



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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TAMARA PRISOCK—ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
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BUREAU OF FACILITY STANDARDS
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March 14, 2016

Marlon Michel, Administrator
Southern Idaho Surgery Center
3235 N Towerbridge Way, Suite 100
Meridian, ID 83646-5721

RE: Southern Idaho Surgery Center, Provider #13C0001069

Dear Dr. Michel:

On March 4, 2016, a follow-up visit of your facility, Southern Idaho Surgery Center, was conducted to verify corrections of deficiencies noted during the survey of December 10, 2015.

We were able to determine that the Condition of Participation of **Surgical Services (42 CFR 416.42)** is now met.

Your copy of a Post-Certification Revisit Report, Form CMS-2567B, listing deficiencies that have been corrected is enclosed.

Also enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicare deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction.

An acceptable plan of correction (PoC) 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;
- A completion date for correction of each deficiency cited must be included;

Marlon Michel, Administrator
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- 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 the Form CMS-2567.

After you have completed your Plan of Correction, return the original to this office by **March 28, 2016**, and keep a copy for your records.

Thank you for the courtesies extended to the surveyors during their visit. If we can be of any help to you, please call us at (208) 334-6626, option 4.

Sincerely,



GARY GUILLES
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

GG/pmt
Enclosures
ec: Lynette Osias, CMS Region X Office

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

PRINTED: 03/11/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001069	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	RECEIVED MAR 28 2016 FACILITY STANDARDS	(X3) DATE SURVEY COMPLETED R 03/04/2016
NAME OF PROVIDER OR SUPPLIER SOUTHERN IDAHO SURGERY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3235 N TOWERBRIDGE WAY, SUITE 100 MERIDIAN, ID 83646		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{Q 000}	INITIAL COMMENTS The following deficiencies were cited during the follow up survey of your Ambulatory Surgery Center conducted from 2/29/16 through 3/04/16. Surveyors conducting the follow up were: Gary Guiles, RN, HFS, Team Leader Rebecca Lara, RN, BA, HFS Acronyms used in this report include: ASC - Ambulatory Surgery Center CRNA - Certified Registered Nurse Anesthetist DON - Director of Nursing LPN - Licensed Practical Nurse ml - milliliter OR - operating room PACU - Post Anesthesia Care Unit PCF - patient care form, a form that included anesthesia information as well as post operative and other care information QA - Quality Assurance QAPI - Quality Assessment Performance Improvement RN - Registered Nurse	{Q 000}	SEE ATTACHED		
Q 043	416.41(c) DISASTER PREPAREDNESS PLAN (1) The ASC must maintain a written disaster preparedness plan that provides for the emergency care of patients, staff and others in the facility in the event of fire, natural disaster, functional failure of equipment, or other unexpected events or circumstances that are likely to threaten the health and safety of those in the ASC. (2) The ASC coordinates the plan with State and local authorities, as appropriate. (3) The ASC conducts drills, at least annually, to	Q 043			

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

[Signature] MDMBA

TITLE

MEDICAL DIRECTOR

(X6) DATE

03.28.2016

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 043	<p>Continued From page 1</p> <p>test the plan's effectiveness. The ASC must complete a written evaluation of each drill and promptly implement any corrections to the plan.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the ASC failed to ensure the Governing Body had an emergency preparedness plan that addressed all hazards, outlined the facility roles in specific emergencies, was coordinated with State and local authorities, and that an emergency preparedness drill was conducted at least annually to test the plan's effectiveness for all patients, staff and visitors. This resulted in the potential for the facility's inability to effectively deal with the care, health and safety of patients, staff and other individuals when a major disruptive event occurred. Findings include:</p> <p>Facility records were reviewed on 3/09/16 from approximately 1:00 - 3:30 PM. The facility's Policies and Procedures manual included a Disaster Preparedness Plan dated January, 2016. The plan did not include the following:</p> <ul style="list-style-type: none"> - No Hazard Vulnerability analysis was conducted to identify site specific hazards or risks. - No information was provided regarding coordination or attempts to coordinate with local jurisdictional authority, such as the Fire Marshall, as to facility response in an emergency. - No information was present as to what specific activities were to be taken to eliminate or reduce the probability of an event. 	Q 043			

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Q 043	Continued From page 2 - No specific information was present regarding how the ASC would meet the needs of the patients, staff and others in the absence of essential services. - The plan did not provide information related to activities taken for impending threats, during and after and event necessary to address immediate and short term effects. - The plan did not identify activities which were to be implemented during and after an event necessary to return the ASC to its usual state. - The plan did not provide information or documentation of staff education on the components of emergency preparedness. Further, the facility's records did not include documentation that an annual drill had been conducted necessary to evaluate the plan's effectiveness. When asked during the exit conference on 3/09/16 from 2:45 - 3:30 PM, the Office Manager stated the ASC's policy on Emergency Preparedness, was the only Emergency Plan the facility had.	Q 043			
Q 062	416.42(a)(2) ANESTHETIC - DISCHARGE Before discharge from the ASC, each patient must be evaluated by a physician or by an anesthesiologist as defined at §410.69(b) of this chapter, in accordance with applicable State health and safety laws, standards of practice, and ASC policy, for proper anesthesia recovery.	Q 062		4/1/16	

