



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
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BUREAU OF FACILITY STANDARDS
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September 25, 2015

Michele A Magnuson , Administrator
North Idaho Pain Center
1686 W Riverstone Drive, Suite 2
Coeur D'Alene, ID 83814-5779

RE: North Idaho Pain Center, Provider #13C0001058

Dear Ms. Magnuson:

Based on the survey completed at North Idaho Pain Center, on September 14, 2015, by our staff, we have determined North Idaho Pain Center is out of compliance with the Medicare ASC Conditions for Coverage of **Governing Body and Management (42 CFR 416.41)** and **Medical Records (42 CFR 416.47)**. 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 North Idaho Pain Center, to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567).

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

An acceptable Plan of Correction contains the following elements:

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

Michele A Magnuson, Administrator
September 25, 2015
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- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the PoC is effective in bringing the ASC into compliance, and that the ASC remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
- The administrator's signature and the date signed on page 1 of each form.

Such corrections must be achieved and compliance verified by this office, before October 29, 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 October 19, 2015.

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **October 8, 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.

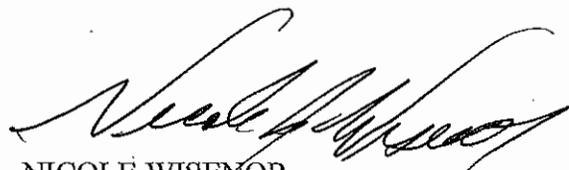
We urge you to begin correction immediately.

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

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

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

PRINTED: 09/25/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001058	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/14/2015
NAME OF PROVIDER OR SUPPLIER NORTH IDAHO PAIN CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1686 W RIVERSTONE DRIVE, SUITE 2 COEUR D'ALENE, ID 83814	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the Medicare recertification survey of your ASC from 8/31/15 to 9/14/15. Surveyors conducting the recertification were:</p> <p>Susan Costa, RN, HFS, Team Leader Teresa Hamblin, RN, MS, HFS</p> <p>Acronyms used in this report include:</p> <p>ASC - Ambulatory Surgical Center CNA - Certified Nursing Assistant EMR - Electronic Medical Record GB - Governing Body H&P - History and Physical IV - Intravenous N/A - not applicable NIPC - North Idaho Pain Center OR - Operating Room QA - Quality Assessment QAPI - Quality Assessment Performance Improvement QI - Quality Improvement RN - Registered Nurse</p>	Q 000	<p>RECEIVED</p> <p>OCT 13 2015</p> <p>FACILITY STANDARDS</p>	
Q 040	<p>416.41 GOVERNING BODY AND MANAGEMENT</p> <p>The ASC must have a governing body that assumes full legal responsibility for determining, implementing, and monitoring policies governing the ASC's total operation. The governing body has oversight and accountability for the quality assessment and performance improvement program, ensures that facility policies and programs are administered so as to provide quality health care in a safe environment, and develops and maintains a disaster preparedness</p>	Q 040		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Scott K. Magnuson, MD TITLE
Medical Director (X6) DATE
10/08/2015

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

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Q 040	<p>Continued From page 1 plan.</p> <p>This CONDITION is not met as evidenced by: Based on observation, staff interview, and review of policies, medical records, meeting minutes, medical staff bylaws, and QAPI documents, it was determined the ASC's GB failed to assume responsibility for determining, implementing, and monitoring policies, and failed to ensure QAPI and medical records requirements were met. The cumulative effect of these systematic failures resulted in a lack of clear processes to guide staff in the provision of care and to evaluate its services, a lack of clarity of the course of patient care, missed opportunities for performance improvement, and a failure to ensure sustained compliance was achieved. The findings include:</p> <p>1. ASC policies were requested for review. The RN Coordinator provided a binder of policies that she described as her "working copy" of policies. The binder included policies with handwritten changes, lines and X's drawn through areas, and multiple handwritten revision dates. When asked for the most current ASC copies, she stated there were electronic versions of the policies, but the ASC Administrator was the only one who had access to the electronic version and she was on vacation for two weeks. She stated she used her working copy.</p> <p>Policies and procedures, in the working binder of ASC policies, were not clear and did not show GB oversight and accountability. Examples follow:</p> <p>a. "II. PATIENT FOCUSED FUNCTIONS 2. Patient Rights 1. Patient Directives," dated 5/15/05, included one page of the document with</p>	Q 040	<p>A procedure, "Procedure for Revisions Made to the Policy & Procedure Manual" has been put in place to provide a clear process to guide staff when referring to the Pol Manual. In addition, all cited Pol's have been printed from the electronic copy and added to the Pol manual, Implemented by Administrator.</p>	10/8/15

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Q 040	<p>Continued From page 2</p> <p>a large X through the page. The last page of the section stated "Revised to reflect practice 8/26/13, [initials]." It could not be determined what was revised or that the GB approved the changes.</p> <p>b. "SECTION V PERFORMANCE IMPROVEMENT 1. Organizational Performance," dated 5/15/05, included a hand-written statement "Reviewed, revised to reflect practice: Standards 11/12/12." Initials followed. It could not be determined what information had been revised as there were no additions to the document.</p> <p>c. "VI SURGERY 2. Administrative Functions D. Chart Requirements," dated 5/15/05, included multiple crossed out items and a couple of insertions. The revisions were not signed or dated.</p> <p>d. "VI. SURGERY 3. General Policies and Procedures B. Surgical Consent," dated 5/15/05, included a hand-written statement "Revised to reflect practices 3/25/15," initials, and "reviewed and accepted 4/10/15," and a signature. It could not be determined what information had been revised as there were no additions to the document.</p> <p>e. "VI. SURGERY 3. General Policy and Procedures D. Monitoring," dated 5/15/05, included hand written crossed out sections, arrows pointing to hand written information, and some information marked "old."</p> <p>f. "VI. SURGERY 3. General Policies and Procedures G. Transfer of Patient to Hospital," dated 5/15/05, include multiple hand written additions, and some information was crossed out.</p>	Q 040			

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Q 040	<p>Continued From page 3</p> <p>The end of the policy included handwritten statements "Policy revised to reflect practice, 3/19/12," "Policy revised to reflect practice, 3/25/15," and "Reviewed and accepted 4/10/15" with a signature. It could not be determined what changes were made in 2012 and what changes were made in 2015.</p> <p>g. "VI. SURGERY 3. General Policies and Procedures 1. Follow Up Call Process," dated 5/15/05, included multiple hand written additions, and some crossed out information. The end of the policy included a handwritten statement "Reviewed/ policy revised to reflect practice" and was dated 1/8/13 at 12:20 PM. It was signed by the RN. There was no indication the owner or GB approved the hand written changes.</p> <p>h. A policy, "VI. SURGERY 4. Operational Policies and Procedures A. Perioperative Nursing Care," dated 5/15/05, included multiple hand written insertions and arrows. The end of the document, stated "Policy revised to reflect practice 3/19/12" and "Policy revised to reflect practice 3/25/15." It could not be determined what revisions were made in 2012 and what revisions were made in 2015. The document was signed by the owner.</p> <p>i. "VI. SURGERY 4. Operational Policies and Procedures C. Care of the Patient Under Local Anesthesia," dated 5/15/05. There were hand written additions to the policy. At the bottom of the policy were the statements "Policy revised to reflect practice 3/19/12" and "Policy Reviewed/ revised to reflect practice 10/7/13." It was signed by the RN. It was not signed by the owner or GB. It could not be determined what information was revised in 2012 and what information was revised in 2013.</p>	Q 040			

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Q 040	Continued From page 4 j. "VI. SURGERY 4. Operational Policies and Procedures D. Administration of Intravenous Conscious Sedation," dated 5/15/05, included multiple hand written additions, and cross-outs. The end of the document included "Reviewed and revised to reflect practice, 12/14/11, 3/12/13, 12/16/13, and 5/06/15." It could not be determined what changes were made in 2011, 3/2013, 12/2013 and 2015. Physician A was interviewed on 9/02/15 at 8:00 AM. When asked how she accessed policies and procedures, she stated she used the hard copy of policies and procedures in the cupboard, referring to the RN Coordinator's working copy. When asked if she had access to current electronic version of policies and procedures, she stated she was not aware of any electronic copies. The ASC Administrator and Physician B were interviewed by telephone on 9/14/15 beginning at 8:15 AM. The Administrator confirmed the updated policies were in the computer, and the staff of the ASC was not able to access them during her absence. 2. Refer to Q0081 as it relates to the failure of the ASC to ensure adverse events were tracked and analyzed as a part of the QAPI program. 3. Refer to Q0084 as it relates to the failure of the GB to ensure the QAPI program was implemented and maintained as defined in the QAPI plan and medical staff bylaws. The ASC was previously cited at Q0084 during a recertification survey, dated 9/30/11, and a follow-up survey, dated 11/14/11. The GB failed to ensure sustained compliance was achieved.	Q 040			

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Q 040	Continued From page 5 4. Refer to Q0160 Condition for Coverage: Medical Records and associated standard level deficiencies as they relate to the GB's failure to ensure accuracy and completeness of medical records. The ASC was previously cited at Q0160 during a recertification survey, dated 9/30/11, and a follow-up survey, dated 11/14/11. The GB failed to ensure sustained compliance was achieved. a. Refer to Q0161 as it relates to the failure of the ASC to create a medical record unique to the ASC. The ASC was previously cited at Q0161 during a recertification survey, dated 9/30/11, and follow-up survey, dated 11/14/11. The GB failed to ensure sustained compliance was achieved. b. Refer to Q0162 as it relates to the failure of the ASC to ensure medical record documentation included properly executed informed consent, a current history and physical examination, discharge diagnosis, or discharge disposition. The ASC was previously cited at Q0162 during a recertification survey, dated 9/30/11. The GB failed to ensure sustained compliance was achieved. 5. Refer to Q0141 as it relates to the failure of the ASC to ensure nursing procedures were conducted in accordance with ASC policies as it related to assessment of vital signs and pain postoperatively. The ASC was previously cited at Q0141 during a recertification survey, dated 9/30/11. The GB failed to ensure sustained compliance was achieved. 6. Refer to Q0181 as it relates to the failure of the ASC to ensure administration of medication was consistent with the orders of a physician. The	Q 040			

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Q 040	Continued From page 6 ASC was previously cited at Q0141 during a recertification survey, dated 9/30/11. The GB failed to ensure sustained compliance was achieved. 7. Refer to Q0220 as it relates to the failure of the ASC to ensure written notice of patient rights was posted in one waiting area. The ASC was previously cited at Q0220 during a recertification survey dated 9/30/11 and a follow-up survey, dated 11/14/11. The GB failed to ensure sustained compliance was achieved. 8. Refer to Q0221 as it relates to the failure of the ASC to ensure verbal and written notice of rights was provided. The ASC was previously cited at Q0221 during a recertification survey, dated 9/30/11, and a follow-up survey, dated 11/14/11. The GB failed to ensure sustained compliance was achieved. 9. Refer to Q0242 as it relates to the failure of the ASC to ensure hand hygiene and infection control practice was performed in accordance with policy or standards of practice. The ASC was previously cited at Q0242 during a recertification survey, dated 9/30/11, and a follow-up survey, dated 11/14/11. The GB failed to ensure sustained compliance was achieved. The cumulative effect of these systematic failures resulted in a lack of clear processes and direction to guide staff in the provision of care and to evaluate its services, missed opportunities for quality improvement, and a clear, complete, and accurate courses of patient care.	Q 040			
Q 081	416.43(a), 416.43(c)(1) PROGRAM SCOPE; PROGRAM ACTIVITIES	Q 081			

