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: 700 1670 0011 3315 1552

July 16, 2015

Denise Rue, Administrator
S I P I Ambulatory Surgery Center
176 Falls Avenue
Twin Falls, ID 83301

RE: S I P I Ambulatory Surgery Center, Provider #13C0001020

Dear Ms. Rue:

Based on the survey completed at S I P I Ambulatory Surgery Center, on July 8, 2015, by our staff, we have determined S I P I Ambulatory Surgery Center is out of compliance with the Medicare ASC Condition for Coverage of **Patient Admission, Assessment and Discharge (42 CFR 416.52)**. To participate as a provider of services in the Medicare Program, a OR an ASC must meet all of the Conditions for Coverage established by the Secretary of Health and Human Services.

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

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

<u>An acceptable Plan of Correction contains the following elements</u>:

- 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;
- 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 August 22, 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 August 12, 2015.

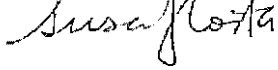
Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **July 29, 2015**.

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.

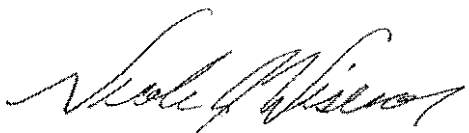
We urge you to begin correction immediately.

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

Sincerely,



SUSAN COSTA
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

SC/pmt
Enclosures
ec: 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: 07/16/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13C0001020		07/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
S I P I AMBULATORY SURGERY CENTER	176 FALLS AVENUE TWIN FALLS, ID 83301

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Q 000	INITIAL COMMENTS The following deficiencies were cited during the Medicare recertification survey of your surgical center from 7/7/15 to 7/8/15. Surveyors conducting the recertification were: Susan Costa, RN, HFS, Team Leader Nancy Bax, RN, HFS Dennis Kelly, RN, HFS Acronyms used in this report include: ASC - Ambulatory Surgery Center CC/HPI - Chief Complaint, History & Physical CDC - Centers for Disease Control CCMA - Certified Clinical Medical Assistant DM - Diabetes Mellitus DON - Director of Nurses EMR - Electronic Medical Record H&P - History and Physical assessment IV - Intravenous mg - milligram ml - milliliter OR - operating room RN - Registered Nurse ROS - Review of Systems	Q 000	Acronyms used in this POC: CMS: Center for Medicare/Medicaid Services POC: Plan of Correction ASC: Ambulatory Surgery Center DON: Director of Nursing Pt: Patient MA: Medical Assistant CMA: Certified Medical Assistant CCMA: Certified Clinical Medical Assistant RR: Recovery Room DC: Discharge IV: Intravenous OR: Operating Room PA: Physician Assistant IIHI: Individual Identifiable Health Information H.& P: History and Physical	
Q 141	416.46(a) ORGANIZATION AND STAFFING Patient care responsibilities must be delineated for all nursing service personnel. Nursing services must be provided in accordance with recognized standards of practice. There must be a registered nurse available for emergency treatment whenever there is a patient in the ASC. This STANDARD is not met as evidenced by: Based on observation, record review and staff	Q 141	Q141 POC In order to meet the goal of delineating pt care responsibilities of all nursing service personnel, the job descriptions of the MA, whether they are a CCMA, CMA or MA, was revised to better define their specific nursing duties. The revisions included the	

RECEIVED
JUL 29 2015
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Denise Rue
TITLE: Administrator
(X6) DATE: 7/29/2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Q 141	Continued From page 1 interview, it was determined the facility failed to ensure qualified nursing personnel were available to provide routine and emergency care. This directly impacted 16 of 17 patients (#2 - #17) whose records were reviewed and had the potential to impact all patients receiving care at the facility. This resulted in the inability of the facility to ensure safe and effective nursing services were provided to patients. Findings include: 1. During a facility tour on 7/7/15 beginning at 11:00 AM, a CCMA was observed to provide post procedural care. The CCMA was also observed providing post procedural care for 2 patients whose care was followed from admission through discharge (#2 and #3). The facility's policy and procedure manual, revised 2/2/15, included under "Standards of Care," stated "Recovery Room Admission...the nursing staff will receive a report of patient's condition and carry out all post-op orders. The nurse will monitor patient's vital signs, and give ordered medications. The patient will be discharged appropriately with discharge instructions." The policy "Staffing," revised 2/2/15, stated "Registered nurses, LPN's [sic], surgical and radiological technologists, medical assistants who are qualified by relevant education, experience and current competency shall supervise the provision of ambulatory surgery nursing." However, the facility's personnel files were reviewed. The ASC employed an RN and a CCMA. The file for the CCMA did not include documentation sufficient to ensure patient care	Q 141	addition of post-procedural recovery assessment, DC assessment, removal of IV catheters and provision of DC instructions. (attached) To ascertain that these tasks are consistent with their abilities, these tasks were also added to the facility's "Skills Lab" form. (attached) This more defined job description and staff instruction will further ensure that safe and effective nursing services are being provided to our patients. The completion date for the correction of this deficiency is 8-10-2015. This corrective measure will be monitored through future skills lab documentation. The DON will be responsible for continuing this program. The comment on page 4 stating "The RN confirmed that when she was in the OR with the physician during a procedure she was not directly available to the CCMA in the recovery area"	

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Q 141	Continued From page 2 responsibilities were appropriately delineated as follows: The job description for the CCMA (Certified Clinical Medical Assistant) stated the CCMA reported to the Office Manager. The job description stated the CCMA must demonstrate competency in all skills related to the performance of patient care. The job description for the CCMA included duties related to patient care. Some of the examples listed were: -"Welcomes patients in person or on the telephone" -"Verifies information by interviewing patient, reviewing and/or recording medical history, taking vital signs, confirming purpose of visit or treatment" -"Prepares patients for the health care visit by directing and/or accompanying them to the examining room" -"Educates patients by providing medication and diet information and instructions, answering questions" -"Completes records by recording patient examination, treatment, and test results" The CCMA job description did not include duties of post procedural assessment of patients, providing discharge instructions, and removing IV catheters. The CCMA employee file included a form titled "Skills Lab." It included dates of 12/5/13, and 10/8/14. Skills that were addressed included IM injection, recapping of needle, drawing up medication, blood glucose, handwashing, blood	Q 141	was found to be rather conflicting. Perhaps the RN's comment was misinterpreted since the RN is always available in our facility. Per CMS interpretive guidelines 416.46 (a) "Available" means on the premises and sufficiently free from other duties that the nurse is available to respond rapidly to emergency situations. Our relatively small facility functions under the premise that an emergency can occur at any time and in any place within the ASC. Whether the RN is assisting the physician in the OR or attending to the needs of a patient in the RR, she always remains "available" to be able to respond rapidly to any emergency situation. We maintain sufficient staff to coordinate emergency protocols such as calling out for help, sending someone for help, use of alarms and switching roles from assisting in the OR to DC needs as emergency situations arise. This is the	

