



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

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

DEBRA RANSOM, R.N., R.H.I.T., Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0009  
PHONE 208-334-6626  
FAX 208-364-1888

**CERTIFIED MAIL: 7000 1670 0011 3315 1866**

June 12, 2015

Lonna Welch, Administrator  
Surgery Center Of Idaho  
2855 East Magic View Drive  
Meridian, ID 83642

RE: Surgery Center Of Idaho, Provider #13C0001060

Dear Ms. Welch:

Based on the survey completed at Surgery Center Of Idaho, on May 29, 2015, by our staff, we have determined Surgery Center Of Idaho is out of compliance with the Medicare ASC Conditions for Coverage of **Governing Body and Management (42 CFR 416.41)**, **Quality Assessment and Performance (42 CFR 416.43)** and **Patient Rights (42 CFR 416.50)**. To participate as a provider of services in the Medicare Program, an ASC must meet all of the Conditions for Coverage established by the Secretary of Health and Human Services.

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

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

An acceptable Plan of Correction contains the following elements:

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

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

**Such corrections must be achieved and compliance verified by this office, before July 13, 2015. To allow time for a revisit to verify corrections prior to that date, it is important that the completion dates on your Credible Allegation/Plan of Correction show compliance no later than July 3, 2015.**

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **June 24, 2015.**

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

We urge you to begin correction immediately.

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

Sincerely,



GARY GUILLES  
Health Facility Surveyor  
Non-Long Term Care



NICOLE WISENOR  
Co-Supervisor  
Non-Long Term Care

GG/pmt

Enclosures

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

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

PRINTED: 06/11/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13C0001060	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  05/29/2015
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NAME OF PROVIDER OR SUPPLIER  SURGERY CENTER OF IDAHO	STREET ADDRESS, CITY, STATE, ZIP CODE 2855 EAST MAGIC VIEW DRIVE MERIDIAN, ID 83642
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Q 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the Medicare recertification survey of your surgery center conducted from 5/26/15 to 5/29/15. Surveyors conducting the recertification were:</p> <p>Gary Guiles, RN, HFS, Team Leader Laura Thompson, RN, HFS Nancy Bax, RN, HFS Dennis Kelly, RN, HFS</p> <p>Acronyms used in this report include: ASC - Ambulatory Surgery Center bpm - beats per minute CEO - Chief Executive Officer ENT - Ear, Nose and Throat H&amp;P - History and Physical Examination IV - intravenous IVP - intravenous push MA - Medical Assistant mg - milligrams OR - Operating Room PACU - Post Anesthesia Care Unit POHA - Pre Operative Holding Area po - by mouth pt - patient QAPI - Quality Assessment Performance Improvement RN - Registered Nurse SCI - Surgery Center of Idaho TURBT - Transurethral resection of bladder tumor TURP - Transurethral resection of prostate</p> <p>Surgical procedures referenced in this report include:</p>	Q 000	<p>SEE ACTION PLANS W/ COMPLETION DATES (MANY INCLUDE SUPPORTING DOCUMENTATION)</p> <p>RECEIVED JUL - 7 2015 FACILITY STANDARDS</p>	N/A
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE CEO	(X6) DATE 6 July 2015
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Q 040	<p>Continued From page 2 develops and maintains a disaster preparedness plan.</p> <p>This CONDITION is not met as evidenced by: Based on observation, interviews, and review of medical records, policies, meeting minutes, and quality program documents, it was determined the ASC failed to ensure the Governing Body assumed responsibility for the management and operational direction of the ASC for all patients receiving services at the ASC. This directly affected 1 of 4 cystoscopy patients (#27), whose procedure was observed, and had the potential to affect all ASC patients. This resulted in a lack of sufficient policy development, implementation and monitoring, a lack of oversight and accountability for the ASC's QAPI program, and a failure to achieve and sustain compliance with regulatory requirements. The findings include:</p> <p>1. The policy "Governing Body and Administrative Staff," Policy 3.01 dated 2/2013, stated "The Governing Body will meet once a month to discuss any pertinent issues and address the following: a. quality assurance b. process improvement d. [sic] infection control e. any and all other important business associated to SCI."</p> <p>Evidence that the Governing Body fulfilled its duties was not present.</p> <p>Governing Body monthly meeting minutes from 5/28/14 - 4/15/15 were reviewed. The meeting minutes did not contain sufficient information necessary to demonstrate the Governing Body's</p>	Q 040			

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Q 040	<p>Continued From page 4</p> <p>member, a review of finances, and an environmental change to ensure physicians could conduct private conversations with patient family members. The partners section of the notes listed 2 physicians' names and stated "INFO (if available)." Under the "INFO" heading, the following was listed:</p> <ul style="list-style-type: none"> <li>- Incident reports</li> <li>- Transfers</li> <li>- Recalls</li> <li>- Near misses</li> <li>- Employee injuries</li> </ul> <p>The section did not identify if the information was available and discussed by the Governing Body. No additional information (e.g. data, data analysis, conclusions, actions taken, monitoring methods, etc.) related to the Governing Body's review of the information was present and the meeting minutes did not contain other information (e.g. the quality of patient care, safety of the environment, review or monitoring of policies and procedures to ensure the effectiveness of the ASC's systems, etc.) related to the total operation of the ASC.</p> <p>2/18/15: The meeting minutes documented "Quorum not available - info meeting only." The partners section of the notes listed 2 physicians' names. The word "DECISIONS" was listed under the physicians' names. However, no additional information regarding what, if any, decisions had been made and by whom were documented in the meeting minutes.</p> <p>Under the word "DECISIONS" the meeting minutes stated "INFO (if available)" and included the same information documented in the 11/19/14</p>	Q 040			

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Q 040	<p>Continued From page 6</p> <p>meeting minutes did not contain other information (e.g. the quality of patient care, safety of the environment, review or monitoring of policies and procedures to ensure the effectiveness of the ASC's systems, etc.) related to the total operation of the ASC.</p> <p>The CEO was interviewed on 5/29/15 beginning at 2:30 PM. He stated the Governing Body reviewed many things at its meetings but he agreed the Governing Body meeting minutes did not document items reviewed or actions taken.</p> <p>The Governing Body failed to ensure it assumed responsibility for the management and operational direction of the ASC.</p> <p>The ASC was previously cited at Q40 during a recertification survey dated 9/27/12. The Governing Body failed to ensure sustained compliance was achieved.</p> <p>2. The Governing Body failed to define all services provided by the ASC.</p> <p>The ASC had 4 procedure rooms where physicians performed cystoscopy. A cystoscopy procedure was observed for Patient #27 on 5/29/15. He was followed from 8:35 AM in the waiting room until his discharge at 9:45 AM. During that time, he was not given a copy of his rights. He did not have a pre or post-procedure examination by a physician or by a nurse. In addition, his medical record did not contain a documented H&amp;P.</p> <p>The Administrator was interviewed on 5/29/15 beginning at 2:30 PM. She stated ASC policies were not followed for cystoscopy patients. She</p>	Q 040			

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Q 040	Continued From page 8  a. Refer to Q81 as it relates to the ASC's failure to ensure its quality program was defined and direction was provided to staff responsible for the program. The ASC was previously cited at Q81 during a recertification survey dated 9/27/12. The Governing Body failed to ensure sustained compliance was achieved.  b. Refer to Q82 as it relates to the ASC's failure to ensure its quality indicator data, including adverse patient events, was analyzed and used to improve the effectiveness and safety of the ASC's services. The ASC was previously cited at Q82 during a recertification survey dated 9/27/12. The Governing Body failed to ensure sustained compliance was achieved.  c. Refer to Q83 as it relates to the ASC's failure to ensure distinct improvement projects were conducted. The ASC was previously cited at Q83 during a recertification survey dated 9/27/12. The Governing Body failed to ensure sustained compliance was achieved.  d. Refer to Q84 as it relates to the Governing Body's failure to ensure the QAPI program was defined, implemented and maintained. The ASC was previously cited at Q84 during a recertification survey dated 9/27/12. The Governing Body failed to ensure sustained compliance was achieved.  5. 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.  6. Refer to Q244 it relates to the Governing	Q 040			

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Q 042	<p>Continued From page 10</p> <p>acute care hospital. This failure directly impacted 1 of 3 patients (Patient #22) reviewed, whose records documented post-operative complications and had the potential to impact all patients who received emergency medical care while at the ASC. This failure resulted in the potential for patients to not receive adequate care for emergent complications. Findings include:</p> <p>1. Patient #22 was a 27 month old male who was admitted to the facility on 7/23/14 for a circumcision. His record documented he was pre-medicated with Versed 6 mg by mouth at 10:50 AM and general anesthesia, without intubation, was initiated at 11:11 AM. The surgical procedure commenced at 11:26 AM and ended at 11:45 AM. At 11:49 AM, Patient #22 was transferred to the PACU.</p> <p>Patient #22's PACU record documented at 11:53 AM he "had laryngeal spasm. Pt. had to be manually ventilated. Pt. returned to spontaneous respirations at 11:55 [AM]." Patient #22's anesthesia record also documented "Pt. in L-spasm just upon arrival to PACU, positive pressure vent., SUK [Succinylcholine]/ATR [Atropine] almost given but spasm broke. SATs returned to normal."</p> <p>However, Patient #22's PACU flowsheet documented at 12:05 PM, he had "0" respirations and an oxygen saturation level of 35%. His PACU record documented "Pt. had another spasm. Pt. manually ventilated. Not successful. Pt. medicated with 2 ml Succinylcholine. Pt. ventilations now successful..."</p> <p>Patient #22's PACU flowsheet documented he was awake and complaining of pain at 12:45 PM.</p>	Q 042			