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Q 062	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation, record review and staff interview it was determined the facility failed to ensure patients were evaluated for proper anesthesia recovery by a physician or anesthetist prior to being discharged for from the ASC, for 12 of 12 patients (#1 - #12) who received general anesthesia and whose records were reviewed. This resulted in patients being discharged without a determination that they were medically stable. Findings include: The ASC policy titled "Section 4.200 General Anesthesia Policies and Procedures" stated "...A qualified anesthetist shall remain with the patient until the patient's status is stable...Every patient must meet medical discharge criteria prior to being discharged from the ASC by anesthesia provider..." Patient #10 was a 5 year old male, who was admitted to the ASC for treatment of dental caries (tooth decay), performed under general anesthesia on 3/01/16. Patient #10 was observed from his admission on 3/01/16, beginning at approximately 10:19 AM, through the surgical procedure, post procedural recovery, and discharge from the ASC, at 12:56 PM. When Patient #10's procedure was competed, but before he was removed from the OR, the CRNA attempted to waken Patient #10, then extubated (removal of previously inserted endo-tracheal tube) him, took a set of vital signs and turned Patient #10 on his left side. An RN then transported Patient #10, via gurney, to a small recovery room. The door to the recovery room was closed, and Patient #10 was left with	Q 062			

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Q 062	<p>Continued From page 4</p> <p>his mother to recover. Patient #10 was not fully awake when he was transported from the OR. As Patient #10 began to awaken in the recovery room with his mother, his behavior was observed as erratic and aggressive. He was crying, screaming, fighting and attempting to bite himself on the hands. Neither the dentist nor the CRNA returned to evaluate Patient #10 before he was discharged by the RN at 12:56 PM.</p> <p>The following patient records were reviewed and did not include documentation that the physician or CRNA performed a post anesthesia evaluation prior to their discharge:</p> <ul style="list-style-type: none"> - Patient #1 was a 17 year old male, who was admitted to the ASC on 2/26/16, for treatment related to extraction of wisdom teeth and root canal. According to the PCF, general anesthesia was administered by a CRNA. Following the procedure, an evaluation for anesthesia recovery was not documented. - Patient #2 was a 2 year old male, who was admitted to the ASC on 2/23/16, for treatment related to dental caries. According to the PCF, general anesthesia was administered by a CRNA. Following the procedure, an evaluation for anesthesia recovery was not documented. - Patient #3 was a 7 year old male, who was admitted to the ASC on 2/22/16, for treatment related to dental caries. According to the PCF, general anesthesia was administered by a CRNA. Following the procedure, an evaluation for anesthesia recovery was not documented. - Patient #4 was a 3 year old male, who was admitted to the ASC on 2/23/16, for treatment 	Q 062			

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Q 062	<p>Continued From page 5 related to dental caries. According to the PCF, general anesthesia was administered by a CRNA. Following the procedure, an evaluation for anesthesia recovery was not documented.</p> <p>- Patient #5 was a 6 year old female, who was admitted to the ASC on 2/23/16, for treatment related to dental caries. According to the PCF, general anesthesia was administered by a CRNA. Following the procedure, an evaluation for anesthesia recovery was not documented.</p> <p>- Patient #6 was a 6 year old female, who was admitted to the ASC on 2/23/16, for treatment related to dental caries, a root canal and extraction of teeth. According to the PCF, general anesthesia was administered by a CRNA. Following the procedure, an evaluation for anesthesia recovery was not documented.</p> <p>- Patient #7 was a 9 year old male, who was admitted to the ASC on 2/23/16, for treatment related to dental caries. According to the PCF, general anesthesia was administered by a CRNA. Following the procedure, an evaluation for anesthesia recovery was not documented.</p> <p>- Patient #8 was a 5 year old male, who was admitted to the ASC on 2/25/16, for treatment related to dental caries and extraction of teeth. According to the PCF, general anesthesia was administered by a CRNA. Following the procedure, an evaluation for anesthesia recovery was not documented.</p> <p>- Patient #9 was a 6 year old male, who was admitted to the ASC on 2/24/16, for treatment related to dental caries and extraction of teeth. According to the PCF, general anesthesia was</p>	Q 062			

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Q 062	Continued From page 6 administered by a CRNA. Following the procedure, an evaluation for anesthesia recovery was not documented. - Patient #11 was a 12 year old male, who was admitted to the ASC on 2/22/16, for treatment related to dental caries. According to the PCF, general anesthesia was administered by a CRNA. Following the procedure, an evaluation for anesthesia recovery was not documented. - Patient #12 was a 4 year old male, who was admitted to the ASC on 2/23/16, for treatment related to dental caries, teeth extraction and a root canal. According to the PCF, general anesthesia was administered by a CRNA. Following the procedure, an evaluation for anesthesia recovery was not documented. During an interview on 3/02/16, beginning at 8:15 AM, the CRNA confirmed she did not routinely evaluate patients after they left the OR and were transported by nursing staff to the recovery room. She stated the nurses routinely determined when patients met criteria for discharge. The ASC did not ensure patients were evaluated for proper anesthesia recovery by an authorized practitioner.	Q 062			
{Q 082}	416.43(b), 416.43(c)(2), 416.43(c)(3) PROGRAM DATA; PROGRAM ACTIVITIES (b)(1) The program must incorporate quality indicator data, including patient care and other relevant data regarding services furnished in the ASC. (b)(2) The ASC must use the data collected to -	{Q 082}			

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{Q 082}	<p>Continued From page 7</p> <p>(i) Monitor the effectiveness and safety of its services, and quality of its care.</p> <p>(ii) Identify opportunities that could lead to improvements and changes in its patient care.</p> <p>(c)(2) Performance improvement activities must track adverse patient events, examine their causes, implement improvements, and ensure that improvements are sustained over time.</p> <p>(c)(3) The ASC must implement preventive strategies throughout the facility targeting adverse patient events and ensure that all staff are familiar with these strategies.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of quality documents and policies, it was determined the ASC failed to ensure data was used to monitor the effectiveness of its services. In addition, the ASC failed to track adverse patient events and examine their causes. This directly affected 2 of 2 patients (#1 and #11) whose medical records and incident reports were reviewed. The failure to use data to monitor effectiveness and to examine the causes of adverse events increased the likelihood that other patients could suffer an adverse event. Findings include:</p> <p>1. The ASC had raw data for approximately 30 observations of infection control practices. Also, there were 15 "Chart Review Checklist" forms which looked at whether medical records contained all information, i.e. consents and orders. In addition, 1 "Chart Review Summary" form stated 5 medical records were reviewed by the Medical Director. The form stated 1 of the medical records was incomplete for a 90%</p>	{Q 082}			

