

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
Western Division of Survey and Certification  
Seattle Regional Office  
701 Fifth Avenue, Suite 1600  
Seattle, WA 98104



**IMPORTANT NOTICE – PLEASE READ CAREFULLY**

April 8, 2015

Shane Ricks, Administrator  
Millenium Surgery Center  
1828 South Millenium Way, Suite 100  
Meridian, Idaho 83642

CMS Provider Number: 13C0001011

**Re: Notice of Enforcement Action  
Recertification Survey completed on February 2, 2015  
Revisit conducted on March 18, 2015  
Conditions of Coverage Not Met  
Placed on 90-day Termination Track**

Dear Ms. Ricks:

After careful review of the facts, the Centers for Medicare and Medicaid Services (CMS) has determined that Millenium Surgery Center no longer meets the requirements for participation as a provider of ASC services in the Medicare program established under Title XVIII of the Social Security Act. The center is now placed on a **90-day termination track** based on the completion date of the survey. This letter serves as notification that effective **May 3, 2015**, the Secretary of the Department of Health and Human Services intends to terminate its provider agreement with Millenium Surgery Center.

**BACKGROUND**

To participate as a provider of ASC services in the Medicare and Medicaid Programs, a provider must meet all the Conditions for Coverage (CfC) established by the Secretary of Health and Human Services. When a provider is found to be non-compliant with the Medicare Conditions of Coverage for ASC, the provider no longer meets the requirements for participation in the Medicare program. The Social Security Act Section 1866(b) authorizes the Secretary to terminate a provider's Medicare provider agreement if the provider no longer meets the regulatory requirements for ASC. 42 CFR § 489.53 authorizes the Centers for Medicare and Medicaid Services to enforce this termination action.

On February 2, 2015, the Idaho Bureau of Facility Standards (State survey agency) completed a recertification survey at Millenium Surgery Center. The survey found deficiencies in the following Medicare Conditions for Coverage . CMS agrees with the State survey agency that these conditions were not met:

Page 3 – Ms. Ricks

- Address process improvement and demonstrate how the hospital has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice.
- A completion date for correction of each deficiency cited;
- The plan must include the individual responsible for implementing the acceptable plan of correction with signature and title.

CMS strongly encourages that your plan of correction be fully implemented by no later than **April 15, 2015**. Please send your plan of correction to the State survey agency and to CMS.

**DHHS Center for Medicare and Medicaid Services  
Division of Survey, Certification & Enforcement – Region 10  
Attention: Fe Yamada  
701 Fifth Avenue, Suite 1600, MSRX-400  
Seattle, WA 98104**

If you have any questions, please contact Fe Yamada of my staff at (206) 615-2313 or by email at [marie.yamada@cms.hhs.gov](mailto:marie.yamada@cms.hhs.gov).

Sincerely,



Patrick Thrift  
Manager, Seattle Regional office  
Division of Survey, Certification & Enforcement

Enclosure: CMS 2567 Summary of Deficiencies

cc: Idaho Bureau of Facility Standards



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

C.L. 'BUTCH' OTTER - Governor  
RICHARD M. ARMSTRONG - Director

DEBBY RANSOM, R.N., R.H.I.T. - Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: (208) 334-6626  
FAX: (208) 364-1888  
E-mail: [fst@dhw.idaho.gov](mailto:fst@dhw.idaho.gov)

**CERTIFIED MAIL: 7000 1670 0011 3315 1606**

April 2, 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 revisit on March 18, 2015 by our staff, we have determined that, Millennium Surgery Center continues to be out of compliance with the Medicare Conditions of Participation of Governing Body and Management (42 CFR 416.41) and Patient Rights (42 CFR 416.50).

The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). Also enclosed is your copy of a Post-Certification Revisit Report (CMS-2567B), listing deficiencies that have been corrected.

In our letter to you dated February 13, 2015, we stated: "failure to correct the deficiencies and achieve compliance will result in our recommending that the Centers for Medicare and Medicaid Services (CMS) Region X Office, Seattle, Washington, terminate your approval to participate in the Medicare program."

Because of your failure to correct, we have made that recommendation. CMS will be in contact with you regarding the procedures, timelines, and appeal rights associated with this recommendation that must be followed.

Sincerely,

NICOLE WISENOR  
Co-Supervisor  
Non-Long Term Care

NW/pmt

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

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April 13, 2015

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

CMS Provider Number: 13C0001011

**Re: Plan of Correction Acceptable**

Dear Ms. Ricks:

After careful review of the plan of correction received in our office by email on April 10, 2015 and upon recommendation by the State agency, CMS has determined that it is acceptable. This will serve as your credible allegation of compliance. You stated in your plan that you will implement corrective actions at the specified timeframe. CMS will suspend its termination action pending results of a follow up survey to be conducted by the State agency. This will be an unannounced revisit survey to determine that you are implementing your plan of correction and that you are in compliance with Medicare requirements.

If you have any questions, please contact **Fe Yamada** of my staff at (206) 615-2381 or by email at [marie.yamada@cms.hhs.gov](mailto:marie.yamada@cms.hhs.gov).

Sincerely,

A handwritten signature in black ink, appearing to read "Patrick Thrift". The signature is fluid and cursive, written over a light gray background.

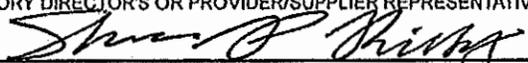
Patrick Thrift, Manager  
Regional Office - Seattle  
Division of Survey, Certification & Enforcement

cc: Idaho Bureau of Facility Standards

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

PRINTED: 04/01/2015  
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  R 03/18/2015
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 follow up survey and complaint investigation of your surgery center conducted from 3/16/15 to 3/18/15. Surveyors conducting the follow up and complaint survey were:  Susan Costa, RN, HFS, Team Leader Laura Thompson, RN, BSN, HFS Nancy Bax, RN, BSN, HFS  Acronyms used in this report include:  ASC - Ambulatory Surgery Center BMI - Body Mass Index BP - Blood Pressure CRNA - Certified Registered Nurse Anesthetist DVT - Deep Vein Thrombosis (blood clot) EKG -Electrocardiogram GB - Governing Board or Governing Body H&P - History and Physical Examination MSC - Millennium Surgery Center mg - milligrams NPO - Nothing by mouth OR - Operating Room PACU - Post Anesthesia Care Unit PARSAP - Post Anesthesia Recovery Score for Ambulatory Patients RN - Registered Nurse VS - vital signs	{Q 000}	<p>RECEIVED</p> <p>APR 10 2015</p> <p>FACILITY STANDARDS</p>	
{Q 040}	416.41 GOVERNING BODY AND MANAGEMENT  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	{Q 040}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE  
 Shane P. Ricks Administrator 4/10/15

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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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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{Q 040}	Continued From page 1 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.  This CONDITION is not met as evidenced by: Based on staff interview and review of medical records, policies, and meeting minutes, it was determined the ASC's Governing Body failed to assume responsibility for determining, implementing, and monitoring policies and failed to ensure patients' rights were upheld and promoted. This resulted in a lack of guidance and direction to staff and the failure to sustain regulatory compliance. Findings include:  1. Refer to Q181 as it relates to the Governing Body's failure to ensure plans of correction were fully implemented necessary to achieve and maintain regulatory compliance.  2. Refer to Q219 Condition for Coverage: Patient Rights and associated standard level deficiencies as they relate to the Governing Body's failure to ensure patients were fully informed of their rights and that patient rights were promoted.	{Q 040}			
Q 061	416.42(a)(1) ANESTHETIC RISK AND EVALUATION  A physician must examine the patient immediately before surgery to evaluate the risk of anesthesia and of the procedure to be performed.  This STANDARD is not met as evidenced by:	Q 061			

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Q 061	Continued From page 2 Based on record review, interview, and review of policies, it was determined the ASC failed to ensure a comprehensive assessment was performed to determine if patients were appropriate candidates for surgery in an ambulatory setting for 1 of 12 patients (#8) whose records were reviewed. The failure to perform a comprehensive assessment resulted in an increased risk of patient safety during the procedure and a less than optimal outcome after the procedure was performed. Findings include:  1. Patient #8 was a 55 year old female admitted to the ASC on 2/24/15 for a surgical procedure on her sinuses.	Q 061		
	Patient #8's record included an admission assessment, dated 2/24/15 at 7:18 AM, completed by an RN. The assessment documented she had hypertension, asthma and sleep apnea. The assessment included her height, weight, BMI of 48, and vital signs. Her blood pressure was documented as 151/99.  (According to the National Institute of Health, BMI is a measure of how much an individual weighs, compared to their height. BMI of 19 to 24 indicates a healthy weight, BMI of 25 to 29 overweight, BMI of 30 to 40 indicates obesity, and >40 is considered morbid obesity. Morbid obesity occurs when the excess body fat becomes a danger to an individual's overall health).  According to the website WebMD.com, accessed on 3/23/15, "The diastolic blood pressure number or the bottom number indicates the pressure in the arteries when the heart rests between beats. A normal diastolic blood pressure number is less than 80. A diastolic blood pressure between 80			

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Q 061	<p>Continued From page 3 and 89 indicates prehypertension. A diastolic blood pressure number of 90 or higher is considered to be hypertension or high blood pressure."</p> <p>Patient #8's record also included a form titled "PREANESTHESIA EVALUATION," dated 2/24/15 at 8:25 AM, and signed by the CRNA. The evaluation included Patient #8's current medications, allergies, and documented the vital signs that the RN had obtained upon her admission, with the BP measurement of 151/99. Patient #8's BMI was noted on the evaluation sheet. The form did not indicate the CRNA evaluated or considered Patient #8 may not be a candidate for surgery in the ASC.</p> <p>Patient #8's records included documentation by the CRNA and physician that there were no complications identified as a result of her surgical procedure. However, review of an incident report documented she was discharged home 7 hours after her procedure and after being placed on supplemental oxygen to maintain her oxygen saturations within an acceptable level.</p> <p>During an interview on 3/18/15 beginning at 10:50 AM, the Administrator reviewed Patient #8's record. The Administrator stated Patient #8's BMI of 48 as well as her other co-morbidities should have disqualified her for a surgical procedure in an ambulatory setting. The Administrator stated the ASC had patient selection criteria, and confirmed that some patients have been disqualified for a procedure after an evaluation by the CRNA. A request for the policy relating to patient admission criteria was requested, but not provided. The Administrator stated the usual cut off point that would disqualify patients for surgery</p>	Q 061			

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Q 061	Continued From page 4 at the ASC was a BMI greater than 42. He stated the decision to perform the surgical procedure ultimately fell to the decision of the CRNA and surgeon.	Q 061			
Q 062	The facility failed to ensure Patient #8's surgical risk was comprehensively evaluated prior to her procedure. 416.42(a)(2) ANESTHETIC - DISCHARGE Before discharge from the ASC, each patient must be evaluated by a physician or by an anesthesiologist as defined at §410.69(b) of this chapter, in accordance with applicable State health and safety laws, standards of practice, and ASC policy, for proper anesthesia recovery.  This STANDARD is not met as evidenced by: Based on record review and staff interview it was determined the facility failed to ensure patients were evaluated by a physician or anesthesiologist prior to being discharged for 1 of 12 patients (#8) whose records were reviewed. This resulted in patients being discharged without a determination that they were medically stable. Findings include:  1. Patient #8 was a 55 year old female admitted to the ASC on 2/24/15 for a surgical procedure to her sinuses.  Patient #8's record included a form titled "Discharge & Post-Op Instructions," signed by her physician on 2/24/15 at 9:30 AM. However, the Anesthesia Record documented Patient #8's surgery was not completed until 9:30 AM. and her Operative Record documented she left the OR and was transferred to Phase I PACU at 9:44 AM.	Q 062			