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Q 042	Continued From page 12	Q 042		
Q 080	cardiac/respiratory arrest was implemented. 416.43 QUALITY ASSESSMENT AND PERFORMANCE  The ASC must develop, implement and maintain an on-going, data-driven quality assessment and performance improvement (QAPI) program. This CONDITION is not met as evidenced by: Based on staff interview and review of policies, meeting minutes, medical records, and quality program documents, it was determined the ASC failed to ensure a comprehensive QAPI program was developed, implemented and maintained. This impeded the ability of the ASC to evaluate its practices and improve care. Findings include:  1. Refer to Q81 as it relates to the ASC's failure to ensure a comprehensive QAPI program was developed, implemented, and monitored.  2. Refer to Q82 as it relates to the ASC's failure to ensure its quality indicator data, including adverse patient events, was analyzed and used to improve the effectiveness and safety of the ASC's services.  3. Refer to Q83 as it relates to the ASC's failure to ensure data was gathered and analyzed necessary to ensure improvement was achieved for each ASC performance improvement project.  4. Refer to Q84 as it relates to the Governing Body's failure to ensure sufficient oversight, monitoring and direction of QAPI activities was provided to improve ASC services.	Q 080	SEE Q80 AP	
Q 081	416.43(a), 416.43(c)(1) PROGRAM SCOPE; PROGRAM ACTIVITIES	Q 081	SEE Q81 AP	

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Q 081	<p>Continued From page 14</p> <p>interviewed on 5/27/15 beginning at 2:20 PM. She confirmed she was responsible for QAPI and Infection Control programs.</p> <p>a. The ASC's policy 8.04 "Quality Assessment and Process Improvement" dated 10/23/12, stated "A Quality Assessment/Improvement Program shall be maintained to evaluate the quality of care and clinical performance, and to insure that care is provided in a consistent and integrated manner."</p> <p>However, a QAPI plan for 2014 and 2015 that identified high risk, high volume, and problem prone areas for study, as well as specifying quality indicators for staff to measure, was not documented.</p> <p>During an interview on 5/29/15 at 2:30 PM, the CEO stated he was not aware of the Medical Director or Governing Board suggesting QAPI indicators or projects.</p> <p>The ASC failed to ensure a comprehensive QAPI plan, including quality indicators focused on high risk, high volume, and problem prone areas, was developed and implemented.</p> <p>b. The "Quality Assessment and Process Improvement" policy stated "The Infection Control Coordinator and Administrator: monitor the quality and appropriateness of all direct patient ancillary services provided by the facility, including: a. holding and documenting monthly meetings..."</p> <p>The Nursing Supervisor was asked to provide documentation of QAPI and Infection Control committee meetings for the last 12 months. On 5/28/15 at 11:40 AM, the Nursing Supervisor</p>	Q 081		

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Q 081	Continued From page 16 accordance with ASC policy.	Q 081		
Q 082	2. Refer to Q82 as it relates to the ASC's failure to ensure its quality indicator data, including adverse patient events, was analyzed and used to improve the effectiveness and safety of the ASC's services. 416.43(b), 416.43(c)(2), 416.43(c)(3) PROGRAM DATA; PROGRAM ACTIVITIES  (b)(1) The program must incorporate quality indicator data, including patient care and other relevant data regarding services furnished in the ASC.  (b)(2) The ASC must use the data collected to - (i) Monitor the effectiveness and safety of its services, and quality of its care. (ii) Identify opportunities that could lead to improvements and changes in its patient care.  (c)(2) Performance improvement activities must track adverse patient events, examine their causes, implement improvements, and ensure that improvements are sustained over time.  (c)(3) The ASC must implement preventive strategies throughout the facility targeting adverse patient events and ensure that all staff are familiar with these strategies.  This STANDARD is not met as evidenced by: Based on staff interview and review of policies, meeting minutes, medical records, and QAPI documents, it was determined the ASC failed to ensure quality indicator data was used to monitor the effectiveness and safety of its services. In	Q 082	SEE Q82 AP	

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Q 082	<p>Continued From page 18 performed in the "Cystoscopy Suite."</p> <p>The ASC failed to analyze data to identify infection trends and their causes.</p> <p>3. During an interview on 5/28/15 at 10:20 AM, the Nursing Supervisor stated infections reported in 2014 were documented, but she had not yet determined the number of infections reported per procedure to identify possible trends.</p> <p>The ASC failed to ensure data was analyzed necessary to identify possible areas of improvement.</p> <p>4. The ASC's policy 7.11, "Incident Reporting," undated, stated "All Incident Reports will be forwarded to the Surgery Center QAPI Coordinator to gather data, review and recommend any necessary changes to the QAPI committee if needed. A summary will be brought to the monthly Governing Body SCI meeting for discussions. Meeting minutes will be taken."</p> <p>Incident reports for the previous 12 months were reviewed. Incidents documented included, but were not limited to, the following:</p> <p>a. Patient #22 was a 2 year old male admitted to the ASC on 7/23/14 for a circumcision. His record documented his surgical procedure commenced at 11:26 AM and ended at 11:45 AM. At 11:49 AM, Patient #22 was transferred to the PACU.</p> <p>An incident report for Patient #22 documented "Patient arrived to PACU at 1149, by 1150 patient apneic [not breathing] from laryngeal spasm. Dr. [name] Anesthesiologist in room not able to bag &amp;</p>	Q 082		

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Q 082	<p>Continued From page 20 discharged home to the care of his parents.</p> <p>Patient #22's incident report included a section for Supervisor investigation and follow-up. It stated "Nursing staff commended for excellent patient care &amp; response to emergent situation. Incident discussed with Dr. [name] Anesthesia liaison, research into situation conducted. [Anesthesia liaison] followed up with [Anesthesiologist]. Administrator notified of incident." The section was unsigned. It did not document lack of adherence to the ASC's policy, or investigation to determine why the policy was not followed.</p> <p>Patient #22's incident report was completed by the RN on 8/1/14. It was signed by the Administrator on 2/13/15. The form included a section for Medical Director recommendations and comments. It stated "excellent care from peri-op staff" and was signed by the Medical Director on 2/13/15, more than 6 months after the incident occurred.</p> <p>Governing Body meeting minutes documented between July 2014 and April 2015 did not include discussion of Patient #22's incident or additional investigation.</p> <p>b. Patient #26 was an 82 year old male admitted to the ASC on 9/26/14 for a TURBT. His record documented he arrived in the PACU at 10:19 AM.</p> <p>The PACU record documented Patient #26 required oxygen via mask at 8 lpm initially and had audible wheezing. Patient #26 was given a treatment of Albuterol for continued wheezing and the oxygen was turned down to 5 lpm via mask. The RN documented Patient #26 did not complain of shortness of breath or chest pain.</p>	Q 082		

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NAME OF PROVIDER OR SUPPLIER  SURGERY CENTER OF IDAHO			STREET ADDRESS, CITY, STATE, ZIP CODE 2865 EAST MAGIC VIEW DRIVE MERIDIAN, ID 83642	
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Q 082	<p>Continued From page 22</p> <p>Patient #26's incident report included a section for Supervisor investigation and follow-up. It stated "Patient evaluated by Hospitalist upon admit, diagnosed with bronchitis with no acute infectious process. Patient started on Zithromax antibiotic and discharged home the following day 9/27/14. Patient had follow up appointments with Dr. [name] on 10/2 and 10/29. No issues with respiratory status noted. No complications from surgery." The section was unsigned. It documented care received by Patient #26 after his transfer to the hospital. However, it did not document an investigation of the incident while he was in the ASC.</p> <p>Patient #26's incident report was completed by the RN on 9/26/14. It was signed by the Administrator on 11/22/14. The form included a section for Medical Director recommendations and comments. It stated "no comment" and was signed by the Medical Director on 2/13/15, more than 4 months after the incident occurred.</p> <p>Governing Body meeting minutes documented between September 2014 and April 2015 did not include discussion of Patient #26's incident or additional investigation.</p> <p>c. Patient #10 was a 72 year old female admitted to the ASC on 4/28/15 for a bilateral ureteroscopy, laser lithotripsy and stone extraction.</p> <p>Patient #10's Preoperative Physician Orders included an order for Ciprofloxin (an antibiotic) 250 mg. Patient #10's Preoperative Nursing Record documented she was given Ciprofloxin 500 mg.</p>	Q 082		

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Q 083	<p>Continued From page 24</p> <p>minimum, must include the reason(s) for implementing the project, and a description of the project's results</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review QAPI documents, it was determined the ASC failed to ensure distinct performance improvement projects had been conducted. The lack of performance improvement projects impeded the ability of the ASC to evaluate specific aspects of patient care. Findings include:</p> <p>1. The ASC's policy 8.01 "Quality Assessment and Process Improvement," reviewed and approved on 10/23/12, did not include performance improvement project information. No other quality documents included a plan for specific performance improvement projects in 2015.</p> <p>During an interview on 5/27/15 at 2:40 PM, the Nursing Supervisor, who was responsible for the QAPI program, stated she was currently working on 2 QAPI projects, post-operative bleeding for ENT patients and Belladonna and Morphine suppository usage to decrease post-operative pain. However, she stated she had no written processes or data for the 2 current QAPI projects.</p> <p>The ASC failed to ensure data was was collected, analyzed and used to improve the quality of the ASC's services.</p> <p>2. The Nursing Supervisor stated on 5/27/15 at 2:40 PM, that the 2014 QAPI projects focused on medication allergy and post-operative hematuria (blood in the urine).</p>	Q 083			