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{Q 082}	<p>Continued From page 8</p> <p>compliance rate. (This information was not correct. Four out of 5 records equal 80%.) The "Chart Review Summary" form stated "Deficiencies will be reviewed for corrections prior to the next QA meeting, scheduled for quarterly." [sic]</p> <p>No other data had been collected. No other data had been tallied. No documentation was present that data had been reviewed by the QA committee.</p> <p>The Office Manager was interviewed on 3/02/16 beginning at 9:45 AM. She confirmed the above data was all that was available. She stated the data would be reviewed at the QA Committee meeting. She stated the QA Committee had not met yet and the first one would probably be held sometime in April 2016. She stated the ASC had not evaluated any data in order to make decisions regarding facility practices.</p> <p>The ASC failed to monitor the quality of its care and identify opportunities that could lead to improvements in patient care.</p> <p>2. The policy "Incident/Event Reporting," updated January 2016, stated "All pertinent information concerning a patient or employee accident or injury should be fully documented in the patient's chart/employee file. The same type of information should be placed in the Incident/Event Report to alert the Administrator/Office Manager to possible problems and solutions." The policy stated all reports would be turned in to the Administrator/Office Manager to be kept in a file. The policy did not specify a process to investigate incidents.</p>	{Q 082}			

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{Q 082}	Continued From page 9 The Office Manager was interviewed on 3/02/16 beginning at 9:45 AM. She stated all incidents were held until the next meeting of the QA Committee. She also stated a QA Committee meeting had not been held yet so she was unsure of the process. Two incidents of adverse patient events were documented between 2/22/16 and 2/29/16. These included: a. Patient #1 was a 17 year old male who had a root canal and 4 wisdom teeth extracted under general anesthesia on 2/26/16. He was discharged from the ASC at 9:05 AM on 2/26/16. A "Quality Assurance Report Form-Staff," dated 2/26/16, stated Patient #1 "...showed up back [on 2/26/16 at 1:35 PM at the ASC]. Still very much bleeding...Gave [Patient #1] some gauze pads and a wet rag to clean up blood. Blood was running down when pulled out bloody ones to change clean gauze. Not just a little bit drainage...Bloody gauze hanging out of mouth dripping blood into a bowl. Hands bloody, shirt bloody, neck bloody. Gauze was saturated." The form stated "Action taken: Referred to dentist." An investigation of Patient #1's adverse event was not documented in order to determine whether anything unusual happened during the surgery that could cause bleeding or if he was bleeding prior to discharge. An examination of post-operative care was not documented. The event was not listed on a tracking document for adverse events. The Office Manager who wrote the incident report	{Q 082}			

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{Q 082}	<p>Continued From page 10</p> <p>was interviewed on 2/29/16 beginning at 9:20 AM. She stated an investigation of the adverse event had not been conducted. She stated the incident would not be reviewed until the next QA Committee meeting, probably sometime in April 2016.</p> <p>b. Patient #2 was a 2 year old male who had 2 teeth extracted under general anesthesia on 2/22/16. His PCF, dated 2/22/16, stated at approximately 2:50 PM Patient #11 was anesthetized and intubated and then vomited approximately 50 ml. The form stated his endotracheal tube cuff was inflated at the time and his breath sounds were normal. The form stated the procedure was performed and Patient #11 was discharged at 4:30 PM.</p> <p>The medical record did not state the CRNA or the dentist evaluated Patient #11 after he was transferred to the recovery room. However, the PCF included a checked box stating Patient #11's respirations were "Unlabored." There was no documentation that staff listened to Patient #11's lungs in the recovery room.</p> <p>A "Quality Assurance Report Form-Staff," dated 2/22/16, stated Patient #11 had an emesis after he was intubated. It stated he was assessed by the CRNA following the incident. It stated the CRNA informed the parents to follow up with their family physician if the child developed a fever or difficulty breathing. The form stated the Medical Director was notified of the incident.</p> <p>An investigation of the incident to determine whether staff provided appropriate care to Patient #11 was not documented. The event was not listed on a tracking document for adverse events.</p>	{Q 082}			

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{Q 082}	Continued From page 11	{Q 082}			
{Q 084}	<p>The Office Manager, who was also the Quality Coordinator, was interviewed on 3/03/16 beginning at 10:50 AM. She stated an investigation of the adverse event had not been conducted. She stated the incident would not be reviewed until the next QA Committee meeting.</p> <p>The ASC failed to develop a policy to define a process to investigate adverse patient events. The ASC did not investigate and track Patient #1's and Patient #11's adverse patient events.</p> <p>416.43(e) GOVERNING BODY RESPONSIBILITIES</p> <p>The governing body must ensure that the QAPI program-</p> <ol style="list-style-type: none"> (1) Is defined, implemented, and maintained by the ASC. (2) Addresses the ASC's priorities and that all improvements are evaluated for effectiveness. (3) Specifies data collection methods, frequency, and details. (4) Clearly establishes its expectations for safety. (5) Adequately allocates sufficient staff, time, information systems and training to implement the QAPI program. <p>This STANDARD is not met as evidenced by: Based on staff interview and review of policies, meeting minutes, and quality documents, it was determined the Governing Body failed to provide sufficient monitoring and oversight of the QAPI program. This interfered with the ability of the ASC to evaluate its processes in order to improve patient care. Findings include:</p>	{Q 084}			