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Q 062	<p>Continued From page 5</p> <p>Patient #8's record did not include documentation that her physician assessed her readiness for discharge after his last written entry into her medical record after 9:30 AM, when she was still in surgery, and under anesthesia.</p> <p>Patient #8's "Discharge &amp; Post-Op Instructions," stated "Discharge per anesthesia and nursing criteria."</p> <p>However, Patient #8's record included an Anesthesia Record, which documented she was transferred to PACU at 9:44 AM. The form also documented Patient #8's anesthesia end time was 9:50 AM. The form was signed by the CRNA. Patient #8's record did not include documentation the CRNA assessed her readiness for discharge.</p> <p>Patient #8's records included a form titled "PACU Record- Phase II," signed by the RN that provided her post operative recovery care. The form included a table with indicators which would assist the recovery staff to determine readiness for discharge. The table indicated the PARSAP score must be 18 or greater for discharge.</p> <p>Patient #8's PACU Record- Phase II documented her PARSAP score on admission to PACU at 9:50 AM, was 15. The time of her discharge was 4:31 PM, and the RN did not document a discharge PARSAP score.</p> <p>Further, Patient #8's records documented she arrived in the PACU on supplemental oxygen which had been initiated during her procedure. Patient #8's PACU Record- Phase II form documented at 10:46 AM, her supplemental</p>	Q 062		

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Q 062	<p>Continued From page 6</p> <p>oxygen was turned off and discontinued. At that time, her oxygen saturations were documented as 92%. At 10:57 AM, the RN documented Patient #8's saturations were 83%. (According to the website MayoClinic.org, accessed on 3/26/15, normal pulse oximeter readings range from 95 to 100%. Values under 90% are considered low).</p> <p>At 11:10 AM, Patient #8's pain was documented as 6 on a scale of 1-10. Her RN noted she discussed with the CRNA Patient #8's low saturations and poor pain control. She noted "options discussed," but there was no further elaboration of which options were discussed. The RN documented she notified Patient #8's physician.</p> <p>However, the record did not include documentation that either the physician or the CRNA evaluated Patient #8 in person.</p> <p>Patient #8's PACU Record- Phase II form stated at 11:25 AM, Patient #8's oxygen saturations were 84%, she was not on supplemental oxygen, and was given Ibuprofen for pain of 6-7 out of 10. Additionally, the RN documented Patient #8 was given Norco 5/325 mg per the physician orders. At 11:37 AM, Patient #8's oxygen saturations were documented as 85%, not on oxygen, and her pain was 6 out of 10. At 11:50 AM, Patient #8's pain was documented as 5 out of 10, and her oxygen saturations were 83%. At 12:15 PM, Patient #8 was started on supplemental oxygen and received oxygen at 5 liters by mask. A physician's order for the oxygen was not present in Patient #8's records and her record did not include documentation that either the physician or the CRNA evaluated Patient #8 in person.</p>	Q 062		

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Q 062	Continued From page 7 The PACU record documented at 12:45 PM, Patient #8's RN discussed her status with her physician. She wrote in the narrative section: "Plan for D/C [with] O2 [oxygen] & pulse ox [oximeter] @ home."  During an interview on 3/18/15 beginning at 10:50 AM, the Administrator reviewed Patient #8's record. He confirmed Patient #8 was placed on supplemental oxygen during her recovery, and was discharged home on supplemental oxygen. The Administrator confirmed Patient #8's discharge PARSAP score was not completed by the RN who provided her care to indicate she was stable for discharge.	Q 062		
Q 141	Patient #8 was discharged home on supplemental oxygen and her record did not document she met discharge criteria as ordered by her physician. Additionally, Patient #8 was not evaluated by her physician or anesthetist prior to her discharge. 416.46(a) ORGANIZATION AND STAFFING  Patient care responsibilities must be delineated for all nursing service personnel. Nursing services must be provided in accordance with recognized standards of practice. There must be a registered nurse available for emergency treatment whenever there is a patient in the ASC.  This STANDARD is not met as evidenced by: Based on staff interview and review of medical records and ASC policies, it was determined the ASC failed to ensure nursing services were provided in accordance with recognized standards of practice and facility policy. This	Q 141		

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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  R 03/18/2015
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 141	<p>Continued From page 8</p> <p>affected the care of 7 of 12 patients (#1, #2, #3, #4, #5, #6, and #8) whose records were reviewed. This had the potential to result in negative patient outcomes. Findings include:</p> <p>1. Patient #8 was a 55 year old female who was admitted to the ASC on 2/24/15, for a surgical procedure on her sinuses.</p> <p>Patient #8's PACU Phase II recovery form stated at 10:46 AM, Patient #8's supplemental oxygen, which was initiated during her procedure, was removed. Her oxygen saturations at that time were documented as 92%. Her oxygen saturations were documented as 83% at 10:57 AM. Patient #8 was placed back on oxygen at 12:15 PM. There was no physician order to restart the oxygen.</p> <p>During an interview on 3/18/15 beginning at 4:10 PM, the RN who provided post-op care for Patient #8, reviewed her record and stated that she placed Patient #8 back on oxygen, but did not have orders to do so.</p> <p>Patient #8 was placed on supplemental oxygen without an order from her physician.</p> <p>2. An agency policy "Admission Process," reviewed 7/07/15, stated that patients would be scheduled to come to the ASC for preadmission preparations after they had been scheduled for surgery. The preadmission process included an interview with the nurse, medication reconciliation, preoperative lab work, orders, preoperative and postoperative teaching, consents, review of prior medical records, and orientation to the facility. Additionally, the policy noted the preoperative assessment would be</p>	Q 141		

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Q 141	Continued From page 9 available to the anesthesiologist and the following would be reported for review:  - Class III patients, - Insulin dependent diabetics, - Prematurity, less than 1 year old, - Uncontrolled Hypertension, - Uncontrolled Cardiac history, - Previous anesthetic problems with patient or family, - Latex allergy.  However, nursing staff failed to ensure preoperative patient information was garnered, as follows:  a. Patient #2 was a 67 year old male admitted to the ASC on 3/12/15 for surgery to his upper eyelids. His record did not include documentation of a preoperative visit to the ASC.  b. Patient #6 was a 64 year old female admitted to the ASC on 3/16/15 for surgery to her left foot. Her record did not include documentation of a preoperative visit to the ASC.  c. Patient #1 was a 65 year old female admitted to the ASC on 2/19/15 for surgery to her upper eyelids. Her record did not include documentation of a preoperative visit to the ASC.  d. Patient #3 was a 44 year old female admitted to the ASC on 3/10/15 for sinus surgery. Her record did not include documentation of a preoperative visit to the ASC.  e. Patient #4 was a 24 year old female admitted to the ASC on 3/02/15 for breast surgery. Her record did not include documentation of a	Q 141		

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Q 141	Continued From page 10 preoperative visit to the ASC.  f. Patient #5 was a 55 year old female admitted to the ASC on 3/11/15 for breast surgery. Her record did not include documentation of a preoperative visit to the ASC.  During an interview on 3/18/15 at 2:30 PM, the Administrator stated adult patients were scheduled for a preoperative visit only when their health record determined there may be a risk related to the administration of anesthesia. The Administrator confirmed adult prescreening, including a preoperative visit to the ASC, was not completed as required by the ASC's policy.	Q 141			
	The ASC failed to ensure nursing staff conducted preoperative screening as outlined in its policy.  3. The ASC's policy, number 2612, titled Postoperative Follow-up Evaluation, included a revision date of 2/10/15. The policy stated "A postoperative Follow-up Evaluation by phone will be made by an Outpatient Surgery RN between 24 and 72 hours following a procedure." The policy stated a "follow-up phone call sheet will be filled out and signed by the nurse."  The corresponding "POSTOPERATIVE FOLLOW-UP EVALUATION" form included questions which the patient was to be asked by the nurse, which included "Post op Infection: questions and teaching. Malaise, Fever, hot at site, swelling, redness, and pain." The policy further stated "Any problems will be referred to the physician. If, after three attempts to contact the patient have failed the chart will be filed."  However, nursing staff failed to ensure				

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Q 141	<p>Continued From page 11</p> <p>postoperative patient information was garnered, as follows:</p> <p>a. Patient #7 was a 3 year old male admitted to the ASC on 3/09/15 for a dental procedure. His record included a postoperative follow-up evaluation form. The form did not include a contact date or time. A hand written note on the form stated "3/10/15 Spanish only."</p> <p>b. Patient #12 was a 5 year old female admitted to the ASC on 3/09/15 for a dental procedure. Her record included a postoperative follow-up evaluation form. The form did not include a contact date or time. A hand written note on the form stated "3/10/15 Spanish only speaker."</p> <p>c. Patient #10 was an 8 year old male admitted to the ASC on 3/09/15 for a dental procedure. His record included a postoperative follow-up evaluation form. The form did not include a contact date or time. A handwritten note on the form stated "3/10/15 left msg [message]."</p> <p>d. Patient #12 was a 4 year old female admitted to the ASC on 3/09/15 for a dental procedure. Her record included a postoperative follow-up evaluation form. The form did not include a contact date or time. A handwritten note on the form stated "3/10/15 left msg [message]."</p> <p>e. Patient #11 was a 6 year old male admitted to the ASC on 3/06/15 for a dental procedure. His record included a postoperative follow-up evaluation form. The form did not include a contact date or time. A handwritten note on the form stated "3/9 message left."</p> <p>During an interview on 3/17/15 at 4:10 PM, an</p>	Q 141			

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Q 141	Continued From page 12 outpatient surgery RN stated for non-English speaking patients, the RN would call and ask if there was anyone in the home who spoke English. If there was not, they would be unable to complete the follow-up call and no further calls would be made. Additionally, she stated for all dental and colonoscopy patients the RN would make one call to the patient for a follow-up evaluation. If there was no answer, they would leave a message, but no additional calls would be made. For all other surgeries, the RN stated that no more than 2 attempts would be made to reach the patient for a follow-up evaluation. If no answer on the 2nd call, no further calls would be made. The RN stated she was not aware of the ASC's policy to make 3 attempts to reach all patients for a follow-up evaluation.	Q 141			
Q 162	During an interview on 3/18/15 at 10:35 AM, the Administrator confirmed follow-up evaluation phone calls were not completed as required by the ASC's policy. He stated he needed to review the policy with the ASC staff.  The ASC failed to ensure patients received post-operative evaluation phone calls as outlined in its policy. 416.47(b) FORM AND CONTENT OF RECORD  The ASC must maintain a medical record for each patient. Every record must be accurate, legible, and promptly completed. Medical records must include at least the following:  (1) Patient identification. (2) Significant medical history and results of physical examination. (3) Pre-operative diagnostic studies (entered	Q 162			