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Q 081	<p>Continued From page 7</p> <p>(a)(1) The program must include, but not be limited to, an ongoing program that demonstrates measurable improvement in patient health outcomes, and improves patient safety by using quality indicators or performance measures associated with improved health outcomes and by the identification and reduction of medical errors.</p> <p>(a)(2) The ASC must measure, analyze, and track quality indicators, adverse patient events, infection control and other aspects of performance that includes care and services furnished in the ASC.</p> <p>(c)(1) The ASC must set priorities for its performance improvement activities that -</p> <ul style="list-style-type: none"> (i) Focus on high risk, high volume, and problem-prone areas. (ii) Consider incidence, prevalence, and severity of problems in those areas. (iii) Affect health outcomes, patient safety, and quality of care. <p>This STANDARD is not met as evidenced by: Based on staff interview and review of the QAPI plan and adverse event reports, it was determined the ASC failed to ensure 1 of 1 known patient event (#17) was tracked and analyzed. This had the potential to result in a missed opportunity for performance improvement. Findings include:</p> <p>The "Quality Improvement Plan - NIPC," dated 12/07/11, was reviewed. It included, but was not limited to, the following information: "The</p>	Q 081		

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Q 081	Continued From page 8 responsibility of risk management includes...analysis of all incidents facility wide." Incident reports were requested for the prior 12 months. An "Incident Occurrence Log" was provided. There were no documented incident reports provided related to occurrences in the prior 12 months. The RN Coordinator was interviewed on 9/01/15 at 1:34 PM and asked if any transfers had occurred within the last year. She stated one patient (#17) had been transferred to a hospital in late 2014 or early 2015. She thought she had completed an incident report but she could not find it. It could not be determined the information was tracked or analyzed. She stated a debriefing or analysis of the incident did not occur. The ASC Administrator and Physician B were interviewed together on the telephone on 9/14/15 beginning at 8:15 AM. They confirmed an occurrence report had not been completed and the incident had not been analyzed.	Q 081	An incident report will be completed ^{and analyzed} by the Nursing Director for the incidents cited. The administrator will review the Pop for incident reports (I, S, H) with staff to refresh and reinforce. To monitor, the administrator will review the Incident log book before each Quality Management meeting to be sure all incidents have been logged.	10/8/15	
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,	Q 084			

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Q 084	<p>Continued From page 9 frequency, and details.</p> <p>(4) Clearly establishes its expectations for safety.</p> <p>(5) Adequately allocates sufficient staff, time, information systems and training to implement the QAPI program.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of the QAPI plan, meeting minutes, and medical staff bylaws, it was determined the GB failed to ensure the QAPI program was implemented and maintained as defined in the QAPI plan and reported to the GB, as specified in the medical staff bylaws. This resulted in missed opportunities for evaluation and oversight of the quality program. Findings include:</p> <p>The "Quality Improvement Plan - NIPC," dated 12/07/11, was reviewed. It included, but was not limited to, the following information:</p> <p>* "QI meetings will occur not less than quarterly and more frequently, if determined necessary by the Medical Director or Administration."</p> <p>* "Minutes will be taken to record items discussed during meetings. The records will be maintained in the QA manual."</p> <p>The "Medical Staff Bylaws," Section "Quality Improvement Committee," dated 8/2005, were reviewed. The bylaws included, but were not limited to, the following information.</p> <p>* "The QI function personnel shall meet on a quarterly basis. Written minutes will document the meeting including agenda items discussed,</p>	Q 084	<p>The change in frequency of QI meetings to every 6 months has been noted in the QI Plan and NIPC bylaws. The Administrator schedules the next QI meeting during the current QI meeting so all in attendance are aware. The date and time are then added to the meeting schedule. The Administrator keeps QI meeting minutes and files them in the QA Manual</p>	10/8/15

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001058	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/14/2015
NAME OF PROVIDER OR SUPPLIER NORTH IDAHO PAIN CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1686 W RIVERSTONE DRIVE, SUITE 2 COEUR D'ALENE, ID 83814		
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Q 084	<p>Continued From page 10 conclusions and recommendations made, actions taken and plans for follow up."</p> <p>* "The QI Committee will report findings and actions quarterly to the GB."</p> <p>QA meeting minutes were reviewed. The last two documented meetings were on 3/05/15 and 9/11/14. Meetings were not conducted quarterly as stated in the QI plan. This was confirmed by the RN Coordinator during interview on 9/03/15 beginning at 7:40 AM.</p> <p>GB meeting minutes were reviewed. The last documented GB meeting minutes were 9/11/14. There was no evidence of quarterly reporting to the GB in accordance with the medical staff bylaw requirements.</p> <p>During an interview on 9/03/15 beginning at 7:45 AM, the RN Coordinator confirmed the date of the last GB meeting was 9/11/14.</p> <p>The ASC Administrator and Physician B were interviewed together by telephone on 9/14/15 beginning at 8:15 AM. They confirmed the date of the last QA meeting was in March 2015 and stated the QA committee met every 6 months and the GB met annually. They provided an electronic copy of the "Quality Improvement Plan - NIPC," dated 10/11/11. It stated "QI meetings will occur not less than every six months." The date of the document, that was provided after the telephone interview, preceded the 12/07/11 version, which was provided to surveyors during the onsite survey. Therefore, the most current reference provided required, at a minimum, quarterly QA meetings.</p>	Q 084		

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Q 084	Continued From page 11 The GB did not ensure quality meetings and reporting were conducted in accordance with medical staff bylaws and the most current QAPI plan.	Q 084			
Q 121	416.45(a) MEMBERSHIP AND CLINICAL PRIVILEGES Members of the medical staff must be legally and professionally qualified for the positions to which they are appointed and for the performance of privileges granted. The ASC grants privileges in accordance with recommendations from qualified medical personnel. This STANDARD is not met as evidenced by: Based on staff interview and review of bylaws and credential files, it was determined the facility failed to ensure all medical staff privileges were current for 1 of 2 physicians (Physician A) practicing at the ASC. This resulted in the facility providing patient care by a physician whose contract was expired. Findings include: The ASC bylaws, dated 8/2005, stated "Every physician or non-physician health professional providing clinical services at the ASC shall, except as expressly provided in these bylaws, be entitled to exercise only those privileges specifically granted to him/her by the Governing Body." It further stated "The privilege to admit must be expressly granted, and is not automatic or assumed." Physician A's credentials file was reviewed. The file included a copy of page 94 of the ASC Bylaws. The section titled "Medical Staff File," listed what each physicians' credentials file would include. Physician A's file included a "Delineation	Q 121	The Administrator completed the Reappointment File for each MD according to policy. Reappointment was granted by the Medical Director at the annual Governing Board meeting on 10/8/15. The Reappointment File included a delineation of privileges for each MD. The Administrator keeps a calendar of the next due date for reappointment, 10/2017 to ensure privileges are current.	10/8/15	

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Q 121	Continued From page 12 of Privileges" form with check marks for "Privileges Requested." It did not include documentation of approval of requested privileges, a date or signature of Physician A. During an interview on 9/02/15 at 7:30 AM, Physician A reviewed her credentials file and confirmed the Delineation of Privileges form was incomplete. Physician A's file also included an "Employment Agreement," which detailed the relationship between Physician A and the ASC. The term of the Employment Agreement was effective from 8/01/13 to 7/31/14. An "Amendment to the Physician Employment Agreement" extended the term of employment of Physician A from 7/31/14 for a period of 90 days, to 10/31/14. There were no further extensions to her employment. During a phone interview with the ASC Administrator and Physician B on 9/14/15 beginning at 8:15 AM, they confirmed the employment agreement expired 10/31/14. The facility failed to ensure medical staff privileges were current.	Q 121	 and  have been and continue to be in negotiations for an Employment Agreement.	
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:	Q 141		

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Q 141	<p>Continued From page 13</p> <p>Based on staff interview, policy review, and medical record review, it was determined the ASC failed to ensure nursing procedures were conducted in accordance with ASC policies as it related to assessment of vital signs and pain postoperatively for 15 of 17 patients (#2 - #8 and #10 - #17) whose records were reviewed. This resulted in incomplete patient assessments and had the potential to interfere with quality and safety of patient care. Findings include:</p> <p>The policy "VI. SURGERY 4. Operational Policies and Procedures C. Care of the Patient Under Local Anesthesia," dated 5/15/05, was reviewed. It included, but was not limited to, the following information:</p> <p>* "Vital signs shall be taken ...every 10 minutes post-operatively until Aldrete score is greater than or equal to 8."</p> <p>* "Vital signs and pain assessment should be recorded on the...post-operative record."</p> <p>1. Assessment of pain and vital signs did not occur in accordance with ASC policy during observations, as follows:</p> <p>a. Patient #15 was a 60 year old female who was admitted to the ASC on 8/31/15, for an epidural steroid injection procedure in her neck. Her care was observed from the time of admission at 2:07 PM until discharge from the facility at 3:04 PM.</p> <p>Patient #15 was transferred to the recovery room at 2:34 PM. Vital signs were observed to be taken one time, after Patient #15's IV was discontinued and she was dressed to leave. At that time, "Discharge Vitals" were taken by the</p>	Q 141	<p><i>This standard was not met based on our own policy for vital signs measurement and pain assessment following a procedure. This policy was reviewed by the Governing Board and further research was done. North Idaho Pain Center (NIPC) performs all of our cases under local anesthesia or with minimal sedation (anxiolysis) as defined by the American Society of Anesthesiologists. ASA has produced guidelines patients undergoing moderate or deep sedation (Anesthesiology, 2002; 96: 1004-1117). However, "because minimal sedation (anxiolysis) entails minimal risk, the Guidelines specifically excludes it." In addition, the 2015 AORN guidelines do not specifically address minimal sedation. Based on the above it was determined that the above named ASC policy needed to be changed to reflect our practice which is supported in</i></p>	10/19/15	

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Q 141	<p>Continued From page 14</p> <p>CNA and recorded at 3:04 PM, 30 minutes after entering the recovering room. Three sets of vital signs would have been indicated based on ASC policy. Additionally, a post-operative assessment of pain was not observed to occur.</p> <p>b. Patient #8 was a 49 year old female who had a joint injection on 8/31/15 related to right hip pain. She was observed from entrance to the waiting area at 10:15 AM until discharge from the facility at 10:53 AM. A post-operative pain assessment was not observed to occur or included in the medical record.</p> <p>2. Assessment of pain and vital signs was not documented to have occurred in accordance with ASC policy in patients whose medical records were reviewed, as follows:</p> <p>a. Patient #2 was an 83 year old female who had an injection procedure on 7/29/15 related to abdominal pain. A post-operative pain assessment was not included in the medical record. The "Procedural Flowsheet," dated 7/29/15, included documentation Patient #2 was in the recovery room for 82 minutes, from 11:50 AM to 1:12 PM, with one set of vital signs documented. Eight sets of vital signs would have been indicated based on ASC policy.</p> <p>b. Patient #5 was a 33 year old female who had a steroid injection procedure on 7/02/15 related to back pain. A post-operative pain assessment was not included in Patient #5's medical record. The "Procedural Flowsheet," dated 7/02/15, included documentation Patient #5 was in the recovery room for 58 minutes from 4:29 PM to 5:27 PM, with one set of vital signs documented. Five sets of vital signs would have been indicated</p>	Q 141	<p>(CONT)</p> <p>the literature.</p> <p>Also NIPC has used a modified Aldrete score for discharge criteria for minimal sedation patients. That does not include a pain score. With the procedures we do, pts are pain is not affected in the immediate post-procedure period and therefore it is unnecessary to measure in the immediate post procedure period. The new policy reflects this practice.</p>		

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Q 141	<p>Continued From page 15 based on ASC policy.</p> <p>c. Patient #6 was a 33 year old female who had a steroid injection on 3/09/15 related to neck and shoulder pain. A post-operative pain assessment was not included in the medical record.</p> <p>d. Patient #7 was a 91 year old male who had a steroid injection on 6/30/15 for low back pain. A post-operative pain assessment was not included in Patient #7's medical record. The "Procedural Flowsheet," dated 6/30/15, included documentation Patient #7 was in the recovery room for 23 minutes, from 10:57 AM to 11:20 AM, with one set of vital signs documented. Two sets of vital signs would have been indicated based on ASC policy.</p> <p>e. Patient #10 was an 80 year old female who had a vertebral augmentation completed on 4/16/15 related to a fracture of the lumbar vertebrae. A post-operative pain assessment was not included in Patient #10's medical record. The "Procedural Flowsheet," dated 4/16/15, included documentation Patient #10 was in the recovery room for 23 minutes, from 4:46 PM to 5:45 PM, with one set of vital signs documented. Two sets of vital signs would have been indicated based on ASC policy.</p> <p>f. Patient #14 was a 31 year old male who had a occipital nerve block on 7/01/15 related to head pain. A post-operative pain assessment was not included in Patient #14's medical record. The "Procedural Flowsheet," dated 7/01/15, included documentation Patient #14 was in the recovery room for 27 minutes from 12:25 PM to 1:02 PM, with one set of vital signs documented. Two sets of vital signs would have been indicated based on</p>	Q 141		