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{Q 084}	Continued From page 12 1. The policy "QA Committee," updated January 2016, stated a QA Committee would consist of the Medical Director, a member of the Governing Body, the Office Manager, the Infection Control Coordinator, the Clinical Coordinator, and other members appointed by the Governing Body. The policy stated the QA Committee would meet at least 2 times a year. The QA Committee policy was revised in response to a Medicare recertification survey conducted from 12/08/15-12/10/15 when it was determined the ASC was not in compliance with the Condition of Participation for Quality Assurance Performance Improvement. No meetings of the QA Committee were documented as of 3/03/16. No documentation was present that the QA Committee had discussed or approved the QA plan. The Office Manager was interviewed on 3/02/16 beginning at 9:45 AM. She stated the QA Committee had not met. She stated she discussed issues related to quality with the Medical Director but no formal meetings were held. The Governing Body failed to ensure the QA Committee monitored and provided oversight of the QAPI program. 2. A document titled "Governing Body Meeting Agenda," dated 1/19/16, stated the Governing Body met. The minutes included an "Objective" which stated "QAPI - HH study, Patient Files." No details were documented. Further down the page, a hand written entry stated "{Performance	{Q 084}			

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{Q 084}	Continued From page 13 Improvement Project} - Hand Hygiene Study." No details were written after this entry. No other documentation was present to show Governing Body involvement in the QAPI program. The Office Manager was interviewed on 3/02/16 beginning at 10:25 AM. She stated except for the above, there was no documentation of Governing Body involvement related to the ASC's QAPI program. The Governing Body failed to monitor and provided oversight for the QAPI program. 3. The Office Manager was interviewed on 3/02/16 beginning at 9:45 AM. She stated 1 of her duties was to coordinate the QAPI program. She stated she was appointed to the Governing Body as a "non-voting" member on 2/19/16. She stated there was no written description of her duties as a member of the Governing Body. She stated there was no written description of her duties in relation to the QAPI program. The Governing Body failed to define the duties of the new Governing Body member with responsibility for the QAPI program.	{Q 084}			
{Q 162}	416.47(b) FORM AND CONTENT OF RECORD The ASC must maintain a medical record for each patient. Every record must be accurate, legible, and promptly completed. Medical records must include at least the following: (1) Patient identification. (2) Significant medical history and results of	{Q 162}			

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{Q 162}	<p>Continued From page 14 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> <p>This STANDARD is not met as evidenced by: Based on review of policies and medical records and staff interview, it was determined the facility failed to ensure medical records were complete and accurate for 12 of 12 patients (Patients #1 - #12) whose records were reviewed. This failure resulted in a lack of clarity in the medical records. The findings include:</p> <p>1. The ASC's policy, titled "Section 2.533 Medical Records" included "The attending physician/anesthesia provider shall be responsible for preparing a complete medical record for each patient undergoing surgery." The policy listed several items, such as diagnosis, dental or surgical treatment plan, operative report and final diagnosis, which "may" be included in the record.</p> <p>The Office Manager was interviewed on 2/29/16, beginning at 9:00 AM. When asked for an example of the ASC's operative report form, the Office Manager presented an untitled document, indicating the document was considered the ASC's operative report. The document included</p>	{Q 162}			

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{Q 162}	<p>Continued From page 15</p> <p>a grid that contained numbers for corresponding teeth, listed down the left side of the page, and categories, such as Surfaces, Pulpectomy, Pulpotomy, Crown, Extracted, Impacted, etc., across the top of the grid. The Office Manager stated she used the completed forms for billing purposes. She confirmed the form did not contain a detailed description of the procedure(s) performed, complications or final diagnoses.</p> <p>Patients #1 - #12's medical records were reviewed. The records did not include complete, accurate information, per ASC policy, as follows:</p> <p>The "Medical Records" policy stated "...A standard operative note by the attending physician/anesthesia provider is to be made immediately after the surgical procedures and completed within forth-eight (48) hours of the surgery. This note will include the names of the physicians/anesthesia provider, diagnosis; surgery performed complications, and signed within forth-eight (48) hours of completion of the surgery." However, patient records did not include a standard operative note. Examples included, but were not limited to, the following:</p> <p>- Patient #1 was a 17 year old male who had a root canal and 4 wisdom teeth extracted under general anesthesia on 2/26/16. He was discharged from the ASC at 9:05 AM on 2/26/16.</p> <p>A "Quality Assurance Report Form-Staff," dated 2/26/16, stated Patient #1 returned to the ASC on 2/26/16 at 1:35 PM. The report stated he was experiencing significant post-operative bleeding.</p> <p>Patient #1's medical record did not document that he was assessed for bleeding by the dentist or</p>	{Q 162}			

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{Q 162}	<p>Continued From page 16</p> <p>the nurse who recovered him prior to discharge.</p> <p>The LPN who cared for Patient #1 was interviewed on 3/03/16 beginning at 11:50 AM. She stated she checked him for bleeding before he left but confirmed this was not documented.</p> <p>A form titled "CONSENT FOR DENTAL SURGERY and ANESTHESIA," was reviewed. It stated Patient #1 consented to "Extraction, Root Canal, and Wisdom Extraction. An untitled operative report, written by the Dental Assistant and initialed by the dentist, dated 2/26/16 but not timed, stated Patient #1 had teeth #1, #16, #17, and #32 extracted. It did not include any other information such as Patient #1's condition following the procedure or estimated amount of blood loss. It did not state a root canal was performed and did not explain why the procedure did not match the consent.</p> <ul style="list-style-type: none"> - Patient #2's 2/23/16 operative report did not contain a description of the procedures performed, complications or final diagnoses. - Patient #3's 2/22/16 operative report did not contain a description of the procedures performed, complications or final diagnoses. - Patient #4's 2/23/16 operative report did not contain a description of the procedures performed, complications or final diagnoses. - Patient #5's 2/23/16 operative report did not contain a description of the procedures performed, complications or final diagnoses. - Patient #6's 2/23/16 operative report did not contain a description of the procedures 	{Q 162}			