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Q 162	<p>Continued From page 13 before surgery), if performed.</p> <p>(4) Findings and techniques of the operation, including a pathologist's report on all tissues removed during surgery, except those exempted by the governing body.</p> <p>(5) Any allergies and abnormal drug reactions.</p> <p>(6) Entries related to anesthesia administration.</p> <p>(7) Documentation of properly executed informed patient consent.</p> <p>(8) Discharge diagnosis.</p> <p>This STANDARD is not met as evidenced by: Based on observation, review of medical records and staff interview, it was determined the facility failed to ensure medical records were complete for 4 of 12 patients (#3, #4, #5, and #8) whose records were reviewed. This failure resulted in a lack of complete comprehensive information being available in patient records. Findings include:</p> <p>1. Patient #4 was a 24 year old female admitted to the ASC on 3/02/15, for breast augmentation, and readmitted on 3/03/15 for hematoma evacuation (removal of the collection of blood in the tissue) of the left breast. Patient #4's record included incomplete documentation, the documentation lacked clarity as follows:</p> <p>a. Patient #4 was admitted to the ASC at 11:00 AM on 3/02/15. Her record included an Admission Assessment form dated, 3/02/15, and signed by the RN. The assessment included a section for VS measurements. The line for temperature measurement was left blank in the VS section.</p> <p>b. The Anesthesia Evaluation form signed by the</p>	Q 162			

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Q 162	<p>Continued From page 14</p> <p>CRNA, dated 3/02/15 and timed at 11:47 AM, included no documentation of VS measurements for Patient #4.</p> <p>c. On 3/03/15 at 2:20 PM, Patient #4 was readmitted to the ASC related to a complication from the previous procedure on 3/02/15. Her Admission Assessment had no documentation of her BP, respiratory rate, or temperature.</p> <p>d. Patient #4's record included the Anesthesia Evaluation form, dated 3/03/15 and timed at 3:10 PM. The CRNA did not document a BP or temperature for Patient #4.</p> <p>e. Patient #4's record, dated 3/03/15, included a PACU record form, signed by the RN. The form included a section for assessing Patient #4's pain. Entries in this section included:</p> <ul style="list-style-type: none"> <li>- At 6:15 PM the RN documented the pain as "sore." There was no further documentation related to pain.</li> <li>- At 6:40 PM the RN documented the pain as "yes." The RN documented Patient #4 was medicated with Valium.</li> <li>- At 6:45 PM the RN documented the pain as "sore." There was no further documentation regarding Patient #4's pain.</li> </ul> <p>According to the Baylor University Medical Center, website accessed 3/20/15, "Pain assessment should be ongoing individualized, and documented so that all involved in the patient's care understand the pain problem. A patient's statement, 'I have pain,' is not descriptive enough to inform a health care</p>	Q 162			

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Q 162	<p>Continued From page 15</p> <p>professional about pain type. Standardization may promote collaboration and consistency among caregivers in multiple settings. Using a pain scale with 0 being no pain and 10 being the worst pain imaginable, a numerical value can be assigned to the patient's perceived intensity of pain. Asking patients to rate their present pain, their pain after an intervention, and their pain over the past 24 hours will enable health care providers to see if the pain is worsening or improving. Also, inquiring about the pain level acceptable to the patient will help clinicians understand the patient's goal of therapy. The Wong/Baker faces rating scale is a visual representation of the numerical scale. Although the faces scale was developed for use in pediatric patients, it has also proven useful with elderly patients and patients with language barriers."</p> <p>During an interview on 3/18/15 at 10:50 AM, the Administrator reviewed the records and confirmed both Admission Assessment forms and both Anesthesia Evaluation forms were missing VS information. He stated the RN and CRNA were required to document VS measurements as part of the pre-operative evaluation. The Administrator stated for pain measurement of patients, staff were to use a numeric pain scale and document responses in the record. The Administrator confirmed Patient #4's pain was not appropriately documented in the record.</p> <p>Patient #4's admission assessment, anesthesia evaluation, and pain levels were not documented in her records.</p> <p>2. Patient #5 was a 56 year old female admitted to the ASC on 3/11/15, for breast augmentation. Patient #5's record included incomplete</p>	Q 162			

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Q 162	<p>Continued From page 16</p> <p>documentation, the documentation lacked clarity as follows:</p> <p>a. Patient #5's record included a PACU record form, dated 3/11/15, and signed by the RN. The form included a section for assessing Patient #5's pain. Entries in this section included:</p> <ul style="list-style-type: none"> <li>- At 12:13 PM the RN documented the pain as 5/10. The RN documented Patient #5 complained of feeling pressure to the surgical area and she was medicated with Valium.</li> <li>- At 12:30 PM the RN documented the pain as 5/10. The RN documented there were no changes to Patient #5.</li> <li>- At 12:45 PM the RN documented the pain as "better." There was no further documentation regarding Patient #5's pain.</li> </ul> <p>b. Patient #5's record included an Anesthesia Evaluation form signed by the CRNA, dated 3/11/15 and timed at 9:48 AM. The evaluation had no documentation of VS measurements for Patient #5.</p> <p>During an interview on 3/18/15 at 10:55 AM, the Administrator reviewed the record and confirmed the Anesthesia Evaluation form was missing VS information. He stated the CRNA was required to document VS measurements as part of the pre-operative evaluation. The Administrator stated, for pain measurement of patients, staff were to use a numeric pain scale and document responses in the record. The Administrator confirmed Patient #5's pain was not appropriately documented in the record.</p>	Q 162			

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Q 162	Continued From page 17 Patient #5's anesthesia evaluation and pain levels were not appropriately documented in her record.  3. Patient #8 was a 55 year old female admitted to the ASC on 2/24/15 for a surgical procedure on her sinuses. Patient #8's record included incomplete documentation, the documentation lacked clarity and accuracy as follows:  a. A form titled "Postoperative Follow-Up Evaluation," dated 2/25/15 indicated Patient #8 was contacted at home by phone at 12:00 PM. However, the documentation on the form did not include an RN signature to indicate who spoke with Patient #8.	Q 162		
	-The follow up form included questions for the RN to ask the patient. One of the questions was twofold, Pain 0-10 scale, and "Are pains [sic] medications working?" There was a check in the box marked "Yes." The "yes" response lacked clarity as to was the patient having pain, and if so, what was the level of pain on the scale of 0-10, or did the "yes" response indicate the pain medications were working?  - The form noted Patient #8 was to see her physician for follow up on 3/05/15. However, the last narrative entry by the RN who provided PACU care and discharged Patient #8 on 2/24/15 at 4:15 PM, noted she was to follow up with her physician in 2-3 days regarding her oxygen use and saturations.  - Patient #8 was not on supplemental oxygen prior to her surgical procedure. However, the form did not include questions for Patient #8 related to her need for supplemental oxygen and oximeter saturations. The post operative follow			

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Q 162	Continued From page 18 up evaluation was not specific to Patient #8's needs.  b. Resident #8's H&P, dictated 2/05/15, included number codes under the sections "Medications," and "Allergies." The codes were not associated with a key to identify what they meant.  c. A form titled "Preanesthesia Evaluation," completed by the CRNA, included a section on the lower right of the page. It was titled "Postanesthesia Note," and was signed by the CRNA. The note stated no complications, but was not timed or dated to indicate when it was written.	Q 162			
	d. A form that included pre-op anesthesia orders, post anesthesia orders, and PACU discharge orders was reviewed. The form did not have a patient name, sticker, or other identification to indicate it was for Patient #8. The form had a section at the bottom to be signed by the provider, with a date and time, as well as, the nurse, with a date and time. It was signed by both the CRNA and the RN on 2/24/15 at 9:50 AM.  e. A form titled "Discharge & Post-Op Instructions," signed by her physician on 2/24/15 at 9:30 AM., was reviewed. The form was signed by the RN on 2/24/15 at 9:59 AM. The section to be signed by the patient included a signature, but it was not Patient #8's signature, and it was undated and untimed. There was no indication who signed that section of the form, or to indicate Patient #8 was unable to sign.  f. The Anesthesia Record included documentation that Patient #8's anesthesia end				

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Q 162	<p>Continued From page 19 time was 9:50 AM, however, it also indicated she was transferred to recovery at 9:44 AM.</p> <p>g. The PACU Record-Phase I, the section for the time that Patient #8 was transitioned to Phase II remained blank.</p> <p>h. The PACU Record-Phase II did not include a discharge PARSAP score or nurse initials to indicate the assessment was completed before determining she met criteria for discharge.</p> <p>During an interview on 3/18/15 beginning at 10:30 AM, the Administrator reviewed Patient #8's record and confirmed the documentation omissions and discrepancies.</p> <p>Patient #8's record did not include accurate and complete documentation.</p> <p>4. Patient #3 was a 44 year old female admitted to the ASC on 3/10/15, for a surgical procedure on her sinuses. Patient #3's record included incomplete documentation, the documentation lacked clarity and accuracy as follows:</p> <p>a. A form titled "Admission Assessment," signed by the RN that provided Patient #3's pre-operative care included a section for vital signs, which was incomplete. The section for pulse and temperature was also blank.</p> <p>b. A form titled "Preanesthesia Evaluation," completed by the CRNA, included a section to document Patient #3's pre-operative vital signs. The vital signs section remained blank, which indicated the CRNA did not perform a full pre anesthesia assessment.</p>	Q 162		

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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  R 03/18/2015
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)	(X6) COMPLETION DATE	
Q 162	Continued From page 20 c. The Anesthesia Record included documentation that Patient #3 was transferred to recovery at 11:11 AM, the record had a section for her blood pressure to be recorded at the time of transfer from anesthesia care, which remained blank.  During an interview on 3/18/15 beginning at 10:30 AM, the Administrator reviewed Patient #3's record and confirmed the CRNA did not complete documentation on the anesthesia forms to include vital signs and blood pressure.  Patient #3's record included incomplete documentation.	Q 162			
{Q 181}	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, policy review, record review and staff interview, it was determined the ASC failed to ensure an accurate accounting of medications was kept and that outdated medications were taken out of stock and discarded. These failures directly impacted 1 of 12 patients (#8) whose records were reviewed and had the potential to impact all patients receiving medications at the facility. This resulted in administration of expired medications and the potential for adverse outcomes. Findings include:  1. During a recertification survey dated 2/02/15,	{Q 181}			

