82 as it relates to the ASC's failure to ensure quality indicator data was used to monitor the effectiveness and safety of its services and to track adverse patient events, examine their causes and implement improvements. 3. Refer to Q83 as it relates to the ASC's failure to ensure distinct quality improvement projects were defined and conducted. 4. Refer to Refer to Q244 as it relates to the ASC's failure to ensure infection control was comprehensively addresses as an integral part of the ASC's QAPI program. The cumulative effect of these systematic failures impeded the ASC's ability to evaluate its practices and identify opportunities to improve patient care.	Q 081			
Q 082	416.43(b), 416.43(c)(2), 416.43(c)(3) PROGRAM DATA; PROGRAM ACTIVITIES (b)(1) The program must incorporate quality indicator data, including patient care and other relevant data regarding services furnished in the ASC. (b)(2) The ASC must use the data collected to - (i) Monitor the effectiveness and safety of its services, and quality of its care. (ii) Identify opportunities that could lead to improvements and changes in its patient care. (c)(2) Performance improvement activities must	Q 082	<i>The QAPI program will have Quality Indicator data to monitor the effectiveness and safety of our services. and will help identify opportunities for improvement and change. this will be included in the QAPI meeting and plan noted in Q 81 and will be supervised and completed in the same time frame.</i>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/02/2015
NAME OF PROVIDER OR SUPPLIER MILLENNIUM SURGERY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1828 SOUTH MILLENNIUM WAY, SUITE 100 MERIDIAN, ID 83642		
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Q 082	<p>Continued From page 10</p> <p>track adverse patient events, examine their causes, implement improvements, and ensure that improvements are sustained over time.</p> <p>(c)(3) The ASC must implement preventive strategies throughout the facility targeting adverse patient events and ensure that all staff are familiar with these strategies.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of policies, meeting minutes, medical records, and QAPI documents, it was determined the ASC failed to ensure quality indicator data was used to monitor the effectiveness and safety of its services. In addition, the ASC failed to track adverse patient events, examine their causes, and implement improvements. This directly affected the care of 2 of 20 patients (#17 and #18), whose records were reviewed. This prevented the ASC from analyzing its processes in order to improve them. Findings include:</p> <p>1. The facility's undated "Quality Improvement Policies and Procedures" stated in the "Program" section that the following would be completed:</p> <p>a. Chart reviews for quality of care standards/criteria were to be reviewed quarterly by randomly selecting 5% or a minimum of 2 patient medical records. Medical Staff meeting minutes dated 3/4/14, 7/8/14, 10/14/14 and 12/9/14 were reviewed and stated the following:</p> <p>3/4/14: "No major areas of concern. Remember to be detail oriented especially on your H&Ps. Especially new EMR templates. Often the location of the surgery plan, and the review of</p>	Q 082			

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Q 082	<p>Continued From page 11 systems are incomplete."</p> <p>7/8/14: "No Issues [sic] to report. Revised new process. Low quantity high quality."</p> <p>10/14/14 and 12/9/14: "No Issues [sic] to report. Continue with low quantity high quality peer review. Please write comments on the form feedback."</p> <p>The meeting minutes did not include quantifiable data which allowed the facility to measure compliance (e.g. percentage or how many records included errors out of how many total records reviewed).</p> <p>The Administrator was interviewed on 1/26/15 beginning at 3:00 PM. He confirmed the minutes did not include quantifiable data.</p> <p>b. Patient Satisfaction was to be monitored through post-operative patient questionnaires, with data being reviewed quarterly. Medical Staff meeting minutes date 3/4/14, 7/8/14, 10/14/14 and 12/9/14 were reviewed and stated the following:</p> <p>3/4/14: "Satisfaction surveys: 4th Q reviewed."</p> <p>7/8/14: "Satisfaction surveys: 1st Q reviewed."</p> <p>10/14/14 and 12/9/14: "Satisfaction surveys: 3rd Q reviewed."</p> <p>The meeting minutes did not include quantifiable data which allowed the facility to measure compliance (e.g. percentage or how many surveys documented satisfaction out of how many total records reviewed) or discussion</p>	Q.082			

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Q 082	<p>Continued From page 12 regarding what information the surveys provided.</p> <p>The Administrator was interviewed on 1/26/15 beginning at 3:00 PM. He confirmed the meeting minutes did not include quantifiable data.</p> <p>c. All cases of post-operative infections were to be reviewed via post-operative telephone interviews, unplanned admissions, and returned infection control reports. Medical Staff meeting minutes date 3/4/14, 7/8/14, 10/14/14 and 12/9/14 were reviewed and stated the following:</p> <p>3/4/14, 10/14/14 and 12/9/14: The minutes did not include information regarding postoperative infections.</p> <p>7/8/14: "Infection Control and Postoperative complications" minutes stated a patient had presented for partial amputation with an infected toe and the infection remained postoperatively. The minutes further stated a second patient had a minor case of cellulitis and slow healing. The minutes documented both patients were treated and the infections resolved. The minutes stated "Reviewed No [sic] action required."</p> <p>Additional information, including a causal analysis, regarding the infections was not present and documentation of how it was determined no further action was warranted related to the facility's infection control program could not be found.</p> <p>The meeting minutes did not include quantifiable data which allowed the facility to measure compliance (e.g. number of post-operative infections or unplanned admissions reported out of total number of procedures performed, and/or</p>	Q 082	<p>ack.</p> <p>MSC will perform a analysis on all incidents complications, and infections</p> <p>Forms include:</p> <ul style="list-style-type: none"> ① Incident Report Form ② Performance improvement incident analysis. "CAUSAL analysis" ③ Surgical site infection form ④ Root cause analysis (use for complex or Sentinel events. ⑤ Grievance report. etc. <p>DAPI Committee, Staff and Governing board will review this information on at least a quarterly basis. Evidence of completion will be in the DAPI Committee, Staff, and governing body reports.</p> <p>Staff and DAPI meeting 3/3/15 GB meeting 3/10/15</p> <p>Sham Ricks and Brent Rodgers will supervise compliance of condition Q 082</p>		

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Q 082	<p>Continued From page 13</p> <p>number of infection control reports indicating infection out of total number of reports returned, etc.).</p> <p>The Administrator was interviewed on 1/26/15 beginning at 3:00 PM. He confirmed the meeting minutes did not include quantifiable data.</p> <p>d. Medical/surgical equipment currently used or proposed for use at the facility was to be reviewed via the facility's equipment management program and biomedical checks.</p> <p>Medical Staff meeting minutes date 3/4/14, 7/8/14, 10/14/14 and 12/9/14 were reviewed. The meeting minutes documented equipment, such as C-arms, a large autoclave, etc. that were under review for purchase. However, quantifiable data related to equipment maintenance and biomedical checks was not present.</p> <p>The Administrator was interviewed on 1/26/15 beginning at 3:00 PM. He confirmed the meeting minutes did not include quantifiable data.</p> <p>e. Quality indicator findings were to be reviewed, with focus on at least one indicator per department until the expected outcome is reached and to determine if corrective action of recurrent problems was adequate. The corresponding "Policy of Quality Indicators" section of the policy stated the "Quality Indicator Sheet (Incident Report Form)" was to be completed to "...track the frequency of deviation from the standards of care, therefore, allowing corrective actions to be taken when deemed necessary."</p> <p>The Administrator was interviewed on 1/26/15</p>	Q 082		