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Q 141	Continued From page 3 pressure, respiratory rate, oxygen saturation, and pulse. The "Skills Lab" form did not include post procedural recovery assessment, discontinuation of IV catheters, or discharge assessment and teaching. During an interview on 7/8/15 beginning at 4.00 PM, the DON stated the CCMA provided recovery care to patients under her supervision. She stated she was close by if the CCMA needed her assistance. The RN confirmed that when she was in the OR with the physician during a procedure, she was not directly available to the CCMA in the recovery area. Patients #2- #17's medical records documented they had procedures performed between 1/1/15 and 7/7/15. All 16 records documented the CCMA provided recovery care to the patients and were discharged by her. Each record included the statement "Patient discharged by [CCMA] and approved for discharge by [RN]." The facility failed to ensure the CCMA's duties were clearly delineated and consistent with her abilities. The ASC failed to ensure that staff were qualified and trained for the duties necessary to ensure pre-operative and post-operative services were provided in a safe manner.	Q 141	advantage a small ASC has over a large medical facility to improve the level of safety and minimize potential risk of our patients. In addition, due to the unique qualities of our facility, a PA and additional clinical staff are always available to assist if the need should arise. Attachments: MA Job Description Skills Lab form	
Q 162	416.47(b) FORM AND CONTENT OF RECORD The ASC must maintain a medical record for each patient. Every record must be accurate, legible, and promptly completed. Medical records must include at least the following:	Q 162	Q162 POC To meet standards of insufficiencies regarding maintaining complete and accurate medication lists, dosages, route and	

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Q 162	Continued From page 4 (1) Patient identification. (2) Significant medical history and results of physical examination. (3) Pre-operative diagnostic studies (entered before surgery), if performed. (4) Findings and techniques of the operation, including a pathologist's report on all tissues removed during surgery, except those exempted by the governing body. (5) Any allergies and abnormal drug reactions. (6) Entries related to anesthesia administration. (7) Documentation of properly executed informed patient consent. (8) Discharge diagnosis. This STANDARD is not met as evidenced by: Based on review of medical records, facility policies and staff interview, it was determined the facility failed to ensure medical records were complete for 13 of 17 patients (#2 - #7, #9, #11-#14, #16 and #17) whose records were reviewed. This failure resulted in a lack of complete comprehensive information being available in patient records. Findings include: 1. The facility's policy titled "Complete and Accurate Documentation of Patient Treatment," revised 2/2/15, stated, "No patient shall enter the OR without history and physical [sic] on the chart. It must include: Diagnosis, Physician examination report, List of current medication, dosages, route and frequency of administration, Any known medication reactions, allergies or intolerance, existing co morbid [sic] conditions." The facility's policy titled "Medical Record Entries," revised 2/2/15, stated "All entries must be initialed or signed with the initial of first name,	Q 162	frequency of administration we have taken the following actions. Although it is important to have a complete list of pts medications, dosages, routes and frequency of administration, maintaining 100 % accuracy is unrealistic. Therefore we have removed the need for dosage, route and frequency of administration from the facility Policy & Procedure. However, in order to address the importance of this issue on 7/15/2015 we have initiated a new QAPI Project. (See attached) We will strive to maintain 90% or greater of documentation of pts prescribed medications. The POC was initiated 7-15-2015 (however due to the magnitude of this Project the completion date is stated as 11-30-2015.) [redacted] will be responsible to	

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Q 162	Continued From page 5 full surname, and credentials." During an interview on 7/7/15 at 1:40 PM, the DON stated each patient's medical record included multiple entries by multiple people. The section of the visit note for 5/11/15, labeled as CC/HPI, ROS, and vital signs was identified by the DON as entered by the CCMA. She stated the section "Medications Prior to Today's Visit," was populated from each patient's clinic record. The visit note which included the description of the operation, was entered by the RN during the procedure. She stated the physician entered the information related to the microgram report. The DON stated the physician would review each patient record, and electronically sign the report. The policies were not followed in all cases. Examples included, but were not limited to, the following: a. Patient #17 was a 64 year old female admitted to the facility on 10/1/14 for a transforaminal epidural steroid injection. Patient #17's record included visit note dated 9/22/14. The section of the note titled "Drug Allergies" included a list of 36 medications. The section of the note titled "Medications Prior to Today's Visit" included 10 medications. However, the frequency of administration was not documented and 3 of the medications did not include dosages. Patient #17's record included a visit note dated 10/1/14, the day of her epidural injection. It included the statement "[Patient name] appeared to have an allergic reaction. My best guess as to the medication that caused this reaction is the	Q 162	assure this POC is a permanent part of the pts charts. In order to correct the issue of insufficiencies of multiple entries by multiple people, the EMR formatting model was modified to include the date and time the note is signed and completed by the physician. The staff was also educated to document specific additions they have made into a chart with their initials, title and time it was entered. The staff was also educated that any medications or allergies with reaction added to the patients chart after their initial visit must be dated and initialed as a clarification to assure that all safety measures are being implemented. A completion date for the correction of this deficiency is 8-10-2015. This corrective measure will be	

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Q 162	Continued From page 6 Omnipaque. We will avoid this in the future and add this to her long list of allergies. She responded very well to the Benadryl and on discharge appeared to be doing well without continued symptoms." There was no documentation to indicate who wrote the statement. The section of Patient #17's visit note dated 10/1/14, titled "Allergies" included only Omnipaque 300. The section of the note titled "Medications Prior to Today's Visit" included Benadryl 50 mg/ml injection solution. The section of the note titled "Medications Prescribed at Today's Visit" was blank. During an interview on 7/8/15 at 3:40 PM, the DON reviewed Patient #17's record and confirmed the entry regarding her allergic reaction was not signed by the author. She confirmed the medication list did not include dosages and frequency of administration for all medications. She stated the allergy section of Patient #17's note dated 10/1/14 was incomplete and confirmed it incorrectly indicated her allergy to Omnipaque was identified prior to her procedure on 10/1/14, rather than following the procedure. She stated this was caused by a problem with the electronic medical record. Additionally, she confirmed Benadryl 50 mg/ml injection solution was administered to Patient #17 following her procedure on 10/1/14 and it should not have been included in her list of medications prior to the visit. Patient #17's medical record did not accurately document her medications, allergies or treatments administered during her visit. Additionally, individual sections of the note were not initialed or signed to indicate the author.	Q 162	monitored periodically by the random chart audits. The Administrator will be responsible for implementing this acceptable POC and monitoring its continuation. Regarding the 13 of 17 charts that had deficiencies pertaining to absence of allergies, medications and past medical history; this is a formatting issue that although the allergy, medication and past medical history are clearly stated within the EMR, they are not being brought forth on the printed note. [redacted] showed the auditors from his EMR how these are clearly visible along the right side of his screen for full view to keep him informed of the pts pertinent medical history, including current medications & allergies.	