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{Q 181}	<p>Continued From page 21</p> <p>deficient practice was identified and cited at Q181, which in part was related to the facility's failure to discard expired medications. The facility submitted a Credible Allegation of Compliance/Plan of Correction, dated 3/6/15, which stated "We will perform monthly audits to ensure all expired medications are properly discarded." The plan stated staff had "signed a memo of understanding by 2/26/15."</p> <p>During the 3/18/15 follow up survey, surveyors requested to view the controlled substance logs for January 2015 through March 2015. Each day the ASC was open and performing procedures, a Controlled Substances Accountability Form was used. A daily Anesthesia Narcotic Record for each CRNA who worked on those days was prepared as well.</p> <p>The facility's Controlled Substances Accountability Forms were reviewed. For the three month period from January 2015 through March 19, 2015, the forms documented hydromorphone was "expired" in handwriting, on the following dates: 1/09/15, 1/12/15, 1/19/15, 1/23/15, 1/26/15, 1/29/15, 2/06/15, 2/16/15-2/19/15, 3/02/15, 3/05/15, and 3/06/15. The remaining forms for the three months did not indicate the hydromorphone was expired, which was inconsistent documentation of the expired controlled substance. Additionally, there was no indication the medication was taken out of availability to prevent administration to patients.</p> <p>Further, on 2/24/15, it was documented on the Controlled Substances Accountability Form that hydromorphone was given to a patient. The corresponding medical record, (Patient #8) was reviewed and included the following:</p>	{Q 181}		

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{Q 181}	<p>Continued From page 22</p> <p>The Phase II PACU record documented that at 1:10 PM, Patient #8's pain was 6-7/10, and hydromorphone 1 mg was administered by IV. The RN did not document the hydromorphone was expired, nor did she document she brought the expiration date to the CRNA or physician's attention before the medication was administered.</p> <p>During an interview on 3/18/15 beginning at 4:10 PM, the RN who provided post-operative care for Patient #8 reviewed her record. She confirmed that she was aware the hydromorphone was expired and that she administered it. The RN stated the CRNA ordered the medication, and she spoke with the Administrator, who authorized her to give the expired hydromorphone.</p> <p>During an interview on 3/17/15 at 2:00 PM, the Administrator reviewed the controlled substance forms and confirmed the hydromorphone was expired and it had been administered to Patient #8. He stated that although the medication was expired, if the CRNA felt it was needed, it could be administered. Further, the Administrator stated expired medications were kept in the narcotic cabinet until he was able to properly dispose of them. The Administrator was not able to describe the process for disposal of medications that have expired in the ASC.</p> <p>However, the ASC policy, 3003, "Procurement of Medications," revised 2/23/15, stated "Outdated medications will be returned to the manufacturer after conferring with the Administrator. Outdated medications including scheduled drugs may also be returned through special drug return/disposal companies."</p>	{Q 181}			

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{Q 181}	Continued From page 23 When asked about policy revisions, during an interview on 3/18/15 beginning at 9:30 AM, the Administrator stated the GB had given him authorization to review and revise all ASC policies without their approval. However, he was unable to provide documentation to support that authorization.	{Q 181}			
Q 184	The facility failed to ensure the 3/6/15 Credible Allegation of Compliance/Plan of Correction was fully implemented and that all expired medications were properly discarded. 416.48(a)(3) VERBAL ORDERS  Orders given orally for drugs and biologcals must be followed by a written order signed by the prescribing physician.	Q 184			
	This STANDARD is not met as evidenced by: Based on observation, review of facility policies, patient records, and staff interview, it was determined the ASC failed to ensure verbal orders were written and signed by the recipient of the order and the physician for 2 of 12 patients (#1 and #8) whose records were reviewed. This failure had the potential to result in patients receiving medications and treatments without orders. Findings include:  1. A policy 3029, titled "Medication Administration," revised 5/29/14, stated "Medications will be administered only upon the order of anesthesia providers, physicians, dentists, or podiatrists, who are members of the medical staff, are authorized members of the house staff or have been granted clinical				

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Q 184	<p>Continued From page 24</p> <p>privileges to write such orders and under the guidelines of their respective scopes of practice. All medication orders are to be timed and dated by the authorized person writing the order." The policy was not consistently implemented, as follows:</p> <p>a. Patient #8 was a 55 year old female who was admitted to the ASC on 2/24/15, for a surgical procedure on her sinuses. Her record included physician verbal orders which were not authenticated, as follows:</p> <p>- A verbal order was written on Patient #8's "Discharge and Post-Op Instruction" sheet for 800 mg Ibuprofen and 2 Norco X 1 to be given "now." The verbal order did not include the Norco dosage and the reason for the Ibuprofen administration was not indicated. The verbal order was timed 11:10 AM, and included the physician name/RN signature. However, the order was not authenticated by the physician.</p> <p>- A verbal order was written on the "Discharge and Post-Op Instruction" sheet for "Pt [Patient #8] to have home oxygen + pulse oxymeter [sic], titrate O2 [oxygen] to keep sats &gt;92%." The verbal order was timed 12:45 PM, and included the physician name/RN signature. The order was not authenticated by Patient #8's physician.</p> <p>During an interview on 3/18/15 beginning at 4:10 PM, the RN who provided post-op care for Patient #8, reviewed her record and stated the "verbal orders" were, in fact, telephone orders. She stated Patient #8's physician left shortly after the surgical procedure was completed, and she spoke with him on the phone.</p>	Q 184		

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Q 184	Continued From page 25 b. Patient #1 was a 65 year old female admitted to the ASC on 2/19/15, for bilateral upper eyelid blepharoplasty (eyelid lift) and bilateral lower lid canthoplasty (removal of drooping or bagginess under the eyes).  Patient #1's Admission Assessment form, dated 2/19/15, signed by the RN documented Patient #1 received Cefazolin at 8:23 AM. A corresponding Physician's Pre-Op Orders form, was signed by her physician on 2/05/15. Under the section Pre-Op medications a box was checked for Cefazolin 1 gm IV. Next to the box was a handwritten note "Per V.O. [verbal order] repeated & verified," with initials signed next to the note. There was no documentation of the date or time next to the handwritten note, or the name of the physician who gave the order.  Without documentation of the date and time the verbal order was given and the time that the physician signed the form, it could not be determined if the verbal order had been authenticated or if the verbal order was written after the physician signed the form.  During an interview on 3/18/15 at 10:45 AM, the Administrator reviewed Patient #1's record and confirmed the verbal order was not timed or dated. He also confirmed the name of the physician who gave the order was not documented. The Administrator confirmed the verbal order was not documented per ASC policy.  The facility failed to ensure verbal orders were written and signed by the recipient of the order and the physician.	Q 184		
Q 219	416.50 PATIENT RIGHTS	Q 219		

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Q 219	<p>Continued From page 26</p> <p>Condition for Coverage - Patient Rights</p> <p>The ASC must inform the patient or the patient's representative or surrogate of the patient's rights and must protect and promote the exercise of these rights, as set forth in this section. The ASC must also post the written notice of patient rights in a place or places within the ASC likely to be noticed by patients waiting for treatment or by the patient's representative or surrogate, if applicable.</p> <p>This CONDITION is not met as evidenced by: Based on record review and interview, it was determined the ASC failed to ensure patients were fully informed of their rights and that patient rights were promoted. This resulted in the potential for patients' rights to be violated. Findings include:</p> <ol style="list-style-type: none"> <li>1. Refer to Q221 as it relates to the ASC's failure to ensure information related to patient rights was provided to each patient in a language or manner that was understood.</li> <li>2. Refer to Q223 as it relates to the ASC's failure to ensure patients were informed of physician financial interests and ownership prior to their procedures.</li> <li>3. Refer to Q229 as it relates to the ASC's failure to ensure patients were fully informed about their procedure and anesthesia and that consents were properly executed.</li> </ol> <p>The cumulative effect of these systematic failures resulted in a lack of information being provided to patients and the potential for patient rights to be violated.</p>	Q 219			

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Q 221	<p>416.50(a) NOTICE OF RIGHTS</p> <p>An ASC must, prior to the start of the surgical procedure, provide the patient, or the patient's representative, or the patient's surrogate with verbal and written notice of the patient's rights in a language and manner that ensures the patient, the representative, or the surrogate understand all of the patient's rights as set forth in this section. The ASC's notice of rights must include the address and telephone number of the State agency to which patients may report complaints, as well as the Web site for the Office of the Medicare Beneficiary Ombudsman.</p> <p>This STANDARD is not met as evidenced by: Based on record review, staff interview, and review of printed patient information forms; it was determined the ASC failed to ensure information related to patient rights was provided to each patient in a language or manner that was understood, prior to the surgical procedure, for 2 of 12 patients (#7 and #12) whose records were reviewed. This had the potential for all patients and their representatives to not be fully informed of their rights. Findings include:</p> <p>1. Posted in the waiting room of the ASC were framed copies of documents titled "Patient Bill of Rights" and "Patient and Family Responsibilities." The documents were in English only.</p> <p>The ASC Administrator presented a Patient Pre-Admission Packet, and stated all patients received the packet prior to their surgery, either from their surgeon or in the mail. The packet included the documents "Patient Bill of Rights" and "Patient and Family Responsibilities." The documents were in English. However, the facility served non-English speaking patients, as follows:</p>	Q 221			

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Q 221	<p>Continued From page 28</p> <p>a. Patient #7 was a 3 year old male admitted to the ASC on 3/9/15 for dental surgery, accompanied by his parents. Patient #7's record included a Postoperative Follow-up Evaluation form. The form included a note, dated 3/10/15, stating a post-operative evaluation phone call was not made because Patient #7's parents spoke only Spanish.</p> <p>Patient #7's record did not include copies of the "Patient Bill of Rights" and "Patient and Family Responsibilities" in Spanish. Additionally, his record did not document the presence of a translator prior to his surgery, to ensure his parents fully understood their rights and responsibilities.</p>	Q 221			
	<p>b. Patient #12 was a 5 year old female admitted to the ASC on 3/9/15 for dental surgery, accompanied by her parents. Patient #12's record included a Postoperative Follow-up Evaluation form. The form included a note, dated 3/10/15, stating a post-operative evaluation phone call was not made because Patient #12's parents spoke only Spanish.</p> <p>Patient #12's record did not include copies of the "Patient Bill of Rights" and "Patient and Family Responsibilities" in Spanish. Additionally, her record did not document the presence of a translator prior to her surgery, to ensure her parents fully understood their rights and responsibilities.</p> <p>During an interview on 3/18/15 at 10:35 AM, the Administrator confirmed the documents posted in the waiting area regarding patient rights and responsibilities were posted in English only. Additionally, he stated the admission packets</p>				

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Q 221	Continued From page 29 given to all patients contained forms in English only. He stated the ASC had forms in Spanish, however, they were given to patients and family members only upon request. The Administrator reviewed Patient #7's and #12's records and confirmed they did not include patient rights and responsibility forms in Spanish. Additionally, he confirmed the 2 records did not document the presence of a translator.	Q 221		
Q 223	The ASC failed to provide the families of Patients #7 and #12 information regarding patient rights in a language that was understood. 416.50(b) NOTICE - PHYSICIAN OWNERSHIP	Q 223		
	The ASC must disclose, in accordance with Part 420 of this subchapter, and where applicable, provide a list of physicians who have financial interest or ownership in the ASC facility. Disclosure of Information must be in writing. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the ASC failed to inform patients of physician financial interests and ownership prior to their procedures for 12 of 12 patients (#1 - #12) whose records were reviewed. This failure resulted in the potential for a lack of information being provided to a patient to make an informed decision regarding their care. Findings include:  A Pre-Surgical Admission Packet was provided to the survey team on 3/16/15 at 2:30 PM, during the entrance conference with the Administrator. The Administrator stated the packet was mailed to each patient or given to them by their physician before the planned surgical procedure, usually during a pre-operative appointment. The packet included information about the ASC, the			