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Q 082	<p>Continued From page 14 beginning at 3:00 PM. He confirmed the policy did not include documentation of measurable baseline data or a measurable goal</p> <p>f. The policy stated incident report forms were to be "...filled out in the appropriate area of the occurrence. At the end of the day, during the daily chart reviews, the QI forms are to be collected and given to the Administrator. The indicators are tallied and entered into a log." The policy did not include specify a process to investigate the incidents to identify causes and potential actions to prevent future incidents.</p> <p>Additionally, the policy "INCIDENT REPORTING," dated 7/01/08, included a list of adverse patient events that staff needed to report. The policy did not address what if any type of investigation of the events would be conducted following a report. As a result, the ASC did not examine the causes of adverse patient events and implement improvements. Nor did the ASC track adverse patient events.</p> <p>Medical Staff meeting minutes date 3/4/14, 7/8/14, 10/14/14 and 12/9/14 were reviewed and stated the following:</p> <p>- 3/4/14: "Risk Management" notes documented a patient had vomited, was turned on her side and suctioned. The notes stated the case was reviewed and the suction machine was not immediately available. The notes stated "staff has discussed processes to insure that we have suction immediately available for all cases."</p> <p>However, additional information, including a causal analysis, regarding the incident was not present and documentation of what procedural</p>	Q 082			

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Q 082	<p>Continued From page 15</p> <p>changes took place to ensure the suction machine was immediately available was not present in the notes. Further, a monitoring plan, which included measurable goals, data collection and analysis, to ensure the changes were effective was not documented in the meeting minutes.</p> <p>- 7/8/14: "Risk Management" notes stated a patients' mother had expressed concerns regarding a "breathing sound" she related to the patient's seizures in the past. The notes stated "We will discuss the importance of listening to family when the [sic] have concerns in our staff meeting. Will be discussing with the staff to listen [sic] to patient's family members especially moms."</p> <p>A monitoring plan, which included measurable goals, data collection and analysis, to ensure the discussions with staff was effective was not documented in the meeting minutes.</p> <p>- The 7/8/14 minutes documented staff had been "poked with a keith needle," another staff had been "poked with the cautery tip" and a third staff had been burnt/poked with a cautery needle. The minutes stated "Reviewed and reviewed [sic] the blood borne pathogen policy. Slow down and be safe."</p> <p>However, additional information, including a causal analysis, regarding the incidents was not present and documentation of a monitoring plan, which included measurable goals, data collection and analysis, to ensure the discussions with staff was effective was not documented in the meeting minutes.</p>	Q 082			

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Q 082	<p>Continued From page 16</p> <p>- The 7/8/14 meeting minutes documented a wrong-site toe surgery. The minutes stated "All appropriate safety measures were done but the surgery was started on the wrong toe." The minutes stated "We discussed this incident in detail. We will use the checklist as designed. The doctors will be the lead on our safety efforts. We clarified the process of the safety program and we will make efforts to work as a team."</p> <p>However, additional information, including a causal analysis, regarding the incident was not present. Additional information, including a causal analysis, regarding the incident was not present. The minutes did not document how the event could have potentially been avoided or what action had been taken to ensure the facility's safety program would be followed in the future. Additionally, the notes did not document a monitoring plan, which included measurable goals, data collection and analysis, to ensure the action taken was effective in preventing similar incidents.</p> <p>An corresponding Incident Report Form, dated 6/27/14 at 11:45 AM, documented Patient #18's stated surgery was done on the incorrect toe. Per Patient #18's medical record, she was a 93 year old female who had surgery on 6/26/14 for correction of a hammertoe. The operative consent stated the surgery was for correction of a hammertoe of the third toe on her right foot.</p> <p>The 6/27/14 Incident Report Form stated surgery was also completed on the correct toe. Under the section "Supervisor investigation/comment/follow up," it stated "Doctors and nurses will all review proper policies and procedures."</p>	Q 082			

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Q 082	<p>Continued From page 17</p> <p>An investigation of the incident was not documented.</p> <p>Further, the ASC had a monthly list of "Quality Measures" that it maintained and reported to CMS. The list included adverse events such as patient burns, falls, transfers, etc. One of the items was wrong site surgery. The list stated there were no wrong site surgeries in June, 2014. The surgery on the wrong toe was not included. The failure to document the wrong site surgery prevented the ASC from accurately tracking adverse patient events.</p> <p>The Administrator was interviewed on 1/30/15 beginning at 3:00 PM. He stated the ASC did not have a formal process to investigate adverse patient events. He confirmed Patient #17's wrong site surgery. He stated investigation details were not documented. He stated actions to prevent future events of this type were not documented. He also stated the wrong site surgery was not included in the "Quality Measures" list. He stated this was an oversight.</p> <p>- The 7/8/14 meeting minutes documented a patient had presented for multiple procedures on his foot. The notes documented it was discovered that a procedure had not been completed. The patient had an unplanned return to the operating room and the final procedure was performed. The notes stated "We reviewed this case in detail. The governing board agreed that we all will make a greater effort to support our culture of safety. This incident could have potentially been avoided if we follow our safety program."</p> <p>However, additional information, including a</p>	Q 082			

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Q 082	<p>Continued From page 18</p> <p>causal analysis, regarding the incident was not present. The notes did not document how the event could have potentially been avoided or what action had been taken to ensure the facility's safety program would be followed in the future. Additionally, the notes did not document a monitoring plan, which included measurable goals, data collection and analysis, to ensure the action taken was effective in preventing similar incidents.</p> <p>An corresponding Incident Report Form, dated 6/30/14 at 3:00 PM, stated after Patient #17 was brought to PACU on 6/27/14. Per Patient #17's medical record he was a 33 year old male who had surgery on 6/27/14 on his left foot and ankle.</p> <p>His surgical consent, dated 6/27/14 but not timed, stated he was to have 4 procedures performed including bunion surgery, osteotomy, removal of ankle spurs, and removal of ankle screws from a prior surgery. The "PACU Record," dated 6/27/14 at 11:30 AM, stated "wife to bedside, ice boot off, Dr. [name] to bedside to consult, [after] talking [with] pt, Dr. needs to take pt back to OR for another procedure." A second surgery was documented that same day.</p> <p>The 6/30/14 Incident Report Form documented "...some hardware that the pt thought was being removed wasn't & after [the physician] looked at chart & talking [with] wife, he wanted to bring pt back to OR to remove remaining hardware." Under the section "Supervisor investigation/comment/follow up," it stated the Administrator reviewed the incident with the staff involved. It stated "They will be more vigilant in verifying the procedure and insuring everything is done."</p>	Q 082			

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Q 082	Continued From page 19 Details of the investigation were not documented. The Administrator was interviewed on 1/30/15 beginning at 3:00 PM. He stated investigation details were not documented for Patient #17. He stated actions to prevent future events of this type were not documented. The ASC did not examine the causes of the events that led to a second surgery or implement specific improvements in order to prevent future events of a similar nature. - 10/14/14 and 12/9/14: "Risk Management" notes stated a patient converted from a normal rhythm to a bradycardia with PVCs. The patient was transferred to the emergency room, evaluated, and released. The notes stated "Reviewed and appropriate care was given." No additional information, including a causal analysis, regarding the incident was present in the notes. The Administrator was interviewed on 1/26/15 beginning at 3:00 PM. He confirmed information including a causal analysis or additional information was not present.	Q 082			
Q 083	416.43(d) PERFORMANCE IMPROVEMENT PROJECTS (1) The number and scope of distinct improvement projects conducted annually must reflect the scope and complexity of the ASC's	Q 083			