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Q 141	<p>Continued From page 16 ASC policy.</p> <p>g. Patient #16 was a 55 year old female admitted to the ASC on 8/26/15, for a Percutaneous Kyphoplasty in her lumbar spine. (Percutaneous kyphoplasty is a minimally invasive treatment that inserts bone cement into the compressed and fractured vertebrae to provide mechanical stabilization.)</p> <p>A post-operative pain assessment was not included in Patient #16's medical record. The "Procedural Flowsheet," dated 8/26/15, included documentation Patient #16 was in the recovery room for 39 minutes, from 3:40 PM to 4:19 PM, with one set of vital signs documented. Three sets of vital signs would have been indicated based on the ASC policy.</p> <p>h. Patient #12 was a 74 year old male admitted to the ASC on 5/18/15 for a nerve block in his abdomen related to metastatic pancreatic cancer and chronic pain.</p> <p>A post-operative pain assessment was not included in Patient #12's medical record. The "Procedural Flowsheet," dated 5/18/15, included documentation Patient #12 was in the recovery room for 36 minutes, from 1:03 PM to 1:39 PM, with one set of vital signs documented. Three sets of vital signs would have been indicated based on the ASC policy.</p> <p>i. Patient #13 was a 66 year old female who was admitted to the ASC on 3/25/15 for a nerve block in her neck.</p> <p>A post-operative pain assessment was not included in Patient #13's medical record. The</p>	Q 141			

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Q 141	<p>Continued From page 17</p> <p>"Procedural Flowsheet," dated 3/25/15, included documentation Patient #13 was in the recovery room for 34 minutes, from 7:25 AM to 7:59 AM, with one set of vital signs documented. Three sets of vital signs would have been indicated based on the ASC policy.</p> <p>j. Patient #3 was a 77 year old male admitted to the ASC on 7/16/15 for a nerve block related to pain as a result of pancreatic cancer.</p> <p>A post-operative pain assessment was not included in Patient #3's medical record. The "Procedural Flowsheet," dated 7/16/15, included documentation Patient #3 was in the recovery room for 157 minutes from 10:15 AM to 12:52 PM, with one set of vital signs documented. Fifteen sets of vital signs would have been indicated based on the ASC policy.</p> <p>k. Patient #17 was a 79 year old male who was admitted to the ASC on 12/10/14, for a dye study to determine if his pain pump catheter was patent.</p> <p>The Procedure note, dictated and signed by Physician B on 12/10/14 at 5:25 PM, included documentation Patient #17 experienced complications and was transported by EMS to the ED at a local hospital.</p> <p>Patient #17's record did not include documentation of times he was admitted or when he was transferred to the hospital. Fifteen sets of vital signs would have been indicated based on the ASC policy. His record included 1 set of vital signs during the episode, and no pain assessment was documented.</p>	Q 141			

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Q 141	<p>Continued From page 18</p> <p>l. Patient #11 was a 68 year old female who was admitted to the ASC on 5/05/15 for a steroid injection related to back pain and non-union of a fracture.</p> <p>A post-operative pain assessment was not included in Patient #11's medical record. The "Procedural Flowsheet," dated 5/05/15, included documentation Patient #11 was in the recovery room for 30 minutes, from 7:30 AM to 8:00 AM, with one set of vital signs documented. Three sets of vital signs would have been indicated based on the ASC policy.</p> <p>m. Patient #4 was a 78 year old male who was admitted to the ASC on 8/11/15 for a steroid injection in his lower back.</p> <p>A post-operative pain assessment was not included in Patient #4's medical record. The "Procedural Flowsheet," dated 8/11/15, included documentation Patient #4 was in the recovery room for 57 minutes, from 8:36 AM to 9:33 AM, with one set of vital signs documented. Five sets of vital signs would have been indicated based on the ASC policy.</p> <p>During an interview with the RN Coordinator on 9/01/15 at 1:34 PM, she stated they did not typically assess pain postoperatively because pain was often worse after the procedure. She also stated vital signs were usually taken one time post-operatively (rather than every 10 minutes).</p> <p>Physician B was interviewed on 9/14/15 beginning at 8:15 AM. He stated he would review the policy for post-operative assessment of vital signs and pain.</p>	Q 141		

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Q 141	Continued From page 19	Q 141			
Q 160	<p>Patients' post procedural assessments and documentation was not performed in accordance with the ASC policy.</p> <p>416.47 MEDICAL RECORDS</p> <p>The ASC must maintain complete, comprehensive, and accurate medical records to ensure adequate patient care. This CONDITION is not met as evidenced by: Based on medical record review, observation, and staff interview, it was determined the ASC failed to ensure a separate and distinct record keeping system was established for the ASC and that accurate and complete medical records entries were maintained for 17 of 17 patients (#1 - #17) whose medical records were reviewed. This resulted in a lack of clarity to the course of patient care. Findings include:</p> <ol style="list-style-type: none"> 1. Refer to Q0161 as it relates to the failure of the ASC to have a separate and distinct system to create ASC records. 2. Refer to Q0162 as it relates to ensure medical record documentation was accurate and complete. 	Q 160	<p><i>See response to Q161 and Q162 for Q160</i></p>		
Q 161	<p>416.47(a) ORGANIZATION</p> <p>The ASC must develop and maintain a system for the proper collection, storage, and use of patient records.</p> <p>This STANDARD is not met as evidenced by: Based on medical record review, observation, and staff interview, it was determined the ASC did not have a system to create medical records</p>	Q 161	<p><i>The electronic medical record system is on an enterprise system and not directly controlled by PMFI or NIPC. The discrepancy of The</i> <i>(cont)</i></p>	<p><i>10/19/15</i></p>	

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Q 161	<p>Continued From page 20</p> <p>separate and distinct to the ASC for 16 of 17 ASC patients (#1 - #13, #15 - #17) whose records were reviewed. This resulted in confusion about whether patients were seen in the ASC or clinic. Findings include:</p> <p>1. During interview on 12/31/15 at 11:34 AM, the Billing and Credentialing Coordinator confirmed the ASC and attached clinic shared one electronic medical record without the ability to separate the records. This resulted in a lack of clarity as to what actually constituted the ASC record, as follows:</p> <p>a. On 8/31/15, surveyors requested a list of ASC patients for sample selection. Patient #9 was included on the list. A copy of the ASC record was requested. A procedure note, dated 3/04/15, for an occipital nerve block was included in the medical record. The paperwork had the name of the clinic on the top of the forms.</p> <p>The RN Clinical Coordinator was interviewed on 9/01/15 at 2:33 PM. She opened the electronic health record. She stated she could not be sure where the procedure was conducted, whether in the ASC or in the clinic. She stated usually the procedure was done in the clinic.</p> <p>Physician A was interviewed on 9/02/15 at 8:00 AM. She stated the procedure was done in the clinic because she remembered the patient. She stated Patient #9 may have shown up on the ASC list of patients if she had been incorrectly checked in.</p> <p>b. Medical records identified by ASC staff as patients who were seen in the ASC, included documentation with the clinic name in the</p>	Q 161	<p>(Cont)</p> <p>Letterhead has been addressed with the EMR enterprise administrator. This is being rectified. The ASC documents from NIPC (procedure notes, order sheets, flow sheets) will be clearly marked with North Idaho Pain Center on the documents. This will be monitored by the front office staff when documents are sent out, the providers during peer review, and periodic chart audits.</p>		

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Q 161	<p>Continued From page 21 letterhead, rather than the ASC name, as follows:</p> <p>i. Patient #8 was a 49 year old female who had a joint injection on 8/31/15 related to right hip pain. She was observed from entrance to the waiting area at 10:15 AM until discharge from the facility at 10:53 AM.</p> <p>The name of the clinic rather than the name of the ASC was on the medical record documentation for Patient #8, including the letterheads for the "Procedure Flowsheet," and the physician's procedure note. This did not accurately reflect where the services were rendered.</p> <p>During an interview on 9/01/15 beginning at 3:00 PM, the RN Coordinator reviewed the record and confirmed the letterhead was not for the ASC, it was for the clinic.</p> <p>ii. Patient #15 was a 60 year old female who was admitted to the ASC on 8/31/15, for an epidural steroid injection procedure in her neck. Her care was observed from the time of admission at 2:07 PM, until discharge at 3:04 PM.</p> <p>The name of the clinic rather than the name of the ASC was on the medical record documentation, including the "Procedure Flowsheet," and the physician's procedure note. This did not accurately reflect where the services were rendered.</p> <p>The RN Coordinator was interviewed on 9/01/15 at 3:00 PM. She reviewed Patient #15's record and confirmed the documents had the letterhead for the clinic and not the ASC.</p>	Q 161			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001058	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/14/2015
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Q 161	<p>Continued From page 22</p> <p>iii. The records of Patients #1 - #7, #10 - #14, and #16 - #17 documented they were admitted to the ASC as follows:</p> <ul style="list-style-type: none"> - Patient #1 was an 80 year old male admitted to the ASC on 4/27/15, for an insertion of an intrathecal catheter for a pain pump trial. - Patient #2 was an 83 year old female who had an injection procedure on 7/29/15 related to abdominal pain. - Patient #3 was a 77 year old male admitted to the ASC on 7/16/15 for a nerve block related to pain as a result of pancreatic cancer. - Patient #4 was a 78 year old male who was admitted to the ASC on 8/11/15 for a steroid injection in his lower back. - Patient #5 was a 33 year old female who had a steroid injection procedure on 7/02/15 related to back pain. - Patient #6 was a 33 year old female who had a steroid injection on 3/09/15 related to neck and shoulder pain. - Patient #7 was a 91 year old male who had a steroid injection on 6/30/15 for low back pain. - Patient #10 was an 80 year old female who had a vertebral augmentation completed on 4/16/15 related to a fracture of the lumbar vertebrae. - Patient #11 was a 68 year old female who was admitted to the ASC on 5/05/15 for a steroid injection related to a non-union of a fracture in her spine. 	Q 161			

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Q 161	<p>Continued From page 23</p> <ul style="list-style-type: none"> - Patient #12 was a 74 year old male admitted to the ASC on 5/18/15 for a nerve block in his abdomen related to metastatic pancreatic cancer and chronic pain. - Patient #13 was a 66 year old female who was admitted to the ASC on 3/25/15 for a nerve block in her neck. - Patient #14 was a 31 year old male who had a occipital nerve block on 7/01/15 related to head pain. - Patient #16 was a 55 year old female admitted to the ASC on 8/26/15, for a Percutaneous Kyphoplasty in her lumbar spine. (Percutaneous kyphoplasty is a minimally invasive treatment that inserts bone cement into the compressed and fractured vertebrae to provide mechanical stabilization). - Patient #17 was a 79 year old male who was admitted to the ASC on 12/10/14, for a dye study to determine if his pain pump catheter was patent. <p>However, the name of the clinic rather than the name of the ASC was on the patients' medical record documentation, including the letterheads for each patient's "Procedure Flowsheet" and the physician's procedure notes. This did not accurately reflect where the services were rendered.</p> <p>During an interview on 9/01/15 beginning at 3:00 PM, the RN Coordinator reviewed the records and confirmed the letterhead was not for the ASC, it was for the clinic.</p>	Q 161			