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Q 162	Continued From page 7 b. Patient #3 was a 53 year old female admitted to the facility on 7/7/15, for insertion of a spinal cord stimulator. The sections of Patient #3's 7/7/15 visit note titled "Drug allergies," "Medications Prior to Today's Visit" and "Medications Prescribed at Today's Visit" were blank. It was unclear whether she had drug allergies, took medications at home or was given medications during or following her procedure. During an interview on 7/8/15 at 3:20 PM, the DON reviewed Patient #3's 7/7/15 visit note. She confirmed the sections related to allergies and medications were blank. She stated the sections should not be left blank, and should state "none" if applicable. Patient #3's medical record was not complete. c. Patient #5 was a 39 year old male admitted to the facility on 2/11/15 for a lumbar epidural steroid injection. The section of Patient #5's 2/11/15 visit note titled "Drug Allergies" was blank. It was unclear whether he had drug allergies. During an interview on 7/8/15 at 3:50 PM, the DON reviewed Patient #5's visit note. She confirmed the section related to allergies was blank. She stated the section should not be left blank, and should state NKA (no known allergies) if the patient had no allergies. Patient #5's medical record was not complete.	Q 162	We are working with our EMR providers to remedy this problem. However this in no way presents a safety issue for the patient since it is clearly stated on our computers. This corrective measure will be completed 8-10-2015 with [redacted] Administrator being the responsible person to assure this does not happen again by conducting periodic chart audits. Attached: QAPI Project	

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Q 162	Continued From page 8 d. Patient #2 was a 67 year old male who was admitted to the ASC on 7/7/15 for a left transforaminal epidural steroid injection. The section of Patient #2's 7/7/15 record titled "Drug Allergies" was blank, however his H&P dated 7/22/14 stated a drug allergy to ibuprofen. During an interview on 7/8/15 at 3:50 PM, the DON reviewed Patient #2's record dated 7/7/15. She confirmed the section related to allergies was blank. She stated the section should not be left blank, and should state his allergy to ibuprofen. The section of Patient #2's record dated 7/7/15 titled "Medications Prior to Today's Visit" included: -Lipitor 10 mg tablet and oral -losartan 25 mg tablet and oral -metformin 500 mg tablet and oral The section of Patient #2's record dated 7/7/15 titled "DX." included: -724.4 Lumbar Radiculopathy -722.10 Lumbar Disc Displacement -721.3 Lumbosacral Spondylosis However Patient #2's record dated 7/22/14 included a patient reported diagnosis of diabetes mellitus type 2. In an interview with the DON on 7/8/15 at 3:50 PM, she reviewed Patient #2's record dated 7/7/15 and confirmed Patient #2's medication record did not contain a clear list of medications with frequencies and doses and did not include Patient #2's diagnosis of diabetes mellitus type 2. Patient #2's medical record was not complete. e. Patient #6 was a 33 year old male admitted to	Q 162		

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(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 162	Continued From page 9 the ASC on 2/10/15 for facet joint injections. The section of Patient #6's 2/10/15 record titled "Drug Allergies" was blank, however his informed consent dated 2/10/15 stated "may have sensitivity to dyes." In an interview with the DON on 7/8/15 at 3:50 PM, she reviewed Patient #6's record dated 2/10/15 and confirmed Patient #6 reported a possible sensitivity to dyes and that his medical record contained blank information under Drug Allergies. The RN stated the physician did not want allergies listed unless a "true allergy" existed. The RN could not produce an ASC policy that defined "true allergy." The section of Patient #6's record dated 2/10/15 titled "Medications Prior to Today's Visit" included: -oxycodone 20 mg tablet and oral -amitriptyline 25 mg tablet and Tablet(s) PO -ibuprofen 800 mg tablet and Tablet(s) PO -Cymbalta oral -albuterol Inhl -ibuprofen 800 mg tablet, 1 Tablet9S) PO TID and 30 days -metoprolol tartate 50 mg tablet and oral -Abilify 2 mg tablet, 1 Tablet(s) PO Q4-6H prn pain and 28 days -oxycodone 20 mg tablet, 1 Tablet(s) PO Q4-6h prn pain and 28 days -lisinopril 20 mg tablet and oral -alprazolam 1 mg tablet and oral In an interview with the DON on 7/8/15 at 3:50 PM, she reviewed Patient #6's record dated 2/10/15 and confirmed Patient #6's medication record did not contain a clear list of medications with frequencies and doses. She also confirmed	Q 162		

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Q 162	Continued From page 10 duplicitous medication entries that made the medication list unclear. Patient #6's medical record was not complete. f. Patient #9 was a 66 year old male admitted to the ASC on 1/12/15 for a left piriformis injection with fluoroscopic guidance. The section of Patient #9's 1/12/15 record titled "Drug Allergies" was blank, however his H&P dated 11/18/14 stated a drug allergy to sulfa. During an interview on 7/8/15 at 3:50 PM, the DON reviewed Patient #9's record dated 1/12/15. She confirmed the section related to allergies was blank. She stated the section should not be left blank, and should state his allegy to sulfa. The section of Patient #9's record dated 1/12/15 titled "Medications Prior to Today's Visit" included: -Medrol (Pak) 4 mg tablets in a dose pack and Tablet(s) PO as instructed -ibuprofen 200 mg tablet and oral -simvastatin oral -digoxin oral -carisoprodol 350 mg tablet and oral -metoprolol succinate oral -Aspir-81 oral -hydrocodone 5mg-acetaminophen 325 mg tablet and oral In an interview with the DON on 7/8/15 at 3:50 PM, she reviewed Patient #9's record and confirmed Patient #9's medication record did not contain a clear list of medications with frequencies and doses. Patient #9's medical record was not complete.	Q 162		

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Q 162	Continued From page 11 g. Patient #14 was a 50 year old female who was admitted to the ASC on 5/7/15, for a cervical epidural steroid injection under fluoroscopy. Her record included a consent form for the procedure, that included a notation that she was allergic to epinepherine. The remaining medical record did not include notation of the allergy. The section of the visit note labeled "Drug Allergies" was blank. The allergy to epinepherine was not brought forward to the visit note from the consent form. During an interview on 7/8/15 beginning at 4:00 PM, the DON reviewed Patient #14's record, and confirmed the section related to allergies was blank. She confirmed the section should have included the allergy to epinepherine. Patient #14's medical record was not complete. h. Patient #13 was a 74 year old female who was admitted to the ASC on 3/16/15, for a lumbar epidural steroid injection under fluoroscopy. Her record did not include a comprehensive H&P. The section of the visit note labeled "Drug Allergies" was blank. It was unclear whether she had drug allergies. During an interview on 7/8/15 beginning at 4:00 PM, the DON reviewed Patient #13's record, and confirmed the section related to allergies was blank. She stated the section should not be left blank, and should state "none" if applicable. Patient #13's medical record was not complete and accurate.	Q 162		

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Q 162	Continued From page 12	Q 162		

i. Patient #12 was a 44 year old male who was admitted to the ASC on 3/16/15, for a transforaminal epidural steroid injection under fluoroscopy.

The section of the visit note labeled "Drug Allergies" was blank. It was unclear whether he had drug allergies.

During an interview on 7/08/15 beginning at 4:00 PM, the DON reviewed Patient #12's record, and confirmed the section related to allergies was blank. She stated the section should not be left blank, and should state "none" if applicable.

Patient #12's medical record was not complete.

j. Patient #16 was a 40 year old female who was admitted to the ASC on 4/06/15, for a caudal epidural injection under fluoroscopy with epidurogram and conscious sedation.

The section of the visit note labeled "Drug Allergies" was blank. It was unclear whether she had drug allergies.

During an interview on 7/08/15 beginning at 4:00 PM, the DON reviewed Patient #16's record, and confirmed the section related to allergies was blank. She stated the section should not be left blank, and should state "none" if applicable.