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Q 083	Continued From page 26 determine trends and opportunities for improvement.  The ASC failed to ensure performance improvement project data was gathered, analyzed and used to improve the quality of care and services at the ASC.	Q 083		
Q 084	416.43(e) GOVERNING BODY RESPONSIBILITIES  The governing body must ensure that the QAPI program- (1) Is defined, implemented, and maintained by the ASC. (2) Addresses the ASC's priorities and that all improvements are evaluated for effectiveness. (3) Specifies data collection methods, frequency, and details. (4) Clearly establishes its expectations for safety. (5) Adequately allocates sufficient staff, time, information systems and training to implement the QAPI program.  This STANDARD is not met as evidenced by: Based on staff interview and review of policies, meeting minutes and QAPI documents, it was determined the ASC failed to ensure the Governing Board defined, implemented, and maintained the QAPI program. This resulted in a lack of oversight of the QAPI program and a lack of direction to staff responsible for the program. Findings include:  1. The ASC's policy 8.01, "Quality Assessment and Process Improvement," approved on 10/23/15, stated "The Medical Director shall direct	Q 084	SEE Q84 AP	

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Q 084	Continued From page 28 related to the items. The other 10 meeting minutes did not include QAPI. The minutes did not document that the Nursing Supervisor responsible for QAPI attended the Governing Body meetings.  During an interview on 5/29/15 at 2:30 PM, the CEO was asked to describe the Governing Board's role in QAPI. He stated the Nursing Supervisor "did all the prep work" and gave information to the Medical Director, who presented the information at the Governing Board meetings. He confirmed this was not documented in the meeting minutes between 5/28/14 and 4/15/15. He stated he was not aware of the Medical Director or Governing Board suggesting QAPI indicators or projects. Additionally, he confirmed there was no documentation of participation from the Medical Director or Governing Board on adverse event investigations. The CEO stated he was not aware of how much time the Nursing Supervisor devoted to QAPI, and stated her QAPI time was not tracked.  The ASC's Governing Body failed to provided sufficient oversight and monitoring necessary to ensure a comprehensive QAPI program was developed, implemented and maintained.	Q 084			
Q 101	416.44(a)(1) PHYSICAL ENVIRONMENT  The ASC must provide a functional and sanitary environment for the provision of surgical services. Each operating room must be designed and	Q 101	SEE Q101 AP		

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Q 101	Continued From page 30 9/8/14: Temperature 65.2. Humidity 19.3. 10/29/14: Temperature 66.2. Humidity 15.9. 11/24/14: Temperature 65.0. Humidity 12.7. 12/5/14: Temperature 65.7. Humidity 15.4. 1/20/15: Temperature 64.8. Humidity 11. 2/18/15: Temperature 65.7. Humidity 8.6. 3/18/15: Temperature 64.3. Humidity 17.8. 4/24/15: Temperature 59.7. Humidity 17.7  b. OR 2:  5/12/14: Temperature 66.2. Humidity 27.9. 6/18/14: Temperature 64.3. 7/3/14: Temperature 64.9. 8/26/14: Temperature 64.9. 9/10/14: Temperature 65.6. Humidity 22.8. 10/15/14: Temperature 66.5. Humidity 24.8. 11/18/14: Temperature 63.6. Humidity 13.1. 12/31/14: Temperature 64.2. Humidity 14.0. 1/15/15: Temperature 64.1. Humidity 17.5. 2/24/15: Temperature 66.0. Humidity 13.9. 3/2/15: Temperature 66.2. Humidity 23.8. 4/16/15: Temperature 66.8. Humidity 26.9.  c. OR 3:  5/30/14: Temperature 65.1. Humidity 15.2. 6/17/14: Temperature 63.4. Humidity was 19.6. 7/25/14: Temperature 64.1. Humidity 25.8. 8/5/14: Temperature 63.7. 9/11/14: Temperature 63.9. Humidity 14.9. 10/27/14: Temperature 65.8. Humidity 16.1. 11/13/14: Temperature 65.1. Humidity 7.1. 12/22/14: Temperature 63.8. Humidity 11.0. 1/16/15: Temperature 63.6. Humidity 9.0. 2/17/15: Temperature 63.5. Humidity 10.0. 3/4/15: Temperature 63.9. Humidity 8.2. 4/10/15: Temperature 63.7. Humidity 14.5.	Q 101			

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Q 162	<p>Continued From page 32 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 review of medical records and staff interview, it was determined the facility failed to ensure medical records were complete for 10 of 25 patients (#2, #3, #4, #5, #6, #9, #10, #11, #13, and #22) 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 #3 was a 69 year old female admitted to the ASC on 5/13/15 for a pubovaginal sling, and cystocele and rectocele repair for uterine prolapse.</p> <p>Patient #3's Anesthesiologist orders included an order for Versed 2 mg IV now. The Anesthesiologist's signature was dated 5/15/15, 2 days after her surgery at the ASC.</p> <p>During an interview on 5/26/15 at 11:15 AM, the Nursing Supervisor reviewed Patient #3's record and confirmed the date of the Anesthesiologist's signature was inaccurate.</p> <p>Patient #3's record did not include accurate and complete documentation.</p> <p>2. Patient #4 was a 59 year old male admitted to the ASC on 5/01/15 for placement of an inflatable penile prosthesis, a surgically implanted device for men with erectile dysfunction.</p> <p>Patient #4's record included a "Postoperative Physician Note/Orders" by the operating surgeon.</p>	Q 162		
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Q 162	<p>Continued From page 34</p> <p>During an interview on 5/28/15 at 3:30 PM, the Nursing Supervisor reviewed Patient #6's record and confirmed the information was not present.</p> <p>Patient #6's record did not include complete documentation.</p> <p>5. Patient #9 was a 68 year old male admitted to the ASC on 4/23/15 for a button vaporization of the prostate.</p> <p>Patient #9's record included a "Postoperative Physician Note/Orders" by the operating surgeon. The entry was dated 4/23/15 but was not timed. The document "noted by" was unsigned, undated, and untimed.</p> <p>During an interview on 5/28/15 at 3:30 PM, the Nursing Supervisor reviewed Patient #9's record and confirmed the information was not present.</p> <p>Patient #9's record did not include complete documentation.</p> <p>6. Patient #11 was a 78 year old male admitted to the ASC on 4/15/15 for a button vaporization of the prostate.</p> <p>a. Patient #11's record included a "Postoperative Physician Note/Orders" completed by the operating surgeon. The entry was dated 4/15/15 but was not timed.</p> <p>b. Patient #11's record included a form titled "Preoperative Nursing Record." The time of Patient #11's arrival into the POHA was not documented.</p> <p>During an interview on 5/28/15 at 3:30 PM, the</p>	Q 162		
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Q 162	<p>Continued From page 36</p> <p>During an interview on 5/28/15 at 2:50 PM, the Nursing Supervisor reviewed the record and confirmed the recovery orders were written prior to her procedure and recovery.</p> <p>Patient #10's record did not include accurate documentation.</p> <p>9. Patient #13 was a 64 year old male admitted to the ASC on 4/15/15 for a hydrocelectomy.</p> <p>Patient #13's record included Anesthesiologist Orders signed by the anesthesiologist and dated 4/15/15. The post-operative and recovery care orders were timed 8:49 AM. Patient #13's record included documentation his procedure start time was 9:01 AM and ended at 9:29 AM, when he was transferred to the PACU.</p> <p>During an interview on 5/28/15 at 3:00 PM, the Nursing Supervisor reviewed the record and confirmed his post-operative orders were signed prior to his procedure and arrival in recovery.</p> <p>Patient #13's record did not include accurate and complete documentation.</p> <p>10. Patient #22 was a 2 year old male admitted to the ASC on 7/23/14 for a circumcision.</p> <p>Patient #22's record included Anesthesiologist Orders signed by the anesthesiologist and dated 7/23/14. The post-operative and recovery care orders were timed 11:06 AM. Patient #22's record included documentation his anesthesia start time was 11:11 AM and he was transferred from the OR to the PACU at 11:49 AM.</p> <p>During an interview on 5/28/15 at 3:05 PM, the</p>	Q 162		
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Q 181	<p>Continued From page 38</p> <p>drowsiness and decrease anxiety) 2 mg IV at 2:25 PM on 5/13/15.</p> <p>Patient #3's record included an order for Versed 2 mg IV now, signed by the Anesthesiologist. However, the Anesthesiologist signature was dated 5/15/15, 2 days after the medication was administered. Patient #3's record did not include a physician's order for Versed to be administered on 5/13/15.</p> <p>b. Patient #3's "PREOPERATIVE NURSING RECORD" dated 5/13/15 documented she received Lactated Ringers intravenously. However, Patient #3's record did not include a physician's order for IV fluids.</p> <p>During an interview on 5/26/15 at 11:15 AM, the Nursing Supervisor reviewed Patient #3's record and confirmed the order for Versed was dated 2 days after the medication was administered. Additionally, she confirmed Patient #3's record did not include a physician's order for IV fluids.</p> <p>Medications were administered to Patient #3 without physician orders.</p> <p>2. Patient #8 was a 44 year old male admitted to the ASC on 4/22/15 for left ureteroscopy, laser lithotripsy and placement of left ureteral stent.</p> <p>Patient #8's record included a "PREOPERATIVE NURSING RECORD" dated 4/22/15. It documented he received Lactated Ringers intravenously. However, Patient #8's record did not include a physician's order for IV fluids.</p> <p>During an interview on 5/28/15 at 3:25 PM, the Nursing Supervisor reviewed Patient #8's record</p>	Q 181			

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Q 181	Continued From page 40	Q 181			
Q 219	<p>a physician's order.</p> <p>416.50 PATIENT RIGHTS</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 observation, record review and staff and patient interview, it was determined the ASC failed to ensure all patients receiving services at the ASC were fully informed of their rights. This failure resulted in the potential for patient rights to be violated. Findings include:</p> <ol style="list-style-type: none"> <li>1. Refer to Q220 as it relates to the ASC's failure to ensure accurate, comprehensive patient rights information was posted for all patients receiving services at the ASC.</li> <li>2. Refer to Q221 as it relates to the ASC's failure to ensure patients were provided with verbal and written comprehensive rights information prior to their procedures.</li> <li>3. Refer to Q223 as it relates to the ASC's failure to ensure patients were provided with written notification of Physician Financial Interests and Ownership.</li> <li>4. Refer to Q224 as it relates to the ASC's failure</li> </ol>	Q 219	SEE Q219 AP		