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{Q 162}	Continued From page 17 performed, complications or final diagnoses. - Patient #7's 2/23/16 operative report did not contain a description of the procedures performed, complications or final diagnoses. - Patient #8's 2/25/16 operative report did not contain a description of the procedures performed, complications or final diagnoses. The report was written by a dental assistant and not by the dentist who performed the procedure. - Patient #9's 2/24/16 operative report did not contain a description of the procedures performed, complications or final diagnoses. - Patient #10's 3/01/16 operative report did not contain a description of the procedures performed, complications or final diagnoses. - Patient #11's 2/22/16 operative report did not contain a description of the procedures performed, complications or final diagnoses. - Patient #12's 2/23/16 operative report did not contain a description of the procedures performed, complications or final diagnoses. The ASC failed to ensure operative reports were complete, accurate and placed in patient records.	{Q 162}			
Q 231	416.50(f)(1) PRIVACY The patient has the right to - (1) Personal privacy This STANDARD is not met as evidenced by: Based on observation, staff interview, and review of policies, it was determined the ASC failed to	Q 231		4/15/16	

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Q 231	<p>Continued From page 18</p> <p>ensure the personal privacy of patients was protected. This failure involved 1 of 1 unauthorized persons observed in the clinical area and had the potential to impact all patients receiving care at the ASC. This resulted in the potential for patients to be observed by unauthorized persons during care. Findings include:</p> <p>On 3/02/16 at 11:30 AM, a teenager was observed in the hallway directly in front of the OR speaking with the CRNA. The CRNA was standing half in and half out of the door to the OR. A child was anesthetized on the OR table undergoing dental surgery. The teenager remained in the hallway for approximately 60 seconds and then left unaccompanied via the back door. The doorway to the OR was open and there were 2 windows into the OR.</p> <p>The CRNA was interviewed on 3/03/16 beginning at 10:40 AM. She stated the teenager was her son. She said he came to the ASC so the Office Manager could assist him with a homework task. She said he walked by the OR and waved at her. She said she stuck her head out of the OR and gave him a kiss. She stated she was not sure if the ASC had a policy regarding unauthorized persons in the clinical area.</p> <p>A policy titled "Non-Authorized Persons," updated January 2016, stated "Only persons granted privileges by the Governing Body will be allowed to have patient care interaction." The policy did not address persons in the clinical area who did not have an official reason for being there. The policy did not address supervision of non-employees.</p>	Q 231			

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Q 231	Continued From page 19 The Office Manager was interviewed on 3/03/16 beginning at 7:45 AM. She stated the ASC did not have a policy regarding access to the clinical areas and what kind of supervision was required for non-employees.	Q 231			
Q 264	The ASC failed to prevent unauthorized persons from observing patients. 416.52(b) POST-SURGICAL ASSESSMENT (1) The patient's post-surgical condition must be assessed and documented in the medical record by a physician, other qualified practitioner, or a registered nurse with, at a minimum, post-operative care experience in accordance with applicable State health and safety laws, standards of practice, and ASC policy. (2) Post-surgical needs must be addressed and included in the discharge notes. This STANDARD is not met as evidenced by: Based on medical record review, policy review and staff interview, it was determined the ASC failed to ensure patients' post-surgical conditions were consistently assessed by a qualified practitioner or RN, in preparation for discharge, and documented in the medical record for 6 of 12 patients (#1, #2, #5, #6, #9 and #12) whose records were reviewed. This had the potential to result in un-met patient needs and unsafe discharge. Findings include: The ASC's policy titled, "Section 4.200 General Anesthesia Policies and Procedures" stated "...Every patient must meet medical discharge criteria prior to being discharged from the ASC by	Q 264		4/15/16	

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Q 264	<p>Continued From page 20 anesthesia provider..."</p> <p>The ASC's policy titled, "Section 3.320 Director of Nursing" documented the DON's duties included, but was not limited to, "...oversee all nursing care."</p> <p>- Patient #1 was a 17 year old male, who was admitted to the ASC on 2/26/16, for treatment related to extraction of wisdom teeth and root canal. The medical record documented Patient #1 was assessed for discharge by the LPN.</p> <p>- Patient #2 was a 2 year old male, who was admitted to the ASC on 2/23/16, for treatment related to dental caries. The medical record documented Patient #2 was assessed for discharge by the LPN.</p> <p>- Patient #5 was a 6 year old female, who was admitted to the ASC on 2/23/16, for treatment related to dental caries. The medical record documented Patient #5 was assessed for discharge by the LPN.</p> <p>- Patient #6 was a 6 year old female, who was admitted to the ASC on 2/23/16, for treatment related to dental caries, a root canal and extraction of teeth. The medical record documented Patient #6 was assessed for discharge by the LPN.</p> <p>- Patient #9 was a 6 year old male, who was admitted to the ASC on 2/24/16, for treatment related to dental caries and extraction of teeth. The medical record documented Patient #9 was assessed for discharge by the LPN.</p> <p>- Patient #12 was a 4 year old male, who was</p>	Q 264			

