IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSSELL S. BARRON– Director

TAMARA PRISOCK—ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
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BUREAU OF FACILITY STANDARDS
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August 1, 2018

Joseph Peterson, Administrator
Ambulatory Surgery Center Of Burley
1344 Hiland Avenue, Suite E
Burley, ID 83318

RE: Ambulatory Surgery Center Of Burley, Provider #13C0001028

Dear Mr. Peterson:

This is to advise you of the findings of the Medicare survey of Ambulatory Surgery Center Of Burley, which was conducted on July 26, 2018.

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 **August 14, 2018,** 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,

Dennis Kelly RN

DENNIS KELLY, RN, Supervisor
Non-Long Term Care

DK/pmt
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13C0001028	A. BUILDING _____ B. WING _____	07/26/2018

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AMBULATORY SURGERY CENTER OF BURLEY	1344 HILAND AVENUE, SUITE E BURLEY, ID 83318

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Q 000	INITIAL COMMENTS The following deficiencies were cited during the Medicare recertification survey of your ASC conducted from 7/24/18 to 7/26/18. Surveyors conducting the recertification were: Teresa L Hamblin, RN, MS, HFS, Team Lead Trish O'Hara, RN, HFS Acronyms used in this report include: ASC - Ambulatory Surgical Center CT - Computed Tomography EGD - EsophagoGastroDuodenoscopy H&P - History and Physical Postop - Postoperative Pt - Patient WHO - World Health Organization	Q 000	RECEIVED AUG 15 2018 FACILITY STANDARDS	
Q 082	PROGRAM DATA; PROGRAM ACTIVITIES CFR(s): 416.43(b), 416.43(c)(2), 416.43(c)(3) (b)(1) The program must incorporate quality indicator data, including patient care and other relevant data regarding services furnished in the ASC. (b)(2) The ASC must use the data collected to - (i) Monitor the effectiveness and safety of its services, and quality of its care. (ii) Identify opportunities that could lead to improvements and changes in its patient care. (c)(2) Performance improvement activities must track adverse patient events, examine their causes, implement improvements, and ensure that improvements are sustained over time.	Q 082		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Owner / MD / DO | (X6) DATE: 8/13/18

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 082	Continued From page 1 (c)(3) The ASC must implement preventive strategies throughout the facility targeting adverse patient events and ensure that all staff are familiar with these strategies. This STANDARD is not met as evidenced by: Based on review of incident reports and staff interview, it was determined the ASC failed to ensure 1 of 1 documented adverse event was analyzed for 1 of 1 patient (Patient #13) who experienced an adverse event and whose record was reviewed. This had the potential to result in a missed opportunity for process improvement that could impact quality and safety of patient care. Findings include: Surveyors requested incident reports for review for 2018. There was 1 documented incident during 2018. The incident involved Patient #13, an 85 year old male who had an endocscopy procedure on 6/06/18. The incident report, documented on a "QUALITY IMPROVEMENT COMMITTEE SHEET," dated 6/06/18, included the following information involving Patient #13: "An EGD was performed with polypectomy of 4 cm - 4.5 cm polyp Random bx [biopsy] of duodenum & abnormal tissue. Pt [patient] c/o [complained of] severe pain postop - no relief with medication. Follow-up to [hospital] for CT scan - microperforation of lower duodenum - No {sic} extending outside. Pt [patient] was sent to Boise where pt was observed - no surgery needed. Pt dc'd [discharged] home doing better." There was no documentation indicating Patient #13's microperforation was evaluated to	Q 082	Q 082 The facility's governing board met and it was determined to continue use of current improvement Committee form with an addition of "analysis "added to section on committee action. (Exhibit Q082) This will prompt the committee to document analysis of patient's adverse event to determine if anything could have been done differently to prevent the incident, or could be done differently in the future to avoid a similar incident.	8/10/18 implemented by emergency nurse manager

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Q 082	Continued From page 2 determine if anything could have been done differently to prevent the incident, or could be done differently in the future to avoid a similar incident. The Nurse Manager was interviewed on 7/26/18 at 2:30 PM. She stated the event was discussed with physicians and it was determined the adverse event was a risk of surgery. The Nurse Manager confirmed there was no documentated analysis of Patient #13's adverse event. The ASC did not document the analysis of Patient #13's adverse event.	Q 082		
Q 162	FORM AND CONTENT OF RECORD CFR(s): 416.47(b) 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 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.	Q 162		