Patient #16's medical record was not complete.

k. Patient #11 was a 77 year old female who was admitted to the ASC on 1/5/15, for a facet joint steroid injection under fluroscopy.

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Q 162	Continued From page 13 The section of the visit note labeled "Drug Allergies" was blank. It was unclear whether she had drug allergies. During an interview on 7/8/15 beginning at 4:00 PM, the DON reviewed Patient #11's record, and confirmed the section related to allergies was blank. She stated the section should not be left blank, and should state "none" if applicable. Patient #11's medical record was not complete. l. Patient #7 was a 44 year old male who was admitted to the ASC on 1/26/15, for a intra articular steroid injection in his hip under fluoroscopy. The section of the visit note labeled "Drug Allergies" was blank. It was unclear whether she had drug allergies. During an interview on 7/8/15 beginning at 4:00 PM, the DON reviewed Patient #7's record, and confirmed the section related to allergies was blank. She stated the section should not be left blank, and should state "none" if applicable. Patient #7's medical record was not complete. m. Patient #4 was an 89 year old female who was admitted to the ASC on 5/11/15, for a lumbar epidural steroid injection under fluoroscopy with epidurogram. Her record did not include a H&P. Patient #4's record was reviewed on 7/7/15. Medications included bumetadine, which, according to drugs.com is a powerful loop diuretic used for CHF to remove excess fluid from the body. Additionally, Patient #4 was taking	Q 162		

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Q 162	Continued From page 14 citalopram, an anti-depressant. Additional medications included anti-anxiety and pain medications. Her record did not include co-morbidities that would indicate the use of the diuretic or the anti-depressant. The section of the visit note labeled "Drug Allergies" was blank. It did not indicate if there were no known drug allergies. During an interview on 7/8/15 beginning at 3:20 PM, the DON reviewed Patient #4's record and confirmed her record did not include co-morbidities or a H&P. Patient #4's record was not complete. The ASC did not ensure patient medical records were complete and accurate.	Q 162		
Q 223	416.50(b) NOTICE - PHYSICIAN OWNERSHIP The ASC must disclose, in accordance with Part 420 of this subchapter, and where applicable, provide a list of physicians who have financial interest or ownership in the ASC facility. Disclosure of information must be in writing. This STANDARD is not met as evidenced by: Based on record review, observations and patient and staff interviews, it was determined the ASC failed to inform patients of physician financial interests and ownership prior to their procedures for 17 of 17 patients (#1 - #17) whose records were reviewed. This failure resulted in the potential for a lack of information being provided to patients necessary to make an informed decision regarding their care. Findings include: A Patient Information Packet was provided to the	Q 223	**Q223 POC** The action taken to correct this insufficiency was to "add back" to the Patient Rights & Responsibilities the statement disclosing the physician ownership of the facility. Unfortunately the statement had inadvertently been omitted during a recent modification on 10-8-14. The corrective measure occurred 7-8-2015 during the auditing process. (see	

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Q 223	Continued From page 15 survey team on 7/7/15 at 10:00 AM during the entrance conference with the Administrator. The Administrator stated the packet was given to each patient by the receptionist upon the patient's arrival to the ASC and prior to the planned surgical procedure. The packet included information about Patients Rights and Responsibilities, the ASC Privacy Practices and a Grievance Procedure. In an interview with the administrator on 7/7/15, she stated the physician is the owner of the ASC. Additionally, a review of the ASC bylaws stated the physician ownership of the ASC. The information packet did not include information that disclosed physician financial interest or ownership in the ASC to the patients. During observations of the admission process of Patient #1 and Patient #2 on 7/7/15, no written or verbal documentation was provided to the patients that informed them the physician scheduled to perform their procedure had a financial interest or was an owner of the ASC. An interview with Patient #1 on 7/7/15 at 11:00 AM, was conducted in an exam room after he had been admitted to the ASC. Patient #1 stated this was his fourth visit to the ASC for a procedure. When asked about information he had received from the ASC, he stated he "had no idea the physician was an owner" of the ASC and had not been given that information verbally or in written form. During an interview on 7/7/15 at 2:30 PM, the Administrator reviewed the packet of information given to ASC patients. She confirmed patients	Q 223	attached) The Administrator was responsible for this corrective measure and will monitor revisions in the future more closely to assure this will always remain in compliance. We will be adding this disclosure of ownership to the IIHI acknowledgement form as well to assure all patients are aware of this important disclosure. (Attached) **Incidentally, 11 of the 17 pts had been seen in the facility prior to 10-8-14 when the inadvertent omission took place therefore they would have been offered the document with the full disclosure on it.** Attachments: Patient Rights and IIHI _____	

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Q 241	Continued From page 17 during the procedure. 2. Patient #2 was a 67 year old male admitted to the facility on 7/7/15 for a transforaminal epidural steroid injection. His procedure was observed on 7/7/15 beginning at 1:20 PM. Patient #2's physician performed an epidurogram (a procedure in which the spine is accessed with a needle and dye injected to facilitate visualization of the spine under fluoroscopy) in the OR. Patient #2's physician then injected a steroid mixed with lidocaine into the epidural space. The physician was assisted by an RN during the procedure. The physician and the RN did not wear surgical facemasks during the procedure. The facility's policy titled Asepsis, revised 2/2/15, stated, "All surgical personnel will adhere to strict aseptic technique." The policy included information on surgical hand scrub and gowning and gloving techniques for surgical personnel. However, the policy did not reference the use of surgical facemasks in the operating room. During an interview on 7/8/15 at 4:00 PM, the DON stated she was responsible for the facility's infection control program. She stated the facility's infection control program was based on nationally recognized infection control guidelines and standards of practice, using guidelines of the Association for Professionals in Infection Control & Epidemiology (APIC) as well as other standards of practice. An APIC publication titled Preventing Infection in Ambulatory Care, 2009, Volume 1, Issue 2, contained an article titled, "Ambulatory Surgical Centers: What the Infection Preventionist Needs to Know." The article stated full barrier	Q 241	**Q241 POC** In order to comply with the recommended regulation assuring a sanitary environment, Policy & Procedure has been changed to include that prior to beginning a sterlle procedure in the OR, all surgical personnel will don face masks. This POC effective date is 8-10-2015 and [redacted] will be responsible to assure all assistants or persons present in the OR except the patient will wear surgical masks prior to a procedure tray being opened and throughout the procedure.	

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Q 241	Continued From page 18 precautions, including a face mask, should be worn during epidurals and spinal anesthesia, procedures in which needles are inserted into the patient's epidural space. The Centers for Disease Control and Prevention (CDC) website, accessed on 7/9/15, contained a "CDC Clinical Reminder: Spinal Injection Procedures Performed without a Facemask Pose Risk for Bacterial Meningitis," updated 10/25/11. It stated "Since facemasks have been shown to limit spread of droplets arising from the oral flora, the CDC has recommended their use by healthcare providers when performing spinal injection procedures." Additionally, it stated "Facemasks should always be used when injecting material or inserting a catheter into the epidural or subdural space." During an interview on 7/8/15 at 1:55 PM, the physician confirmed he did not wear a facemask during procedures in which needles were inserted into the epidural space. Additionally, he stated the facility did not require surgical personnel to wear masks during spinal injection procedures. He stated he did not feel it was necessary. The facility failed to follow professionally acceptable standards of practice, resulting in an increased risk of patient infections following spinal injection procedures.	Q 241		
Q 260	416.52 PATIENT ADMISSION, ASSESSMENT AND DISCHARGE The ASC must ensure each patient has the appropriate pre-surgical and post-surgical assessments completed and that all elements of the discharge requirements are completed.	Q 260	**Q260 POC** Issues regarding Patient admission, assessment and discharge will be addressed individually as listed below.	