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Q 161	Continued From page 24	Q 161		
Q 162	<p>The facility failed to ensure a separate, distinct record keeping system was maintained for the ASC.</p> <p>416.47(b) FORM AND CONTENT OF RECORD</p> <p>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:</p> <ol style="list-style-type: none"> (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. <p>This STANDARD is not met as evidenced by: Based on medical record review, observation, and staff interview, it was determined the ASC failed to ensure complete, accurate medical records entries were maintained for 15 of 17 patients (#1 - #8 and #10 - #16) whose medical records were reviewed. This resulted in a lack of clarity to the course of patient care. Findings include:</p> <p>1. Patient #8 was a 49 year old female who had a</p>	Q 162	<p><i>VI. 3.B.</i></p> <p><i>The policies for Medical record documentation have been reviewed with all nursing personnel and providers. Risks and benefits are always discussed at the clinic visit. Documentation has been changed to reflect this.</i></p> <p><i>Recording of the lot # for steroids used during the procedure is important. This will still be done but the position for recording this in the EMR has been moved out of the Time Out checklist.</i></p> <p><i>A discharge diagnosis and discharge (cont)</i></p>	10/19/15

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Q 162	<p>Continued From page 25</p> <p>joint injection on 8/31/15 related to right hip pain. She was observed from entrance to the waiting area at 10:15 AM until discharge from the facility at 10:53 AM. Patient #8's record did not include accurate, comprehensive information, as follows:</p> <p>a. During the observation for Patient #8's care, the CNA was observed to obtain Patient #8's signature on the consent form while Patient #8 was in the pre-operative area. No one was observed to explain the procedure and risks or to encourage or answer questions as stated in the written narrative.</p> <p>However, the physician's procedure note, dated 8/31/15, under the section "Pre-Procedure Care:" stated "Consent was obtained. The procedure and risks were explained in detail. Questions were encouraged and answered."</p> <p>The physician who performed the procedure was interviewed on 9/01/15 at 9:23 AM. She stated the procedure and risks were explained at a prior clinic visit rather than on the date of the procedure. This information was not stated on the medical record entry.</p> <p>b. The "Procedure Flowsheet," dated 8/31/15, was reviewed. The "Time out check list" stated "Steroid given Triamcinolone Lot # AAB8035." No medication was given to Patient #8 during the timeout period.</p> <p>The RN Coordinator was interviewed on 9/01/15 at 1:51 PM. She stated that the steroid was not given during the timeout and she was not sure why the medical record printed out that way. She stated her electronic view of the medical record did not include the word "given." She stated it</p>	Q 162	<p>(CONT)</p> <p>Disposition will be added to the EMR record.</p> <p>- The consent policy was reviewed and updated. The provider starts the consent process during the clinic visit with a thorough discussion of the procedure, procedure risks & benefits. At the time of the procedure, the provider ensures the patient has an understanding of the procedure and any further questions are answered. Nursing personnel may obtain the signed consent and witness the signature.</p> <p>(CONT)</p>	10/19/15

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Q 162	<p>Continued From page 26</p> <p>was meant to document the lot number of the steroid that would be administered by the physician during the procedure.</p> <p>c. Patient #8 was observed to be provided written discharge instructions without verbal instructions.</p> <p>However, the physician's procedure note, under a section "Instruction," stated "Patient was asked to call in the event of worsening pain, fever, weakness, numbness or bladder or bowel incontinence." This was not observed to occur.</p> <p>During an interview with the RN Coordinator on 9/01/15 at 9:51 AM, she stated the information was provided to Patient #8 in writing. The word "asked to call" implied verbal rather than written communication and therefore was not accurately communicated in writing.</p> <p>d. A discharge diagnosis and discharge disposition were not included in Patient #8's medical record. During an interview on 9/01/15 at 1:45 PM, the RN Coordinator confirmed the information was not present.</p> <p>Patient #8's record did not accurately reflect the timing and course of her care.</p> <p>2. Patient #15 was a 60 year old female who was admitted to the ASC on 8/31/15, for an epidural steroid injection procedure in her neck. Her care was observed from the time of admission at 2:07 PM, until discharge at 3:04 PM. Patient #15's record did not include accurate, comprehensive information, as follows:</p> <p>a. During the observation for Patient #15's care, the CNA was observed to provide the consent to</p>	Q 162	<p>(CONT)</p> <p>- The postop instruction sheet has been reviewed and updated. The providers have been counseled on making sure the documentation reflects accurately the postop instructions being given in written form.</p> <p>- Nursing staff reminded that all documentation needs to be completed in a timely manner. In those instances when a chart cannot be completed at the time of discharge, a "late documentation" field but was added to the chart so the reason the chart was completed late can be documented.</p> <p>- The medications have orders have (CONT)</p>	10/19/15 10/19/15 10/19/15	

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Q 162	<p>Continued From page 27</p> <p>Patient #15 when she was admitted to the pre-procedure/recovery area. The CNA and the RN who started Patient #15's IV asked Patient #15 if she had questions, and she responded "No." Physician A was not observed to speak with Patient #15 until she was in the OR and prone on the table. Physician A was not observed to provide the consent to Patient #15 or encourage her to ask questions before the procedure.</p> <p>However, the procedure note for Patient #15, dated 8/31/15, was dictated and electronically signed by Physician A. The "Pre-Procedure Care:" section of the procedure note stated "Consent was obtained. The procedure and risks were explained in detail. Questions were encouraged and answered."</p> <p>The physician who performed the procedure was interviewed on 9/01/15 at 9:23 AM. She stated the procedure and risks were explained at a prior clinic visit rather than on the date of the procedure. This information was not stated on the medical record entry.</p> <p>b. The "Procedure Flowsheet," dated 8/31/15, was reviewed. The "Time out check list" stated "Steroid given Dexamethasone Lot # 6009217." No medication was given to Patient #15 during the timeout period.</p> <p>The RN Coordinator was interviewed on 9/01/15 at 3:00 PM. She reviewed Patient #15's record and confirmed the steroid was not given during the timeout, and she was not sure why the medical record printed out that way. She stated her electronic view of the medical record did not include the word "given." It was meant to</p>	Q 162	<p>(cont)</p> <p>been amended to include IV fluids and Toradol.</p> <p>- The PMNI letterhead has been removed from the documents generated in the ASC and North Idaho Pain Center has been added. 10/19/15</p> <p>- To ensure that medical record documentation is comprehensive and accurate, 10 charts from each provider will be randomly chosen each month for 3 months for an audit. If medical record accuracy is above 90%, 10 charts from each provider will be</p> <p>(cont)</p>	10/19/15	

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Q 162	<p>Continued From page 28</p> <p>document the lot number of the steroid that would be administered by the physician during the procedure.</p> <p>c. During the observation of Patient #15's care, it was noted she was transferred to the recovery room at 2:34 PM. However, her "Procedure Flowsheet" documented Patient #15 was transferred to the recovery room at 3:34 PM.</p> <p>The RN Coordinator was interviewed on 9/01/15 at 3:00 PM. She confirmed the record indicated Patient #15 transferred to the recovery room at 3:34 PM, and stated it was a typo, and she was transferred at 2:34 PM.</p> <p>d. Patient #15 was observed to be provided written discharge instructions without verbal instructions.</p> <p>However, the physician's procedure note, under a section "Instruction," stated "Patient was asked to call in the event of worsening pain, fever, weakness, numbness or bladder or bowel incontinence." This was not observed to occur.</p> <p>During an interview with the RN Coordinator on 9/01/15 at 9:51 AM, she stated the information was provided to Patient #8 in writing. The word "asked to call" implied verbal rather than written communication and therefore was not accurately communicated in writing.</p> <p>e. A discharge diagnosis and discharge disposition were not included in Patient #15's medical record. During an interview on 9/01/15 at 3:00 PM, the RN Coordinator confirmed the information was not present.</p>	Q 162	<p>(CONT)</p> <p>randomly chosen every 6 months for audit. If accuracy dips below 90%, 10 charts from each provider will be audited every month until accuracy is again satisfactory</p>		

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Q 162	<p>Continued From page 29</p> <p>Patient #15's record did not accurately reflect the timing and course of her care.</p> <p>3. Patient #5 was a 33 year old female who had a steroid injection procedure on 7/02/15 related to back pain. Patient #5's record did not include accurate, comprehensive information, as follows:</p> <p>a. The "Procedure Flow Sheet," dated 7/02/15, included an order to admit Patient #5 to the Pain Center. The time of the order was 5:26 PM. The same note stated the procedure started at 4:46 PM and ended at 5:04 PM. The timing in the chart did not accurately reflect the time of the order.</p> <p>The RN Coordinator was interviewed on 9/01/15 at 2:02 PM. She confirmed the time of the order did not accurately reflect when the order was received. She stated it was a standing order that was entered late.</p> <p>b. The "Procedure Flowsheet," dated 7/02/15, was reviewed. The "Time out check list" stated "Steroid given Triamcinolone Lot # 6009217." No medication would have been given during the timeout period."</p> <p>The RN Coordinator was interviewed on 9/01/15 at 2:02 PM. She confirmed it was not given, rather it was intended to document the steroid that was planned to be given during the procedure.</p> <p>c. A discharge diagnosis and discharge disposition were not included in Patient #5's medical record. During an interview on 9/01/15 at 2:02 PM, the RN Coordinator confirmed the information was not present and stated Patient #5</p>	Q 162			

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Q 162	<p>Continued From page 30 went home in a wheelchair.</p> <p>Patient #5's record did not accurately reflect the timing and course of her care.</p> <p>4. Patient #6 was a 33 year old female who had a steroid injection on 3/09/15 related to neck and shoulder pain. Patient #6's record did not include accurate, comprehensive information, as follows:</p> <p>a. Patient #6's "Procedure Flowsheet," dated 3/09/15, was reviewed. The "Time out check list" stated "Steroid given Dexamethasone Lot #054377." No medication would have been given during a time out period.</p> <p>The RN Coordinator was interviewed on 9/01/15 at 2:02 PM. She confirmed it was not given, rather it was intended to document the steroid that would be given during the procedure.</p> <p>b. A discharge diagnosis and discharge disposition were not included in Patient #6's medical record. During an interview on 9/01/15 at 2:06 PM, the RN Coordinator confirmed the information was not present.</p> <p>Patient #6's record did not include accurate, comprehensive information.</p> <p>5. Patient #7 was a 91 year old male who had a steroid injection on 6/30/15 for low back pain. Patient #7's record did not include accurate, comprehensive information, as follows:</p> <p>a. Patient #7's "Procedure Flowsheet," dated 6/30/15, was reviewed. The "Time out check list" stated "Steroid given Triamcinolone Lot #AAB3000." No medication would have been</p>	Q 162			

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Q 162	<p>Continued From page 31 given during a time out period.</p> <p>The RN Coordinator was interviewed on 9/01/15 at 2:12 PM. She confirmed it was not given, rather it was intended to document the steroid that would be given during the procedure.</p> <p>b. A signed consent for Patient #7's procedure was dated 6/30/15. The consent did not include the time consent was given.</p> <p>During an interview on 9/01/15 at 2:12 PM, the RN Coordinator confirmed the information was not present.</p> <p>c. A discharge diagnosis and discharge disposition were not included in Patient #7's medical record. During an interview on 9/01/15 at 2:12 PM, the RN Coordinator confirmed the information was not present.</p> <p>Patient #7's record did not include accurate, comprehensive information.</p> <p>6. Patient #10 was an 80 year old female who had a vertebral augmentation completed on 4/16/15 related to a fracture of the lumbar vertebrae. Patient #10's record did not include accurate, comprehensive information, as follows:</p> <p>a. Patient #10's "Procedure Flowsheet," documented the date of the vertebral augmentation as 4/20/15 by a physician that differed from the physician's procedure note, dated 4/16/15. The date on the flowsheet and the name of the doctor who performed the procedure were not accurate.</p> <p>The RN Coordinator was interviewed on 9/01/15</p>	Q 162		