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Q 223	Continued From page 30 scheduling process, Patient Bill of Rights, patient and family responsibilities, and advance directives. The packet also included 4 forms for the patient to fill out and sign. Patients were to bring the forms with them on the day of the procedure or mail them in to the ASC.  The first page of the packet included a letter. The first paragraph in the letter stated "This surgery center is privately owned and some of the physicians have financial interests in the success of it." The names of the physicians who had financial interest were not included on the letter, or on any other forms that were included in the packet.	Q 223			
Q 229	During an interview on 3/18/15 at 2:30 PM, the Director reviewed the packet of information given to ASC patients. He confirmed patients were not given a list of the physicians who had financial interest or ownership in the ASC, prior to or during their ASC admission.  The ASC failed to inform patients of physician financial interests and ownership prior to their procedures. 416.50(e)(1)(iii) EXERCISE OF RIGHTS - INFORMED CONSENT  [[ (1) The patient has the right to the following:]  (iii) Be fully informed about a treatment or procedure and the expected outcome before it is performed. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the ASC failed to ensure that informed consents for surgical procedures and	Q 229			

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Q 229	Continued From page 31 anesthesia were properly executed and translated for 8 of 11 patients (#1, #3, #4, #5, #6, #7, #8, and #12) whose records were reviewed. This resulted in the potential for a lack of information being provided to a patient on which to base informed consent decisions prior to administration of medications or before undergoing a procedure. Findings include:  1. The facility did not ensure informed consents, for surgical procedures and anesthesia were properly executed, as follows:  a. Patient #1 was a 65 year old female admitted to the ASC on 2/19/15 for bilateral upper eyelid blepharoplasty and bilateral lower lid canthoplasty.  Patient #1's record included a surgical consent form, dated 2/19/15. The consent was signed by Patient #1, a representative for the ASC, and the physician. There were no times documented next to the signatures of Patient #1 or the physician on the consent.  During an interview on 3/18/15 at 10:45 AM, the Administrator reviewed the record and confirmed there were no times documented on the consent for the procedure. He further confirmed Patient #1 and the staff member did not document a time next to their signatures. The Administrator stated there was not a space on these forms indicating a time needed to be filled in, but stated they needed to be reviewed by him and possibly update.  Patient #1's record also included an anesthesia consent form, dated 2/19/15. The anesthesia consent was signed by Patient #1, a representative for the ASC, and the CRNA.	Q 229			

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Q 229	Continued From page 32 There was no time documented on the consent next to Patient #1's signature. Additionally, the anesthesia consent did not include documentation of what type of anesthesia was used for Patient #1's procedure.  During an interview on 3/17/15 at 2:35 PM, the CRNA who administered Patient #1's anesthesia reviewed the record. He confirmed there was not a time documented next to Patient #1's signature. He also confirmed the consent did not include a description of the type of anesthesia that was used. The CRNA stated patients should have a time filled out next to the date, to confirm they consented prior to receiving any medications.	Q 229			
	Patient #1's record did not include documentation if consents were signed prior to her procedure or prior to receiving any medications.  b. Patient #4 was a 24 year old female admitted to the ASC on 3/02/15, for breast augmentation, and readmitted on 3/03/15 for hematoma (collection of blood in the tissue) of the left breast. Records from both admissions were reviewed.  Patient #4's record included a surgical consent form, dated 3/02/15. The consent was signed by Patient #4, a representative for the ASC, and the physician. There were no times documented next to the 3 signatures on the consent.  The consent for the procedure dated 3/02/15, stated at the bottom "Female patients- Signature is required on one of the statements below." The statements were "I am not pregnant" and "I am/may be pregnant." There was no patient signature next to either statement.				

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Q 229	<p>Continued From page 33</p> <p>Patient #4's record also included an anesthesia consent form, dated 3/02/15. The anesthesia consent was signed by Patient #4, a representative for the ASC, and the CRNA. There were no times documented on the consent next to Patient #1's signature or the CRNA's signature. Additionally, the anesthesia consent did not include documentation of what type of anesthesia was used for Patient #4's procedure. There was also no documented time next to the CRNA's signature.</p> <p>During an interview on 3/18/15 at 10:50 AM, the Administrator reviewed both records and confirmed no times were next to the signatures on either the procedural consent or the anesthesia consent forms in both records.</p> <p>Patient #4's records did not include documentation if consents were signed prior to her procedure or prior to receiving any medications.</p> <p>c. Patient #5 was a 56 year old female admitted to the ASC on 3/11/15, for breast augmentation.</p> <p>Patient #5's record included a surgical consent form, dated 3/11/15. The consent was signed by Patient #5, the RN, and the physician. There were no times documented next to any of the signatures on the consent.</p> <p>Patient #5's record also included an anesthesia consent form, dated 3/11/15. The anesthesia consent was signed by Patient #5, a representative for the ASC, and the CRNA. There was no time documented on the consent next to Patient #5's signature. Additionally, the anesthesia consent did not include</p>	Q 229			

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Q 229	Continued From page 34 documentation of what type of anesthesia was used for Patient #5's procedure. There was also no documented time next to the CRNA's signature.  During an interview on 3/18/15 at 11:00 AM, the Administrator reviewed the record and confirmed no times were next to the signatures on either the procedural consent or the anesthesia consent forms in the record.  Patient #5's record did not include documentation if consents were signed prior to her procedure or prior to receiving any medications.	Q 229			
	d. Patient #8 was a 55 year old female admitted to the ASC on 2/24/15 for a surgical procedure on her sinuses.  Patient #8's record included a surgical consent form, dated 2/24/15. The consent was signed by Patient #8, a representative for the ASC, and her physician. The consent was dated, but there was no time to indicate when the consent was signed.  Patient #8's record also included an anesthesia consent form, dated 2/24/15. The anesthesia consent was signed by Patient #8, a representative for the ASC, and the CRNA who performed anesthesia services for Patient #8. The anesthesia consent did not include a time to indicate when the consent was signed by each individual. Additionally, the anesthesia consent did not include who would be providing the anesthesia, and documentation of what type of anesthesia was planned for Patient #8's procedure.  During an interview on 3/18/15 at 1:30 PM, the				

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Q 229	Continued From page 35 Administrator reviewed Patient #8's record and confirmed there were no times documented on the consents for the operative procedure and the anesthesia consent. The Administrator stated the form should be updated to include a place for the time by each signature and date.  Patient #8's consents for the operative procedure and anesthesia were signed and dated, but did not include a time to indicate when consent was actually given.  e. Patient #3 was a 44 year old female admitted to the ASC on 3/10/15 for a surgical procedure on her sinuses.	Q 229			
	Patient #3's record included a surgical consent form, dated 3/10/15. The consent was signed by Patient #3, a representative for the ASC, and her physician. The consent was dated, but there was no time to indicate when the consent was signed.  Patient #3's record also included an anesthesia consent form, dated 3/10/15. The anesthesia consent was signed by Patient #3, a representative for the ASC, and the CRNA who performed anesthesia services for Patient #3. The anesthesia consent did not include a time to indicate when the consent was signed by each individual. Additionally, the anesthesia consent did not include who would be providing the anesthesia or documentation of what type of anesthesia was planned for Patient #3's procedure.  During an interview on 3/18/15 beginning at 1:30 PM, the Administrator reviewed Patient #3's record and confirmed there were no times documented on the consents for the operative				

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Q 229	Continued From page 36 procedure and the anesthesia consent. The Administrator stated the form should be updated to include a place for the time by each signature and date.  Patient #3's consents for the operative procedure and anesthesia were signed and dated, but did not include a time to indicate when consent was actually given.  f. Patient #6 was a 54 year old female admitted to the ASC on 3/16/15 for a surgical procedure to remove foreign bodies from her left foot.  Patient #6's record included a surgical consent form, dated 3/16/15. The consent was signed by Patient #6, a representative for the ASC, and her physician. The consent was dated, but there was no time to indicate when the consent was signed.  Patient #6's record also included an anesthesia consent form, dated 3/16/15. The anesthesia consent was signed by Patient #6, a representative for the ASC, and the CRNA who performed anesthesia services for Patient #6. The anesthesia consent did not include a time to indicate when the consent was signed by each individual. Additionally, the anesthesia consent did not include who would be providing the anesthesia or documentation of what type of anesthesia was planned for Patient #6's procedure.  During an interview on 3/18/15 beginning at 1:30 PM, the Administrator reviewed Patient #6's record and confirmed there were no times documented on the consents for the operative procedure and the anesthesia consent. The Administrator stated the form should be updated	Q 229		

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Q 229	Continued From page 37 to include a place for the time by each signature and date.  Patient #6's consents for the operative procedure and anesthesia were signed and dated, but did not include a time to indicate when consent was actually given.  2. The U.S. Department of Health and Human Services website, accessed 3/20/15, stated, when obtaining informed consent a translator may be helpful in facilitating conversation with a non-English speaking subject, but routine unplanned translation of the consent document should not be substituted for a written translation.	Q 229			
	a. Patient #7 was a 3 year old male admitted to the ASC on 3/9/15 for dental surgery, accompanied by his parents. Patient #7's record included a Postoperative Follow-up Evaluation form. The form included a note, dated 3/10/15, stating a post-operative evaluation phone call was not made because Patient #7's parents spoke only Spanish.  Patient #7's record included a surgical consent form and a consent for anesthesia form, both dated 3/9/15 and signed by his father. Both forms were in English. Patient #7's record did not document the presence of a translator to ensure his father fully understood the procedure and anesthesia prior to giving consent.  b. Patient #12 was a 5 year old female admitted to the ASC on 3/9/15 for dental surgery, accompanied by her parents. Patient #12's record included a Postoperative Follow-up Evaluation form. The form included a note, dated 3/10/15, stating a post-operative evaluation				

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Q 229	Continued From page 38 phone call was not made because Patient #12's parents spoke only Spanish.  Patient #12's record included a surgical consent form and a consent for anesthesia form, both dated 3/9/15 and signed by her father. Both forms were in English. Patient #12's record did not document the presence of a translator to ensure her father fully understood the procedure and anesthesia prior to giving consent.  During an interview on 3/18/15 at 10:35 AM, the Administrator stated the ASC had consent forms in Spanish, however, they were given to patients and family members only upon request. The Administrator confirmed the consents signed by Patients #7's and #12's fathers were in English. He stated the dentist who performed the dental procedures on Patients #7 and #12 was fluent in Spanish and was able to translate. However, the Administrator confirmed their records did not document the presence of a translator.	Q 229		
Q 261	416.52(a)(1) ADMISSION ASSESSMENT  Not more than 30 days before the date of the scheduled surgery, each patient must have a comprehensive medical history and physical assessment completed by a physician (as defined in section 1861(r) of the Act) or other qualified practitioner in accordance with applicable State health and safety laws, standards or practice, and ASC policy.	Q 261		