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Q 083	<p>Continued From page 20 services and operations.</p> <p>(2) The ASC must document the projects that are being conducted. The documentation, at a minimum, must include the reason(s) for implementing the project, and a description of the project's results</p> <p>This STANDARD is not met as evidenced by: Based on staff interview, review of policies and quality program documents, it was determined the ASC failed to ensure distinct quality improvement projects were defined and conducted. This limited the ASC's opportunities to improve patient care and patient safety. Findings include:</p> <p>1. The facility's undated "Quality Improvement Policies and Procedures" were reviewed. The policy did not address PI projects."</p> <p>Four "MSC Staff Meeting" minutes were documented in 2014. The MSC staff constituted the Quality Improvement Committee. Meeting minutes were dated 3/04/14, 7/14/14, 10/16/14, and 12/15/14. Meeting minutes included the following QAPI items:</p> <p>A "DVT Prevention Project," dated December, 2011, stated the ASC would promote the use of sequential compression devices to prevent DVTs. The project stated the ASC would "...track all incidents of DVTs." The project did not require any other data to be collected, such as tracking whether staff were following the protocols.</p> <p>All 4 "MSC Staff Meeting" minutes stated "DVT Program: We are doing well. No incident of DVT</p>	Q 083	<p>MSC will improve the quality and quantifiable data pertaining to Performance Improvement. PI is now included in the Quality and Performance Improvement policy projects will be up to date by 3/6/15 and plans will be coordinated to keep data and projects up to date on a quarterly basis. To be completed by the QAPI Committee supervised by Shanna Pucks Admin and Brad Rodgers M.D.</p>		

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Q 083	<p>Continued From page 21 reported in the last year." None of the minutes discussed the collection of data, the reason for implementing the project or a description of the project's results.</p> <p>The Administrator was interviewed on 1/26/15 beginning at 3:00 PM. He stated the DVT Prevention Project noted if a patient developed a DVT or pulmonary embolism. He stated no other quality indicators were monitored and no data was gathered to evaluate whether staff was following the DVT prevention guidelines.</p> <p>2. A "HRET Patient Safety Program," dated 9/19/13, stated the program goals were 1) to reduce surgical site infections and surgical complications and 2) to improve safety culture as evidenced by improved teamwork, and communication by employing a surgical safety checklist.</p> <p>The program did not state specific quality indicators to be measured, a plan explaining the ASC's role in the program was not documented, and the start of the Safety program was not documented.</p> <p>Additionally, "MSC Staff Meeting" minutes for dated 3/04/14, 7/14/14, 10/16/14 and 12/15/14 were reviewed. The minutes did not include quantifiable data which allowed the facility to measure compliance or information related to data analysis or a description of the project's results.</p> <p>The Administrator was interviewed on 1/26/15 beginning at 3:00 PM. He stated neither "MSC Staff Meeting" minutes nor Medical Staff meeting minutes mentioned data collected by the</p>	Q 083		
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NAME OF PROVIDER OR SUPPLIER MILLENNIUM SURGERY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1828 SOUTH MILLENNIUM WAY, SUITE 100 MERIDIAN, ID 83642		
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Q 083	<p>Continued From page 22 program.</p> <p>3. "MSC Staff Meeting" minutes for 3/04/14 stated the handwashing policy was reviewed. The minutes stated the observation process was also reviewed. The minutes stated the ASC would "...have [patient] and family evaluations of hand washing periodically." The minutes did not define issues surrounding handwashing or a specific plan to measure hand washing at the facility. "MSC Staff Meeting" minutes for 3/04/14 stated "CDC hand hygiene policy and protocol reviewed. We will have pt and family evaluations of hand washing periodically. We reviewed the hand hygiene policy. We reviewed the observation process. We will increase access with Avagard D [a hand antiseptic] in critical areas. We will begin observations after Avagard D is in place and all staff and doctors have had a chance to be educated on the policy and our observational tools. We will ramp up our measurement. We feel like the added access and emphasis on hand hygiene has help[ed] we need to measure to see where we are at."</p> <p>A plan to monitor hand hygiene, including quality indicators and directions to staff, the reason for implementing the project or a description of the project's results was not documented. Additionally, no hand hygiene data was documented between 1/01/14 and 1/26/15.</p> <p>The Administrator was interviewed on 1/26/15 beginning at 2:35 PM. He stated no hand hygiene data had been gathered between 1/01/14 and 1/26/15.</p> <p>The ASC failed to comprehensively define and implement performance improvement projects.</p>	Q 083			

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Q 084	<p>416.43(e) GOVERNING BODY RESPONSIBILITIES</p> <p>The governing body must ensure that the QAPI program-</p> <ul style="list-style-type: none"> (1) Is defined, implemented, and maintained by the ASC. (2) Addresses the ASC's priorities and that all improvements are evaluated for effectiveness. (3) Specifies data collection methods, frequency, and details. (4) Clearly establishes its expectations for safety. (5) Adequately allocates sufficient staff, time, information systems and training to implement the QAPI program. <p>This STANDARD is not met as evidenced by: Based on staff interview and review of policies, meeting minutes and QAPI documents, it was determined the ASC failed to ensure the Governing Board defined, implemented, and maintained the QAPI program. This resulted in a lack of oversight of the QAPI program and a lack of direction to staff responsible for the program. Findings include:</p> <p>1. The policy "Quality Improvement Plan Statement of Philosophy," dated 8/20/11, stated "...the ultimate responsibility for the quality of care rests with the Governing Board..." The policy stated the Governing Board would be notified of quality activities. The policy did not state what the duties of the Governing Board were in relation to the QAPI program. The policy did not state which members of the Governing Board were responsible to ensure a QAPI plan was developed. The policy did not state specifically how the Governing Board was responsible to</p>	Q 084	<p>① In the QAPI policy it was state the G.B. Responsibility. See Governing Board policy 6020 which shows GB members and responsibilities. updated and reviewed by the Medical Director approval by governing board 3/16/15 for final approval. Completed by Sarah Riches 2/2/15</p>		

CAUSAL Analysis will be completed on all incidents unless a more specific analysis is required, Root Cause analysis for complex or sentinel events or medication interactions ETC →

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Q 084	<p>Continued From page 24</p> <p>ensure the QAPI program was monitored and to ensure actions were taken to address deficiencies. The plan did not state how the Governing Board would monitor the QAPI program to determine whether it was functioning as defined and how resources were allocated to the program.</p> <p>The Administrator was interviewed on 1/26/15 beginning at 3:00 PM. He confirmed the policy did not define the role of the Governing Board.</p> <p>2. Medical Staff meeting minutes dated 3/4/14, 7/8/14, 10/14/14 and 12/9/14 were reviewed. These also served as Governing Board minutes. The minutes did not show oversight of the QAPI program as follows:</p> <p>a. A specific plan for the ASC's QAPI program, including quality indicators, priorities, and time frames, was not documented between 1/01/14 and 1/26/15.</p> <p>None of the Medical Staff meeting minutes mentioned a QAPI plan or review of a QAPI plan to determine if quality activities were being conducted as needed to evaluate care at the facility.</p> <p>The Administrator was interviewed on 1/26/15 beginning at 3:00 PM. He stated the ASC had ongoing quality activities but said a plan had not been developed that defined the overall QAPI program and directed staff as to how to carry out those activities. He confirmed Medical Staff meeting minutes did not address a QAPI plan.</p> <p>b. All of the Medical Staff meeting minutes included data gathered from the QAPI program.</p>	Q 084	<p><i>This process was implemented 2/20/15. Will be up for Final Approval 3/16/15 Governing board meetings completed and supervised by Shane Pickett</i></p>		