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Q 260	Continued From page 19	Q 260		

This CONDITION is not met as evidenced by:
Based on review of patient records, facility policies and staff interview it was determined the facility failed to ensure each patient had the appropriate pre-surgical and post-surgical assessments completed, were discharged by a physician, and were discharged in the company of a responsible adult. This resulted in lack of appropriate evaluation of the patient's pre-operative and post-operative condition and increased potential for patients to suffer adverse events following their procedures. Findings include:

1. Refer to Q-261 as it relates to the failure of the ASC to ensure a comprehensive H&P was completed no more than 30 days before the surgery was performed.

2. Refer to Q-264 as it relates to the failure of the ASC to ensure the patients' post-surgical condition was assessed and documented in the medical record.

3. Refer to Q-266 as it relates to the failure of the ASC to ensure each patient had a discharge order signed by the physician who performed the surgery.

4. Refer to Q-267 as it relates to the failure of the ASC to ensure all patient were discharged in the company of a responsible adult, unless exempted by the attending physician.

The cumulative effect of these systemic omissions resulted in the inability of the ASC to

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Q 260	Continued From page 20 ensure the safety of patients during and following procedures.	Q 260		
Q 261	416.52(a)(1) ADMISSION ASSESSMENT Not more than 30 days before the date of the scheduled surgery, each patient must have a comprehensive medical history and physical assessment completed by a physician (as defined in section 1861(r) of the Act) or other qualified practitioner in accordance with applicable State health and safety laws, standards or practice, and ASC policy. This STANDARD is not met as evidenced by: Based on observation, record review, policy review, and staff interview it was determined the ASC failed to ensure a current comprehensive history and physical was included in the patient record prior to the procedure for 12 of 16 patients (#2, #3, #6, #8 - 10, #12, #13 and #15 - 17) whose records were reviewed. This had the potential to prevent the finding of possible contraindications to the procedures being performed. Findings include: 1. During an interview at 1:40 PM, the DON stated each patient's medical record included multiple entries by multiple people. The section of the visit note labeled as CC/HPI, ROS, and vital signs was identified by the DON as entered by the CCMA. She stated the section "Medications Prior to Today's Visit," was populated from each patient's clinic record. The visit note which included the description of the operation, was entered by the RN during the procedure. She stated the physician entered the information related to the microgram report. The	Q 261	Q261 POC Corrective measures taken to ensure a comprehensive H&P must be completed no more than 30 days prior to the pt undergoing surgery will be performed either in the clinic portion of the facility prior to their surgical appointment or if an emergency arise or time allows, the H&P may be performed in the ASC. Obviously we are unable to bill for an H&P performed in the ASC. [redacted] will be responsible for assuring this corrective measure is ongoing with a POC date of 8-10-15.	

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Q 261	Continued From page 21 DON stated the physician would review each patient record, and electronically sign the report. During an interview on 7/8/15 beginning at 1:45 PM, the physician stated he did not perform a physical assessment, he performed a focused review, and stated "I know these patients, if they have co-morbidities, I would expect the primary care provider to address those issues. If they were too unstable to have the procedure done, they would not be treated by me." The physician stated he did not need to listen to the patient with a stethoscope, and he could tell at a glance if the patient was breathing easy, or appeared to be ill. The policy "Complete and Accurate Documentation of Patient Treatment," revised 2/2/15, stated "No patient shall enter the OR without history and physical on the chart. It must include diagnosis, physician examination report, list of current medication, dosages, route and frequency of administration, any known medication reactions, allergies or intolerance, existing co morbid [sic] conditions." Patient records did not include evidence a comprehensive assessment was performed to determine co-morbidities or other factors that may place the patient at an increased risk of complications, and/or to indicate the patient was appropriate for surgery in an outpatient setting, as follows: a. Patient #17 was a 64 year old female admitted to the ASC on 10/1/14 for a transforaminal epidural injection. Patient #17's record included a clinic visit note, dated 9/22/14. The note documented her	Q 261		

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Q 261	Continued From page 22 diagnoses included insulin dependent DM, and stated she took Lantus insulin. The insulin dosage and frequency was not documented. Additionally, the note did not document Patient #17's current or recent blood glucose levels to determine whether her DM was well controlled. Patient #17's record included a visit note, dated 10/1/14. The note documented her procedure which included an injection of methylprednisolone (a steroid) into her epidural space. The National Institutes of Health website, accessed on 7/10/15, stated "ESIs [epidural steroid injections] were noted to cause a significant increase in the blood glucose levels in diabetics." However, Patient #17's blood glucose level was not assessed prior to her procedure to determine the possible risk of a significant increase in the level. During an interview on 7/8/15 at 1:55 PM, Patient #17's physician confirmed he did not question her about her blood sugar levels prior to the steroid injection. He stated he did not manage his patients DM, and it was up to the patients to tell him if their blood glucose levels were not within the normal limits. When asked if he would perform a steroid injection if he was aware the patient's blood glucose level was significantly elevated he stated he would not. However, he confirmed he did not routinely include an assessment of diabetic patients' blood glucose levels in his assessment prior to a procedure. Patient #17's H&P assessment was not comprehensive to determine a potential risk related to elevated blood glucose levels caused by an epidural steroid injection.	Q 261		

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(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 261	Continued From page 23 b. Patient #3 was a 53 year old woman admitted to the facility on 7/7/15, for insertion of a spinal cord stimulator. Patient #3's record included a clinic visit note dated 6/1/15, which contained an H&P. However, it was performed more than 30 days prior to her procedure in the ASC on 7/7/15. Patient #3's care was observed from the time of admission to the time of discharge from the ASC. Upon admission, she was taken to an examination room by the CCMA, who obtained and recorded her blood pressure, heart rate, respiratory rate and oxygen saturation. The physician entered the examination room and interviewed Patient #3 regarding her level and location of pain. He palpated Patient #3's back. The physician did not perform a review of systems, auscultate her heart and lungs, or review medications and allergies with her. Patient #3 was transferred to the OR and the procedure was performed. Patient #3 did not have a comprehensive H&P assessment completed within 30 days prior to her procedure. c. Patient #2 was a 67 year old male admitted to the facility on 7/7/15, for a transforaminal epidural steroid injection. His admission, procedure, recovery and discharge from the ASC was observed on 7/7/15 beginning at 1:20 PM. A review of Patient #2's record included an H&P dated 7/22/14. His H&P was greater than 30 days old and included the diagnosis of diabetes	Q 261		