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Q 261	<p>Continued From page 39</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the ASC failed to ensure a comprehensive H&amp;P was completed for 1 of 12 patients (#8) whose records were reviewed. This had the potential to result in missed contraindications to surgery in an outpatient setting. Findings include:</p> <p>1. Patient #8 was a 55 year old female admitted to the ASC on 2/24/15 for a surgical procedure on her sinuses.</p> <p>Patient #8's record included a form titled "Medical/Surgical History," that was completed and signed by Patient #8 on 2/05/15. She listed on the form that she had high blood pressure, sleep apnea (for which she used CPAP, a device used at night to treat sleep apnea), arthritis, and artificial joints. Additionally, her weight and height were noted on the form, which placed her BMI at 48. Patient #8's record also included a handwritten paper that listed her current medications, medical and surgical history, and allergies. Patient #8 identified her allergies as aspirin, Ceclor, penicillin, and Mucinex.</p> <p>a. Patient #8's H&amp;P was dated 2/05/15, and was completed by the Otolaryngologist (also known as an Ear, Nose, and Throat doctor) who was to perform her surgical procedure.</p> <p>- The H&amp;P noted Patient #8's past medical history was significant for asthma, reflux disease, and sinus disease. The H&amp;P did not include the additional medical history, as disclosed by Patient #8, of sleep apnea, arthritis, artificial joints, and BMI of 48.</p>	Q 261		

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Q 261	<p>Continued From page 40</p> <ul style="list-style-type: none"> <li>- The H&amp;P did not include all the medications that were listed on the medication list provided by Patient #8. The H&amp;P that was dictated by her physician, noted she was on 8 medications, and included a number (0.56).</li> <li>- The H&amp;P included Patient #8's allergies as aspirin, penicillin, and guaifenesin. A code of (1.03) was listed in the allergy section. Her physician did not include Ceclor as an allergy.</li> <li>- The H&amp;P concluded with "The risk and complications were discussed with the patient. She understands and will plan on proceeding as outlined." The physician did not identify risk factors that may have indicated Patient #8 was not a candidate for a surgical procedure in the ASC. Additionally, the H&amp;P did not indicate that Patient #8 was cleared for surgery in an ambulatory setting.</li> </ul> <p>b. Patient #8's record included a form titled "Physician's Pre-Op Orders," which was signed by her physician, and dated 2/05/15. The orders included a request under the section "Pre Op. Diagnostics," EKG was listed.</p> <p>Patient #8's record included an EKG, however it was dated 6/25/12, and was not an indicator of her current status.</p> <p>During an interview on 3/18/15 beginning at 10:50 AM, the Administrator reviewed Patient #8's record. He confirmed the H&amp;P completed by Patient #8's physician did not include all the details as the one completed by Patient #8. Additionally, the Administrator stated he did not know what the coded numbers indicated on the H&amp;P in the medication and allergy section. The</p>	Q 261		

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Q 261	Continued From page 41 Adminislrator confirmed Patient #8's EKG was over a year and a half old, and stated the policy of the ASC was for any pre-operative diagnostics to be less than 30 days from the date of the surgical procedure.  Patient #8's H&P was not comprehensive to include her co-morbidities that may have disqualified her for surgery in an ASC setting.	Q 261			

# MSC Millennium SURGERY CENTER

1828 S. Millennium Way, Suite 100, Meridian, ID 83642  
Phone 208-381-0262, Fax 208-429-8575

April 10, 2015

DHHS Center for Medicare and Medicaid Services  
Division of Survey, Certification and Enrollment – Region 10  
701 Fifth Avenue Suite 1600 MSRX-400  
Seattle WA, 98104  
Attn: Patrick Thrift Manager Seattle Regional Office

RECEIVED

APR 10 2015

FACILITY STANDARDS

Bureau of Facility Standards  
3232 Elder St  
PO Box 83720  
Boise Id 83720  
Attn: Nicole Wisenor Co-Supervisor Non-Long term care

Millennium Surgery Center # 13C0001011

## Plan of Correction

Thank you for the opportunity to address the deficiencies noted below. MSC strives to provide safe, efficient, cost effective health care to all patients. The deficiencies noted have been corrected and it is our intent to make them strengths to the care we provide. Millennium Surgery Center Governing Board reviewed and finalized approval of this Plan of Correction (PoC) April 10, 2015. Completion and implementation date for plans of correction listed below is April 13, 2015.

Deficiency Cited: 040 Governing Board

Description of actions to correct the deficiency: Governing Board met on April 7, 2015 deficiencies were reviewed. 6020 GOVERNING BOARD POLICY (See Addendum 1) reviewed will abide by the policy agreed upon. Plan of actions for each condition for coverage deficiencies were assessed, reviewed and approved. Implementation will take effect April 13, 2015.

Implementation procedure of PoC: Governing body assessed reviewed and approved the corrections of the deficiencies as evidence of Governing Board notes from the April 7, 2015 meeting.

Monitoring and tracking procedures: MSC's Medical Director and Administrator will work with the staff to ensure that MSC complies with the plans of correction implemented. The Governing Board will be informed of compliance to deficiencies via reporting at governing board meetings. The Quality Assurance Performance Improvement QAPI committee will be the primary source of data. The Governing Board will review QAPI reports and will provide feedback on areas of concern to be addressed. Governing Board Meetings will be held quarterly and QAPI reports will be reviewed at a minimum annually. Our current practice is quarterly meetings with QAPI review.

Person responsible for implementation of PoC: Shane Ricks MSC Administrator

Completion date: April 13, 2015

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Deficiency Cited: 061 Anesthetic Risk and evaluation

Description of actions to correct the deficiency: Anesthesia Providers, Clinical Staff and the Governing Board have read and agreed to abide by the following policies and procedures. 2015 PRE AND POST ANESTHESIA EVALUATION POLICY (See Addendum 2), 2309 ASSESSMENT PRIOR TO INDUCTION OF ANESTHESIA/SEDATION (See Addendum 3).

Implementation procedure of PoC: Evidence of compliance will be complete documentation of a comprehensive assessment of the patient's anesthesia risk on the PREANESTHESIA RECORD (See Addendum 4). MSC will follow the PRE-OPERATIVE DIAGNOSTIC PROTOCOL (See Addendum 5). MSC will use clinical judgment and established protocols to determine safe care of patients at MSC. Documentation of evaluations will be complete.

Monitoring and tracking procedures: Clinical Staff, QAPI Committee, and Shane Ricks Administrator will audit all charts for 30 days to observe and document compliance to the above stated policies and procedures. Long term plan for compliance: One month all charts will be audited. If less than 5 % need any correction after the first month we will audit 50% of the charts. If less than 5 % need correction then we will audit 25 % of charts for 3 months. If less than 5 % need correction the QAPI committee will determine a percentage of charts that need to be audited on a continual basis and will have the proposal approved by the governing board.

Person responsible for implementation of PoC: Shane Ricks Admin with the assistance of Anesthesia Providers, and Clinical Staff.

Completion date: April 13, 2015

Deficiency Cited: 062 Anesthetic Discharge

Description of actions to correct the deficiency: Patients will meet discharge criteria prior to discharge. If there are any alterations to the discharge orders, i.e. complications, the event will be completely documented reviewed and signed by those altering the orders and the clinical staff.

Implementation procedure of PoC: Clinical Staff, Anesthesia Providers and Governing Board have reviewed the following policies and are committed to abide by the policies and procedures set forth in the following policies. 2332 DISCHARGE CRITERIA FROM PACU (See Addendum 6) 2615 DISCHARGE FROM AMBULATORY CARE SERVICES DEPARTMENT (See Addendum 7).

Monitoring and tracking procedures: Clinical Staff, QAPI Committee, and Shane Ricks Administrator will audit all charts for 30 days to observe and document compliance to the above stated policies and procedures. Long term plan for compliance: One month all charts will be audited. If less than 5 % need any correction after the first month we will audit 50% of the charts. If less than 5 % need correction then we will audit 25 % of charts for 3 months. If less than 5 % need correction the QAPI committee will

# MSC Millennium SURGERY CENTER

1828 S. Millennium Way, Suite 100, Meridian, ID 83642

Phone 208-381-0262, Fax 208-429-8575

determine a percentage of charts that need to be audited on a continual basis and will have the proposal approved by the governing board.

Person responsible for implementation of PoC: Shane Ricks Admin with the assistance of Anesthesia Providers, and Clinical Staff

Completion date: April 13, 2015

Deficiency Cited: Q 141 (1) Organization and Staffing

Description of actions to correct the deficiency: Review of 3029 MEDICATION ADMINISTRATION policy (See Addendum 8). RN must have an order to provide medications post operatively. There was an order to titrate oxygen by the Anesthesia Provider for the Post-operative phase of care that is intact until patient meets discharge criteria. MSC staff is committed to comply with the standards set forth. MSC staff and governing board have reviewed the patients' record and agree to abide by the MEDICATION ADMINISTRATION policy. Analysis and review of the policy and procedure were completed as evidence documented in the staff meeting and governing board notes.

Implementation procedure of PoC: Policy 3029 MEDICATION ADMINISTRATION reviewed. Evidence will be complete documentation of medication orders and execution of orders.

Monitoring and tracking procedures: Clinical Staff, QAPI Committee, and Shane Ricks Administrator will audit all charts for 30 days to observe and document compliance to the above stated policies and procedures. Long term plan for compliance: One month all charts will be audited. If less than 5 % need any correction after the first month we will audit 50% of the charts. If less than 5 % need correction then we will audit 25 % of charts for 3 months. If less than 5 % need correction the QAPI committee will determine a percentage of charts that need to be audited on a continual basis and will have the proposal approved by the governing board.

Person responsible for implementation of PoC: Shane Ricks with the support of the clinical staff.

Completion date: April 13, 2015

Deficiency Cited: Q 141 (2) Organization and Staffing

Description of actions to correct the deficiency: Policy does not follow our practice. Policy 2006 ADMISSION PROCESS (See Addendum 9) has been revised to match our current practice. Policy has been assessed and reviewed and approved by the Administrator, Clinical Staff, and Governing Board. Governing Board and Staff Meetings occurred on April 7, 2015.

Implementation procedure of PoC: Clinical Staff will continue to follow our Admission Process policy. Admission Process has been reviewed in the staff meeting. MSC nurses are committed to follow our preadmission process and documentation of preadmission will be documented on the Pre-Anesthesia Assessment Form (See Addendum 26). Nurses will call selected higher risk patients for a preadmission assessment. Intent is to insure safe care.

# **MSC** Millennium **SURGERY CENTER**

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Monitoring and tracking procedures: Clinical Staff, QAPI Committee, and Shane Ricks Administrator will audit all charts for 30 days to observe and document compliance to the above stated policies and procedures. Long term plan for compliance: One month all charts will be audited. If less than 5 % need any correction after the first month we will audit 50% of the charts. If less than 5 % need correction then we will audit 25 % of charts for 3 months. If less than 5 % need correction the QAPI committee will determine a percentage of charts that need to be audited on a continual basis and will have the proposal approved by the governing board. QAPI will review monthly Admission assessments to insure patients are being appropriately assessed.

Person responsible for implementation of PoC: Shane Ricks Administrator with the help of the clinical staff.

Completion date: April 13, 2015

Deficiency Cited: Q 141 (3) Organization and Staffing

Description of actions to correct the deficiency: Post-Operative evaluation will be completed as outlined by policy 2612 POSTOPERATIVE FOLLOW-UP EVALUATION Phone Call (See Addendum 10). MSC's practice did not match the policy and procedure. MSC is following our policy.