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Q 084	<p>Continued From page 25</p> <p>However, none of the minutes documented discussion of specific data or specific recommendations for changes to the QAPI program or to patient care. Specific follow though was not documented.</p> <p>For example, the Medical Staff meeting minutes, dated 3/04/14, stated "The Board discussed hand washing and how to improve compliance. We will increase accessibility to hand cleaning products." The minutes also stated "We will have pt and family evaluations of hand washing periodically." Following this meeting, no data was documented regarding hand hygiene. Subsequent Medical Staff meeting minutes did not discuss specific hand hygiene data nor did they state if accessibility to hand cleaning products had been increased.</p> <p>The Administrator was interviewed on 1/26/15 beginning at 3:00 PM. He stated no hand hygiene data had been gathered following the 3/04/14 meeting. He confirmed Medical Staff meeting minutes did not mention the lack of data or recommend changes to the QAPI program.</p> <p>c. The Medical Staff meeting minutes, dated 3/04/14, told physicians "Remember to be detail oriented especially on your H&Ps. Especially new EMR templates. Often the location of the surgery, surgical plan, and review of systems are incomplete." The minutes did not specify action that would be taken to correct the deficient practice.</p> <p>No data related to the completeness of physician documentation was collected. The incomplete H&Ps were not mentioned in subsequent Medical Staff meeting minutes.</p>	Q 084			

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Q 084	<p>Continued From page 26</p> <p>The Administrator was interviewed on 1/26/15 beginning at 3:00 PM. He stated no data related to physician documentation had been collected. He confirmed physician documentation was not followed up on in Medical Staff meeting minutes.</p> <p>d. Medical Staff meeting minutes, dated 7/8/14, documented a wrong-site toe surgery. The minutes stated "All appropriate safety measures were done but the surgery was started on the wrong toe." The minutes stated "We discussed this incident in detail. We will use the checklist as designed. The doctors will be the lead on our safety efforts. We clarified the process of the safety program and we will make efforts to work as a team."</p> <p>However, additional information, including a causal analysis of the incident was documented. A monitoring plan, which included measurable goals, data collection and analysis, to ensure the discussions with staff were effective was not documented in subsequent meeting minutes.</p> <p>The Administrator was interviewed on 1/26/15 beginning at 3:00 PM. He stated a causal analysis of the incident was not conducted. He stated no data was gathered following the incident and no follow up actions were documented in Medical Staff meeting minutes.</p> <p>The Governing Board did not ensure the incident was thoroughly investigated and action was taken to prevent further incidents.</p> <p>e. Medical Staff meeting minutes, dated 7/8/14, also documented a patient had presented for multiple procedures on his foot. The minutes</p>	Q 084			

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Q 084	<p>Continued From page 27</p> <p>documented it was discovered that a procedure had not been completed. The patient had an unplanned return to the operating room and the final procedure was performed. The minutes stated "We reviewed this case in detail. The governing board agreed that we all will make a greater effort to support our culture of safety. This incident could have potentially been avoided if we follow our safety program."</p> <p>A causal analysis of the incident was not documented. A monitoring plan, which included measurable goals, data collection and analysis, to ensure the discussions with staff were effective was not documented in subsequent meeting minutes.</p> <p>The Administrator was interviewed on 1/26/15 beginning at 3:00 PM. He stated a causal analysis of the incident was not conducted. He stated no data was gathered following the incident and no follow up actions to indicate staff were following the safety program were documented in Medical Staff meeting minutes.</p> <p>The Governing Board did not ensure the incident was thoroughly investigated and action was taken to prevent further incidents.</p> <p>3. The ASC did not have documentation of the amount of time and resources devoted to the QAPI program.</p> <p>The policy "Quality Improvement Plan Statement of Philosophy," dated 8/20/11, stated the activities central to quality improvement would be carried out by a "Quality Improvement Committee." The policy stated the Quality Improvement Committee included the Administrator and all clinical staff.</p>	Q 084			

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Q 084	<p>Continued From page 28</p> <p>The policy stated, "The Quality Improvement Committee will be responsible for ensuring appropriate review and follow up of the ongoing activities pertaining to patient care." The policy did not address the role of physicians in the facilities QAPI program.</p> <p>The Administrator was interviewed on 1/26/15 beginning at 3:00 PM. He stated the Quality Improvement Committee consisted of the entire nursing staff, including OR technicians, and occasionally a CRNA. He stated the role of physicians in the QAPI process was not defined. He also stated specific roles of nursing staff was not defined.</p> <p>The ASC did not define the duties of persons responsible for its QAPI program.</p> <p>The Administrator was interviewed on 1/26/15 beginning at 3:00 PM. He stated he was the main person conducting QAPI activities. He stated he did not know how many hours per month he spent on these activities. He stated he did not know how much time or other resources all staff spent on on QAPI activities. He stated this was not monitored.</p> <p>A physician member of the Governing Board and former Medical Director was interviewed on 1/30/14 beginning at 11:00 AM. He stated he was not familiar with the specifics of the QAPI program. He stated he did not know if data had been collected on the safe surgery program in the past year. He stated he did not know if staff time and resources were tracked related to the QAPI program.</p> <p>The Governing Board did not monitor resources</p>	Q 084			

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Q 084	Continued From page 29 utilized for its QAPI program.	Q 084			
Q 181	4. Refer to Q81 as it relates to the ASC's failure to ensure its quality program was defined and direction was provided to staff responsible for the program. 416.48(a) ADMINISTRATION OF DRUGS Drugs must be prepared and administered according to established policies and acceptable standards of practice. This STANDARD is not met as evidenced by: Based on observation, record review, staff interviews, and review of policies, it was determined the ASC failed to ensure medications were administered in accordance with acceptable standards of practice. The ASC failed to ensure medications were administered as ordered by medical staff for 2 of 3 pediatric dental patients (#3 and #10) whose medical records were reviewed and the ASC failed to ensure multi-dose medications were properly labeled and discarded when outdated. Failure to adhere to acceptable standards of practice placed all patients who received medications at risk of medication errors and/or adverse drug reactions. Findings include: 1. Medication administration was not properly documented and did not follow provider orders, as follows: a. Patient #3 was a 3 year old male admitted to the ASC on 11/14/14, for dental restoration and possible extractions.	Q 181	Policy # 3035 Use of Multidose vials. Disposal of expired MDV will be reviewed with staff at staff meeting. We will perform monthly audits to ensure all expired medications are properly discarded. Staff meeting is scheduled for 3/3/15. Staff signed a memo of understanding by 2/26/15. It was filed in their employee files		

Supervised and Completed
by Shene Ricks Admin.