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Q 162	<p>Continued From page 32</p> <p>at 2:17 PM. She stated the date of the note, 4/20/15, should have been 4/16/15. She confirmed the name of the provider listed was not accurate. She said it was probably because the procedure note was created late.</p> <p>b. Patient #10's "Procedure Flowsheet," dated 4/20/15, included a section "Time out check list" which stated "Steroid given." No medication would have been given during a time out period. This was confirmed by the RN Coordinator during an interview on 9/01/15 at 2:17 PM.</p> <p>c. A discharge diagnosis and discharge disposition were not included in Patient #10's medical record. During an interview on 9/01/15 at 2:17 PM, the RN Coordinator confirmed the information was not present.</p> <p>Patient #10's record did not include accurate, comprehensive information.</p> <p>7. Patient #16 was a 55 year old female admitted to the ASC on 8/26/15, for a Percutaneous Kyphoplasty in her lumbar spine. (Percutaneous kyphoplasty is a minimally invasive treatment that inserts bone cement into the compressed and fractured vertebrae to provide mechanical stabilization.) Patient #16's record documented she had a history of osteoporosis and pathologic fractures of her spine. Patient #16's record did not include accurate, comprehensive information, as follows:</p> <p>a. Patient #16's "Procedure Flowsheet," included a section "Time out check list," which noted "No Prophylactic antibiotics indicated." However, the flowsheet included documentation Ancef 1 Gm was administered at 2:50 PM, but the "Orders"</p>	Q 162			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001058	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/14/2015
NAME OF PROVIDER OR SUPPLIER NORTH IDAHO PAIN CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1686 W RIVERSTONE DRIVE, SUITE 2 COEUR D'ALENE, ID 83814		
(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	<p>Continued From page 33</p> <p>section of the flowsheet did not include the Ancef.</p> <p>During an interview on 9/01/15 beginning at 1:40 PM, the RN Coordinator reviewed Patient #16's record and confirmed the "Time out check list" noted that no prophylactic antibiotics were indicated, but Ancef was administered and not included in the orders.</p> <p>b. Patient #16's "Procedure Flowsheet" included intraoperative vital signs that were recorded every 5 minutes. The flowsheet documented oxygen saturations that ranged from 69 to 73% over a 15 minute period:</p> <p>-2:55 PM, her blood pressure was 109/57 and oxygen saturations were 69%.</p> <p>-3:00 PM, her blood pressure was 104/61 and oxygen saturations were 73%.</p> <p>-3:05 PM, her blood pressure was 100/66 and oxygen saturations were 73%.</p> <p>During an interview on 9/02/15 beginning at 7:30 AM, Physician A reviewed Patient #16's record and confirmed the documentation of vital signs which were abnormal. She stated she remembered the blood pressure cuff was on the same side as Patient #16's pulse oximeter. She stated she was sure that when the blood pressure was being measured, the pulse oximeter would not read accurately. Physician A stated the abnormally low pulse oximeter readings should not have been recorded.</p> <p>Patient #16's oxygen saturations were not accurately recorded.</p> <p>c. The Medication section of Patient #16's flowsheet included discrepancies as follows:</p>	Q 162			

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Q 162	<p>Continued From page 34</p> <ul style="list-style-type: none"> - At 2:49 PM, Fentanyl 100 mcgs IV was administered. - At 2:50 PM, "todol [sic]" 5 mg IV was administered. - At 3:06 PM, Fentanyl 100 mcgs IV was administered. - At 3:11 PM, Fentanyl 50 mcgs IV was administered. - At 3:12 PM, Fentanyl 50 mcgs IV was administered. <p>A total of 300 mcg of Fentanyl was administered.</p> <p>However, the orders for Patient #16's sedation were as follows: "Titrate Fentanyl IV 50 X 200 mcg, and Titrate Midazolam IV 1 X 5 mg," indicating a maximum dosage of Fentanyl as 200 mcg. Further, the "Orders" section of the flowsheet did not include the "todol [sic]"</p> <p>During an interview on 9/01/15 beginning at 1:40 PM, the RN Coordinator reviewed Patient #16's record. She stated the medication documented as "todol," was "Toradol" and the RN documented the medication incorrectly. She confirmed that Toradol was administered and not included in the orders. The RN Coordinator confirmed 300 mcg Fentanyl was administered, however a total of 200 mcg was ordered.</p> <p>d. Patient #16's record included an Aldrete Score which was performed for all patients who received conscious sedation during the recovery phase. However, the RN documented the scoring was completed at 2:51 PM, before the surgical procedure started. The surgical procedure was documented as starting at 3:00 PM and ended at 3:40 PM.</p>	Q 162			

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Q 162	<p>Continued From page 35</p> <p>During an interview on 9/01/15 beginning at 1:40 PM, the RN Coordinator reviewed Patient #16's record and confirmed the documentation of Aldrete score was before the procedure occurred, and was unable to determine why it was documented at that time.</p> <p>e. A discharge diagnosis and discharge disposition were not included in Patient #16's medical record. During an interview on 9/01/15 at 1:40 PM, the RN Coordinator confirmed the information was not present.</p> <p>Patient #16's record did not include accurate, comprehensive information.</p> <p>8. Patient #1 was an 80 year old male admitted to the ASC on 4/27/15, for an insertion of an intrathecal catheter for a pain pump trial. Patient #1's record did not include accurate, comprehensive information, as follows:</p> <p>a. Patient #1's "Procedural Flowsheet" included a "Time out check list," completed at 2:08 PM. It included documentation "No prophylactic antibiotics indicated" and "Steroid given." However, antibiotics were ordered and administered at 2:00 PM. Steroids were not administered or ordered.</p> <p>During an interview on 9/01/15 beginning at 1:40 PM, the RN Coordinator reviewed Patient #1's record and confirmed his record included documentation that a steroid was given and no antibiotics were indicated in the time out check list section. She confirmed the documentation was incorrect, and said it was a problem with the EMR software program.</p>	Q 162			

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Q 162	<p>Continued From page 36</p> <p>b. Patient #1's record documented "No concerns for recovery," however in the operative note, his physician documented he was admitted to the hospital for a pain pump trial. Additionally, a discharge diagnosis and discharge disposition were not included in Patient #1's medical record.</p> <p>During an interview on 9/01/15 beginning at 1:40 PM, the RN Coordinator reviewed Patient #1's record and confirmed he was discharged, accompanied by his family, and was then transported by private car to the hospital. She stated she did not include that information on the flowsheet when Patient #1 was discharged. Additionally, she confirmed Patient #1's record did not include a discharge diagnosis.</p> <p>Patient #1's record did not include accurate, comprehensive information.</p> <p>9. Patient #12 was a 74 year old male admitted to the ASC on 5/18/15 for a nerve block in his abdomen related to metastatic pancreatic cancer and chronic pain. Patient #12's record did not include accurate, comprehensive information, as follows:</p> <p>a. The "Orders" section of Patient #12's flowsheet did not include IV fluids, sedation and oxygen orders. However, the flowsheet documented oxygen was started at 12:05 PM. Patient #12's flowsheet included documentation Midazolam 2 mg IV, and Fentanyl 50 mcg IV was administered by the RN at 12:13 PM. The Procedure note, dictated by Physician A and signed on 5/18/15 at 1:08 PM, included documentation that Patient #12 received 1 liter of normal saline prior to his procedure. The Procedure Flowsheet, completed</p>	Q 162			

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Q 162	<p>Continued From page 37</p> <p>by the RN Coordinator, did not include documentation Patient #12 received the IV fluid before his procedure.</p> <p>During an interview on 9/01/15 at 3:00 PM, the RN Coordinator confirmed the oxygen, IV fluids, and sedation orders were not entered.</p> <p>b. Patient #12's record included an Aldrete Score, which was performed during the recovery phase for all patients who had received conscious sedation. However, the RN documented the scoring was completed at 4:39 PM, 3 hours after he was discharged.</p> <p>During an interview on 9/01/15 at 3:00 PM, the RN Coordinator stated she documented Patient #12's care later in the day, and she forgot to include the late documentation entry.</p> <p>c. A discharge diagnosis and discharge disposition were not included in Patient #12's medical record. During an interview on 9/01/15 at 3:00 PM, the RN Coordinator confirmed the information was not present.</p> <p>Patient #12's record did not include accurate, comprehensive information.</p> <p>10. Patient #13 was a 66 year old female who was admitted to the ASC on 3/25/15 for a nerve block in her neck. Patient #13 had a history of pain related to a shingles outbreak. Patient #12's record did not include accurate, comprehensive information, as follows:</p> <p>a. Patient #13's "Procedural Flowsheet" included a "Time out check list," completed at 7:07 AM. It included documentation "Steroid given."</p>	Q 162			

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Q 162	<p>Continued From page 38</p> <p>However, steroids were not administered or ordered. Additionally, the flowsheet documented Patient #13 received Midazolam 2 mg IV for sedation. There was no order for Midazolam.</p> <p>During an interview on 9/01/15 beginning at 3:00 PM, the RN Coordinator reviewed Patient #13's record and confirmed an order for Midazolam was not entered.</p> <p>b. The Aldrete Score for Patient #13 was 10, however, the RN documented the scoring was done at 9:05 AM, which was more than an hour after her discharge.</p> <p>During an interview on 9/01/15 beginning at 3:00 PM, the RN Coordinator reviewed Patient #13's record and confirmed the Aldrete Score was documented after her discharge.</p> <p>c. A discharge diagnosis and discharge disposition were not included in Patient #13's medical record. During an interview on 9/01/15 at 3:00 PM, the RN Coordinator confirmed the information was not present.</p> <p>Patient #13's record did not include accurate, comprehensive information.</p> <p>11. Patient #3 was a 77 year old male admitted to the ASC on 7/16/15 for a nerve block related to pain as a result of pancreatic cancer. Patient #3's record did not include accurate, comprehensive information, as follows:</p> <p>a. Patient #3's "Procedural Flowsheet" included a "Time out check list," completed at 9:29 AM. It included documentation "Steroid given." However, steroids were not administered or</p>	Q 162		

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Q 162	<p>Continued From page 39 ordered.</p> <p>During an interview on 9/01/15 beginning at 3:00 PM, the RN Coordinator reviewed Patient #3's record and confirmed steroids were not ordered or administered during his procedure.</p> <p>b. Patient #3's Procedural Record, dictated by Physician B, documented he was placed on oxygen and received 500 ml of normal saline IV fluid prior to the procedure. However, there was no order for the oxygen or IV fluids. His procedural flowsheet documented he was on room air during the procedure.</p> <p>During an interview on 9/01/15 beginning at 3:00 PM, the RN Coordinator reviewed Patient #3's record and confirmed the orders for IV fluids and oxygen were not entered.</p> <p>c. A discharge diagnosis and discharge disposition were not included in Patient #3's medical record. During an interview on 9/01/15 at 3:00 PM, the RN Coordinator confirmed the information was not present.</p> <p>Patient #3's record did not include accurate, comprehensive information.</p> <p>12. Patient #4 was a 78 year old male who was admitted to the ASC on 8/11/15 for a steroid injection in his lower back. Patient #4's record did not include comprehensive information, as follows:</p> <p>a. Patient #4's Procedure Note was dictated and signed by Physician B on 8/11/15, included an incomplete sentence: "The patient was taken to the..."</p>	Q 162			

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Q 162	<p>Continued From page 40</p> <p>During an interview on 9/01/15 beginning at 3:00 PM, the RN Coordinator reviewed Patient #4's record and confirmed the record had an incomplete sentence.</p> <p>b. A discharge diagnosis and discharge disposition were not included in Patient #4's medical record. During an interview on 9/01/15 at 3:00 PM, the RN Coordinator confirmed the information was not present.</p> <p>Patient #4's record did not include comprehensive information.</p> <p>13. Patient #11 was a 68 year old female who was admitted to the ASC on 5/05/15 for a steroid injection related to back pain and nonunion of a fracture.</p> <p>A discharge diagnosis and discharge disposition were not included in Patient #11's medical record. During an interview on 9/01/15 at 3:00 PM, the RN Coordinator confirmed the information was not present.</p> <p>Patient #11's record did not include comprehensive information.</p> <p>14. Patient #2 was an 83 year old female who had an injection procedure on 7/29/15 related to abdominal pain.</p> <p>A discharge diagnosis and discharge disposition were not included in Patient #2's medical record. During an interview on 9/01/15 at 1:40 PM, the RN Coordinator confirmed the information was not present.</p>	Q 162			