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Q 162	Continued From page 3 This STANDARD is not met as evidenced by: Based on review of medical records and incident reports and staff interview, it was determined the ASC failed to ensure documentation was accurate and complete for 1 of 20 patients (Patient #13) whose record was reviewed. This resulted in a lack of clarity as to the actual course of patient care. Findings include: 1. Patient #13 was an 85 year old male admitted on 6/06/18 for an endocscopy procedure. An incident report, dated 6/06/18, documented Patient #13 had severe post-operative pain and was sent for a follow-up CT scan. The results of the scan showed a microperforation of the lower abdomen. Following the CT scan, Patient #13 was transferred to a hospital for observation. Patient #13's medical record did not accurately and completely describe the course of care, as follows: a. The physician's "EGD Report" for Patient #13, documented "There were no apparent limitations or complications." The initial physician's documentation in Patient #13's medical record was not updated to reflect complications that occurred (documented in the incident report, dated 6/06/18). b. The "Discharge Instructions," dated 6/06/18, did not include instructions to follow-up at a hospital for a CT scan. The Nurse Manager was interviewed on 7/26/18 at 11:10 AM. She confirmed the operative report for Patient #13 did not document complications of the procedure. The Nurse Manager also	Q 162	Q 162 Chart committee will review all Physicians documentation for accuracy on charts of patients that have complications with procedures. This will ensure documentation is updated, accurate and complete and that discharge reflects changes. Chart committee will then report back to QI/QA committee. If it is determined to be a a trend ASC of Burley will develop a Quality Improvement Study to help improve patient care. Met with Physician for follow up Patient #13 and instructions and expectation of post op charting to reflect any changes to plan of care. 8/10/18 Implemented by Chart Review Committee Nurse Manager	

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Q 162	Continued From page 4 confirmed discharge instructions did not instruct Patient #13 to follow-up immediately for the CT scan. She explained the operative report and the discharge instructions were written by the physician immediately after the procedure and they were not updated to reflect Patient #13's postoperative complications and updated discharge instructions. The Nurse Manager stated it would have been necessary for the physician to go back into the report and amend it. Patient #13's operative report and discharge instructions did not accurately reflect complications and follow-up instructions.	Q 162		
Q 203	RADIOLOGIC SERVICES CFR(s): 416.49(b)(1) [Radiologic services...] must meet the requirements specified in § 482.26(b), (c)(2), and (d)(2) of this chapter. This STANDARD is not met as evidenced by: Based on policy review, observation, record review, and staff interview, it was determined the ASC failed to ensure radiology policies were current and accurately reflected the scope of ASC services. This failure impacted 1 of 1 patient (Patient #20) who was observed to have x-rays during a procedure and 3 of 3 patients (#3, #6, and #16) whose medical records documented dental x-rays taken during the procedures. This resulted in the use of dental x-ray equipment that had not been specifically approved by the governing body. It also resulted in a lack of clarity as to any necessary safety measures for the dental x-ray equipment. Findings include:	Q 203		

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Q 203	Continued From page 5 Radiology policies and procedures, dated 11/21/12, were reviewed. They addressed "fluoroscopy with the C-arm ..." They did not address the use of digital dental x-ray equipment ("NOMAD Pro 2") brought into the ASC for use during certain dental procedures. Patient #20 was a 23 month old female admitted on 7/26/18 for full dental rehabilitation. Dental x-rays were observed to be taken on 7/26/18 after 7:45 AM by the Dental Assistant in coordination with the Dentist prior to the procedure. A review of closed medical records documented dental x-rays taken in the surgical suite prior to dental procedures for Patients #3, #6, and #16. The Nurse Manager was interviewed on 7/24/18 at 3:09 PM. She stated their radiology policies were outdated as they no longer used C-Arms." She stated the only radiology equipment used at the ASC was a portable dental x-ray machine brought in by the contracted dentists. During a second interview on 7/26/18 at 10:30 AM, the Nurse Manager confirmed the ASC's radiology policies did not address the digital x-ray equipment and there had not been any specific Governing Body approval of the radiology equipment. The current scope and complexity of radiological services provided within the ASC were not specified in writing and approved by the governing body.	Q 203	Q 203 Radiology policy has been updated and approved by Governing Board. (Exhibit Q 203 pages 1-4) Dental x-ray machines Nomad Pro and Nomad Pro II have been approved for use at The Ambulatory Surgery Center of Burley for the use of diagnostic imaging during dental procedures. Radiology policy to include dental x-ray machine have been posted and staff has been educated. This provides safety measures for patients and staff.	8/10/18 implemented by Chief Nurse Manager
Q 222	NOTICE OF RIGHTS - POSTING CFR(s): 416.50(a)(1)(i)	Q 222		

