IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T. – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

May 22, 2017

Karen Sines, Administrator
North Idaho Cataract & Laser Center
1814 Lincoln Way
Coeur D'Alene, ID 83814

RE: North Idaho Cataract & Laser Center, Provider #13C0001009

Dear Ms. Sines:

This is to advise you of the findings of the Medicare survey of North Idaho Cataract & Laser Center, which was conducted on May 17, 2017.

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. It is important that your Plan of Correction address each deficiency in the following manner:

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;
- 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 **June 5, 2017,** and keep a copy for your records.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Dennis Kelly, RN or Nicole Wisenor, Co-Supervisors, Non-Long Term Care at (208) 334-6626, option 4.

Sincerely,

NICOLE WISENOR, Supervisor
Non-Long Term Care

NW/pmt
Enclosures

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13C0001009	A. BUILDING _____ B. WING _____	05/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH IDAHO CATARACT & LASER CENTER	1814 LINCOLN WAY 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 APPRO PRIATE DEFICIENCY)	(X5) COMPLETION DATE

Q 000 INITIAL COMMENTS

The following deficiencies were cited during the Medicare recertification survey of your Ambulatory Surgery Center conducted from 5/15/17 through 5/17/17. Surveyors conducting the recertification survey were:

Brian Osborn, RN, HFS, Team Lead
Trish O'Hara, RN, HFS

Acronyms used in this report include:
QA - Quality Assurance

Q 225 416.50(d)(4),(5), & (6) SUBMISSION AND INVESTIGATION OF GRIEVANCES

The ASC must establish a grievance procedure for documenting the existence, submission, investigation, and disposition of a patient's written or verbal grievance to the ASC. The following criteria must be met:

(1) The grievance process must specify timeframes for review of the grievance and the provisions of a response.

(2) The ASC, in responding to the grievance, must investigate all grievances made by a patient, the patient's representative, or the patient's surrogate regarding treatment or care that is (or fails to be) furnished.

(3) The ASC must document how the grievance was addressed, as well as provide the patient, the patient's representative, or the patient's surrogate with written notice of its decision. The decision must contain the name of an ASC contact person, the steps taken to investigate the grievance, the result of the grievance process and the date the

Q 000 The grievance policy and procedure was established July 7, 2004 and revised for CMS guidelines and review on May 24, 2007. The policy (attached) reflects the following requirements:

Definition of a grievance as a formal or informal written or verbal complaint made to a staff member of the ASC or administration of North Idaho Eye Institute by a patient or the patient's representative

Q 225 **(1) All patient complaints will be addressed immediately and documented on the grievance log, which will be kept as a secure electronic file.** (print form attached). Reports of concerns will be reported to the nurse manager and should occur within time frame: 5/26/2017

Immediate to within one work week.
The nurse manager will attempt to satisfy the patient's grievance. If the manager is not able to satisfy the patient's grievance, the matter will be brought to the attention of the NIEI administrator with the following time frame: **Immediate to within one work week.**

If the administrator is not able to resolve the concern, the Medical Director will refer the grievance to the majority of the Board of Directors with the following time frame:
Immediate to within one work week.

A written notice of the board decision will be provided to the patient within fourteen days of the final decision

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Ben Gaby | Administrator | 5/31/2017

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13C0001009	A. BUILDING _____ B. WING _____	05/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH IDAHO CATARACT & LASER CENTER	1814 LINCOLN WAY 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 225 Continued From page 1
grievance process was completed.
This STANDARD is not met as evidenced by:
Based on staff interview, review of policies and patient rights information, and QAPI incident report data, it was determined the ASC failed to ensure a procedure for documenting the submission, investigation, and disposition of grievances had been implemented. This failure impacted all patients receiving care at the facility by potentially allowing grievances to remain unresolved. Findings include:

A document titled Patient Grievance Policy, revised 6/14/2009, delineated a grievance process to be implemented in the facility. The policy included directions for receiving a complaint, assigned responsibility for investigation of a complaint, assigned time frames for response to the complainant, and described a process for review by the Board of Directors and the Quality Assurance Committee.

A Patient Rights and Responsibilities pamphlet, present in the admission packet given to each patient at their pre-op appointment, was reviewed. The pamphlet directed patients with a grievance to contact the facility administrator, the medical director, the nurse manager, the accrediting agency, or the state licensing office. Current names and contact information was included.

No grievance log was available for review.

In an interview on 5/17/17 at 9:30 A.M., the Administrator said a separate grievance log was not maintained. She said grievances were included in Incident/Accident reporting and a specific process for receiving, investigating, and

(continued from page 1)

Q 225 **(2) The Grievance log will be kept in secured electronic format and reviewed by Quality Assurance Committee at each scheduled meeting.**

Review of patient case on QA Committee was conducted by Nurse Manager on 5/26/2017 notes the following facts:

A. The grievance was originally filed by the patient on October 21, 2016 by the patient who spoke to the NIEI administrator. **The event was not recorded on the existing grievance log.** A second note via patient satisfaction survey for surgical date 11-2-2016 noted a complaint that she had had contact with the same nurse and additional complaints about medications called to the pharmacy was not ready early enough on the day to provide time for a shower and rest on the night before surgery.
B. The patient had requested a specific nurse not be involved in her care on 11-2-2016 because she was unhappy with previous IV access attempts on 10-14-16.
C. That specific nurse did not start the IV for the 2nd surgery date, but did help the surgeon during the retrobulbar block. She was un aware of what patient had complained about her.
D. The report was made by a different staff member after observing the patient become hostile toward the first nurse on surgery date 11-2-2016. The existing Nurse manager initiated an unusual occurrence form for QA committee review as follow-up for previous complaint on 10-21-2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13C0001009	A. BUILDING _____ B. WING _____	05/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH IDAHO CATARACT & LASER CENTER	1814 LINCOLN WAY 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 225	Continued From page 2 resolving grievances was not used. She said information related to specific grievances was documented in staff's personal notes. The QA Committee Incident Report Review for the calendar year 2016 was reviewed. It included columns with headings for description, plan of action, and re-evaluation. One grievance, included on the QA Committee Incident Report Review, occurred on 11/2/16. The description stated "Multiple Patient Complaints." The plan of action stated "Reviewed with Administrator-'personality disorder'-unable to formulate plan." The re-evaluation stated "Closed." It was unclear how the grievance had been received and by whom, how the grievance was investigated and resolved, or if and when the facility had responded to the complainant. In an interview on 5/17/17 at 9:30 AM., the Administrator acknowledged the 11/2/16 grievance and confirmed the required grievance process was not included in the QA Committee Incident Report Review. The facility failed to ensure the facility grievance policy was implemented appropriately.	Q 225	(Continued from page 2) E. The original complaint was addressed by the NIEI Administrator and ASC nurse manager with the Pre-op nurse. The Pre-op nurse was counseled and IV skill and professional communication was noted as a deficiency on her evaluation and placed in her employee file. The nurse was retrained on IV Access policy and technique. F. Staff witnesses state they felt the patient was very rude but the staff involved maintained composure during the patient's care on 11-2-2016. G. Additional attempts to contact the patient have been unsuccessful as of time of report. H. Written notice of the investigation was not provided to the patient or the patient's advocate and the issue was forwarded to the Board of director within the time frame of the policy existing at the time of the incident, I. Both Nurse Manager and NIEI Administrators involved during the incident in question have retired from employment with the ASC. J. At the time of the incident, the grievance log was only available in the Nurse Manager's office in the incident log binder.	