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Q 162	Continued From page 41 Patient #2's record did not include comprehensive information. 15. Patient #14 was a 31 year old male who had an occipital nerve block on 7/01/15 related to head pain. A discharge diagnosis and discharge disposition were not included in Patient #14's medical record. During an interview on 9/01/15 at 2:40 PM, the RN Coordinator confirmed the information was not present. Patient #14's record did not include comprehensive information.	Q 162		
Q 181	The ASC did not ensure patient records included accurate, comprehensive information. 416.48(a) ADMINISTRATION OF DRUGS Drugs must be prepared and administered according to established policies and acceptable standards of practice. This STANDARD is not met as evidenced by: Based on medical record review, policy review, and staff interview, it was determined the ASC failed to ensure administration of medication was consistent with the orders of a physician for 5 of 17 patients (#1, #3, #12, #13, and #16) whose records were reviewed. This had the potential to interfere with patient safety. Findings include: An ASC policy titled "Administration of Intravenous Conscious Sedation," dated 5/15/05,	Q 181	<i>The ASE policy was titled "Administration of Intravenous Conscious Sedation" was reviewed with nursing personnel and providers. Attention to detail was stressed. The EMR orders template revised to add IV fluids and Toradol. The medical chart audit</i> <i>(CONT)</i>	<i>10/19/15</i>

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Q 181	<p>Continued From page 42</p> <p>stated that medications given during the procedure would be documented as verbal orders. Verbal orders for medications were not documented as follows:</p> <p>1. Patient #16 was a 55 year old female admitted to the ASC on 8/26/15, for a Percutaneous Kyphoplasty in her lumbar spine. (Percutaneous kyphoplasty is a minimally invasive treatment that inserts bone cement into the compressed and fractured vertebrae to provide mechanical stabilization.) Patient #16's record documented she had a history of osteoporosis and pathologic fractures of her spine.</p> <p>The "Procedure Flowsheet," in the section "Time out check list" noted "No Prophylactic antibiotics indicated." However, the flowsheet included documentation Ancef 1 Gm was administered at 2:50 PM.</p> <ul style="list-style-type: none"> - At 2:49 PM, Fentanyl 100 mcgs IV was administered. - At 2:50 PM, "todol [sic]" 5 mg IV was administered. - At 3:06 PM, Fentanyl 100 mcgs IV was administered. - At 3:11 PM, Fentanyl 50 mcgs IV was administered. - At 3:12 PM, Fentanyl 50 mcgs IV was administered. <p>A total of 300 mcg of Fentanyl was administered.</p> <p>However, the orders for Patient #16's sedation were as follows: "Titrate Fentanyl IV 50 X 200 mcg, and Titrate Midazolam IV 1 X 5 mg," indicating a maximum dosage of Fentanyl as 200 mcg. Further, the "Orders" section of the</p>	Q 181	<p><i>(CONT)</i></p> <p><i>will be conducted as outlined in Q162.</i></p>		

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Q 181	<p>Continued From page 43 flowsheet did not include the "todol [sic]"</p> <p>During an interview on 9/01/15 beginning at 1:40 PM, the RN Coordinator reviewed Patient #16's record. She stated the medication documented as "todol," was "Toradol" and the RN documented the medication incorrectly. She confirmed that Toradol was administered and not included in the orders. The RN Coordinator confirmed 300 mcg Fentanyl was administered, however, a total of 200 mcg was ordered.</p> <p>2. Patient #1 was an 80 year old male admitted to the ASC on 4/27/15, for an insertion of an intrathecal catheter for a pain pump trial.</p> <p>Patient #1's Procedural Flowsheet included a "Time out check list," completed at 2:08 PM. It included documentation "No prophylactic antibiotics indicated" and "Steroid given." However, antibiotics were ordered and administered at 2:00 PM. Steroids were not administered or ordered.</p> <p>During an interview on 9/01/15 beginning at 1:40 PM, the RN Coordinator reviewed Patient #1's record and confirmed Patient #1's record included documentation that a steroid was given and no antibiotics were indicated in the time out check list section. She confirmed the documentation that steroids were given was incorrect, and said it was a problem with the EMR software program.</p> <p>3. Patient #12 was a 74 year old male admitted to the ASC on 5/18/15 for a nerve block in his abdomen related to metastatic pancreatic cancer and chronic pain.</p> <p>The Procedure note, dictated by Physician A and</p>	Q 181			

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Q 181	<p>Continued From page 44</p> <p>signed on 5/18/15 at 1:08 PM, included documentation that Patient #12 received 1 liter of Normal Saline prior to his procedure. The Procedure Flowsheet, completed by the RN Coordinator, did not include documentation Patient #12 received IV fluids.</p> <p>His flowsheet included documentation Midazolam 2 mg IV, and Fentanyl 50 mcg IV were administered by the RN at 12:13 PM, and the flowsheet documented oxygen was started at 12:05 PM. The "Orders" section of the flowsheet did not include IV fluids, sedation or oxygen orders.</p> <p>During an interview on 9/01/15 at 3:00 PM, the RN Coordinator confirmed the oxygen, IV fluids, and sedation orders were not entered, and she did not document the administration of IV fluids.</p> <p>4. Patient #13 was a 66 year old female who was admitted to the ASC on 3/25/15 for a nerve block in her neck. Patient #13 had a history of pain related to a shingles outbreak.</p> <p>Patient #13's Procedural Flowsheet included documentation Patient #13 received Midazolam 2 mg IV for sedation. There was no order for Midazolam.</p> <p>During an interview on 9/01/15 beginning at 3:00 PM, the RN Coordinator reviewed Patient #13's record and confirmed order for Midazolam was not entered.</p> <p>5. Patient #3 was a 77 year old male admitted to the ASC on 7/16/15 for a nerve block related to pain as a result of pancreatic cancer.</p>	Q 181			

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Q 181	Continued From page 45 Patient #3's Procedural Record, dictated by Physician B, documented he was placed on oxygen and received 500 ml of Normal Saline IV fluid prior to the procedure. However, there was no order for the oxygen or IV fluids. During an interview on 9/01/15 beginning at 3:00 PM, the RN Coordinator reviewed Patient #3's record and confirmed the orders for IV fluids and oxygen orders were not entered. She confirmed the orders for IV fluids and oxygen were not entered. Medications were not administered in accordance with ASC policies.	Q 181		
Q 220	416.50 NOTICE - POSTING ... 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 and interview, it was determined the ASC failed to ensure written notice of patient rights was posted in one waiting area where 2 of 2 patients (#8 and #15) were observed to wait. This had the potential to interfere with patient familiarity with rights. Findings include: During a tour of the ASC on 8/31/15 at 8:00 AM, two waiting areas were observed, one associated with the clinic and a second one associated with the ASC. A patient rights poster was observed to be posted in the ASC waiting area but not the clinic waiting area. The RN Coordinator explained that patients could wait in either area,	Q 220	Pt. Rights and Responsibilities document is framed and hung in each waiting room. This improves the patients' ability to be aware of their rights/responsibilities. The above follows the Policy & Procedure II.1.A. already in place. To monitor, the Administrator will check that R&R are hanging in each waiting room during random weekly checks of the waiting rooms.	10/19/15

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Q 220	Continued From page 46 per their preference, until called back to the pre-operative area. Patient #8 and Patient #15 were observed during the survey. Patient #8 was observed to wait in the clinic waiting area from 10:15 AM until arrival in the pre-operative area at 10:26 AM. Patient #18 was observed to wait in the clinic waiting area from 2:00 PM, until she was brought to the pre-operative area at 2:07 PM. The receptionist who greeted the patients in the clinic waiting area was not observed to offer a choice of waiting areas. Multiple procedures were scheduled to be performed in the ASC during the day on 8/31/15 and 9/02/15 during the dates of the survey. No patients were observed to sit in the ASC waiting area. During an interview on 9/01/15 at 9:23 AM, the RN Coordinator confirmed there were no patient rights posted in the clinic waiting area. She expressed surprise and stated she thought they were posted.	Q 220			
Q 221	The ASC failed to ensure written notice of patient rights was posted in the waiting area. 416.50(a) NOTICE OF RIGHTS 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	Q 221			

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Q 221	<p>Continued From page 47</p> <p>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 staff interview and medical record review, it was determined the ASC failed to ensure verbal notice of rights was provided to 2 of 2 patients (#8 and #15) whose care was observed. It also failed to provide written notice of rights to 2 of 17 patients (#1 and #10) whose medical records were reviewed. These omissions had the potential to interfere with the exercise of patient rights. Findings include:</p> <p>A policy, "VI. SURGERY 4. Operational Policies and Procedures A. Perioperative Nursing Care," dated 5/15/05, included a hand written addition that stated "Inform each patient, their representative, or their surrogate of the patient's rights in verbal and written form prior to surgical procedure."</p> <p>1. Patients who were observed did not receive verbal notice of rights, as follows:</p> <p>a. Patient #8 was a 49 year old female who had a joint injection on 8/31/15 related to right hip pain. She was observed from entrance to the waiting area at 10:15 AM until discharge from the ASC after 10:53 AM. She was not observed to be notified verbally regarding her rights.</p> <p>b. Patient #15 was a 60 year old female who was admitted to the ASC on 8/31/15 for a steroid injection in her neck. Her care was observed from the time of arrival in the clinic at 2:07 PM until her discharge at 3:04 PM. She was not observed to be notified verbally regarding her</p>	Q 221	<p>"Procedure for Distribution of Pt. Rights and Responsibilities" is in place. This will give all staff direction on how to distribute and document Pt. R&R. The current procedure will be reviewed by all staff. Monitoring will be done when surgery center nursing staff completes the "Consent for Procedure" form and double checks that Pt. R&R was given.</p>		10/19/15

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Q 221	<p>Continued From page 48 rights.</p> <p>The receptionist who provided patient rights information was interviewed on 9/02/15 at 8:25 AM. She stated she gave patients a written copy of rights but did not talk about the information with patients.</p> <p>The ASC did not have a process to ensure patients were notified verbally of their rights.</p> <p>2. Patient records did not include documentation that rights were provided in writing prior to the surgical procedure, as follows:</p> <p>a. Patient #10 was an 80 year old female who had a vertebral augmentation completed on 4/16/15 related to a fracture of the lumbar vertebrae. The medical record included documentation patient rights information was provided on 5/28/15, over a month after the procedure was completed. There was no documentation Patient Rights were provided prior to the procedure, dated 4/16/15.</p> <p>The receptionist was interviewed who provided written patient rights information to ASC patients on 9/01/15 at 11:33 AM. She stated Patient #10 did not get her rights ahead of time so she was given them late.</p> <p>Written patient rights information was not provided to Patient #10 prior to the procedure.</p> <p>b. Patient #1 was an 80 year old male admitted to the ASC on 4/27/15, for an insertion of an intrathecal catheter for a pain pump trial. Patient #1's medical record did not include documentation he received written notice of</p>	Q 221	<p>Pt. did state she received the R/R as documented on the "Consent for procedure" form dated 4/16/15</p> <p>Pt. did state he received the R/R as documented on the "Consent for Procedure" form dated 4/27/15</p>	

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Q 221	Continued From page 49 rights.	Q 221			
Q 229	<p>During an interview on 9/01/15 beginning at 1:40 PM, the RN Coordinator reviewed Patient #1's record and confirmed there was no evidence Patient #1 received information related to Patient Rights.</p> <p>The ASC did not consistently provide patients with written and verbal notice of rights.</p> <p>416.50(e)(1)(iii) EXERCISE OF RIGHTS - INFORMED CONSENT</p> <p>[[(1) The patient has the right to the following:]</p> <p>(iii) Be fully informed about a treatment or procedure and the expected outcome before it is performed.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview, and review of medical staff bylaws and medical records, it was determined the ASC failed to ensure informed consent was obtained in accordance with medical staff requirements for 2 of 2 patients (#8 and #15) whose care was observed. This resulted in the potential for patients to sign their consent before information was provided which would not constitute informed consent. Findings include:</p> <p>The "Medical Staff Bylaws," Section VIII General Conduct of Care, dated 8/2005, was reviewed. The bylaws included, but were not limited to, the following information:</p> <p>* "The attending medical staff member will be responsible for obtaining the patient's informed consent."</p>	Q 229	<p><i>This condition was not met. The Medical Staff Bylaws and The ASC Policy & Procedures are not congruent.</i></p> <p><i>The informed consent process begins at the patient visit in clinic when the procedure is first introduced. It is then that the provider explains the procedure in detail, including the potential risks,</i></p> <p><i>(CONT)</i></p>	10/19/15	