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Q 264	Continued From page 21 admitted to the ASC on 2/23/16, for treatment related to dental caries, teeth extraction and a root canal. The medical record documented Patient #12 was assessed for discharge by the LPN. According to the LPN, who was interviewed on 3/02/16, beginning at 10:00 AM, she was often independently responsible for discharging patients from the facility. She stated she was responsible for completing the modified Aldrete score when discharging patients from the facility. She stated when discharging patients from the ASC, she completed the "RN Assessment PACU" section of the PCF.	Q 264			
Q 266	The ASC did not ensure all patients received a post procedure/discharge assessment by a qualified practitioner or RN. 416.52(c)(2) DISCHARGE - ORDER [The ASC must -] Ensure each patient has a discharge order, signed by the physician who performed the surgery or procedure in accordance with applicable State health and safety laws, standards of practice, and ASC policy. This STANDARD is not met as evidenced by: Based on review of medical records, ASC policies and staff interview, it was determined the facility failed to ensure patients were discharged based on a physician's order for 12 of 12 patients (#s 1- #12) whose records were reviewed. This resulted in orders that lacked clarity and validity. Findings include:	Q 266		4/15/16	

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Q 266	<p>Continued From page 22</p> <p>1. The policy "Patient Discharge Criteria," updated December 2015, stated "The decision to discharge a patient from the ASC will be made by the ASC nurse staff or anesthesia provider based on the following criteria:</p> <p>"Discharge Criteria: Use Modified ALDRETE." The ALDRETE was a list of 8 items for which patients received points. Items included adequacy of respirations, circulation, level of consciousness, pain, nausea, and others. A score of 14 to 16 was required in order to discharge the patient.</p> <p>The ALDRETE score was not adequate for the population served by the ASC because the assessment tool required patients to be verbally capable of informing staff about how they perceived their condition, e.g. telling staff they were in pain or were nauseated. The ASC served patients between the ages of 2 and young adulthood who required general anesthesia in order to perform dental procedures. Many patients were not able to evaluate their feelings and respond to questions.</p> <p>For example, Patient #10 was a 5 year old male with a diagnosis of autism. He had 8 crowns applied under general anesthesia on 3/01/16. His procedure and care was observed by surveyors with permission from the mother. Following the procedure, he was returned asleep to the recovery room at 12:15 PM. He awoke during transfer from the gurney to a couch where his mother was. He immediately began crying, yelling, flailing and kicking his feet. He was inconsolable. At times he tried to bite his hands for which he had a history. He was not able to communicate effectively. This continued until</p>	Q 266			

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Q 266	<p>Continued From page 23</p> <p>12:39 PM, when he became slightly calmer. At 12:47 PM he was able to follow simple instructions. He became fairly calm and was discharged at 12:55 PM. During his time in recovery, Patient #10 was not asked if he was in pain or if he was nauseated.</p> <p>Patient #10's medical record stated a 2 for both pain and nausea, indicating he was experiencing neither. The PCF included PACU orders that were part of the form. The orders stated "Discharge patient when criteria met." The orders were not signed by a practitioner.</p> <p>The CRNA who treated Patient #10 was interviewed on 3/03/16 beginning at 10:40 AM. She stated the ASC did not have a formal PACU. She stated she considered PACU to be while the patient was still in the OR. She stated she was discharging patients from the OR to go to recovery. She stated she normally did not see patients after they left the OR.</p> <p>Patient #10 was not discharged on the order of a practitioner.</p> <p>2. Medical records were reviewed for Patients #1- #12. Physician/dentist discharge orders were not included on the following PCFs:</p> <ul style="list-style-type: none"> - Patient #1 was a 17 year old male, who was admitted to the ASC on 2/26/16, for treatment related to extraction of wisdom teeth and root canal. - Patient #2 was a 2 year old male, who was admitted to the ASC on 2/23/16, for treatment related to dental caries. 	Q 266			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001069	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 03/04/2016
NAME OF PROVIDER OR SUPPLIER SOUTHERN IDAHO SURGERY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3235 N TOWERBRIDGE WAY, SUITE 100 MERIDIAN, ID 83646		
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Q 266	<p>Continued From page 24</p> <ul style="list-style-type: none"> - Patient #3 was a 7 year old male, who was admitted to the ASC on 2/22/16, for treatment related to dental caries. - Patient #4 was a 3 year old male, who was admitted to the ASC on 2/23/16, for treatment related to dental caries. - Patient #5 was a 6 year old female, who was admitted to the ASC on 2/23/16, for treatment related to dental caries. - Patient #6 was a 6 year old female, who was admitted to the ASC on 2/23/16, for treatment related to dental caries, a root canal and extraction of teeth. - Patient #7 was a 9 year old male, who was admitted to the ASC on 2/23/16, for treatment related to dental caries. - Patient #8 was a 5 year old male, who was admitted to the ASC on 2/25/16, for treatment related to dental caries and extraction of teeth. - Patient #9 was a 6 year old male, who was admitted to the ASC on 2/24/16, for treatment related to dental caries and extraction of teeth. - Patient #10 was a 5 year old male, who was admitted to the ASC for treatment related to dental caries. - Patient #11 was a 12 year old male, who was admitted to the ASC on 2/22/16, for treatment related to dental caries. - Patient #12 was a 4 year old male, who was admitted to the ASC on 2/23/16, for treatment 	Q 266			

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

PRINTED: 04/07/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001069	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 03/04/2016
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Q 266	<p>Continued From page 25 related to dental caries, teeth extraction and a root canal.</p> <p>The ASC's policy titled, "Section 2.500 Rules and Regulations of the Medical Staff," last updated in December of 2015, documented "...All orders shall be in writing...Orders must be written clearly, legibly and completely..."</p> <p>An ASC policy was not provided that addressed the requirement to ensure patients medical records contained a discharge order signed by the physician who performed the surgery. During an interview on 3/03/16, beginning at 7:45 AM, the Office Manager confirmed physician discharge orders were not included on the PCFs.</p> <p>ASC patients were discharged without physician/dentist discharge orders.</p>	Q 266			



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FACILITY STANDARDS

Q 043

The ASC will maintain a written disaster preparedness plan that will provide for the care of patients, staff and others that may be in the facility in the event of a fire, natural disaster, equipment failure, or any other event which disrupts the day to day operations of the ASC and which could potentially cause harm to health and safety of anyone in the ASC. The Governing Body spoke with the local fire department to determine which natural disaster were a possibility in this area. We are in a unique location that makes our natural disaster minimal. The greatest threat to our rural location would be wildfire. Idaho is also the 5th most active earthquake state. Most are on a minute scale, but they are causing shifts, which could cause a larger earthquake. Here in Meridian we would most likely not see any major damage due to the location of the major fault lines being closer to Eastern Idaho.