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Q 181	<p>Continued From page 30</p> <p>Patient #3's record included a form titled "Physician's Pre-Op Orders" signed by the dentist on 11/11/14. The section of the form titled "Pre-Op Medications" contained an order for intravenous fluids. There were no orders for additional medications. The form included the statement "Orders noted by," which was signed by the RN and dated 11/14/14.</p> <p>Patient #3's record included a form titled "Admission Assessment" dated 11/14/14, and signed by the RN. The form documented Patient #3 was given Versed (a sedative) 6 mg and Tylenol 240 mg pre-operatively. There was no documentation of the time the medications were administered. Additionally, there were no orders signed by a provider for Versed or Tylenol.</p> <p>The Administrator was interviewed on 1/26/15 at 11:00 AM. He reviewed Patient #3's record and confirmed the administration time was not documented and the medications were administered without an order.</p> <p>b. Patient #10 was a 9 year old female admitted to the ASC on 11/03/14, for dental restoration and possible extractions.</p> <p>Patient #10's record included a form titled "Physician's Pre-Op Orders" signed by the dentist on 10/22/14. The section of the form titled "Pre-Op Medications" contained an order for intravenous fluids. There were no orders for additional medications. The form included the statement "Orders noted by," which was signed by the RN and dated 11/03/14.</p> <p>Patient #10's record included a form titled</p>	Q 181	<p><i>Medication Administration # 3029 "Medications will be administered only upon orders by approved personnel. Medications will only be given after order is given. Question with Pediatric dentistry patients and documentation. We will ensure that medications are given only after order is given and documented. This will be reviewed in a 3/3/15 staff meeting. We will be auditing charts to ensure this is being completed. It will be an area of focus on our monthly chart reviews.</i></p>		

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Q 181	<p>Continued From page 31</p> <p>"Admission Assessment" dated 11/03/14, and signed by the RN. The form documented Patient #10 was given Versed 10 mg and Tylenol at 9:25 AM. There was no documentation of the dosage of Tylenol administered. Additionally, there were no orders from a provider for Versed or Tylenol.</p> <p>The Administrator was interviewed on 1/26/15 at 10:55 AM. He reviewed Patient #10's record and confirmed the dosage of Tylenol was not documented and the medications were administered without an order.</p> <p>Medications were administered to patients without provider orders. Additionally, the medication administration was not thoroughly documented.</p> <p>2. A policy titled "INJECTABLE MEDICATION USAGE" undated, stated "Vials must be dated when opened and discarded if not used in 28 days or upon manufactures expiration date, whichever comes first."</p> <p>During an interview on 1/26/15 beginning at 4:00 PM, the Administrator stated when multi-dose vials were opened they were marked with the date they were to be discarded, 28 days after they were opened.</p> <p>However, the policy was not implemented as follows:</p> <p>a. A surgical procedure was observed in OR #1 on 1/26/15 beginning at 11:30 AM. A medication cabinet was observed to contain a vial of Bupivacaine 0.5% (a local anesthetic drug) with an expiration date of 1/24/15.</p>	Q 181	See pg 30.		

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Q 181	<p>Continued From page 32</p> <p>Another surgical procedure was observed in OR #2 on 1/27/15 beginning at 1:00 PM. Prior to the start of the surgery, multi-dose medications and syringes were observed on a counter surface in the OR, in preparation for administration to the patient. A 50 ml vial of Lidocaine 2%, 20 mg/ml, vial had an expiration date of 1/21/15.</p> <p>During an interview on 1/28/15 at 10:54 AM, the RN confirmed the 2 medication in the OR rooms were expired and should have been discarded.</p> <p>The ASC failed to discard medications in the OR rooms on the date of expiration.</p> <p>b. A medication refrigerator in the ASC contained multi-dose injectable medication vials. A vial of Humulin Regular U100 Insulin was noted to be opened, however, the vial was not marked to indicate the date it should be discarded. A bottle of Proparacaine Hydrochloride ophthalmic solution was noted to be opened, and a handwritten date indicated it was to be discarded on 2/07/16, 13 months after it was opened, rather than 28 days as directed in the facility's policy.</p> <p>During an interview on 1/27/15 at 8:35 AM, the RN examined the medications. She confirmed the insulin had been opened and was not dated to indicate the discard date. She confirmed the ophthalmic solution should be discarded 28 days after it was opened, and stated the discard date was written in error.</p> <p>The ASC failed to accurately label multi-dose medications to ensure they were not administered after the expiration date.</p>	Q 181	See Pg 30	
Q 202	416.49(b)(1) RADIOLOGIC SERVICES	Q 202		

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O 202	<p>Continued From page 33</p> <p>(1) Radiologic services may only be provided when integral to procedures offered by the ASC...</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview, and review of policies, it was determined the ASC failed to ensure proper safety precautions (adequate shielding devices) against radiation hazards for patients and staff were used for 1 of 1 patient (#20) observed, who required radiation services. This had the potential risk of exposure of ionizing radiation to patients and staff. Findings include:</p> <p>The ASC's Radiation Control policy, dated 4/16/13, stated "Procedure: the following protective measures are available for staff and/or patient use: shielding devices, including lead aprons and gonadal shields."</p> <p>However, during an observation of Patient #20's surgery, on 12/27/15 beginning at approximately 1:30 PM the surgeon ordered an x-ray of her right foot. The surgical technician positioned the C-Arm (x-ray machine) near Patient #20's right foot. The surgeon then positioned Patient #20's right foot for x-ray. Once her foot was in place, the surgical technician took x-rays. The surgeon and surgical technician were in close proximity of the foot being x-rayed. The surgeon, surgical technician and Patient #20 were not protected with shielding devices.</p> <p>In an interview at 1:15 PM on 2/02/15, the Administrator confirmed podiatry patients, and OR staff do not wear protective shielding devices when conducting x-rays.</p> <p>The ASC Administrator presented a letter from</p>	O 202	<p><i>Radiation Control Policy was reviewed updated and approved by The Radiation Safety Officer and Medical Director.</i></p> <p><i>Due to the nature of our radiation devices we use at MSG we do not require staff to wear radiation protective apparel. All will observe that adequate protective apparel is available and staff is encouraged to use it.</i></p> <p><i>The standard of care in the Treasure Valley does not require and intention to wear protective apparel when using a mini C-arm.</i></p> <p><i>This is true at [redacted] and [redacted]</i></p>	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/02/2015
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NAME OF PROVIDER OR SUPPLIER MILLENNIUM SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1828 SOUTH MILLENNIUM WAY, SUITE 100 MERIDIAN, ID 83642
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Q 202 Continued From page 34
the Idaho Department of Health and Welfare Radiological Health Program, dated 4/11/13. The letter stated the ASC was granted a waiver of personnel monitoring during the operation of their x-ray system. The waiver relieved the ASC of the requirement to maintain personal radiation monitoring devices for all employees who may be exposed to radiation due to working near radiation sources. Additionally, the letter stated, "It should be noted that radiation safety should always be used during exposures and no one should be in the area of the primary beam except for the part being radiographed. Lead aprons should be worn during the procedure as well."

Q 202

Q 204 The ASC failed to ensure shielding devices were used to protect Patient #20 and OR staff when conducting x-rays.

Q 204

416.49(b)(2) RADIOLOGIC SERVICES

(2) If radiologic services are utilized, the governing body must appoint an individual qualified in accordance with State law and ASC policies who is responsible for assuring all radiologic services are provided in accordance with the requirements of this section.