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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 observation, review of the ASC's printed materials, and patient and staff interview, it was determined the ASC failed to ensure patients were provided with verbal and written comprehensive rights information prior to their procedures. This failure directly impacted 23 of 25 patients (#1 - #17, #19 - #21, #23 - #25) whose records were reviewed and 1 patient (#28), whose record was not reviewed. This resulted in the potential for patients and their representatives to not be fully informed of their rights. Findings include:</p> <p>1. Patients #1 - #17, #19, and #28 received services in the ASC's ORs. The records of Patients #21 and #23 - #25 documented they received services in the ASC's procedure rooms. The patients were not provided with comprehensive rights information as follows:</p> <p>a. Patient #28 was a 69 year old male surgical patient admitted to the ASC on 5/27/15 for a TURBT to be performed in the OR. His admission process was observed on 5/27/15 at 9:20 AM.</p>	Q 221	SEE Q 221 AP		

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Q 221	Continued From page 44 The ASC failed to ensure all patients, including Patients #1 - #17, #19, and #28 were provided with verbal and written comprehensive, accurate rights information prior to their procedures in the OR.  b. On 5/28/15 at 8:50 AM, Patient #25 was observed in the waiting room. When asked, Patient #25 stated he had not been given any paperwork or asked to sign any documents at that time. At no time during observations of Patient #25, from 8:50 AM until his discharge from the ASC at 9:36 AM, was patient rights information observed to be given or discussed with Patient #25.  During an interview with the Administrator and the Nursing Supervisor on 5/28/15 at 1:45 PM, the Administrator stated the ASC did not provide written copies of Patients' Rights, Release of Liability, Disclosure of Physician Ownership or Advance Directives to patients.  The ASC failed to ensure all patients, including Patients #21, #23, #24 and #25 were provided with verbal and written rights information prior to their receiving services in the ASC's procedure rooms.  2. Refer to Q223 as it relates to the ASC's failure to ensure patients were provided with written notification of Physician Financial Interests and Ownership.  3. Refer to Q224 as it relates to the ASC's failure to ensure patients were provided with information regarding advanced directives.	Q 221			
Q 223	416.50(b) NOTICE - PHYSICIAN OWNERSHIP	Q 223	SEE Q 223 AP		

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Q 223	<p>Continued From page 46 form to keep.</p> <p>During an interview on 5/27/15 at 9:30 AM, Patient #28 stated he did not receive written information on patients' rights prior to arriving at the ASC.</p> <p>During an interview on 5/27/15 at 9:35 AM, the front office employee stated the ASC did not mail the ASC physician owned facility information to patients prior to their admission. Additionally, she stated patients were given a laminated copy of Physician Owned Facility, but they were not given a paper copy to keep.</p> <p>During an interview on 5/27/15 at 10:20 AM, the Administrator verified patients were not given a copy of the ASC physician ownership notification prior to or upon arrival at the surgery center. She confirmed patients reviewed a laminated copy of Physician Owned Facility and signed a form to acknowledge notification of Surgery Center of Idaho's physician ownership notification.</p> <p>The ASC failed to ensure all patients, including Patients #1 - #17, #19, and #28 were provided with verbal and written notification of the ASC physician ownership prior to their procedures in the OR.</p> <p>b. On 5/28/15 at 8:50 AM, Patient #25 was observed in the waiting room. When asked, Patient #25 stated he had not been given any paperwork or asked to sign any documents at that time. At no time during observations of Patient #25, from 8:50 AM until his discharge from the ASC at 9:36 AM, was physician ownership of the ASC information observed to be given or discussed with Patient #25.</p>	Q 223			

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Q 224	<p>Continued From page 48</p> <p>written notification of Advance Directives prior to their procedures. This failure directly impacted 23 of 25 patients (#1 - #17, #19 - #21, #23 - #25) whose records were reviewed and 1 patient (#28), whose record was not reviewed. This resulted in the potential for patients and their representatives to not be fully informed of their rights. Findings include:</p> <p>1. Patients #1 - #17, #19, and #28 received services in the ASC's ORs. The records of Patients #21, and #23 - #25 documented they received services in the ASC's procedure rooms. The patients were not provided with comprehensive rights information as follows:</p> <p>a. Patient #28 was a 69 year old male surgical patient admitted to the ASC on 5/27/15 for a TURBT to be performed in the OR. His admission process was observed on 5/27/15 at 9:20 AM.</p> <p>Patient #28 was given the opportunity to review a laminated copy of a form titled "Advance Directives" by a front office employee. He was asked to initial a form that stated "I have received a copy Advance Directives information prior to my surgery date. I understand the information that was provided to me and all my questions have been answered to my satisfaction." He was not given a copy of the Advance Directives form to keep.</p> <p>During an interview on 5/27/15 at 9:30 AM, Patient #28 stated he did not receive written information on patients' rights prior to arriving at the ASC.</p> <p>During an interview on 5/27/15 at 9:35 AM, the</p>	Q 224			

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Q 224	Continued From page 50	Q 224		
Q 244	<p>The ASC failed to ensure all patients, including Patients #21, #23, #24 and #25 were provided with verbal and written physician ownership information prior to their receiving services in the ASC's procedure rooms.</p> <p>416.51(b)(2) INFECTION CONTROL PROGRAM - QAPI</p> <p>[The program is -] An integral part of the ASC's quality assessment and performance improvement program</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of facility policies and QAPI documents, it was determined the ASC failed to ensure the infection control program was incorporated into the facility QAPI program for all patients receiving services at the ASC. This resulted in the inability of the ASC to evaluate its infection control processes necessary for improving the quality of patient care. Findings include:</p> <p>The ASC's policy 8.01 "Quality Assessment and Process Improvement," dated 10/23/12, stated "Activities designed to ensure high-quality patient care shall include...infection prevention and control..." However, there was no evidence to indicate the Infection control program had been incorporated into the QAPI program in accordance with the policy.</p> <p>During the survey entrance conference on 5/26/15 at 9:00 AM the Administrator stated the Nursing Supervisor was responsible for QAPI and</p>	Q 244	SEE Q244 AP	

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Q 244	<p>Continued From page 52</p> <p>Governing Body monthly meeting minutes were reviewed. A meeting documented on 1/21/15 stated physician and clinical staff were reminded to report post-operative infections. No additional information related to QAPI or infection control was included in the minutes. No meeting was documented in July, 2014 and the meeting minutes for 8/20/14, 9/17/14, 10/15/14, 11/19/14, 12/17/14, 2/18/15, 3/18/15 and 4/15/15 did not contain information related to QAPI or infection control.</p> <p>On 5/27/15 beginning at 2:20 PM, the Nursing Supervisor stated post-operative infections were self-reported by the surgeons within 60 days of the procedure. During a subsequent interview on 5/28/15 at 10:20 AM, the Nursing Supervisor stated no trends were documented or examined related to the reported 2013 infections.</p> <p>The Nursing Supervisor presented a document titled "2013 Infections by Procedure." The document indicated an overall infection rate for 2013 of 1%. However, it indicated 37% of reported infections occurred after a cystoscopy procedure, and 13% occurred after a ureteroscopy procedure. Both procedures were performed in the "Cystoscopy Suite," which consisted of 4 procedure rooms within the ASC. Therefore, 50% of infections reported in 2013 occurred in patients following procedures performed in the "Cystoscopy Suite."</p> <p>During an interview on 5/28/15 at 10:20 AM, the Nursing Supervisor stated infections reported in 2014 were documented, but she had not yet determined the number of infections reported per procedure to identify possible trends.</p>	Q 244		
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Q 262	<p>Continued From page 54 addendum or stamped with update on existing H &amp; P."</p> <p>"If the History and Physical is written by a Physician Assistant or Non Operating Surgeon, the Operating Surgeon will document indications, risk, benefits, and alternatives to surgery discussion with patient prior to initiating the surgical procedure."</p> <p>1. Patient #3 was a 69 year old female admitted to the ASC on 5/13/15 for a pubovaginal sling, and cystocele and rectocele repair for uterine prolapse.</p> <p>Patient #3's record included an H&amp;P electronically signed by her physician on 4/24/15. The last page of the H&amp;P contained a stamped box to document updates to the H&amp;P. There was a check mark next to "No change in History and Physical and indications for procedure unchanged." The box contained her physician's signature. However, the signature was not dated to determine when her physician examined her to determine there were no changes to her H&amp;P.</p> <p>During an interview on 5/28/15 at 3:20 PM, the Nursing Supervisor reviewed Patient #3's record and confirmed the physician's update to the H&amp;P was not dated.</p> <p>2. Patient #8 was a 44 year old male admitted to the ASC on 4/22/15 for left ureteroscopy, laser lithotripsy and placement of left ureteral stent.</p> <p>Patient #8's record included an H&amp;P electronically signed by a Physician's Assistant on 4/16/15. The last page of the H&amp;P contained a stamped box to document updates to the H&amp;P. There was</p>	Q 262		
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Q 262	<p>Continued From page 56</p> <p>document an update to her H&amp;P on the day of her surgical procedure.</p> <p>During an interview on 5/28/15 at 3:25 PM, the Nursing Supervisor reviewed Patient #16's record and confirmed there was no documentation of a physician's update to the H&amp;P prior to her surgical procedure.</p> <p>5. Patient #13 was a 64 year old male admitted to the ASC on 4/15/15 for a hydrocelectomy.</p> <p>Patient #13's record included an H&amp;P completed by his physician on 4/3/15. His record did not document an update to his H&amp;P on the day of his surgical procedure.</p> <p>During an interview on 5/28/15 at 3:00 PM, the Nursing Supervisor reviewed Patient #13's record and confirmed there was no documentation of a physician's update to the H&amp;P on the day of his surgical procedure.</p> <p>6. Patient #22 was a 2 year old male admitted to the ASC on 7/23/14 for a circumcision.</p> <p>Patient #22's record included an H&amp;P electronically signed by his Physician on 6/27/14. The last page of the H&amp;P contained a stamped box to document updates to the H&amp;P. There was a check mark next to "No change in History and Physical and indications for procedure unchanged" The box contained his physician's signature, dated 7/23/14. The signature was not timed to determine it was completed prior to his surgery.</p> <p>During an interview on 5/28/15 at 3:05 PM, the Nursing Supervisor reviewed Patient #22's record</p>	Q 262			