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Q 261	Continued From page 24 mellitus type 2 in review of symptoms. The H&P listed ibuprofen as a drug allergy. Patient #2 was placed in an examination room by the CCMA who obtained and recorded his blood pressure, heart rate, respiratory rate and oxygen saturation. The CCMA did not review Patient #2's medications or allergies with him. The physician entered Patient #2's room and interviewed him regarding his level and location of pain and palpated the location of pain indicated by the patient. The physician did not question Patient #2 for an updated review of systems, question Patient #2 regarding his blood glucose levels, auscultate his heart and lungs or review his medications and allergies with him. Patient #2 was transferred to the OR and the procedure performed. Patient #2 did not have a comprehensive H&P assessment completed within 30 days prior to his procedure. d. Patient #6 was a 33 year old male admitted to the ASC on 2/10/15 for facet joint injections. Patient #6's record was reviewed and contained an H&P dated 12/13/14, greater than 30 days old. His record did not contain an updated H&P prior to his procedure performed on 2/10/15. In addition, Patient #6's records dated 12/13/14 and 2/10/15 contained blank information under Drug Allergies although a potential sensitivity to dyes was indicated on his Informed Consent dated 2/10/15. In an interview with the DON on 7/8/15, she reviewed Patient #6's record and confirmed his	Q 261		

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Q 261	Continued From page 25 H&P was dated 12/13/14 and was greater than 30 days old. The RN confirmed Patient #6 reported a possible sensitivity to dyes and that his medical record contained blank information under Drug Allergies. Patient #6 did not have a comprehensive H&P assessment completed within 30 days prior to his procedure. e. Patient #9 was a 66 year old male admitted to the ASC on 1/12/15 for a left piriformis injection with fluoroscopic guidance. Patient #9's record was reviewed and contained an H&P dated 11/18/14, greater than 30 days old. His record did not contain an updated H&P prior to his procedure performed on 1/12/15. In addition, Patient #9's records dated 11/18/14 contained a drug allergy to sulfa. Patient #9's record dated 1/12/15 contained blank information under Drug Allergies. In an interview with the DON on 7/8/15, she reviewed Patient #9's record and confirmed his H&P was dated 11/18/14, and was greater than 30 days old. The RN confirmed Patient #9's record dated 1/12/15 did not contain drug allergy information. Patient #9 did not have a comprehensive H&P assessment completed within 30 days prior to his procedure. e. Patient #10 was a 56 year old male who was admitted to the ASC on 1/6/15, for a transforaminal epidural steroid injection under fluoroscopy. His record did not include a comprehensive H&P.	Q 261		

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Q 261	Continued From page 26 During an interview on 7/8/15 beginning at 3:20 PM, the DON reviewed Patient #10's record and confirmed his record did not include a H&P. Patient #10 did not have a comprehensive H&P assessment completed within 30 days prior to his procedure. f. Patient #15 was a 30 year old female who was admitted to the ASC on 2/11/15, for a lumbar epidural steroid injection under fluoroscopy, with conscious sedation. Her record did not include a comprehensive H&P. During an interview on 7/8/15 beginning at 3:20 PM, the DON reviewed Patient #15's record and confirmed her record did not include a H&P. Patient #15 did not have a comprehensive H&P assessment completed within 30 days prior to her procedure. g. Patient #8 was a 30 year old female who was admitted to the ASC on 1/19/15, for a facet joint steroid injection under fluroscopy. Her record did not include a H&P. During an interview on 7/8/15 beginning at 3:20 PM, the DON reviewed Patient #8's record and confirmed her record did not include a H&P. Patient #15 did not have a comprehensive H&P assessment completed within 30 days prior to her procedure. h. Patient #13 was a 74 year old female who was admitted to the ASC on 3/16/15, for a lumbar epidural steroid injection under fluoroscopy. Her	Q 261		

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Q 261	Continued From page 27 record did not include a comprehensive H&P. During an interview on 7/8/15 beginning at 3:20 PM, the DON reviewed Patient #13's record and confirmed her record did not include a H&P. Patient #13 did not have a comprehensive H&P assessment completed within 30 days prior to her procedure. i. Patient #12 was a 44 year old male who was admitted to the ASC on 3/16/15, for a transforaminal epidural steroid injection under fluoroscopy. His record did not include a comprehensive H&P. During an interview on 7/8/15 beginning at 3:20 PM, the DON reviewed Patient #12's record and confirmed his record did not include a H&P. j. Patient #16 was a 40 year old female who was admitted to the ASC on 4/6/15, for a caudal epidural injection under fluoroscopy with epidurogram and conscious sedation. Her record did not include a comprehensive H&P. During an interview on 7/8/15 beginning at 3:20 PM, the DON reviewed Patient #16's record and confirmed her record did not include a H&P. The ASC did not ensure each patient record included a comprehensive history and physical which was performed not more than 30 days prior to the date of the scheduled procedure.	Q 261		
Q 264	416.52(b) POST-SURGICAL ASSESSMENT (1) The patient's post-surgical condition must be assessed and documented in the medical record	Q 264	Q264 POC Corrective measures regarding documentation of postsurgical assessments	

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Q 264	Continued From page 28 by a physician, other qualified practitioner, or a registered nurse with, at a minimum, post-operative care experience in accordance with applicable State health and safety laws, standards of practice, and ASC policy. (2) Post-surgical needs must be addressed and included in the discharge notes. This STANDARD is not met as evidenced by: Based on observation, record review, policy review, and staff interview it was determined the ASC failed to ensure patients' post-surgical conditions were assessed and documented in the medical record for 16 of 17 patients (#2 - #17) whose records were reviewed. This had the potential to result in un-met patient needs and unsafe discharge. Findings include: 1. Patient #2 was a 67 year old male who was admitted to the ASC on 7/7/15 for a left transforaminal epidural steroid injection. His care was observed throughout his admission, procedure, recovery, and discharge. Patient #2 was transferred to the recovery area on 7/7/15 at 1:56 PM by the RN that assisted the physician in the OR. The RN transferred his care to the CCMA in the recovery area. The CCMA obtained and recorded two sets of vital signs that included blood pressure, heart rate and oxygen saturation. At 2:03 PM, the CCMA stated to Patient #2 she would show the vital signs to the RN and return. The CCMA exited the recovery area and left Patient #2 unattended. The CCMA returned to the recovery area at 2:05 PM and told Patient #2 he was discharged to go home.	Q 264	will include a new check list. This checklist will provide more accurate documentation of the post-operative assessment which is completed by the team of the MD, RN and MA. The facility has fallen short at documenting the recovery assessment and the team's participation in this process. The check list will provide more complete documentation of each member of the team's involvement. The checklist will be incorporated 8-10-2015 and may evolve from a paper checklist to an EMR generated document. The DON will assure the completion of this POC and will monitor this implementation to ensure that the postsurgical assessment & documentation provides the highest patient safety standards on an ongoing basis. (See attached check list.)	