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Q 229	<p>Continued From page 50</p> <p>* "The patient shall sign the consent form affirming that the attending medical staff member has personally informed the patient."</p> <p>An ASC policy "VI. SURGERY 3. General Policies and Procedures B. Surgical Consent," dated 5/15/05, included, but was not limited to, the following information:</p> <p>* "The Ambulatory Surgery Services nurse is responsible for obtaining the proper surgical consents."</p> <p>The bylaws and policy differed, as the bylaws required the physician to obtain consent and the policy identified the RN as responsible.</p> <p>Two patients were observed prior to and during procedures. In both cases, the CNA, rather than the physician or RN, was observed to obtain consent by having patients sign the consent form, as follows:</p> <p>1. Patient #8 was a 49 year old female who had a joint injection on 8/31/15 related to right hip pain. She was observed from entrance to the waiting area at 10:15 AM until discharge from the ASC after 10:53 PM.</p> <p>The CNA was observed to obtain Patient #8's signature on the consent form in the pre-operative area after arrival at 10:26 AM, prior to the start of the procedure 10:44. This was confirmed by the RN Coordinator during interview on 9/01/15 at 1:34 PM. She stated that either the RN or CNA generally obtained patient's signature for consent.</p>	Q 229	<p>(cont)</p> <p>and answers any questions the patient may have. For most procedures, the patient is also given a description sheet for their review. At the time of the procedure, the provider ensures prior to the procedure that the patient has an understanding of the procedure and any further questions answered. The nursing staff may obtain the patient's signature on the consent and witness the consent.</p> <p>The Medical Staff Bylaws and ASC Policy regarding informed consent</p> <p>(cont)</p>		

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

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Q 229	Continued From page 51 Procedural consent was not obtained for Patient #8 in accordance with ASC bylaws and policy. 2. Patient #15 was a 60 year old female who was admitted to the ASC on 8/31/15, for an epidural steroid injection procedure in her neck. Her care was observed from the time of admission at 2:07 PM, until discharge at 3:04 PM. The CNA was observed to obtain Patient #15's signature on the procedure consent form while in the pre-operative area, after arrival in the pre-operative area at 2:07 PM and prior to the procedure start time of 2:15 PM. This was confirmed by the RN Coordinator during interview on 9/01/15 at 3:00 PM.	Q 229	(CONT) has been updated to reflect this. Compliance will be monitored in the chart audits described in Q162.	
Q 242	Procedural consent was not obtained for Patient #15 in accordance with ASC bylaws and policy. 416.51(b) INFECTION CONTROL PROGRAM The ASC must maintain an ongoing program designed to prevent, control, and investigate infections and communicable diseases. In addition, the infection control and prevent program must include documentation that the ASC has considered, selected, and implemented nationally recognized infection control guidelines. This STANDARD is not met as evidenced by: Based on observation, staff interview, and policy review, the ASC failed to ensure hand hygiene and infection control practice was performed in accordance with policy or standards of practice for 2 of 2 ASC patients (#8 and #15), whose procedures were observed. This had the	Q 242		

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Q 242	<p>Continued From page 52 potential to increase risk of patient infection. Findings include:</p> <p>1. The ASC handwashing policy, "V. PERFORMANCE IMPROVEMENT 4. Infection Control D. Hand Washing," dated 5/15/05, included, but was not limited to, the following information:</p> <p>* "Wash hands after touching blood, body fluids, secretions, excretions, and contaminated items even when gloves are worn."</p> <p>* "Wash hands immediately after gloves are removed, between patient contacts, and when otherwise indicated to avoid transfer of microorganisms to other patients or environments."</p> <p>* "Wash hands between the tasks and procedures on the same patient to prevent cross hatch contamination of different body sites."</p> <p>The policy did not specifically address the requirements to perform hand hygiene before direct patient contact and after direct patient contact and before performing invasive procedures (e.g. placing an IV).</p> <p>Breaches in hand hygiene and infection control were observed as follows:</p> <p>a. Patient #8 was a 49 year old female who had a joint injection on 8/31/15 related to right hip pain. She was observed from entrance to the waiting area at 10:15 AM until discharge from the ASC after 10:53 PM.</p> <p>- In the pre-operative area, a CNA was not</p>	Q 242	<p>Hand washing policy revised to include performing hand hygiene before performing invasive procedures. By reviewing the hand washing policy with staff on 10/14/15 staff will have a clear refresher of proper hand hygiene. Monitoring will be done by performing a hand hygiene QI study.</p>	10/19/15

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Q 242	<p>Continued From page 53</p> <p>observed to wash her hands prior to obtaining Patient #8's vital signs or after leaving the pre-operative area and entering the procedure room.</p> <p>- In the pre-operative area, an RN was observed to wash her hands and don gloves prior to starting Patient #8's IV. However, after donning gloves, she was observed to adjust her glasses with her gloved hand, and proceed with the IV start. Eye glasses would have been considered contaminated.</p> <p>b. Patient #15 was a 60 year old female who had a steroid injection in her neck on 8/31/15 related to neck and arm pain. Her care was observed from entrance to the waiting area at 2:07 PM, until her discharge at 3:04 PM.</p> <p>In the pre-operative area, at 2:10 PM, the RN was observed as she started the IV in Patient #15's right arm. After she wiped the antecubital area with alcohol, she palpated the cleansed site with her gloved finger then proceeded to insert the IV catheter over the area she potentially contaminated.</p> <p>In the operating room, the RN was observed to enter information on the computer. She was wearing gloves. After the computer, she stood up, touched her face, then her hair, her gloves were still on after the computer. When the patient was finished with the procedure, the RN assisted her off the table, while wearing the same gloves. When the gloves were removed, hand hygiene was not performed.</p> <p>During an interview on 9/01/15 beginning at 3:00 PM, the RN Coordinator reviewed Patient #15's</p>	Q 242	<p>The venipuncture policy was revised to include a "no touch" technique. The policy was reviewed with staff to reinforce and provide better compliance. Monitoring will be done by performing a QI study.</p>	10/19/15	

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Q 242	<p>Continued From page 54</p> <p>procedure the day before. She stated she sometimes forgot to change her gloves after touching her hair or glasses. She confirmed she touched the site she had cleansed before she started the IV.</p> <p>Breaches in hand hygiene occurred.</p> <p>2. Additional infection control issues were noted during observation of the environment and staff procedures, as follows:</p> <p>a. After Patient #8's procedure was completed, the cleaning of the operating room was observed. The cords from the monitor fell on the floor, the CNA picked up the cords, coiled them, then placed them on a hook by the monitor. She did not wipe down the cords with a disinfectant.</p> <p>The CNA removed the linens from the table and pillows. She wiped them down with a disinfectant, then placed the pillows on a counter. The top pillow slid to the floor. The CNA picked the pillow up and replaced it atop the other pillow. She did not wipe it before placing it on the clean pillow. The CNA put clean linens on the table, and then on each pillow. After placing the pillowcases on both pillows, upon surveyor prompting, the CNA removed the pillowcase, wiped down the pillow and placed a new pillowcase on.</p> <p>During an interview with the CNA after the room was finished and declared to be ready for the next patient. When asked about the care of the monitor cords that fell to the ground, she stated she should have wiped them down after they fell. She stated the cords are not disinfected between patients, they are cleaned at the end of the day by</p>	Q 242	<p>The policy for Universal Precautions will be reviewed by all staff. This will serve to reinforce proper cleaning of procedure rooms between patients. Monitoring will be done by performing a QI study</p>	10/19/15	

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Q 242	<p>Continued From page 55 the contracted cleaning company.</p> <p>b. A tour of the ASC was conducted on 9/01/15, beginning at 1:20 PM. During a tour of the ASC recovery patient care area, supplies were found to be outdated and staff food and medications were in a common area with the patient care foods and supplies:</p> <ul style="list-style-type: none"> - Adhesive remover was in a cabinet in the recovery room, partially used, expiration date 8/15. - In a cabinet above the back counter in the recovery patient care area, the following was noted: <ul style="list-style-type: none"> - a Formalin jar for tissue specimens, - an open undated jar of peanut butter, - a personal coffee cup, - an opened bottle of Pepto Bismol expiration date 5/2010, - instant soup, - a specimen jar containing approximately 20 pills, which was unlabeled. <p>During a tour of the ASC operating rooms, open vials of multiple dose steroids and anaesthetizing medications were noted. The medications were labeled with expiration dates, however, they were in an open container, in the patient care area.</p> <p>The RN Coordinator who was present during the tour of the ASC, confirmed the open vials of multiple dose medications was in a direct patient care area. She stated she was not sure where to keep the medications, as the physicians would draw them up at the beginning of each procedure. She confirmed the adhesive remover that was in</p>	Q 242	<p><i>Policy V. 4. H. House-keeping will be revised to include keeping recovery room cabinets free of employee personal items. This policy will be reviewed with staff to reinforce and improve the cleanliness of the Rm. Monitoring will be done by performing a QI study.</i></p> <p><i>Multi-dose Medications will not be kept in patient care areas. They will be kept in the Clean core - <u>cont</u></i></p>	<p><i>10/19/15</i></p> <p><i>10/19/15</i></p>	

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Q 242	Continued From page 56 the recovery area was expired, and stated it was not used very often. Additionally, the RN Coordinator confirmed the staff food, coffee cup, and medications were in the recovery patient care area. She stated the expired Pepto Bismol was hers, as was the unlabeled container of pills. She stated the pills were an over the counter anti-inflammatory that she brought in from home. She stated the Formalin jar belonged in the cabinet next to the one it was found in. The ASC did not follow Infection Control Guidelines as they related to hand hygiene, cleaning of equipment, medication storage, and staff food in patient care areas.	Q 242	<i>When those medications need to be accessed, they will be drawn up in the clean core. The policy of procedures have been changed to reflect this. This will ensure compliance with guidelines regarding main pt treatment areas and decrease potential for possible cross-contamination/infection</i>	
Q 262	416.52(a)(2) PRE-SURGICAL ASSESSMENT Upon admission, each patient must have a pre-surgical assessment completed by a physician or other qualified practitioner in accordance with applicable State health and safety laws, standards of practice, and ASC policy that includes, at a minimum, an updated medical record entry documenting an examination for any changes in the patient's condition since completion of the most recently documented medical history and physical assessment, including documentation of any allergies to drugs and biologicals. This STANDARD is not met as evidenced by: Based on observation, staff interview, and medical record review, it was determined the ASC failed to ensure pre-surgical assessments were completed by a physician or other qualified	Q 262	<i>The providers have been counseled on ASC "Medical Staff Bylaws" and the ASC's Policies and Procedures as regards to pre-surgical assessment. Every patient is to be evaluated prior to the procedure by the attending physician. Documentation will reflect this. This compliance will be ensured by chart review.</i>	<i>10/19/15</i>

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Q 262	<p>Continued From page 57</p> <p>practitioner in accordance with medical staff bylaws for 2 of 2 patients (#8 and #15) whose care was observed, and 4 of 15 patients (#6, #7, #10, and #14) whose medical records were reviewed. This resulted in missed opportunity for risk assessment and had the potential to interfere with safety of patient care. Findings include:</p> <p>1. The "Medical Staff Bylaws," dated 8/2005, were reviewed. Section III: Anesthesia, included, but was not limited to, the following information: "Prior to any procedure in the ASC, the treating physician shall examine the patient and evaluate the risk of anesthesia and of the procedure to be performed."</p> <p>Patient care was observed that did not include examination of patients prior to procedures, as follows:</p> <p>a. Patient #8 was a 49 year old female who had a joint injection on 8/31/15 related to right hip pain. She was observed from entrance to the facility at 10:15 AM until discharge from the facility at 10:53 AM. A physician or other qualified individual was not observed to perform a pre-surgical assessment prior to the procedure.</p> <p>The RN Coordinator was interviewed on 8/31/15 at 12:03 PM. She stated Patient #8 did not have any questions, otherwise the physician would have seen her prior to the procedure. During a second interview on 9/01/15 at 9:51 AM, the RN Coordinator stated a pre-surgical assessment was not required because Patient #8 had been seen within 30 days.</p> <p>b. Patient #15 was a 60 year old female who was admitted to the ASC on 8/31/15, for an epidural</p>	Q 262	<p><i>This will improve patient safety by ensuring each patient has an adequate pre-surgical assessment.</i></p>		