This STANDARD is not met as evidenced by: Based on staff interview, and review of radiology policy and procedure documentation, it was determined the ASC's Governing Body failed to appoint a qualified individual to assume responsibility for all radiological services. This had the potential to result in improper use of equipment and risk of over-exposure of radiation to patients and staff. Findings include:

The ASC's Radiation Control policy, dated

2/10/2015 [REDACTED]
DPM was assigned the duty of Radiology Safety Officer at Millennium Surgery. His Educational training in Podiatry qualifies him to fill this position. He will at least annually Review Radiological Services provided at MSC.

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Q 204	Continued From page 35 4/16/13, stated "To ensure that diagnostic image services meet the needs of the patients and are provided in accordance [sic] with ethical and professional practices and legal requirements." However, the policy did not include information regarding the appointment of a person responsible for the facility's radiological services. The Administrator was interviewed on 2/02/15 beginning at 1:20 PM. He confirmed the ASC excluded an appointed individual responsible for all radiological services.	Q 204			
Q 240	The ASC failed to ensure radiological services had a responsible individual. 416.51 INFECTION CONTROL The ASC must maintain an infection control program that seeks to minimize infections and communicable diseases. This CONDITION is not met as evidenced by: Based on observation, ASC policy review, and staff interview, it was determined the facility failed to ensure a comprehensive infection control program was developed, implemented and monitored for staff and all patients receiving care at the facility. This resulted in the inability of the facility to minimize infections and communicable diseases. Findings include:	Q 240	See Q 241		
Q 241	1. Refer to Q242 as it relates to the facility's failure to ensure an ongoing program to prevent, control, and investigate infections and communicable diseases was maintained. 416.51(a) SANITARY ENVIRONMENT The ASC must provide a functional and sanitary	Q 241			

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Q 241	<p>Continued From page 36 environment for the provision of surgical services by adhering to professionally acceptable standards of practice.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain a sanitary and functional environment. This failure resulted in infection control breaches that directly impacted 2 of 2 patients (#19 and #20) who were observed during surgery and discharge from the facility, and had the potential to impact all patients receiving care at the facility. This resulted the potential for patients to experience negative health outcomes due to infections. Findings include:</p> <p>1. Patient #20 was a 78 year old female admitted to the ASC on 1/27/15, for surgery to her right foot.</p> <p>Patient #20's surgical procedure was observed in OR #2 on 1/27/15 beginning at 1:00 PM. The surgery included an amputation of her right second toe. The surgeon placed the amputated digit on the surgical field near Patient #20's foot.</p> <p>Following the surgical procedure Patient #20 was moved from the OR table to a bed for transport to the PACU. The amputated digit was observed to be on a disposable pad on the OR table.</p> <p>After Patient #20 was transported to the PACU, the turnover of the OR by the surgical technician was observed. The surgical technician was observed to gather up the disposable pad, which included the amputated digit, and dispose of it in the trash receptacle in the OR.</p>	Q 241	<p>① All clinical Staff member in question reviewed the the policies on Biohazard Waste - she wrote a statement of understanding, and it is in her personnel file. These policies will be reviewed as Education during our 3/3/15 staff meetings supervised and completed by Shane Rizks</p>		

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Q 241	<p>Continued From page 37</p> <p>The surgical technician was interviewed on 1/27/15 at approximately 2:30 PM. She confirmed the amputated digit had been placed in the trash receptacle and stated it should have been placed in biohazard waste. She stated she would retrieve it and put it in the biohazard waste receptacle.</p> <p>The Administrator was interviewed on 2/02/15 beginning at 1:00 PM. He confirmed the amputated digit should have been placed in the biohazard waste receptacle.</p> <p>The ASC failed to properly dispose of biohazard waste.</p> <p>2. The ASC had a wheelchair to transport patients to their cars following discharge from the facility. On 1/26/15 and 1/30/15, Patients #19 and #20 were observed in the wheelchair for transport to the parking lot by an RN. The RN was observed to bring the wheelchair back into the facility. The wheelchair was not cleaned or sanitized following patient use.</p> <p>During an interview on 2/02/15 beginning at 1:00 PM, the Administrator stated the ASC did not have a protocol in place for cleaning the wheelchair. He was unable to state how often the wheelchair was sanitized.</p> <p>The ASC failed to sanitize the wheelchair after patient use.</p> <p>3. The ASC's 2014 Autoclave Logs were reviewed and documented the following regarding the utilization of flash sterilization:</p>	Q 241	<p>② Staff were educated on the need for overall cleanliness. resolution to reminding staff to wipe down the wheel chair has been done. see Solution Sani Wipe are now attached to the wheel chair as a reminder. [redacted] A RN will spot check and report compliance or non compliance.</p>		

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Q 241	<p>Continued From page 38</p> <p>a. The Autoclave Logs documented flash sterilization was utilized for dental no fewer than 278 times over 52 different treatment dates, and did not identify what instruments were flashed. Examples included, but were not limited to, the following:</p> <ul style="list-style-type: none"> - 2/7/14 at 8:19 AM, 9:01 AM, 9:37 AM, 10:57 AM, 11:37 AM 1:30 PM and 1:12 PM - 4/11/14 at 8:19 AM, 8:47 AM, 9:47 AM, 11:06 AM, 11:41 AM, 12:28 PM, 1:09 PM and 1:38 PM - 6/30/14 at 8:03 AM, 8:47 AM, 9:30 AM, 10:30 AM, 11:16 AM, 12:22 PM and 1:11 PM - 8/22/14 at 8:49 AM, 10:21 AM, 10:58 AM, 11:33 AM, 12:19 PM, 1:41 PM and 3:23 PM - 10/6/14 at 8:21 AM, 9:03 AM, 9:24 AM, 9:47 AM, 10:32 AM, 11:12 AM and 11:57 AM - 12/8/14 at 8:24 AM, 9:12 AM, 10:05 AM, 11:01 AM, 11:45 AM, 12:35 PM and 1:11 PM <p>b. The Autoclave Logs documented flash sterilization was utilized for blue monopoles, no fewer than 24 times over 18 different treatment dates. Examples included, but were not limited to, the following:</p> <ul style="list-style-type: none"> - 2/12/14 at 10:12 AM - 3/20/14 at 9:23 AM, 11:44 AM and 1:01 PM - 6/2/14 at 1:20 PM - 1/20/15 at 10:09 AM 	Q 241	<p>(3) Immediate use sterilization policy was reviewed with the dental staff in question. They were educated on the proper cycle to run their instruments. The dental staff signed the policy as proof of understanding.</p> <p>(b) msc has developed a tracking method of Flash Cycles. If an instrument is flashed more than 3 times in a month - A Report to the QAPI Committee will be given to the Administrator for Review. If time sensitive the issue will be resolved immediately by the Admin and Medical Director. QAPI committee will review the findings and</p>	
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determine a resolution. Information will be included in the QAPI Report to the Governing Board.