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Q 264	Continued From page 29 Patient #2's record dated 7/7/15 stated "patient discharged by [name] CCMA." Patient #2 was not assessed by the physician or RN after his procedure in the OR. During an interview on 7/8/15 at 3:05 PM, the following records were reviewed by the DON. She confirmed the physician did not see patients after they left the OR. She stated she would check on patients after their procedure. However, she confirmed she did not document a post-operative assessment. She stated the CCMA was responsible for taking post-operative vital signs. The DON stated the CCMA brought the vital signs to her for review and she approved the patient for discharge based on the vital signs and CCMA's report. The DON confirmed a post-operative assessment was not documented by a physician or RN. a. Patient #3 was a 53 year old female admitted to the facility on 7/7/15, for insertion of a spinal cord stimulator. Patient #3's record did not document an assessment by the physician or RN following her procedure. Her record documented she was approved for discharge by the RN and discharged by the CCMA. b. Patient #5 was a 39 year old male admitted to the facility on 2/11/15 for a lumbar epidural steroid injection. Patient #5's record did not document an assessment by the physician or RN following his procedure. His record documented he was approved for discharge by the RN and discharged	Q 264	Clarification: Patient #2 was evaluated at length during the recovery period **by all members of the ASC team.** Attachment: RR and DC Checklist	

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Q 264	Continued From page 30 by the CCMA. c. Patient #17 was a 64 year old female admitted to the facility on 10/1/14 for a transforaminal epidural steroid injection. Patient #17's record did not document an assessment by the physician or RN following her procedure. Her record documented she was approved for discharge by the RN and discharged by the CCMA. d. Patient #6 was a 33 year old male admitted to the ASC on 2/10/15 for facet joint injections. Patient #6's record did not document an assessment by the physician or RN following her procedure. Her record documented she was approved for discharge by the RN and discharged by the CCMA. e. Patient #9 was a 66 year old male admitted to the ASC on 1/12/15 for a left piriformis injection with fluoroscopic guidance. Patient #9's record did not document an assessment by the physician or RN following her procedure. Her record documented she was approved for discharge by the RN and discharged by the CCMA. f. Patient #14 was a 50 year old female who was admitted to the ASC on 5/7/15, for a cervical epidural steroid injection under fluoroscopy. Patient #14's record did not document an assessment by the physician or RN following her procedure. Her record documented she was approved for discharge by the RN and discharged	Q 264		

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Q 264	Continued From page 31 by the CCMA. g. Patient #4 was an 89 year old female who was admitted to the ASC on 5/11/15, for a lumbar epidural steroid injection under fluoroscopy with epidurogram. Patient #4's record did not document an assessment by the physician or RN following her procedure. Her record documented she was approved for discharge by the RN and discharged by the CCMA. h. Patient #10 was a 56 year old male who was admitted to the ASC on 1/06/15, for a transforaminal epidural steroid injection under fluoroscopy. Patient #10's record did not document an assessment by the physician or RN following his procedure. His record documented he was approved for discharge by the RN and discharged by the CCMA. i. Patient #15 was a 30 year old female who was admitted to the ASC on 2/11/15, for a lumbar epidural steroid injection under fluoroscopy, with conscious sedation. Patient #15's record did not document an assessment by the physician or RN following her procedure. Her record documented she was approved for discharge by the RN and discharged by the CCMA. j. Patient #8 was a 30 year old female who was admitted to the ASC on 1/19/15, for a facet joint steroid injection under fluoroscopy.	Q 264		

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Q 264	Continued From page 32 Patient #8's record did not document an assessment by the physician or RN following her procedure. Her record documented she was approved for discharge by the RN and discharged by the CCMA. k. Patient #13 was a 74 year old female who was admitted to the ASC on 3/16/15, for a lumbar epidural steroid injection under fluoroscopy. Patient #13's record did not document an assessment by the physician or RN following her procedure. Her record documented she was approved for discharge by the RN and discharged by the CCMA. l. Patient #12 was a 44 year old male who was admitted to the ASC on 3/16/15, for a transforaminal epidural steroid injection under fluoroscopy. Patient #12's record did not document an assessment by the physician or RN following his procedure. His record documented he was approved for discharge by the RN and discharged by the CCMA. m. Patient #16 was a 40 year old female who was admitted to the ASC on 4/6/15, for a caudal epidural injection under fluoroscopy with epidurogram and conscious sedation. Patient #16's record did not document an assessment by the physician or RN following her procedure. Her record documented she was approved for discharge by the RN and discharged by the CCMA. n. Patient #11 was a 77 year old female who was	Q 264		

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Q 264	Continued From page 33 admitted to the ASC on 1/5/15, for a facet joint steroid injection under fluoroscopy. Patient #11's record did not document an assessment by the physician or RN following her procedure. Her record documented she was approved for discharge by the RN and discharged by the CCMA. o. Patient #7 was a 44 year old male who was admitted to the ASC on 1/26/15, for a intra articular steroid injection in his hip under fluoroscopy. Patient #7's record did not document an assessment by the physician or RN following his procedure. His record documented he was approved for discharge by the RN and discharged by the CCMA. During an interview on 7/8/15 beginning at 4:00 PM, the DON stated the CCMA provided recovery care to patients under her supervision. She stated she was close by if the CCMA needed her assistance. The RN confirmed that when she was in the OR with the physician during a procedure, she was not directly available to the CCMA in the recovery area. The ASC did not ensure patients were evaluated by an RN or the physician prior to discharge.	Q 264		
Q 266	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,	Q 266		

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Q 266	Continued From page 34 standards of practice, and ASC policy. This STANDARD is not met as evidenced by: Based on observation, record review, review of policies, and staff interview it was determined the facility failed to ensure patients were discharged on the order of a physician for 16 of 17 patients (#2 - #17) whose records were reviewed. This resulted in patients being discharged without an evidence-based determination that they were medically stable. Findings include: 1. The policy "Surgery," revised 2/2/15, stated "Post-procedure visits must be made by the physician and the patient must be evaluated by a physician prior to discharge from the Center OR and meet approved discharge criteria." The policy was not implemented, as follows: a. Patient #2 was a 67 year old male who was admitted on 7/7/15 for a left transforaminal epidural steroid injection. His care was observed throughout his admission, procedure, recovery, and discharge. Patient #2 was transferred on 7/7/15 at 1:56 PM to the recovery area by the RN that assisted in the OR. The RN transferred his care to the CCMA in the recovery area. The CCMA obtained and recorded two sets of vital signs that included blood pressure, heart rate and oxygen saturation. At 2:03 PM, the CCMA informed Patient #2 that she was going to show the vital signs to the RN and return. The CCMA exited the recovery area and left Patient #2 unattended. The CCMA returned to the recovery area at 2:05 PM and told Patient #2 he was discharged to go home. The physician and the RN did not see Patient #2 after	Q 266	Q266 POC DC Order: In order to comply with applicable State health and safety laws, standards of practice and the ASC policy, the facility has taken the remediation measure to include in every chart a written statement by the physician that a "discharge order" was issued and will include the time it was posted by him. [redacted] will be responsible for this measure effective 8-10-2015 and will be monitored on an ongoing basis by the Administrator through chart audits. _____	