Implementation procedure of PoC: 2612 POSTOPERATIVE FOLLOW-UP EVALUATION (Phone Call) policy and procedure have been reviewed by the clinical staff and governing board meetings on April 7, 2015. Staff is committed to abide by the Policy 2612 POSTOPERATIVE FOLLOW-UP EVALUATION (Phone Call). Evidence of compliance will be completed POSTOPERATIVE FOLLOW-UP EVALUATION forms correctly completed and filed in the medical record. Patients with limited English proficiency will be contacted by a Spanish interpreter arranged by Millennium Surgery Center.

Monitoring and tracking procedures: Clinical Staff, QAPI Committee, and Shane Ricks Administrator will audit all charts for 30 days to observe and document compliance to the above stated policies and procedures. Long term plan for compliance: One month all charts will be audited. If less than 5 % need any correction after the first month we will audit 50% of the charts. If less than 5 % need correction then we will audit 25 % of charts for 3 months. If less than 5 % need correction the QAPI committee will determine a percentage of charts that need to be audited on a continual basis and will have the proposal approved by the governing board.

Person responsible for implementation of PoC: Shane Ricks Administrator with the help of the clinical staff.

Completion date: April 13, 2015

Deficiency Cited: Q 162 Form and Content of Record

Description of actions to correct the deficiency: The policies listed have been reviewed by the Clinical Staff and Governing Board during meetings conducted on April 7, 2015. Clinical Staff and the governing

# **MSC Millennium** **SURGERY CENTER**

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board will abide by the policies reviewed. 9002 DOCUMENTATION REQUIRED FOR A SURGICAL CASE (See Addendum 11), 2018 PAIN ASSESSMENT IN CHILDREN (See Addendum 12), 2017 PAIN ASSESSMENT, REASSESSMENT AND MANAGEMENT (See Addendum 13), 2021 - Behavioral-Physiological Pain Scale for Nonverbal or Preverbal Patients (See Addendum 14), and 2601 DISCHARGE INSTRUCTIONS (See Addendum 15).

Implementation procedure of PoC: Clinical staff has reviewed the policies in relation to proper form and content of records. Staff is committed to insure that records and forms are complete. Evidence will be proven with complete records. Pain will be assessed and documented in appropriate scale. Pain requiring intervention, intervention and reassessment will be documented.

Monitoring and tracking procedures: Clinical Staff, QAPI Committee, and Shane Ricks Administrator will audit all charts for 30 days to observe and document compliance to the above stated policies and procedures. Long term plan for compliance: One month all charts will be audited. If less than 5 % need any correction after the first month we will audit 50% of the charts. If less than 5 % need correction then we will audit 25 % of charts for 3 months. If less than 5 % need correction the QAPI committee will determine a percentage of charts that need to be audited on a continual basis and will have the proposal approved by the governing board.

Person responsible for implementation of PoC: Shane Ricks Administrator with the help of the clinical staff.

Completion date: April 13, 2015

Deficiency Cited: Q 181 Administration of Drugs

Description of actions to correct the deficiency: Clinical Staff and the Governing board have reviewed the 3027 UNUSABLE AND OUTDATED DRUGS (See Addendum 16) and 3029 MEDICATION ADMINISTRATION (See Addendum 8) policies at meetings held on April 7, 2015. Staff and Governing board agree with and will abide by the policies for Medication Administration and Unusable and Outdated Drugs.

Implementation procedure of PoC: Chart Records will indicate proper disposal of medications and administration of medications. Evidence of compliance will be in complete records verifying safe Administration and disposal of Medications and completing the Monthly Pharmacy Inspection Report (See Attached 27).

Monitoring and tracking procedures: Clinical Staff, QAPI Committee, and Shane Ricks Administrator will audit all charts for 30 days to observe and document compliance to the above stated policies and procedures. Long term plan for compliance: One month all charts will be audited. If less than 5 % need any correction after the first month we will audit 50% of the charts. If less than 5 % need correction then we will audit 25 % of charts for 3 months. If less than 5 % need correction the QAPI committee will determine a percentage of charts that need to be audited on a continual basis and will have the proposal approved by the governing board. Also the monthly Pharmacy inspection report will be completed monthly and will be reviewed at QAPI meetings.

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Person responsible for implementation of PoC: Shane Ricks Administrator with the help of the clinical staff.

Completion date: April 13, 2015

Deficiency Cited: Q184 Verbal Orders

Description of actions to correct the deficiency: Clinical Staff and the Governing board and Clinical Staff have reviewed 3018 - Telephone, Verbal and Written Orders for Medication (See Addendum 17) at the April 7, Staff and Governing Board Meetings. Staff and Governing Board agree to abide the Verbal order policy.

Implementation procedure of PoC: Policy 3018 - Telephone, Verbal and Written Orders for Medication will be followed as evidence by properly executed verbal orders.

Monitoring and tracking procedures: Clinical Staff, QAPI Committee, and Shane Ricks Administrator will audit all charts for 30 days to observe and document compliance to the above stated policies and procedures. Long term plan for compliance: One month all charts will be audited. If less than 5 % need any correction after the first month we will audit 50% of the charts. If less than 5 % need correction then we will audit 25 % of charts for 3 months. If less than 5 % need correction the QAPI committee will determine a percentage of charts that need to be audited on a continual basis and will have the proposal approved by the governing board.

Person responsible for implementation of PoC: Shane Ricks Administrator with the help of the clinical staff.

Completion date: April 13, 2015

Deficiency Cited: Q 219 Patient Rights refer to Q221, Q223, and Q229

Deficiency Cited: Q221 (1) Notice of Rights

Description of actions to correct the deficiency: Patient Rights and Responsibilities are available in the Spanish Binder located in the waiting room. Spanish Patient packets (See Addendum 18) have been distributed to offices that have a high volume of Spanish speaking patients. Consents are given in Spanish (See Addendum 19) to Spanish speaking patients. Offices have been contacted and reminded to identify patients that have limited English proficiency. This will allow MSC staff to be prepared for patients with a language barrier.

Implementation procedure of PoC: Spanish information is available in a clearly marked binder in the waiting room. Pertinent documents are provided in the appropriate language or communicated thru the use of a translator or other approved technology. See 1041 - Interpreter Services policy (See Addendum 20)

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Monitoring and tracking procedures: Insure the Spanish binder is in a visible area in the waiting area. The information is also provided to every patient in their preadmission packet. Consent forms provided in the appropriate language. : Monitoring and tracking procedures: Clinical Staff, QAPI Committee, and Shane Ricks Administrator will audit all charts for 30 days to observe and document compliance to the above stated policies and procedures. Long term plan for compliance: One month all charts will be audited. If less than 5 % need any correction after the first month we will audit 50% of the charts. If less than 5 % need correction then we will audit 25 % of charts for 3 months. If less than 5 % need correction the QAPI committee will determine a percentage of charts that need to be audited on a continual basis and will have the proposal approved by the governing board. QAPI will audit Patient Rights. The committee created a monthly report to insure QAPI information is in its proper place and available and up to date.

Person responsible for implementation of PoC: Shane Ricks Administrator with the help of the clinical staff and QAPI committee.

Completion date: April 13, 2015

Deficiency Cited: Q221 (2) Notice of Rights

Description of actions to correct the deficiency: Use of an Interpreter will be documented. 1041 - Interpreter Services policy (See Addendum 20) has been reviewed by the Staff and Governing Board at meetings held on April 7, 2015.

Implementation procedure of PoC: Staff will document the use of an interpreter.

Monitoring and tracking procedures: Clinical Staff, QAPI Committee, and Shane Ricks Administrator will audit all charts for 30 days to observe and document compliance to the above stated policies and procedures. Long term plan for compliance: One month all charts will be audited. If less than 5 % need any correction after the first month we will audit 50% of the charts. If less than 5 % need correction then we will audit 25 % of charts for 3 months. If less than 5 % need correction the QAPI committee will determine a percentage of charts that need to be audited on a continual basis and will have the proposal approved by the governing board.

Person responsible for implementation of PoC: Shane Ricks Administrator with the help of the clinical staff and QAPI committee.

Completion date: April 13, 2015

Deficiency Cited: Q223 Notice of Ownership

Description of actions to correct the deficiency: Welcome letter in the surgical packet given to patients has a list of Owners in the letter (See Addendum 21).

Implementation procedure of PoC: Packets have been be updated and include a list of owners. The letter will also be posted in the waiting area and in the Spanish Binder.

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Monitoring and tracking procedures: Surgical Packets at Millennium Surgery Center we have been updated and the electronic documents have been updated to reflect the list of owners. QAPI will audit Patient Rights responsibilities monthly. The committee created a monthly report to insure QAPI information is in its proper place and available and up to date. QAPI patient rights monthly audit will insure information is accessible and up to date.

Person responsible for implementation of PoC: Shane Ricks Administrator with the help of the clinical staff and QAPI committee.

Completion date: April 13, 2015

Deficiency Cited: Q 229 Informed consent

Description of actions to correct the deficiency:

1. Policy 1018 Informed Consent policy and procedure (See Addendum 22) has been reviewed by staff and the Governing Board at the April, 7 2015 meetings.
2. Anesthesia Consent has been updated to better reflect the type of anesthesia that will be provided. (See Addendum 23)
3. Consents available in English and Spanish.

Implementation procedure of PoC: Policy 1018 Informed Consent policy and procedure have been reviewed by staff and the Governing Board at the April, 7 2015 meetings. Special emphasis placed on consents being timed in the appropriate language and that the anesthesia type is properly identified. Staff members and the Governing Board have agreed to abide by the Informed Consent policy and procedure.

Monitoring and tracking procedures: Clinical Staff, QAPI Committee, and Shane Ricks Administrator will audit all charts for 30 days to observe and document compliance to the above stated policies and procedures. Long term plan for compliance: One month all charts will be audited. If less than 5 % need any correction after the first month we will audit 50% of the charts. If less than 5 % need correction then we will audit 25 % of charts for 3 months. If less than 5 % need correction the QAPI committee will determine a percentage of charts that need to be audited on a continual basis and will have the proposal approved by the governing board.

Person responsible for implementation of PoC: Shane Ricks Administrator with the help of the clinical staff.

Completion date: April 13, 2015

Deficiency Cited: Q 261 Admission Assessment

Description of actions to correct the deficiency: The staff and Governing board analyzed and reviewed the following policies and procedures during meetings held on April 7, 2015, 2010 History and

# MSC Millennium SURGERY CENTER

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Physical(See Addendum 24), 2006 Admission Assessment(See Addendum 9), 2003 Outpatient Admission Criteria(See Addendum 25), Pre-operative Diagnostic Protocol(See Addendum 4).

Implementation procedure of PoC: The staff and Governing board analyzed and reviewed the following policies and procedures during meetings held on April 7, 2015, 2010 History and Physical, 2006 Admission Assessment, 2003 Outpatient Admission Criteria, Pre-operative Diagnostic Protocol. The staff and governing body agree to abide by the policies and procedures stated above. Specifically comprehensive H&P completed and in the chart, risk factors identified and ordered diagnostics are filed in the chart.