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Q 241	<p>Continued From page 39</p> <p>c. The Autoclave Logs documented flash sterilization was utilized for instruments. Examples included, but were not limited to, the following:</p> <ul style="list-style-type: none"> - 2/6/14 at 3:54 PM: Mayos/Rasp - 3/18/14 at 12:53 PM: Osteotomy guide, distractor, and curette - 4/7/14 at 9:40 AM: Lapidus instrument - 1/7/14 at 12:35 PM: Joseph rasp - 1/7/14 at 3:50 PM: Saw guide - 1/9/14 at 3:47 PM: Curette, long - 1/21/14 at 9:20 AM: Curette - 4/4/14 at 1:18 PM: Enucleation retractor - 1/13/15 at 8:30 AM: Shaver - 1/13/15 at 9:00 AM: Sinus instrument, scopes <p>The 2010 Perioperative Standards and Recommended Practices stated "Flash sterilization should be used only when there is insufficient time to process by the preferred wrapped or container method. Flash sterilization should not be used as a substitute for sufficient instrument inventory."</p> <p>The ASC's Flash Sterilization policy, revised 3/7/13, stated, "Flash sterilization is to be avoided if possible. Not having enough instruments is not a valid reason for flash sterilization."</p>	Q 241			

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Q 241	Continued From page 40 A CST was interviewed on 12/28/15 beginning at 2:30 PM. She confirmed dental flashed items were not identified on the Autoclave Logs, and the 3 minute unwrapped method. She stated the overall use of flash sterilization was mostly due to a shortage of instruments.	Q 241	Correction not due to lack of instruments it was due to lack of communication of the correct cycle to run. Dental staff were educated on the proper cycle to run. Flash policy was reviewed with them. Signed copy of policy is in [redacted] file for proof of education performed by Shane Poles	
Q 242	416.51(b) INFECTION CONTROL PROGRAM The ASC must maintain an ongoing program designed to prevent, control, and investigate infections and communicable diseases. In addition, the infection control and prevent program must include documentation that the ASC has considered, selected, and implemented nationally recognized infection control guidelines. This STANDARD is not met as evidenced by: Based on policy review and staff interview, it was determined the ASC failed to ensure an ongoing infection control program was maintained for patients and staff at the facility. This resulted in the facility's inability to minimize patients' risks of infection. Findings include: 1. A review of the ASC's Infection Control policy binder did not include a policy related to an Infection Prevention program. Additionally, the ASC did not document plans related to the control of infectious disease hazards, preventing surgical site infections, or document a plan to follow AORN nationally recognized guidelines. The Administrator was interviewed on 1/26/15 at	Q 242	242 Infection control program policy in infection control P&P binder The program has a lot of scattered information this will be corrected and will be in a more concise organized format	

Annual Planning will be performed
Goals and Tracking methods will be developed
This will be part of the QAPI Committee

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Q 242	Continued From page 41 2:30 PM. He confirmed the ASC did not have a policy defining an infection prevention program, plan, and goals or tracking methods for the year 2015. The facility failed to ensure an ongoing infection control program based on nationally recognized standards was maintained. 2. Refer to Q241 as it relates to the ASC's failure to ensure patients were provided with a functional and sanitary environment in accordance with acceptable standards of practice. 3. Refer to Q244 as it relates to the ASC's failure to ensure infection control was addressed as an integral part of the ASC's QAPI program. 4. Refer to Q245 as it relates to providing a plan of action for preventing, identifying and managing infections, and immediately implementing corrective and preventive measures that result in improvement.	Q 242	Program. See Q 080 Q 81, Q82, Q84		
Q 244	416.51(b)(2) INFECTION CONTROL PROGRAM - QAPI [The program is -] An integral part of the ASC's quality assessment and performance improvement program This STANDARD is not met as evidenced by: Based on staff interview and review of facility policies and records, it was determined the ASC failed to ensure the infection control program was incorporated into the facility QAPI program for all patients receiving services at the ASC. This	Q 244	See Q 80, Q 81, Q 82, Q 84		

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Q 244	<p>Continued From page 42</p> <p>resulted in the inability of the ASC to evaluate its infection control processes necessary for improving the quality of patient care. The findings include:</p> <p>1. The facility's updated "Quality Improvement Policies and Procedures" were reviewed. The policy stated in the "Program" section that program activities were to be completed which included the following related to infection control:</p> <p>a. All cases of post-operative infections were to be reviewed via post-operative telephone interviews, unplanned admissions, and returned infection control reports. Medical Staff meeting minutes date 3/4/14, 7/8/14, 10/14/14 and 12/9/14 were reviewed and stated the following:</p> <p>3/4/14, 10/14/14 and 12/9/14: The minutes did not include information regarding postoperative infections.</p> <p>7/8/14: "Infection Control and Postoperative complications" minutes stated a patient had presented for partial amputation with an infected toe and the infection remained postoperatively. The minutes further stated a second patient had a minor case of cellulitis and slow healing. The minutes documented both patients were treated and the infections resolved. The minutes stated "Reviewed No [sic] action required."</p> <p>Additional information, including a causal analysis, regarding the infections was not present and documentation of how it was determined no further action was warranted related to the facility's infection control program could not be found.</p>	Q 244		

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Q 244	<p>Continued From page 43</p> <p>The meeting minutes did not include quantifiable data which allowed the facility to measure compliance (e.g. number of post-operative infections or unplanned admissions reported out of total number of procedures performed, and/or number of infection control reports indicating infection out of total number of reports returned, etc.).</p> <p>The Administrator was interviewed on 1/26/15 beginning at 3:00 PM. He confirmed the meeting minutes did not include quantifiable data.</p> <p>d. Medical/surgical equipment currently used or proposed for use at the facility was to be reviewed via the facility's equipment management program and biomedical checks.</p> <p>Medical Staff meeting minutes date 3/4/14, 7/8/14, 10/14/14 and 12/9/14 were reviewed. The meeting minutes documented equipment, such as C-arms, a large autoclave, etc. that were under review for purchase. However, quantifiable data related to equipment maintenance and biomedical checks was not present.</p> <p>The Administrator was interviewed on 1/26/15 beginning at 3:00 PM. He confirmed the meeting minutes did not include quantifiable data.</p> <p>e. Quality indicator findings were to be reviewed, with focus on at least one indicator per department until the expected outcome is reached and to determine if corrective action of recurrent problems was adequate. The corresponding "Policy of Quality Indicators" section of the policy stated the "Quality Indicator Sheet (Incident Report Form)" was to be completed to "...track the frequency of deviation</p>	Q 244		
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Q 244	<p>Continued From page 44 from the standards of care, therefore, allowing corrective actions to be taken when deemed necessary."</p> <p>The Administrator was interviewed on 1/26/15 beginning at 3:00 PM. He confirmed the policy did not include documentation of measurable baseline data or a measurable goal</p> <p>f. The policy stated incident report forms were to be "...filled out in the appropriate area of the occurrence. At the end of the day, during the daily chart reviews, the QI forms are to be collected and given to the Administrator. The indicators are tallied and entered into a log." The policy did not include specify a process to investigate the incidents to identify causes and potential actions to prevent future incidents.</p> <p>Additionally, the policy "INCIDENT REPORTING," dated 7/01/08, included a list of adverse patient events that staff needed to report. The policy did not address what if any type of investigation of the events would be conducted following a report. As a result, the ASC did not examine the causes of adverse patient events and implement improvements. Nor did the ASC track adverse patient events.</p> <p>Medical Staff meeting minutes date 3/4/14, 7/8/14, 10/14/14 and 12/9/14 were reviewed and included the following related to infection control:</p> <p>- The 7/8/14 minutes documented staff had been "poked with a keith needle," another staff had been "poked with the cautery tip" and a third staff had been burnt/poked with a cautery needle. The minutes stated "Reviewed and reviewed [sic] the blood borne pathogen policy. Slow down and be</p>	Q 244			