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Q 266	Continued From page 35 his procedure. Patient #2's record dated 7/7/15 stated "patient discharged by [name] CCMA." Patient #2's record did not include a discharge order signed by the physician who performed his procedure. b. Patient #3 was a 53 year old woman admitted to the facility on 7/7/15, for insertion of a spinal cord stimulator. Her care was observed throughout her admission, procedure, recovery and discharge. Following the conclusion of her procedure in the OR, Patient #3 was escorted to the recovery area by the RN, who transferred her care to the CCMA. The CCMA obtained her blood pressure, heart rate and oxygen saturation. While in the recovery area, Patient #3 was educated on the use of her spinal cord stimulator by the provider representative. The physician did not see Patient #3 following her transfer from the OR. At 5:02 PM the CCMA informed Patient #3 she was going to show the vital signs to the RN. The CCMA returned to the recovery area and informed Patient #3 she was approved for discharge. Patient #3's record did not include a discharge order signed by the physician who performed her procedure. c. The remaining closed records reviewed (#4 - #16) did not include documentation of a physician discharge order prior to the patients' discharge. During an interview on 7/08/15 beginning at 3:30 PM, the DON reviewed patient records and stated "The record stated the patient is to return in 1 week or as needed, that is a discharge order."	Q 266		

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Q 266	Continued From page 36 She confirmed the record did not include an actual discharge order, and stated she did not know where it would go, as the EMR software program did not include the discharge as an option. During an interview on 7/08/15 beginning at 1:30 PM, the physician confirmed patients were discharged from the ASC without a physician order. He stated patient records were electronic, and he would review each patient record before signing. He stated the signature at the end of the procedural record for each patient would indicate his approval for discharge. The physician confirmed he did not perform a post procedural assessment before discharging each patient, that the RN and MA discharged patients when they met criteria. The facility failed to ensure patients were discharged on the order of a physician.	Q 266		
Q 267	416.52(c)(3) DISCHARGE WITH RESPONSIBLE ADULT [The ASC must -] Ensure all patients are discharged in the company of a responsible adult except those patients exempted by the attending physician. This STANDARD is not met as evidenced by: Based on observation, staff interview, and review of records and policies, it was determined the ASC failed to ensure patients were discharged post-procedure in the company of responsible adults for 1 of 2 patients (#2) observed, and 5 of 17 patients (#6 - #10), whose records were reviewed for discharge from the ASC. This	Q 267	**Q267 POC** In order to be compliant with regulation #416.52(c)(3) of discharge with a responsible adult the facility has incorporated the following protocol: --all pts who receive sedation will be accompanied by a responsible driver following a DC order by the physician.	

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	13C0001020		07/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
S I P I AMBULATORY SURGERY CENTER	176 FALLS AVENUE TWIN FALLS, ID 83301

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Q 267	Continued From page 37 resulted in an increased potential for patients to suffer adverse events following their procedures. Findings include: 1. A Patient Discharge Criteria policy revised 2/2/15, stated, "Patients are discharged at the discretion of the physician by established and approved discharge criteria. Patients receiving sedation are accompanied at discharge by a designated person who is responsible for the patient." A policy titled "Scheduling Procedures," revised 2/2/15, stated "Patients undergoing invasive procedures or minor surgical procedures receiving local anesthesia with no sedation may be discharged to drive themselves. In addition, patients receiving limited doses of sedation, such as less than 5 mg of Versed and/or 5 ml of Fentanyl, under local anesthesia for minor surgical procedures may be discharged home to ride a taxi or public transportation after they have met discharge criteria." a. Patient #2's medical record documented a 67 year old male admitted to the ASC on 7/7/15, for a transforaminal epidural steroid injection. Patient #2's care was observed from his admission through his discharge from the ASC on 7/7/15 from 1:20 PM to 2:08 PM. The physician performed an epidurogram (a procedure in which the spine is accessed with a needle and dye injected to facilitate visualization of the spine under fluoroscopy) in the OR. Patient #2's physician then injected a steroid mixed with lidocaine into the epidural space. The needle was removed and the physician asked Patient #2 if he experienced any numbness or tingling in his	Q 267	--Pt's are requested to bring a responsible adult. --following the physicians evaluation, an individual pt may be exempted from requirement to be accompanied by a responsible adult. --Exemptions will be specific to individual patients. --A Physician Order will state the individual will be discharged without the need of a responsible adult. This change in protocol will help and prevent adverse events. [redacted] will be responsible to put this change into place effective 8-10-2015. Periodic chart audits by the Administrator will be performed to monitor this change on an ongoing basis.	

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Q 267	Continued From page 38 legs. The RN, assisted Patient #2 at 1:56 PM, by holding his arm as he walked from the OR to the recovery room. The RN asked Patient #2 if he experienced any loss of sensation in his legs and she transferred his care to the CCMA in the recovery room. Patient #2 was observed in the recovery room. The CCMA obtained two sets of vital signs, left the area from 2:03 PM to 2:05 PM to consult with the RN, returned and discharged Patient #2 to leave the facility unaccompanied. The patient stated he would be driving home by himself, and stated he lived 70 miles away. During an interview on 7/7/15 at 2:15 PM, the CCMA confirmed Patient #2 was discharged from the ASC and was not accompanied by a responsible adult. b. Patient #6 was a 33 year old male admitted to the ASC on 2/10/15 for facet joint injections. Patient #6's record dated 2/10/15 stated "Pt. released to self care. Pt approved for discharge by [RN NAME] and discharged at 1548 by [CCMA name]." During an interview with the DON on 7/8/15 at 3:30 PM she stated Patient #6's record did not indicate he was discharged accompanied by a responsible adult and did not include an exemption by the physician. c. Patient #9 was a 66 year old male admitted to the ASC on 1/12/15 for facet joint injections, whose record was reviewed on 7/7/15.	Q 267		

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Q 267	Continued From page 39 Patient #9's record dated 1/12/15 stated "Pt. released to self care. Pt approved for discharge by [RN NAME] and discharged at 1503 by [CCMA name]." During an interview with the DON on 7/8/15 at 3:30 she stated Patient #9's record did not indicate he was discharged accompanied by a responsible adult and did not include an exemption by the physician. d. Patient #10 was a 56 year old male who was admitted to the ASC on 1/06/15, for a transforaminal epidural steroid injection under fluoroscopy. Patient #10's record dated 1/06/15 stated "Pt. released to self care. Pt approved for discharge by [RN NAME] and discharged at 1554 by [CCMA name]." During an interview with the DON on 7/8/15 at 3:30 she confirmed Patient #10's record did not indicate he was discharged accompanied by a responsible adult and did not include an exemption by the physician. e. Patient #8 was a 30 year old female who was admitted to the ASC on 1/19/15, for a facet joint steroid injection under fluoroscopy. Patient #8's record dated 1/19/15 stated "Pt. released to self care. Pt approved for discharge by [RN NAME] and discharged at 1104 by [CCMA name]." During an interview with the DON on 7/8/15 at 3:30 she confirmed Patient #8's record did not indicate she was discharged accompanied by a responsible adult and did not include an exemption by the physician.	Q 267		

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Q 267	Continued From page 40 f. Patient #7 was a 44 year old male who was admitted to the ASC on 1/26/15, for a intra articular steroid injection in his hip under fluoroscopy. Patient #7's record dated 1/26/15 stated "Pt. released to self care. Pt approved for discharge by [RN NAME] and discharged at 1005 by [CCMA name]." During an interview with the DON on 7/8/15 at 3:30 she confirmed Patient #7's record did not indicate he was discharged accompanied by a responsible adult and did not include an exemption by the physician. The ASC failed to ensure all patients were discharged in the company of a responsible adult or that a policy was established with criteria for exempting patients from the requirement.	Q 267		