Our biggest disaster threat would be man-made, such as an armed intruder or domestic altercation. The Governing Body has designated [REDACTED], [REDACTED] as the primary crisis manager for the ASC. The primary crisis manager will serve as the ASC spokesperson in an emergency. The secondary on site manager, if the primary manager is unable to manage the crisis will be [REDACTED], [REDACTED]. The off-site crisis manager will be [REDACTED].

The GB has written emergency orders (Appendix A) to be followed by incident specific plans (Appendix B). As part of the incident specific plan there have been protocols put in place to help the ASC return to its usual state as quickly as possible

The GB will be responsible for seeing that the staff is trained on the protocol for the plans. The GB will conduct a staff in-service that will introduce the ASC's personnel to the disaster plans and go over protocol with them to ensure understanding. A list of those in attendance will be maintained by the office manager and will also be included in the persons in attendance personnel files. Any member of the staff or GB who is unable to attend the training shall be responsible for ensuring that they have a competent understanding of the different emergency orders and disaster



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plans. A separate form will be provided for them to complete stating their understanding and will be kept in their personnel file. After the initial training there will be annual reviews.

A member of the GB will conduct drills annually to ensure the staff has been trained and to test the plans effectiveness. At the conclusion of the drill there will be a discussion with all those involved. The member of the GB who conducted the drill will do a write up. These write ups will be discussed by the Quality Committee, which will then make suggestions for any needed improvement or updating needed. These suggestions will be discussed at the annual GB meeting and put into place if unanimously agreed upon. The write ups and meeting notes will be maintained by the office manager in a binder, set aside for this purpose, with the most current being placed the front.

Completion 04/15/2016

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Q 062

Prior to discharge from the ASC's OR/PACU, each patient will be evaluated by an anesthetist. Section 4.120 (Appendix C), Section 4.20(Appendix D), and Section 4.5(Appendix E) of the ASC's Policy and Procedure Manual have been rewritten to ensure that the patient has been cleared as medically stable by the anesthetist prior to being returned to the parent. The ASC nursing staff will continue to monitor the patient for any digressions or late occurring complications after being discharged by the CRNA and returned to parent. The nursing staff will also continue to monitor to ensure that the parent has had all questions and/or concerns addressed.



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The CRNA will fill out the Modified Aldrete score of the GA sheet prior to discharging patient to parents care. This will be monitored by the office manager and Medical Director by observation and file review. If any deficiencies are noted, MDA, PLLC will be notified of the CRNA's failure to comply with ASC's policy and disciplinary action will be taken.

Completion 04/01/2016

Q 082

The data that has been collected was discussed at a Quality meeting that was held in March (Appendix F). At the meeting in April a project to focus on will be discussed based on the data that is being collected.

The GB will be assigning different members to follow up on the investigation aspect of the data that is collected on the incident reports. The information that is collected will be presented to the Quality Committee by a GB member. The committee will make recommendations if it feels there needs to be any changes in current policy or procedure.

The GB feels that there may need to be some parameters put in place to dictate what is or isn't considered an investigable "incident". There are times when the investigation process can be done by the nursing staff or office manager and a quick conclusion can be achieved if it is all documented correctly. These parameters will be presented to the QC in April for further discussion and recommendation.

Completion 04/15/2016



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Q 082

The data that has been collected was discussed at a Quality meeting that was held in March (Appendix F). At the meeting in April a project to focus on will be discussed based on the data that is being collected.

Any incident, documented by ASC staff, must be reported to the OM. The OM will initially investigate the incident to determine: type, severity, and prevalence. After initial investigation the OM will determine if further action is required based on severity and type, if it is deemed that further investigation is required the OM will delegate it to another member of the GB or complete the investigation alone. If the incident was medically related it will be referred to the MD, [REDACTED] for follow up. If it was dental related it will be referred to [REDACTED] for consultation or follow up. All other incidents will be discussed as a GB to determine the follow up course of action. The investigation into the reports will be documented by way of an annotated addition into the original log. This follow up should be done within 14 days following the incident. This log will be reviewed by the QC at the quarterly meetings to determine if and what the ASC's problem prone areas are. The QC will then make recommendations to the GB regarding policy or procedural changes. If there is a severe incident the QC will be called together for a meeting by the GB to discuss immediate changes or training if necessary.

The details of these incidents will be tracked in a log book, the basics on an Excel spread sheet. With the spread sheet we will be tracking the frequency or rate of any areas specific incidents; from parent/patient interaction to provider communication to employee performance. The main focus of these will be the type of incident, the severity of the incident, and the prevalence, how it may have had an effect on patient safety, of the incident. The goal of the spread sheet is to target problem prone areas of the practice so that the ASC can make appropriate adjustments. This spread sheet will be reviewed by the QC at the quarterly meeting. The QC will make suggestions to the GB once the area that needs the most improvement has been identified.

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The severity will be based on if it was an honest mistake or if a blatant disregard for policy and procedure was shown. The initial investigations and determination will be done by the OM. If the OM feels that the mistake was an honest mistake then there will be a reminder of training and discussion of consequences. If the OM deems it was more than an honest mistake the situation will be turned over to the GB. The GB will investigate the event further. At the completion the GB will then determine what, if any, changes need to occur and present the changes to the QC for review and adjustment.