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Q 262	Continued From page 58  9. Patient #24 was a 67 year old female admitted to the ASC on 4/21/15 for cystoscopy.  Patient #24's record included an H&P electronically signed by her physician on 1/19/15. No other documentation of an H&P was provided. No pre-surgical assessment by the physician was documented. No pre-surgical vital signs, medication reconciliation or allergies verification documentation were present in the medical record.  During an interview on 5/28/15 at 3:20 PM, the Nursing Supervisor reviewed Patient #24's record and confirmed the pre-surgical assessment was not updated.  10. Patient #25 was a 72 year old male admitted to the ASC on 5/28/15 for cystoscopy.  No pre-surgical assessment by the physician was documented. Patient #25's record did not contain pre-surgical vital signs, medication reconciliation or allergies verification documentation data.  Patient #25's procedure was observed on 5/28/15 beginning at 9:00 AM. The MA took vital signs, verified an allergies list and verified current medications. The patient's blood pressure was 143/119. Patient #25 disclosed a previous reaction to lidocaine. The MA reported the potential allergy to the physician prior to the procedure. The MA did not report the elevated blood pressure to the physician prior to the procedure. The vital signs, allergies and medication verification did not become a part of the medical record.	Q 262			

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Q 262	Continued From page 60 During an interview on 5/28/15 at 2:55 PM, the Nursing Supervisor reviewed the record and confirmed the pre-surgical assessment was not complete.  Patient #2's record did not include complete documentation.	Q 262		
Q 265	The facility failed to ensure patient assessments were completed prior to procedures. 416.52(c)(1) DISCHARGE - SUPPLIES AND INFORMATION  The ASC must - Provide each patient with written discharge instructions and overnight supplies. When appropriate, make a followup appointment with the physician, and ensure that all patients are informed, either in advance of their surgical procedure or prior to leaving the ASC, of their prescriptions, post-operative instructions and physician contact information for followup care.  This STANDARD is not met as evidenced by: Based on review of medical records and staff interview, it was determined the ASC failed to provide appropriate discharge instructions to patients and family members who experienced post-operative complications. This failure directly impacted 1 of 25 patients (Patient #22) whose records were reviewed. This resulted in the potential for patients to not receive adequate care or monitoring of possible complications upon discharge from the ASC. Findings include:  1. Patient #22 was a 2 year old male who was admitted to the facility on 7/23/14 for a	Q 265	SEE Q 265 AP	

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Q 265	Continued From page 62 During an interview on 5/28/15 at 3:05 PM, the Nursing Supervisor reviewed the medical record. She confirmed the discharge instructions did not include information related to his post-operative complications. The Nursing Supervisor confirmed there was no documentation in the record that Patient #22's parents were informed or educated about his post-operative complications.	Q 265		
Q 266	Patient #22's record did not include adequate or appropriate discharge instructions related to his post-operative complications. 416.52(c)(2) DISCHARGE - ORDER  [The ASC must -] Ensure each patient has a discharge order, signed by the physician who performed the surgery or procedure in accordance with applicable State health and safety laws, standards of practice, and ASC policy.  This STANDARD is not met as evidenced by: Based on record review, review of policies, and staff interview it was determined the facility failed to ensure patients were discharged on the order of the physician who performed their surgery for 13 of 25 patients (#2, #3, #8, #10, #12, #13, #16, #18, #21, #22, #23, #24 and #25) whose records were reviewed. This resulted in patients being discharged without an evidence-based determination that they were medically stable. Findings include:  1. Patient #3 was a 69 year old female admitted to the ASC on 5/13/15 for a pubovaginal sling, and cystocele and rectocele repair for uterine	Q 266	SEE Q266 AP	

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Q 266	<p>Continued From page 64</p> <p>contained a check mark next to "Discharge from Phase II per Criteria for Medical Discharge from Anesthesia." However, his record did not include a discharge order written by the physician who performed his surgery.</p> <p>During an interview on 5/28/15 at 3:25 PM, the Nursing Supervisor reviewed Patient #8's record and confirmed it did not include a discharge order written by the physician who performed his surgery.</p> <p>5. Patient #12 was a 37 year old male admitted to the ASC on 5/22/15 for a lithotripsy due to a left ureteral stone.</p> <p>Patient #12's Anesthesiologist order sheet contained a check mark next to "Discharge from Phase II per Criteria for Medical Discharge from Anesthesia." However, his record did not include a discharge order written by the physician who performed his surgery.</p> <p>During an interview on 5/28/15 at 3:30 PM, the Nursing Supervisor reviewed Patient #12's record and confirmed it did not include a discharge order written by the physician who performed his surgery.</p> <p>6. Patient #10 was a 72 year old female admitted to the ASC on 4/28/15 for a bilateral ureteroscopy, laser lithotripsy and stone extraction.</p> <p>Patient #10's Anesthesiologist order sheet contained a check mark next to "Discharge from Phase II per Criteria for Medical Discharge from Anesthesia." However, her record did not include a discharge order written by the physician who</p>	Q 266			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13C0001060	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  05/29/2015
NAME OF PROVIDER OR SUPPLIER  SURGERY CENTER OF IDAHO			STREET ADDRESS, CITY, STATE, ZIP CODE 2855 EAST MAGIC VIEW DRIVE 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 266	<p>Continued From page 66</p> <p>9. Patient #13 was a 64 year old male admitted to the ASC on 4/15/15 for a hydrocelectomy.</p> <p>Patient #13's Anesthesiologist order sheet contained a check mark next to "Discharge from Phase II per Criteria for Medical Discharge from Anesthesia." However, his record did not include a discharge order written by the physician who performed his surgery.</p> <p>During an interview on 5/28/15 at 3:00 PM, the Nursing Supervisor reviewed Patient #13's record and confirmed it did not include a discharge order written by the physician who performed his surgery.</p> <p>10. Patient #21 was a 71 year old female admitted to the ASC on 5/14/15 for cystoscopy.</p> <p>Patient #21's record did not include a physician's order for discharge.</p> <p>In an interview with the Nursing Supervisor on 5/28/15 at 3:30 PM, she confirmed Patient #21's record did not include a physician's order for discharge.</p> <p>11. Patient #23 was a 55 year old female admitted to the ASC on 5/13/15 for cystoscopy.</p> <p>Patient #23's record did not include a physician's order for discharge.</p> <p>In an interview with the Nursing Supervisor on 5/28/15 at 3:30 PM, she confirmed Patient #23's record did not include a physician's order for discharge.</p>	Q 266			

**ACTION PLAN**

RECEIVED  
JUL 15 2015  
FACILITY STANDARDS

Date: 6.26.2015

Problem Reference (CMS Section): Q 040

In-house point-of-contact: Greg Feltenberger, CEO

Problem Statement: Governing Board did not assume responsibility for the management and operational direction of the ASC.

Problem Narrative/Background/Details: There was a lack of sufficient policy development, implementation and monitoring, a lack of oversight and accountability for the ASC's QAPI program and a failure to achieve and sustain compliance with regulatory requirements.

Estimated Completion Date (ECD): 7.7.2015

**Solution/Action Plan:**

Task 1 and ECD: Fully developed QAPI program (see Q080 Action Plan; ECD: 6.23.2015)

Task 2 and ECD: Include incident reports, transfers, recalls, near misses, employee injuries, and infection info, medical record review status, QAPI status, areas for improvement, and long-range plans to monthly Governing Body agenda (See SCI Governing Board Meeting minutes from June; ECD: 6.17.2015)

Task 3 and ECD: Administration review and update of Policy & Procedure Manual to include Section 3.01 "Governing Board and Administrative Staff" that describes the role and responsibilities of the board (ECD: 7.7.2015)

Task 4 and ECD: Submit Policy & Procedure Manual and new cysto H&P to Governing Board for review/approval at July Governing Body Board Meeting (ECD: 7.15.2015)

Actual Completion Date (ACD): 7.7.2015 (exception Task 4, pending Governing Board meeting)

Monitoring/tracking: Future governing board agenda will include "enduring" topic categories to ensure all required areas are presented or evaluated for discussion

ACD Validated by: Greg Feltenberger, CEO

## ACTION PLAN

**Date:** 6.17.2015

**In-house point-of-contact:** Sam Owens, Quality Assurance & Infection Control Coordinator (Nurse Supervisor)

**Problem Reference (CMS Section):** Q 042

**Problem Statement:** Hospitalization: Inefficient written procedure for transfer of patient to an acute care hospital

**Problem Narrative/Background/Details:** Patient #22 at 11:55 am had laryngeal spasm in PACU. Patient was manually ventilated and returned to spontaneous respirations. At 12:05 pm patient had another spasm with respirations at "0" and oxygen saturation level of 35% at this time per SCI Code Blue policy 911 should have been dispatched. According to the current SCI Transfer Policy patient should have been transferred to acute care hospital. After patient received rescue medication (succinylcholine) patient was able to manually ventilate. At 12:10 pm patient showed normal vital signs until patient was discharged at 1:20 pm. Patient remained stable for 70 minutes post respiratory arrest. Patient discharged from facility to his parents at 1:20 pm.