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Q 262	<p>Continued From page 58</p> <p>steroid injection procedure in her neck. Her care was observed from the time of admission at 2:07 PM, until discharge at 3:04 PM.</p> <p>The procedure note for Patient #15, dated 8/31/15, was dictated and electronically signed by Physician A. A physician or other qualified individual was not observed to perform a pre-surgical assessment prior to the procedure.</p> <p>The RN Coordinator was interviewed on 9/01/15 at 3:00 PM. She reviewed Patient #15's record and confirmed a pre-surgical assessment was not completed, as Patient #15 was seen in the clinic within 30 days of her procedure.</p> <p>Physician A was interviewed on 9/02/15 beginning at 8:00 AM. She stated she did not routinely do a pre-surgical assessment on the day of the procedure. She stated she would see a patient prior to a procedure if the patient had questions or if they had not been seen within 30 days, or if there were new lab results.</p> <p>Pre surgical assessments for Patients #8 and #15 were not performed.</p> <p>2. Medical records were reviewed that did not include documentation of pre-surgical assessments, as follows:</p> <p>a. Patient #6 was a 33 year old female who had a steroid injection on 3/09/15 related to neck and shoulder pain. Patient #6's medical record did not include documentation of a pre-surgical assessment. This information was confirmed by the RN Coordinator during interview on 9/01/15 at 2:06 PM. She stated a pre-surgical assessment would not have been required because Patient #6</p>	Q 262			

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Q 262	Continued From page 59 had been seen within 30 days. b. Patient #7 was a 91 year old male who had a steroid injection on 6/30/15 for low back pain. Patient #7's medical record did not include documentation of a pre-surgical assessment. This was confirmed by the RN Coordinator during interview on 9/01/15 at 2:12 PM. c. Patient #10 was an 80 year old female who had a vertebral augmentation completed on 4/16/15 related to a fracture of the lumbar vertebrae. Patient #10's medical record did not include documentation of a pre-surgical assessment. This was confirmed by the RN Coordinator during interview on 9/01/15 at 2:17 PM. She stated a pre-surgical assessment would not have been required because Patient #10 had been seen within 30 days. d. Patient #14 was a 31 year old male who had a occipital nerve block on 7/01/15 related to head pain. Patient #14's medical record did not include documentation of a pre-surgical assessment. This was confirmed by the RN Coordinator during interview on 9/01/15 at 2:40 PM. She stated it would not have been required because Patient #14 had been seen within 30 days.	Q 262			
Q 267	The ASC failed to ensure pre surgical assessments were performed on each patient. 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.	Q 267			

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Q 267	Continued From page 60 This STANDARD is not met as evidenced by: Based on staff interview and review of medical records and medical staff bylaws, it was determined the ASC failed to ensure 8 of 17 patients (#2, #5, #6, #7, #10, #12, #14, and #16) were discharged in the company of a responsible adult unless specifically exempted from the requirement by the attending physician. This had the potential to interfere with patient safety. Findings include: 1. The "Medical Staff Bylaws," dated 8/2005, were reviewed. Section II: Admission and Discharge, included, but was not limited to, the following information: "A 'responsible individual' must accompany patients, upon admission and discharge, unless specifically exempted by written order of the attending physician." Medical record review did not include evidence patients were discharged to the company of a responsible adult unless specifically exempted, as follows: a. Patient #2 was an 83 year old female who had an injection treatment on 7/29/15 related to abdominal pain. The medical record did not include documentation that Patient #2 was discharged in the company of a responsible adult or specifically exempted from the requirement. This was confirmed by the RN Coordinator during interview on 9/01/15 at 1:44 PM. b. Patient #5 was a 33 year old female who had a steroid injection procedure on 7/02/15 related to back pain. The medical record did not include documentation that Patient #5 was discharged in	Q 267	The great majority of the procedures performed at NIPC are done under local anesthesia only and in the majority it is not necessary for the patient to be discharged under the care of a responsible adult. In order to meet compliance with ASC CFC, an order will be added to the orders template when it is acceptable to discharge the patient under their own recognizance. This can be entered directly by the (CONT)	10/19/15	

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Q 267	<p>Continued From page 61</p> <p>the company of a responsible adult or specifically exempted from the requirement. This information was confirmed by the RN Coordinator during interview on 9/01/15 at 2:02 PM.</p> <p>c. Patient #6 was a 33 year old female who had a steroid injection on 3/09/15 related to neck and shoulder pain. The medical record did not include documentation that Patient #6 was discharged in the company of a responsible adult or specifically exempted from the requirement. This information was confirmed by the RN Coordinator during interview on 9/01/15 at 2:06 PM. She stated Patient #6 was not given sedation and would not have been required to be discharged to a responsible adult, per ASC policy.</p> <p>d. Patient #7 was a 91 year old male who had a steroid injection on 6/30/15 for low back pain. The medical record did not include documentation that Patient #7 was discharged in the company of a responsible adult or specifically exempted from the requirement. This information was confirmed by the RN Coordinator during interview on 9/01/15 at 2:12 PM. She stated Patient #7 was not given sedation and would not have been required to be discharged to a responsible adult, per ASC policy.</p> <p>e. Patient #10 was an 80 year old female who had a vertebral augmentation completed on 4/16/15 related to a fracture of the lumbar vertebrae. The medical record did not include documentation that Patient #10 was discharged in the company of a responsible adult or specifically exempted from the requirement. This information was confirmed by the RN Coordinator during interview on 9/01/15 at 2:17 PM. She stated Patient #10 was discharged to a</p>	Q 267	<p>(CONT)</p> <p>provider or via a verbal order from The provider.</p> <p>The importance of complete and accurate documentation when it comes to patient discharge was reviewed with ASC nursing personnel. Compliance with this CFC will be ensured with the chart review as outlined in Q162.</p> <p>This change in workflow will help improve patient safety by ensuring only those patients</p> <p>(CONT)</p>	

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Q 267	<p>Continued From page 62</p> <p>responsible adult but the printed medical record did not reflect this information. She thought it was an issue with the electronic health record.</p> <p>f. Patient #14 was a 31 year old male who had a occipital nerve block on 7/01/15 related to head pain. The medical record did not include documentation that Patient #14 was discharged in the company of a responsible adult or specifically exempted from the requirement. This information was confirmed by the RN Coordinator during interview on 9/01/15 at 2:40 PM.</p> <p>g. Patient #16 was a 55 year old female admitted to the ASC on 8/26/15, for a Percutaneous Kyphoplasty in her lumbar spine. (Percutaneous kyphoplasty is a minimally invasive treatment that inserts bone cement into the compressed and fractured vertebrae to provide mechanical stabilization.) Patient #16's record documented she had a history of osteoporosis and pathologic fractures of her spine.</p> <p>Patient #16 was documented as receiving sedation during her procedure.</p> <p>Patient #16's medical record did not include documentation that she was discharged in the company of a responsible adult or specifically exempted from the requirement. This information was confirmed by the RN Coordinator during an interview on 9/01/15 beginning at 3:00 PM.</p> <p>h. Patient #12 was a 74 year old male admitted to the ASC on 5/18/15 for a nerve block in his abdomen related to metastatic pancreatic cancer and chronic pain.</p> <p>Patient #12 was documented as receiving</p>	Q 267	<p>(CONT)</p> <p>suitable for discharge without an accompanying responsible adult are discharged in this way.</p>		

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Q 267	<p>Continued From page 63 sedation during his procedure.</p> <p>Patient #12's medical record did not include documentation that he was discharged in the company of a responsible adult or specifically exempted from the requirement. This information was confirmed by the RN Coordinator during an interview on 9/01/15 beginning at 3:00 PM.</p> <p>Physician A was interviewed on 9/02/15 at 8:00 AM. She stated they did not require a driver if the patient did not have sedation, unless a problem occurred, such as a numb leg.</p> <p>The RN Coordinator was interviewed on 9/01/15 beginning at 1:34 PM. She stated patients who were not sedated during the procedure were not generally required to have a driver.</p> <p>The ASC did not ensure patients were discharged in the company of a responsible adult.</p>	Q 267		

October 16, 2015

Susan Costa, Health Facility Surveyor
Bureau of Facility Standards
323 Elder St.
PO Box 83720
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208-364-1888 (fax)



FACILITY STANDARDS

Re: POC Addendum
North Idaho Pain Center

Q081

Re: Monitoring- Appropriate follow-up will be initiated by the Department Director. Incident reports will be reviewed by the Quality Assurance Committee. Incidents will be analyzed by the QA committee. Analysis should include attempts to identify processes or systems that could be improved in order to prevent the reoccurrence of the incident. Reports of the analysis will be brought to the governing body.

Q141

Re: Monitoring- See Chart Audit Study attached. Specifically, a chart audit will be done by [REDACTED] and [REDACTED] in which ten charts from each provider will be reviewed each month for three months checking for documentation of vital signs according to NIPC Policies and Procedures. If less than 90% accuracy is found, a plan of action for correction will be made and the study will be completed again to ensure compliance. If the 90% goal is met or exceeded, chart reviews on ten charts from each provider will be continued quarterly.

Q161

Re: Monitoring- See Chart Audit Study attached. Specifically, a chart audit will be done by [REDACTED] and [REDACTED] in which ten charts from each provider will be reviewed each month for three months checking for appropriate letterhead on NIPC documents. If less than 90% accuracy is found, a plan of action for correction will be made and the study will be completed again to ensure compliance. If the 90% goal is met or exceeded, chart reviews on ten charts from each provider will be continued quarterly.

Q162

Re: Monitoring by whom- See Chart Audit Study attached. Specifically, this will be done by [REDACTED] and [REDACTED]

Q221

Re: Monitoring- See Chart Audit Study attached. Specifically, a chart audit will be done by [REDACTED] and [REDACTED] in which ten charts from each provider will be reviewed each month for three months checking that The Patient Rights and Responsibilities is documented as given on the Conditions of Admission form. If less than 90% accuracy is found, a plan of action for correction will be made and the study will be completed again to ensure compliance. If the 90% goal is met or exceeded, chart reviews on ten charts from each provider will be continued quarterly.

Q229

Re: Monitoring- See Chart Audit Study attached. Specifically, a chart audit will be done by [REDACTED] and [REDACTED] in which ten charts from each provider will be reviewed each month for three months checking that informed consent is documented per NIPC Policies and Procedures. If less than 90% accuracy is found, a plan of action for correction will be made and the study will be completed again to ensure compliance. If the 90% goal is met or exceeded, chart reviews on ten charts from each provider will be continued quarterly.

Q242

Re: Monitoring- See Handwashing Study attached. This has been an ongoing study with several action plans resulting from each study completed. The latest action plan is attached indicating the next study is due January of 2016. In light of the surveyors' findings, the study will be done in November of 2015 instead and repeated in three months (Feb. 2016). Data will be collected by the Administrator.

Re: Monitoring- See Venipuncture Study attached. This study will be monitored by the Administrator.

Re: Monitoring- See Clean Recovery Room Study attached. This study will be monitored by the Administrator.

Q262

Re: Monitoring- See Chart Audit Study attached. Specifically, a chart audit will be done by [REDACTED] and [REDACTED] in which ten charts from each provider will be reviewed each month for three months checking for an adequate pre-surgical assessment completed by the provider. If less than 90% accuracy is found, a plan of action for correction will be made and the study will be completed again to ensure compliance. If the 90% goal is met or exceeded, chart reviews on ten charts from each provider will be continued quarterly.