Monitoring and tracking procedures: Clinical Staff, QAPI Committee, and Shane Ricks Administrator will audit all charts for 30 days to observe and document compliance to the above stated policies and procedures. Long term plan for compliance: One month all charts will be audited. If less than 5 % need any correction after the first month we will audit 50% of the charts. If less than 5 % need correction then we will audit 25 % of charts for 3 months. If less than 5 % need correction the QAPI committee will determine a percentage of charts that need to be audited on a continual basis and will have the proposal approved by the governing board.

Person responsible for implementation of PoC: Shane Ricks Administrator with the help of the clinical staff and QAPI committee.

Completion date: April 13, 2015

Thank you to allow Millennium Surgery Center to make the corrections implemented above. We are committed to follow these plans of correction and deliver safe high quality care.

Regards,

Shane Ricks RN MHS  
MSC Administrator



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

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April 9, 2015

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

Provider #13C0001011

Dear Mr. Ricks:

An unannounced on-site complaint investigation was conducted from March 16, 2015 to March 18, 2015 at Millennium Surgery Center. The complaint allegations, findings, and conclusions are as follows:

**Complaint #ID00006893**

**Allegation #1:** The Ambulatory Surgical Center (ASC) propped the main door open between the waiting room and patient recovery area. This violated patient privacy and infection control.

**Findings #1:** During the investigation complaint and grievance logs were reviewed, observations were conducted, and staff were interviewed.

Throughout the time of the survey, the door between the waiting area and the patient recovery area remained closed, only opening for patient and staff members to pass through. The door was not observed to be in a propped open position at any time during the survey.

One grievance that was reviewed, indicated the door to the waiting room was propped open, and impeded the privacy of any patients that may be in the recovery area. Additionally, the grievance stated the open door may increase the risk of infection.

During an interview on 3/17/15 at 9:00 AM, the Administrator reviewed the grievance log and confirmed the door between the reception area and the recovery areas was propped open. The Administrator stated there were no other patients in the recovery area on the day of the incident. He stated that after he discussed the matter with the patient who filed the grievance, he met with the staff to remind them that the door was not to be propped open.

Shane Ricks, Administrator  
April 9, 2015  
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Although the door had been propped open, the ASC had implemented appropriate corrective action prior to the investigation survey. Therefore, no deficiencies were cited.

**Conclusion #1:** Substantiated. No deficiencies related to the allegation are cited.

**Allegation #2:** The ASC did not disclose information related to physician ownership to patients before their surgical procedures.

**Findings #2:** During the investigation, patient records were reviewed and staff were interviewed.

When asked, the Administrator presented a "Pre-Surgical Admission Packet." He stated the packet was provided to all patients that were scheduled for surgery at the ASC. The packet would be mailed to the patient or given to them by their physician. It included information about the ASC, the scheduling process, the Patient Bill of Rights, patient and family responsibilities, and advance directives.

The first page of the packet included a letter. The first paragraph in the letter stated "This surgery center is privately owned and some of the physicians have financial interests in the success of it." The names of the physicians were not listed on the letter, or included on any other forms in the packet.

During an interview on 3/18/15 at 2:30 PM, the Administrator reviewed the packet of information given to ASC patients. He confirmed patients were not given a list of the physicians who had financial interest or ownership in the ASC, prior to or during, their ASC admission.

The allegation of the failure of the ASC to disclose information related to physician ownership to patients before their surgical procedures were substantiated and a deficiency was cited at Q223, 416.50(b).

**Conclusion #2:** Substantiated. Federal deficiencies related to the allegation are cited.

**Allegation #3:** The ASC did not ensure informed consents were properly executed.

**Findings #3:** During the investigation, patient records were reviewed and staff were interviewed.

Twelve patient records were reviewed. Eight of the records did not demonstrate properly executed informed consents. For example, one patient's record included a surgical consent form, dated 2/24/15. The consent was signed by the patient, a representative for the ASC, and her physician. The consent was dated, but there was no time to indicate when the consent was signed.

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The patient's record also included an anesthesia consent form, dated 2/24/15. The anesthesia consent was signed by the patient, a representative for the ASC, and the Certified Registered Nurse Anesthetist (CRNA) who performed anesthesia services for the patient. The anesthesia consent did not include a time to indicate when the consent was signed by each individual. Additionally, the anesthesia consent did not include who would be providing the anesthesia, and documentation of what type of anesthesia was planned for the patient's procedure. Similar omissions were found in 5 other patient records.

Further, 2 additional patient records documented the patients' parents were non-English speaking. Both of the patients' surgical consent forms and consent for anesthesia forms, were written in English and signed by the patients' parents. Neither record included documentation of the presence of a translator to ensure the patients' parents fully understood the procedures and anesthesia prior to giving their consent.

During an interview on 3/18/15 beginning at 10:35 AM, the Administrator was asked about the consents. The Administrator confirmed there were no times documented on the consent for the procedure. He further confirmed the patient and the staff member did not document a time next to their signatures. The Administrator stated there was not a space on these forms indicating a time needed to be filled in, but stated they needed to be reviewed by him and possibly updated. The Administrator also stated the ASC had consent forms in Spanish. However, they were given to patients and family members only upon request. The Administrator confirmed the patients' records did not document the presence of a translator.

The allegation of the failure of the ASC to ensure informed consents were properly executed was substantiated and a deficiency was cited at Q229, 416.50(e)(1)(iii).

**Conclusion #3:** Substantiated. Federal deficiencies related to the allegation are cited.

**Allegation #4:** Patients' records did not reflect consistent, comprehensive information related to medications, including administration times and documentation patients received appropriate medications.

**Findings #4:** During the investigation, patient records were reviewed, narcotic administration logs were reviewed, and staff were interviewed.

Twelve patient records were reviewed. The records did not consistently include comprehensive information related to medication administration. For example, one patient record included documentation of medications administered during the patient's surgical procedure. The medications administered were compared to the narcotic administration record. The CRNA documented the patient received 300 mcg of Fentanyl during the procedure, which was reflected accurately on the narcotic administration record. However, the record did not include documentation of Versed administration, as the narcotic administration record indicated.

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The narcotic administration record documented Versed 2 mg was administered to the patient during the procedure.

During an interview on 3/17/15 at 2:35 PM, the CRNA reviewed the patient record and Narcotic Administration Record. He confirmed the Versed was administered, and stated he forgot to write down on the anesthesia record that it was administered during the procedure.

Further, the patient's Admission Assessment form, signed by the Registered Nurse (RN), documented the patient received an antibiotic. A corresponding physician's pre-operative order form, was signed and dated by the patient's physician. However, there was no time on the form to indicate what time the order was signed. Additionally, under the section pre-operative medications, a box was checked for the antibiotic. Next to the box was a handwritten note "Per V.O. {verbal order} repeated & verified," with initials signed next to the note. There was no documentation of the date or time next to the handwritten note, or the name of the physician who gave the order.

During an interview on 3/18/15 at 10:45 AM, the Administrator reviewed the patient's record and confirmed the verbal order was not timed or dated. He also confirmed the name of the physician who gave the order was not documented.

Additionally, another patient's record included a verbal order which was written on the patient's discharge and post-operative instruction sheet. The order stated 800 mg Ibuprofen and 2 Norco were to be given "now." The verbal order did not include the Norco dosage and the reason for the Ibuprofen administration was not indicated. The verbal order was timed 11:10 AM, and included the physician name/RN signature. However, the order was not authenticated by the physician.

During an interview on 3/18/15 beginning at 4:10 PM, the RN who provided post-operative care for the patient, reviewed her record and stated the "verbal orders" were, in fact, telephone orders. She stated the patient's physician left shortly after the surgical procedure was completed, and she spoke with him on the phone.

The allegation of medication administration and documentation inconsistencies was substantiated and deficiencies were cited at Q181, 416.48(a) and Q184, 416.48(a)(3).

**Conclusion #4:** Substantiated. Federal deficiencies related to the allegation are cited.

**Allegation #5:** The ASC did not provide appropriate assessment and management of pain at the time of discharge and after procedures.

**Findings #5:** During the investigation, patient records were reviewed, facility policies were reviewed, and staff were interviewed.

Shane Ricks, Administrator

April 9, 2015

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Twelve patient records were reviewed. The records did not consistently include documentation that patient pain was adequately assessed. For example, one patient's record included a post-anesthesia care unit (PACU) form, signed by the RN. The form included a section for assessing the patient's pain. Entries in this section included:

- At 6:15 PM the RN documented the pain as "sore." There was no further documentation related to pain.
- At 6:40 PM the RN documented the pain as "yes." The RN documented the patient was medicated with Valium.
- At 6:45 PM the RN documented the pain as "sore." There was no further documentation regarding the patient's pain.

During an interview on 3/18/15 at 10:50 AM, the Administrator reviewed the record. The Administrator stated for pain measurement of patients, staff were to use a numeric pain scale and document responses in the record.

Additionally, a second patient's record documented her pain as a 6 on a scale of 1-10. The RN documented she discussed the patient's status with the CRNA, including her poor pain control. She noted "options discussed," but there was no further elaboration of which options were discussed.

The patient's record also included a form titled "Postoperative Follow-Up Evaluation." The form indicated the patient was contacted at home by phone on the day following her surgery. The follow-up form included questions for the RN to ask the patient. One of the questions was twofold, Pain 0-10 scale, and "Are pains (###) medications working?" There was a check in the box marked "Yes." The "yes" response lacked clarity as to was the patient having pain, and if so, what was the level of pain on the scale of 0-10, or did the "yes" response indicate the pain medications were working?

The ASC's policy titled "Postoperative Follow-up Evaluation," revised 2/10/15, stated "A postoperative Follow-up Evaluation by phone will be made by an Outpatient Surgery RN between 24 and 72 hours following a procedure. Any problems will be referred to the physician. If, after three attempts to contact the patient have failed the chart will be filed."

However, the patients' records did not demonstrate the policy was consistently implemented. For example, one patient's record included a postoperative follow-up evaluation form. The form was dated 5 days after the patient's surgery date.

Shane Ricks, Administrator  
April 9, 2015  
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Further, 2 other patient records documented the follow-up evaluation phone call was not attempted because the patients' parents were non-English speaking. Three additional patient records documented a phone call, and stated a message was left. However, there was no documentation of further attempts to reach the patients by phone.

During an interview on 3/18/15 at 10:45 AM, the Administrator confirmed a patient was called 5 days after the surgery. He stated the record was misplaced for several days and once it was located the patient was contacted. The Administrator also confirmed follow-up evaluation phone calls were not completed as required by the ASC's policy for other patients. He stated he needed to review the policy with the ASC staff.

The allegation of the failure of the ASC to provide appropriate assessment and management of pain at the time of discharge and after procedures was substantiated, and deficiencies were cited at Q62, 416.42(a)(2) and Q162, 416.47(b).

**Conclusion #5:** Substantiated. Federal deficiencies related to the allegation are cited.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it will be addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626, option 4. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,



SUSAN COSTA  
Health Facility Surveyor  
Non-Long Term Care



NICOLE WISENOR  
Co-Supervisor  
Non-Long Term Care

SC/pmt