**Estimated Completion Date (ECD):** 6.23.2015

**Solution/Action Plan:**

**Task 1:** Review and update Management of Cardiac / Respiratory Arrest Policy and Code Blue, Know Your Role Procedure - See revised policy attached (See Policy and Procedure 18.02 and 23.22)

**Task 2:** Review and Update Transfer Policy – See revised policy attached (See Policy and Procedure 18.02 and 23.22)

**Actual Completion Date (ACD):** 6.23.2015

**Monitoring/tracking:** Monthly review of all patient care emergencies with emphasis on nursing care and documentation. Monthly review of all incident reports with committee for detail and completeness. Enduring item on Governing Board agenda for presentation by President/Medical Director.

**ACD Validated by:** Lonna Welch, Administrator & Greg Feltenberger, CEO

## ACTION PLAN

**Date:** 6.26.2015

**Problem Reference (CMS Section):** Q 043

**In-house point-of-contact:** Greg Feltenberger, CEO

**Problem Statement:** Disaster preparedness plan was not shared with the Ada County Emergency Management Agency and SCI did not engage ACEM to discuss their expectations for our assistance during a natural disaster event.

**Problem Narrative/Background/Details:** Not a discrepancy per the final report; this was mentioned as an area for improvement; see Q043 for requirements/expectations; see Section 6 of the Policy & Procedure Manual for "Emergency Services – Acts of Nature (Life and Safety)"

**Estimated Completion Date (ECD):** 7.6.2015

### **Solution/Action Plan:**

**Task 1 and ECD:** Email sent to ADEM on 6.26.2015 awaiting reply (See scanned email and reply titled, "ACEM Email.pdf"; ECD: 6.26.2015)

**Task 2 and ECD:** Fire drill history (See "SCI Facility One" binder, Tab 6 located in Facility Management Office and see "2015 Fire Drill Reports.pdf"; ECD: 6.26.2015)

**Actual Completion Date (ACD):** 7.6.2015

**Monitoring/tracking:** Annual task reminder placed in Outlook to engage ACEM; fire drill history presented quarterly by Facility Manager at staff meeting (this is added as a standard agenda item as a reminder to present quarterly)

**ACD Validated by:** Greg Feltenberger, CEO

## ACTION PLAN

**Date:** 6.19.2015

**Problem Reference (CMS Section):** Q 080

**In-house point-of-contact:** Sam Owens, Quality Assurance & Infection Control Coordinator (Nurse Supervisor)

**Problem Statement:** Quality Assessment and Performance Improvement: Underdeveloped comprehensive QAPI program. (See Policy and Procedure 7.01 – 7.12)

**Problem Narrative/Background/Details:** Quality Assessment and Performance Improvement: Underdeveloped comprehensive QAPI program to include lack of data collection, analysis, reporting to the Board for oversight, monitoring and direction, underutilization of quality indicators based on adverse patient events to improve the effectiveness and safety of the ACS's services.

**Estimated Completion Date (ECD):** 7.7.2015

### **Solution/Action Plan:**

**Task 1:** Review and update QAPI Policy – see revised policy (Policy and Procedure 7.01 – 7.12)

**Task 2:** Institute a Risk assessment tool based on Adverse Patient events to identify quality indicators for possible PI and QA studies. Get Board approval on indicators. (Policy and Procedure 7.01 – 7.12)

**Task 3:** Implement QAPI studies based on Board approval. Implement gathering, analyzing, and summarizing of data to ensure / improve patient services. (Policy and Procedure 7.01 – 7.12)

**Actual Completion Date (ACD):** 7.7.2015

**Monitoring/tracking:** Review of QAPI studies with committee monthly with use of project update form. Meet with Administrator bi-monthly to review progress and receive feedback. Implement spread sheet to assist with progress.

**ACD Validated by:** Lonna Welch, Administrator & Greg Feltenberger, CEO

## ACTION PLAN

**Date:** 6.19.2015

**Problem Reference (CMS Section):** Q 081

**In-house point-of-contact:** Sam Owens, Quality Assurance & Infection Control Coordinator (Nurse Supervisor)

**Problem Statement:** Program Scope; Program Activities: Incomplete comprehensive QAPI plan to include quality indicators focused on high risk, high volume, and problem prone areas, was developed and not fully implemented. Lack of communication / documentation to and for the Governing Board.

**Problem Narrative/Background/Details:** Program Scope; Program Activities: Incomplete comprehensive QAPI plan to include quality indicators focused on high risk, high volume, and problem prone areas, was developed and not fully implemented. Lack of communication / documentation to and for the Governing Board. Board meeting minutes lacked evidence of documentation and communication regarding the SCI QAPI program.

**Estimated Completion Date (ECD):** 7.7.2015

### **Solution/Action Plan:**

**Task 1:** Review and update QAPI Policy – see revised policy attached (Policy and Procedure 7.01 – 7.12)

**Task 2:** Institute a Risk assessment tool based on Adverse Patient events to identify quality indicators for possible PI and QA studies. Get Board approval on indicators. (Policy and Procedure 7.01 – 7.12)

**Task 3:** Implement QAPI studies based on Board approval. Implement gathering, analyzing, and summarizing of data to ensure / improve patient services. (Policy and Procedure 7.01 – 7.12)

**Actual Completion Date (ACD):** 7.7.2015

**Monitoring/tracking:** Review of QAPI studies with committee monthly with use of project update form. Meet with Administrator bi-monthly to review progress and receive feedback. Implement spread sheet to assist with progress.

**ACD Validated by:** Lonna Welch, Administrator & Greg Feltenberger, CEO

## **ACTION PLAN**

**Date:** 6.19.2015

**Problem Reference (CMS Section):** Q 082

**In-house point-of-contact:** Sam Owens, Quality Assurance & Infection Control Coordinator (Nurse Supervisor)

**Problem Statement:** Program Data; Program Activities: Inefficient tracking of adverse patient events by examine cause, identifying trends and implementing improvement where needed. Lack of communication to the Governing Board quarterly, during Board meeting.

**Problem Narrative/Background/Details:** Program Data; Program Activities: Inefficient tracking of adverse patient events by examine cause, identifying trends and implementing improvement where needed. The QAPI program must incorporate quality indicator data, including patient care and other relevant data regarding services furnished in the ASC. The ASC must have data collected to monitor effectiveness and safety of its services and quality of its care and identify opportunities that could lead to improvement and changes in patient care. Performance improvement must track adverse patient event, examine the cause, implement improvement, and ensure improvements sustains over time. The ASC must implement preventive strategies throughout facility and ensure that all staff is familiar with these strategies. The ASC must communicate back to the Governing Board quarterly, adverse patient events which had thoroughly been reviewed by the Medical Director that includes feedback to the board and staff if necessary. Lack of communication to the Governing Board at the partner meeting.

**Estimated Completion Date (ECD):** 7.7.2015

### **Solution/Action Plan:**

**Task 1:** Review and update QAPI Policy – see revised policy attached (Policy and Procedure 7.01 – 7.12)

**Task 2:** Institute a Risk assessment tool based on Adverse Patient events to identify quality indicators for possible PI and QA studies. Get Board approval on indicators (Policy and Procedure 7.01 – 7.12)

**Task 3:** Implement QAPI studies based on Board approval. Implement gathering, analyzing, and summarizing of data to ensure / improve patient services. (Policy and Procedure 7.01 – 7.12)

## ACTION PLAN

**Date:** 6.19.2015

**Problem Reference (CMS Section):** Q 083

**In-house point-of-contact:** Sam Owens, Quality Assurance & Infection Control Coordinator (Nurse Supervisor)

**Problem Statement:** Performance Improvement Projects: Inefficient distinct performance improvement projects

**Problem Narrative/Background/Details:** Performance Improvement Projects: Inefficient distinct performance improvement projects are incomplete. Current performance improvement projects the ASC listed have not had any analysis, or data collection done, therefore this data could not be used to determine trends and opportunities to improve the quality of the ASC's services.

**Estimated Completion Date (ECD):** 7.7.2015

### **Solution/Action Plan:**

**Task 1:** Review and update QAPI Policy – see revised policy attached (Policy and Procedure 7.01 – 7.12)

**Task 2:** Institute a Risk assessment tool based on Adverse Patient events to identify quality indicators for possible PI and QA studies. Get Board approval on indicators (Policy and Procedure 7.01 – 7.12)

**Task 3:** Implement QAPI studies based on Board approval. Implement gathering, analyzing, and summarizing of data to ensure / improve patient services. (Policy and Procedure 7.01 – 7.12)

**Task 5:** Update Policy to reflect all Incidents, Transfers, near misses' etc. need to be reviewed and signed by the Medical Director and Administrator within 30 days (Policy and Procedure 7.01 – 7.12)

**Actual Completion Date (ACD):** 7.7.2015

**Monitoring/tracking:** Review of QAPI studies with committee monthly with use of project update form. Meet with Administrator bi-monthly to review progress and receive feedback. Implement spread sheet to assist with progress.