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Q 244	Continued From page 45 safe. However, additional information, including a causal analysis, regarding the incidents was not present and documentation of a monitoring plan, which included measurable goals, data collection and analysis, to ensure the discussions with staff was effective was not documented in the meeting minutes. 2. Four "MSC Staff Meeting" minutes were documented in 2014. The MSC staff constituted the Quality Improvement Committee. Meeting minutes were dated 3/04/14, 7/14/14, 10/16/14, and 12/15/14. Meeting minutes included the following QAPI items related to infection control: a. A "HRET Patient Safety Program," dated 9/19/13, stated the program goals were 1) to reduce surgical site infections and surgical complications and 2) to improve safety culture as evidenced by improved teamwork, and communication by employing a surgical safety checklist. The program did not state specific quality indicators to be measured, a plan explaining the ASC's role in the program was not documented, and the start of the Safety program was not documented. Additionally, "MSC Staff Meeting" minutes for dated 3/04/14, 7/14/14, 10/16/14 and 12/15/14 were reviewed and stated the following: 3/04/14: The minutes did not mention the Patient Safety Program. 7/14/14: The minutes stated the program was	Q 244		

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Q 244	<p>Continued From page 46</p> <p>going "very well." No data was documented. The minutes stated "We will review data and overall morale to identify room for improvement." The minutes did not state what data would be reviewed. Minutes stated staff was "very happy" but did not include any data or state how this was determined.</p> <p>10/18/14 and 12/15/14: The minutes for both dates included the same information. Both sets of minutes stated the ASC's owners met on December 9 and discussed the safety program. It was not clear what the date referred to. Both sets of minutes stated "Make sure the checks are being done the right way." The minutes did not state what the right way was or how this would be measured. Further, both sets of minutes stated morale was "high" but did not include any data or state how this was determined.</p> <p>The Administrator was interviewed on 1/26/15 beginning at 3:00 PM. He stated the "MSC Staff Meeting" minutes did not included data collected by the program.</p> <p>b. "MSC Staff Meeting" minutes for 3/04/14 stated the handwashing policy was reviewed. The minutes stated the observation process was also reviewed. The minutes stated the ASC would "...have [patient] and family evaluations of hand washing periodically." The minutes did not define issues surrounding handwashing or a specific plan to measure hand washing at the facility. "MSC Staff Meeting" minutes for 3/04/14 stated "CDC hand hygiene policy and protocol reviewed. We will have pt and family evaluations of hand washing periodically. We reviewed the hand hygiene policy. We reviewed the observation process. We will increase access</p>	Q 244		
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Q 244	Continued From page 47 with Avagard D [a hand antiseptic] in critical areas. We will begin observations after Avagard D is in place and all staff and doctors have had a chance to be educated on the policy and our observational tools. We will ramp up our measurement. We feel like the added access and emphasis on hand hygiene has help[ed] we need to measure to see where we are at." A plan to monitor hand hygiene, including quality indicators and directions to staff, was not documented. No hand hygiene data was documented between 1/01/14 and 1/26/15. The Administrator was interviewed on 1/26/15 beginning at 2:35 PM. He stated no hand hygiene data had been gathered between 1/01/14 and 1/26/15. The Administrator was interviewed on 1/26/15 at 2:20 PM. He confirmed the infection control program was not incorporated in the QAPI program. He stated the ASC had not developed a QAPI plan for monitoring purposes. He confirmed there was no documentation which demonstrated quality reports to include infection control. The ASC failed to ensure infection control was incorporated into the facility's QAPI program.	Q 244			
Q 245	416.51(b)(3) INFECTION CONTROL PROGRAM The program is - Responsible for providing a plan of action for preventing, identifying, and managing infections and communicable diseases and for immediately	Q 245			

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Q 245	Continued From page 48 implementing corrective and preventive measures that result in improvement. This STANDARD is not met as evidenced by: Based on observation, interview, review of policies, and infection control documentation, it was determined the facility failed to ensure the infection control program established a plan of action for preventing and identifying communicable diseases. This failure had the potential to impact all patients receiving care at the facility. This resulted in the potential for all patients to experience preventable infections. Findings include: The ASC's Infection Prevention policy binder did not include a written Infection Control program for the ASC, or a plan of action to implement surveillance's for controlling of infectious disease hazards and preventing surgical site infections. The Administrator of the ASC was interviewed on 12/26/15 at 2:20 PM. He confirmed there is no defined infection control program, or an infection control plan of action to support a program at the ASC. The ASC did not ensure an Infection Control program was implemented to include a plan of action for preventing, identifying, actively surveillance, and implementing corrective measures that would result in improvement.	Q 245			
Q 267	416.52(c)(3) DISCHARGE WITH RESPONSIBLE ADULT [The ASC must -] Ensure all patients are discharged in the	Q 267			

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Q 267	<p>Continued From page 49</p> <p>company of a responsible adult except those patients exempted by the attending physician.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview, and review of records and policies, it was determined the ASC failed to ensure patients were discharged post-procedure in the company of responsible adults for 3 of 20 patients (#1, #8, and #9) whose records were reviewed. This resulted in an increased potential for patients to suffer adverse events following their procedures. Findings include:</p> <p>1. A policy titled "DISCHARGE CRITERIA - SURGICAL PATIENTS" revised 7/08/11, and approved by the Administrator, stated, "The nurse will ensure that all patients will have a responsible adult accompany them to their home at the time of discharge."</p> <p>The policy was not observed to be implemented as follows:</p> <p>a. Patient #1 was a 74 year old male admitted to the ASC on 9/23/14 for an amputation of the left second toe.</p> <p>Patient #1's medical record documented he was discharged in stable condition on 9/23/14 at 10:41 AM. However, his record did not document he was accompanied by a responsible adult at the time of discharge.</p> <p>During an interview on 1/27/15 at 10:55 AM, the RN reviewed Patient #1's record and confirmed there was no documentation to indicate he was accompanied by a responsible adult.</p>	Q 267	<p>Policy 2611 Discharge Criteria was reviewed by the Staff the information was a result in miss communication of Charting. All RN staff reviewed the Policy. They all signed a memo covering updates of improved wheel chair sanitation, Glucometer and Nerve Stimulator and ultrasound machine. PACU Pain Assessment documentation.</p>	

This will be placed in the Staff Files for proof of Education. Supervised by Shane Ricks Administrator

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Q 267	<p>Continued From page 50</p> <p>b. Patient #8 was a 45 year old female admitted to the ASC on 9/05/14 for an EGD.</p> <p>Patient #8's medical record documented she was discharged to her home on 9/05/14 at 10:22 AM. However, her record did not document she was accompanied by a responsible adult at the time of discharge.</p> <p>During an interview on 1/27/15 at 10:55 AM, the RN reviewed Patient #8's record and confirmed there was no documentation to indicate she was accompanied by a responsible adult.</p> <p>c. Patient #9 was a 36 year old male admitted to the ASC on 9/16/14 for an open reduction and internal fixation of the second metatarsal (bone of the mid foot) on the right side.</p> <p>Patient #9's medical record documented he was discharged in stable condition on 9/16/14 at 5:00 PM. However, his record did not document he was accompanied by a responsible adult at the time of discharge.</p> <p>During an interview on 1/27/15 at 10:55 AM, the RN reviewed Patient #9's record and confirmed there was no documentation to indicate he was accompanied by a responsible adult.</p> <p>The ASC failed to ensure all patients were discharged in the company of a responsible adult.</p>	Q 267		
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*Completed and Returned
on Friday Feb 27, 2015*

Shane P. Ricks USC Admin