In an effort to minimize the quarterly data dump, a monthly Statim overview form has been created (Appendix H). This overview will be filled out at the end of each month by the Infection Control Coordinator. The ICC will review the data and present it to the Quality Committee. The QC will review the data looking for a pattern, or reoccurring failure in the loads that do not pass and if there is one, to determine if any procedures need to be modified to ensure a higher pass rate. If any modifications to procedure are warranted, the QC will make a recommendation to the GB.

The GB feels that there may need to be some parameters put in place to dictate what is or isn't considered an investigable "incident" based on the severity, type, and prevalence. There are times when the investigation process can be done by the nursing staff or office manager and a quick conclusion can be achieved if it is all documented correctly. These parameters will be presented to the QC in April for further discussion and recommendation.

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Q 084

The GB added another member to help with the day to day supervision of the ASC (Appendix G). The Office Manager as part of the GB will be responsible for the monitoring of the quality programs and data collection. There is raw data that needs to be tallied. The new member of the GB will coordinate that effort.

The GB will assign a member to be in charge of the follow up of the incident reports. The investigation into the reports will be documented by way of an annotated addition into the original log. This follow up should be done within 14 days following the incident. In an effort to minimize the quarterly data dump, a monthly Statim overview form has been created (Appendix H). This overview will be filled out at the end of each month by the Infection Control Coordinator.

Completion 04/15/2016

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Q 162

The ASC has a responsibility to maintain an accurate medical record on each patient. Upon review it was noted that the ASC's 'discharge diagnosis' was deficient in its completeness. To rectify this, a Post Procedure form has been recreated to account for the details that were missing (Appendix I). It will now include operative notes, final diagnosis, and discharge orders. The doctors will be asked to fill this out within 24 hours of surgery but preferably prior to leaving the facility the day of.

After these forms have been introduced to the doctor, they will be reviewed for completeness by the Office Manager, for each dentist, within



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24 hours after the doctor has been to the ASC. Any deficiencies noted will be documented per policy. Any doctor who continually fails to submit a completed form will be referred to the GB for disciplinary action. The Medical Director and Office Manager will also check for completeness during the file reviews.

Completion 04/01/2015

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Q 231

Section 12.40 has been amended to include persons visiting the ASC (Appendix J) that are non-credentialed. A sign will be posted on the back door informing any non-authorized personnel of the need to check in at the front desk. The ASC staff will be informed of this policy change at the next staff meeting in April.

The Front Desk will notify the Office Manager of any outside visitors, which are here for more than just a delivery. The Office Manager will escort the visitor to the breakroom and monitor the visitors to ensure that patient privacy is maintained. If an ASC staff member fails to follow policy and patient privacy is not maintained, the staff member will be informed of the failure to comply and a write up will be put in the personnel file of the offender. Repeated failure to comply will result in the ASC staff member being referred to the GB for disciplinary action.

Completion 04/15/2016

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Q264

The 2015 Idaho Nursing Practice Act, Idaho Code, 54-1407 states that for a person to qualify as a licensed practical nurse they must have completed a basic curriculum and either passed a board exam or have a LPN license in good standing, and be of "sufficiently sound physical and mental health as will not impair or interfere with the ability to practice nursing."

Furthermore, under the 2015 Administrative Rules, IDAPA 23.01.01, section 460, pg.38 it states that the LPN can "provide nursing care at the delegation of a licensed registered nurse...or licensed dentist..." "The stability of the patient's environment, the patient's clinical state, and the predictability of the outcome determine the degree of direction and supervision that must be provided..." 460-01 the standard refers to the decision making model (section 400) in which it describes the process in which a LPN evaluates whether a particular act is within the legal scope. One of questions is does the act "exceed any existing policies and procedures established by the employer" and "'Performance of the act is within the accepted standard of care that would be provided in a similar situation by a reasonable and prudent nurse..."

Section 460-02 lists some of the functions that are within the legal definition of a LPN (Section 54-1402(3), Idaho Code) they include, but are not limited to contributing "to the assessment of health status," "participates in the development and modification of the plan of care," "maintains safe and effective nursing care," and "accepts delegated assignments only as allowed by application of the decision making model" that was referenced previous. Under these guidelines set forth by the 2015 Idaho Practicing Nurse Act(IPNA) and with changes made to Section 4 (refer to Q 062) and Policy and Procedure Manual Section 3.310 (Appendix H) the GB feels that this standard has been met. If additional training is needed for any LPN employed by SISC, according to the IPNA, documentation of the LPN's training by qualified persons is sufficient. Records of this training will be maintained in the LPN's personnel file.

Completion 04/15/2016



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Q264

The CRNA will be conducting the initial post-operative surgical assessment prior to discharging the patient to the parent. The secondary discharge will be concluded by the RN or LPN.

The 2015 Idaho Nursing Practice Act, Idaho Code, 54-1407 states that for a person to qualify as a licensed practical nurse they must have completed a basic curriculum and either passed a board exam or have a LPN license in good standing, and be of "sufficiently sound physical and mental health as will not impair or interfere with the ability to practice nursing." Furthermore, under the 2015 Administrative Rules, IDAPA 23.01.01, section 460, pg.38 it states that the LPN can "provide nursing care at the delegation of a licensed registered nurse...or licensed dentist..." "The stability of the patient's environment, the patient's clinical state, and the predictability of the outcome determine the degree of direction and supervision that must be provided..." 460-01 the standard refers to the decision making model (section 400) in which it describes the process in which a LPN evaluates whether a particular act is within the legal scope. One of questions is does the act "exceed any existing policies and procedures established by the employer" and ""Performance of the act is within the accepted standard of care that would be provided in a similar situation by a reasonable and prudent nurse..."

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Q 266

Refer to Q 162 as it refers to complete patient medical records. Appendix F includes Post Procedure Orders that are to be signed by the doctor.

Completion 04/15/2016

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