**ACD Validated by:** Lonna Welch, Administrator & Greg Feltenberger, CEO

## ACTION PLAN

**Date:** 6.26.2015

**Problem Reference (CMS Section):** Q 084

**In-house point-of-contact:** Greg Feltenberger, CEO

**Problem Statement:** Governing Body did not assume responsibility for the QAPI program.

**Problem Narrative/Background/Details:** Governing board did not define, implement, and maintain the QAPI program (lacking in oversight)

**Estimated Completion Date (ECD):**

**Solution/Action Plan:**

**Task 1 and ECD:** Fully developed QAPI program (see Q080 Action Plan; ECD: 6.23.2015)

**Task 2 and ECD:** Include incident reports, transfers, recalls, near misses, employee injuries, and infection info, medical record review status, QAPI status, areas for improvement, and long-range plans to monthly Governing Body agenda (See SCI Governing Body Board Meeting minutes from June & July; ECD: 6.17.2015)

**Task 3 and ECD:** President and/or Medical Director to report QAPI program highlights to Governing Body for review/approval at June Governing Body Board Meeting (ECD: 6.17.2015)

**Task 4 and ECD:** Administration review and update of QAPI program and review/approval by President and/or Medical Director (ECD: 7.8.2015)

**Task 5 and ECD:** Quality Assurance and Infection Control Coordinator (Nursing Supervisor) to attend Governing Board meeting to support President/Medical Director and provide additional details on QAPI if needed (ECD: 7.15.2015)

**Task 6 and ECD:** Submit QAPI program overview (program process/operations/time) to Governing Body for review/approval at July Governing Body Board Meeting (ECD: 7.15.2015)

**Actual Completion Date (ACD):** 7.8.2015 (exception Task 5 & 6 w/ ECD of 7.15.2015)

## ACTION PLAN

**Date:** 6.19.2015

**Problem Reference (CMS Section):** Q101

**In-house point-of-contact:** Frank Smith, Facility Manager

**Problem Statement: Physical Environment:** Humidity is not consistent 30 to 60% in OR suites.

**Problem Narrative/Background/Details: Physical Environment:** The ASC must provide a function and sanitary environment for the provision of surgical services. Each operating room must be designed and equipped so that the types of surgery conducted can be performed in a manner that protects the lives and assures the physical safety of all individuals in the area.

The STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure appropriate OR temperature and humidity was maintained in 3 of 3 ORs (ORs 1 – 3) whose temperature and humidity logs were reviewed. This resulted in the potential for all patients to be exposed to an increased risk of infections. Findings include:

1. The ASC's undated "opening and Closing OR suite" stated each working day, the first person on duty in the OR was to complete multiple tasks which included visual inspection of the OR temperature and humidity.

The "Opening and Closing OR Suite" policy stated OR temperature was to be between 68 and 73 degrees Fahrenheit and OR humidity was to be between 30% and 60%. The policy stated if the temperature or humidity was out of range, staff was to contact the Maintenance Coordinator. The OR temperature and humidity logs from 5/2014 – 4/2015 were reviewed and documented ongoing temperature and humidity readings which were out of range.

**Estimated Completion Date (ECD):** ASAP

### **Solution/Action Plan:**

**Task 1:** 6.23.2015, we had an RM Mechanical technician do a survey on our present humidifiers. The tech is looking for a solution to provide consistent humidity to OR's 1, 2, and 3. We will look at improving duct humidity injectors in the air circulation ducts to maintain 30 to 60% humidity in the OR's.

**Task 2:** Will follow up in two weeks with RM Mechanical to see if a solution has been defined for implementation. We are also looking to receive a bid from RM Mechanical to upgrade the current Humidifiers if a viable solution is not reached to correct the current decrease in humidity

**Actual Completion Date (ACD):** ASAP

**Monitoring/tracking:** Assessed by Facility Manager during periodic (weekly & monthly) checks of all building areas

## ACTION PLAN

**Date:** 6.27.2015

**Problem Reference (CMS Section):** Q 162

**In-house point-of-contact:** Sam Owens, Quality Assurance & Infection Control Coordinator (Nurse Supervisor)

**Problem Statement:** Form and Content of Record: Review of 25 records, 10 had incomplete medical record documentation.

**Problem Narrative/Background/Details:** Form and Content of Record: Review of 25 records, 10 had incomplete medical record documentation. Missing documentation included Anesthesiologist signature on pre-op medication orders was dated for 2 days after surgery. Missing time from physician on post operative medication orders, making it impossible to note when the order was determined and given. Consent for Anesthesia Services missing signature for witness. Patient arrival into pre-op was not times. Missing time for Anesthesia orders postoperatively. Missing signatures, dates and times, dates being listed either prior to prior or days after surgery.

**Estimated Completion Date (ECD):** 7.7.2015

### **Solution/Action Plan:**

**Task 1:** Educate and train all staff, physicians and Anesthesia to sign, date and time all documentation when required.

**Task 2:** Policy for Ensuring Chart Completion: Each patient chart is audited by nursing staff upon arrival to PACU. Prior to scanning the chart documents and sending the chart to the front desk for finalization, the chart is thoroughly reviewed to ensure all necessary signatures, times, and dates have been obtained. Upon the finding of a missing entry, the chart is flagged with a "sign here" sticker. The PACU team will attempt to obtain missing content from the appropriate party (doctor, anesthesiologist, RN, etc.) the same day the chart is received. Should attempts at obtaining such information be unsuccessful, the front desk staff will make efforts to obtain the missing information within 1 week. Upon obtaining the missing documentation, the chart will be scanned and finalized by front desk staff. At this point the chart is complete (ECD: 7.7.2015).

**Actual Completion Date (ACD):** 7.7.2015

## ACTION PLAN

**Date:** 6.27.2015

**Problem Reference (CMS Section):** Q 181

**In-house point-of-contact:** Sam Owens, Quality Assurance & Infection Control Coordinator (Nurse Supervisor)

**Problem Statement:** Administration of Drugs: 21 patient medical records were reviewed and 4 were found to be incomplete, missing physicians order for medication.

**Problem Narrative/Background/Details:** Administration of Drugs: 21 patient medical records were reviewed and 4 were found to be incomplete, missing physicians order for medication. Versed was given to a patient preoperatively and Anesthesia did not sign the order until 2 days after the medication was administered. No physician orders for IV fluids, Cipro ordered 250 mg but patient documentation stated patient was given 500 mg without documented order from physician.

**Estimated Completion Date (ECD):** 7.7.2015

### **Solution/Action Plan:**

**Task 1 and ECD:** After further review, verbal orders were not being documented. Educated and trained clinical staff to document all verbal orders. Reviewed all patient forms and developed a nursing narrative document. Reviewed these changes at the clinical staff meeting (ECD: 6.5.2015).

**Task 2 and ECD:** Will review all forms with anesthesia and physicians for awareness of documentation of all medication at July Governing Board meeting (ECD: 7.7.2015)

**Actual Completion Date (ACD):** 7.7.2015

**Monitoring/tracking:** Nursing Supervisor and Administrator will periodically review forms; staff will be educated to conduct "spot" quality control checks

**ACD Validated by:** Lonna Welch, Administrator & Greg Feltenberger, CEO

## ACTION PLAN

Date: 6.22.2015

**Problem Reference (CMS Section):** Q-219

**In-house point-of-contact:** Stephanie Morgan, Surgical Staff Coordinator

**Problem Statement:** The Patient's Rights hanging on the wall did not have the accurate address or phone number, the front office staff was not handing patients their written writes, physician ownership, or advanced directives.

**Problem Narrative/Background/Details:** Condition for Coverage – Patient Rights

The ASC must inform the patient or the patient's representative or surrogate of the patient's right and must protect and promote the exercise for these rights, as set forth in this section. The ASC must also post written notice of patients' rights in a place within the ASC likely to be noticed by patients waiting for treatment or by the patient's representative or surrogate, if applicable

The CONDITION is not met as evidenced by: Based on observation, records review and staff and patient interview, it was determined the ASC failed to ensure all patients receiving services at the ASC were fully informed of their rights. This failure resulted in the potential for patients' rights to be violated. Findings include: (1) Refer to Q-220 as it relates to the ASC's failure to ensure accurate, comprehensive patients' rights information was posted for all patients receiving services at the ASC. (2) Refer to Q221 as it relates to the ASC's failure to ensure patients were provided with verbal and written comprehensive rights information prior to their procedures. (3) Refer to Q223 as it relates to the ASC's failure to ensure patients were provided with written notification of Physician Financial Interests and Ownership. (4) Refer to Q224 as it relates to the ASC's failure to ensure patients were provided with information regarding advanced directive

**Estimated Completion Date (ECD):** 7.6.2015

**Solution/Action Plan:**

**Task 1 and ECD:** All paperwork has been updated with corrections.

**Task 2 and ECD:** Talked with front office staff and stressed the importance of giving each patient verbal rights/ownership/advanced directive along with their own copy of their rights/ownership/advanced directives.

**Task 3 and ECD:** Add revision date to pertinent documents (ECD: 7.6.2015)

**Actual Completion Date (ACD):** 7.6.2015

## ACTION PLAN

**Date:** 6.18.2015

**Problem Reference (CMS Section):** Q-0220

**In-house point-of-contact:** Stephanie Morgan, Surgical Staff Coordinator

**Problem Statement:** Our Notice of Rights had the incorrect address and phone number for filing a written complaint.

**Problem Narrative/Background/Details:** 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. This STANDARD is not met as evidenced by: Based on observation, review of the ASC's printed materials, and staff interview, it was determined the ASC failed to ensure accurate, comprehensive patients' rights information was posted for all patients receiving services at the ASC. This Failure is lack of information being available to patients and their representatives

**Estimated Completion Date (ECD):** 7.6.2015

### **Solution/Action Plan:**

**Task 1 and ECD:** Policy and paperwork updated with correct address and phone number (See attached current and updated policy)

**Task 2 and ECD:** Hung newly updated policy in our frames at the front and educated front office staff of updated policy.

**Task 3 and ECD:** Add revision date to pertinent documents (ECD: 7.6.2015)

**Actual Completion Date (ACD):** 7.6.2015

**Monitoring/tracking:** Educate all staff to review revision date in footer to ensure most current form is being used.

**ACD Validated by:** Lonna Welch, Administrator & Greg Feltenberger, CEO

## ACTION PLAN

**Date:** 6.18.2015

**Problem Reference (CMS Section):** Q-0221

**In-house point-of-contact:** Stephanie Morgan, Surgical Staff Coordinator

**Problem Statement:** Our Notice of Rights were not given to patients verbally or written.

**Problem Narrative/Background/Details:** Based on observation, review of the ASC's printed materials, and patient and staff interview, it was determined the ASC failed to ensure patients were provided with verbal and written comprehensive rights information prior to their procedures. This failure directly impacted 23 of 25 patients (#1 - #17, #19 - #21, #23 - #25) whose records were reviewed and 1 patient (#28), whose records was not reviewed. This resulted in the potential for patients and their representatives to not fully be informed of their rights.

**Estimated Completion Date (ECD):** 7.6.2015

### **Solution/Action Plan:**

**Task 1 and ECD:** Policy and paperwork updated with correct address and phone number (See attached Current and Updated policy)

**Task 2 and ECD:** Educated front office staff of updated form and policy of providing each patient with a copy of the Notice of Rights along with provided staff with a laminate copy ways to verbally educate patients of their rights.

**Task 3 and ECD:** Add revision date to pertinent documents (ECD: 7.6.2015)

**Actual Completion Date (ACD):** 7.6.2015

**Monitoring/tracking:** Educate all staff to review revision date in footer to ensure most current form is being used.

**ACD Validated by:** Lonna Welch, Administrator & Greg Feltenberger, CEO

## ACTION PLAN

**Date:** 6.18.2015

**Problem Reference (CMS Section):** Q 223

**In-house point-of-contact:** Stephanie Morgan, Surgical Staff Coordinator

**Problem Statement:** Disclosure that our physicians own Surgery Center of Idaho, LLC was not given in writing or verbally to our patients.

**Problem Narrative/Background/Details:** The ASC must disclose, in accordance with Part 420 of this subchapter, and where applicable, provided 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 observation, review of ASC's printed materials, and patients and staff interview, it was determined ASC failed to provide patients with written notification of Physician Financial Interest and Ownership prior to their procedures. This failure directly impacted 23 of 25 patients (#1 - #17, #19 - #21, #23 - #25) whose records were reviewed and 1 patient (#28), whose records were reviewed and 1 patient (#28), whose record was not reviewed. This resulted in the potential for patients and their representatives to not be fully informed of their rights.

**Estimated Completion Date (ECD):** 7.6.2015

### **Solution/Action Plan:**

**Task 1 and ECD:** Informed and educated front office staff on policy of providing written and verbal notification on our physicians ownership in the ASC.

**Task 2 and ECD:** Each patient will now receive a copy of the Physician Financial Interest and Ownership at check in (See attached form)

**Task 3 and ECD:** Add revision date to pertinent documents (ECD: 7.6.2015)

**Actual Completion Date (ACD):** 7.6.2015

**Monitoring/tracking:** Educate all staff to review revision date in footer to ensure most current form is being used.

**ACD Validated by:** Lonna Welch, Administrator & Greg Feltenberger, CEO

## ACTION PLAN

**Date:** 6.19.2015

**Problem Reference (CMS Section):** Q 224

**In-house point-of-contact:** Stephanie Morgan, Surgical Staff Coordinator

**Problem Statement:** Advanced Directives are not being given to patients to review 24-hrs prior to arrival, along with not receiving verbal or written documentation about their Advanced Directive rights.

**Problem Narrative/Background/Details:** The ASC must comply with the following requirements: (1) Provide the patients or, as appropriate, the patient's representative with written information concerning its policies on advance directives, including a description of applicable State health and safety laws and, if requested, official State advance directive forms. (2) Inform the patient or as appropriate, the patient's representative of the patient's rights to make informed decisions regarding the patient's care. (3) Document in a prominent part of the patient's current medical record, whether or not the individual has executed an advance directive. This STANDARD is not met as evidenced by: Based on observation, review of ASC's printed materials, and patient and staff interview, it was determined ASC failed to provide patients with written notification of Advance Directives prior to their procedures. This failure directly impacted 23 of 25 patients (#1 - #17, #19 - #21, #23 - #25) whose records were reviewed and 1 patient (#28), whose record was not reviewed. This resulted in the potential for patients and their representative to not be fully informed to their rights.

**Estimated Completion Date (ECD):** 7.6.2015

### **Solution/Action Plan:**

**Task 1 and ECD:** Changed policy to have surgery scheduler send copy of Advanced Directive form with patient's surgical information when she schedules patient for surgery. Cystoscopy patients will be offered the Advanced Directive at the front desk when making the appointment or will have the opportunity to read it online located on our website ([www.idurology.com](http://www.idurology.com)) (ECD: 6.18.2015)

**Task 2 and ECD:** Reviewed the Advanced Directive policy with front office staff and they will be reminding patients when they call to remind of appointment to read through the form prior to arrival. Once patient arrives in facility they will have them review the form and sign the Advanced Directives form/waiver (See attached Advanced Directives form and Advanced Directives waiver; ECD: 6.18.2015)

**Task 3 and ECD:** Add revision date to pertinent documents (ECD: 7.6.2015)

## ACTION PLAN

**Date:** 6.19.15

**Problem Reference (CMS Section):** Q 244

**In-house point-of-contact:** Samantha Owens, Quality Assurance Infection Control Coordinator (QAICC; Nursing Supervisor)

**Problem Statement:** Quality Assessment and Process Improvement / Infection Control Program: Underdeveloped comprehensive QAPI program with lack of emphasis on the Infection Control Program.

**Problem Narrative/Background/Details:** Quality Assessment and Process Improvement / Infection Control Program: Underdeveloped comprehensive QAPI program with lack of emphasis on the Infection Control Program including data collection, analysis, reporting to the Board for oversight, monitoring and direction, underutilization of quality indicators based on adverse patient events and postoperative infection rates to improve quality of patient care.

**Estimated Completion Date (ECD):** 7.7.2015

### **Solution/Action Plan:**

**Task 1:** Review and update QAPI Policy – see revised policy (Policy and Procedure 7.01-7.12)

**Task 2:** Review and update Infection Control Policy – see revised policy (Policy and Procedure 8.01-8.17)

**Task 3:** Reported infections will be categorized by procedure and a root cause analysis will be conducted if necessary.

**Actual Completion Date (ACD):** 7.7.2015

**Monitoring / Tracking:** Review Infection Control Policy and QAPI studies monthly with Committee. Weekly evaluation of QAPI/Infection Control Practices by QAICC with use of project update form.

**ACD Validated by:** Lonna Welch, Administrator & Greg Feltenberger, CEO

## ACTION PLAN

**Date:** 6.27.2015

**Problem Reference (CMS Section):** Q 262

**In-house point-of-contact:** Sam Owens, Quality Assurance & Infection Control Coordinator (Nurse Supervisor)

**Problem Statement:** Pre-Surgical Assessment: Incomplete assessments were done by a qualified practitioner prior to procedures.

**Problem Narrative/Background/Details:** Pre-Surgical Assessment: Incomplete assessments were done by a qualified practitioner prior to the procedure. This led to the potential for patients to receive inadequate care during their procedures.

**Estimated Completion Date (ECD):** 6.27.2015

### **Solution/Action Plan:**

**Task 1:** Train and educate both clinical staff and Medical Staff that all H&P's need to be within 30 days. Once the physician sees the patient and reviews their H&P the physician can utilize the stamp to document updates to the H&P but this must be signed, dated and timed by the physician to reflect this was done prior to surgery.

**Task 2:** Training for the clinical staff and Medical staff that all H&P's need to be within 30 days will be implemented within the Cysto Suites. Due to the way the cystoscopy are scheduled a hand written H&P will be filled out from the physician and scanned into the patients EHR. This needs to include signature, date and time. All vital signs, allergies and medications are documented in the patients EHR.

**Actual Completion Date (ACD):** 6.27.2015

**Monitoring/tracking:** Medical record review check off sheets will updated and staff feedback will be used to ensure this process is being completed.

**ACD Validated by:** Lonna Welch, Administrator & Greg Feltenberger, CEO

## ACTION PLAN

Date: 2.26.2015

**Problem Reference (CMS Section):** Q 265

**In-house point-of-contact:** Sam Owens, Quality Assurance & Infection Control Coordinator (Nurse Supervisor)

**Problem Statement:** Facility did not provide appropriate discharge instructions to patients and family members who experienced post-operative complications

**Problem Narrative/Background/Details:** Facility did not provide appropriate discharge instructions to patients and family members who experienced post-operative complications

**Estimated Completion Date (ECD):** 6.23.2015

**Solution/Action Plan:**

**Task 1:** Review discharge instructions and documentation

**Task 2:** Educate and train staff to provide patients and family members post-operative instructions if complications arise during the patients visit to SCI.

**Actual Completion Date (ACD):** 6.23.15

**Monitoring/tracking:** Ongoing review and evaluation of incident reporting and nursing documentation for detail and completeness. Medical records review used as tool to evaluate.

**ACD Validated by:** Lonna Welch, Administrator & Greg Feltenberger, CEO

## ACTION PLAN

**Date:** 6.26.2015

**Problem Reference (CMS Section):** Q 266

**In-house point-of-contact:** Sam Owens, Quality Assurance & Infection Control Coordinator (Nurse Supervisor)

**Problem Statement:** SCI did not have documentation showing patients were being discharged on the order of the physician who performed the surgery. This resulted in patients being discharged without an evidence based determination that they were medically stable by the physicians.

**Problem Narrative/Background/Details:** Updated physician discharge orders to include a box for the physician to check "discharge from the Phase II per Criteria for Medical Discharge from Physician" (See Policy & Procedure 23.22).

**Estimated Completion Date (ECD):** 7.6.2015

### **Solution/Action Plan:**

Task 1: NA; COMPLETED 5.29.2015

Task 2 and ECD: Add revision dates as a footer to all clinical forms and educate staff; this will ensure the most current forms are in use (ECD: 7.6.2015)

**Actual Completion Date (ACD):** 7.6.2015

**Monitoring / Tracking:** Educate all staff to review revision date in footer to ensure most current form is being used.

**ACD Validated by:** Lonna Welch, Administrator & Greg Feltenberger, CEO