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Q 222	Continued From page 6 (1)[...] In addition, the ASC must - (i) Post written notice of patient rights in a place or places within the ASC likely to be noticed by patients (or their representatives, if applicable) waiting for treatment. The ASC's notice of rights must include the name, address, and telephone number of a representative in the State agency to whom patients can report complaints, as well as the Web site for the Office of the Medicare Beneficiary Ombudsman. This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the ASC failed to ensure an accurate phone number was posted in the waiting area to report complaints to the State Agency. This had the potential to interfere with the ability of patients to file a verbal complaint with the State Agency. Findings include: Upon entrance to the facility on 7/24/18 at 12:00 PM, surveyors observed posted patient rights information on the wall of the ASC lobby. The phone number listed to report a complaint to the State Agency was not recognizable. The surveyor called the phone number which resulted in a non-working number. During an interview on 7/24/18 at 3:09 PM, the Nurse Manager stated she did not realize they had a non-working number on the patient rights information post. She obtained the correct phone number from surveyors and stated she would correct the patient rights information to reflect the correct telephone number. The ASC's posted notice of rights did not include a correct telephone number for patients to call to	Q 222	Q 222 [redacted] [redacted] Public information Manager @ Idaho Health and Welfare. Updated on Patients' Rights to reflect: Idaho Bureau of Facility Standards PO Box 83720 Boise, Idaho 83720-0009 Email: FSB@dhw.idaho.gov 208-334-6626 Option #4 Medicare Beneficiary Ombudsman www.cms.hhs.gov/ombudsman/resources.asp (Exhibit Q 222 page 1-2)	7/26/18 implemented per Change to meet requirements

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Q 222	Continued From page 7 file complaints with the State Agency.	Q 222		
Q 224	ADVANCED DIRECTIVES CFR(s): 416.50(c)(1)(2)(3) The ASC must comply with the following requirements: (1) Provide the patient or, as appropriate, the patient's representative with written information concerning its policies on advance directives, including a description of applicable State health and safety laws and, if requested, official State advance directive forms. (2) Inform the patient or, as appropriate, the patient's representative of the patient's rights to make informed decisions regarding the patient's care. (3) Document in a prominent part of the patient's current medical record, whether or not the individual has executed an advance directive. This STANDARD is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the ASC failed to ensure documentation was included in medical records whether patients had executed an advance directive, including durable medical power of attorney, for 20 of 20 patients (#'s 1-20). It also failed to have an established process to collect advance directive information from patients. This had the potential to interfere with the ability of the ASC to communicate the patients' wishes to a receiving facility in the event of an emergency transfer. Findings include: 1. Medical records for Patients #1-20 documented "Y" [Yes] or "N" [No] as to whether	Q 224	ASC of Burley currently documents in patients charts if they have a Living Will. For those who do not have a Living Will and are interested. Referral information is given for obtaining information on Living Will/Durable Power of Attorney. ASC of Burley has updated our current face sheet to reflect that we have requested a copy of Living Will and Durable Power of Attorney to be placed in patients chart. (Exhibit Q 224) We will implement a QI study to evaluate effectiveness of requests of additional information to the face sheet concerning Living Will and Durable Power of Attorney.	8/10/18 Implemented by Omaya RN nurse manager 9/1/18 T. Hayes Harris RN QI/QA

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Q 224	Continued From page 8 patients had a living will. The medical records did not include information as to whether patients had other types of advance directives, such as a durable power of attorney for healthcare. During an interview on 7/26/18 at 10:30 AM, the Nurse Manager confirmed they asked patients about living wills, but not any other type of advance directive. Medical record documentation related to advance directives was incomplete. 2. ASC policy "ADVANCE HEALTHCARE DIRECTIVES," dated 1/25/18, stated "Patients will be encouraged to communicate their desires in regard to advance directives to their significant others, to allow for guidance of significant others and healthcare providers in following the patient's wishes should the patient become incapacitated, rendering them unable to make decisions." The policy did not address collecting advance directive information for the ASC record to transfer with the patient to a hospital if the patient became incapacitated. The Receptionist was interviewed on 7/25/18 at 8:15 AM. She stated they did not ask patients for a copy of advance directives for filing in the medical record. The Nurse Manager was interviewed on 7/24/18 at 3:09 PM. She stated it was not there process to collect advance directive information. Rather, she stated, they instructed patients to provide information to their support people in the event they need to be transferred. The ASC failed to collect advance directive	Q 224	This allows guidance to the significant other and healthcare providers in following the patient's wishes should the patient become incapacitated, rendering them unable to make a decision. This is beneficial in the event the patient is transferred to another facility and provides and wishes can be met.	

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Q 224	Continued From page 9 information to communicate the patients' wishes to a receiving facility in the event of an emergency transfer.	Q 224		
Q 241	SANITARY ENVIRONMENT CFR(s): 416.51(a) The ASC must provide a functional and sanitary environment for the provision of surgical services by adhering to professionally acceptable standards of practice. This STANDARD is not met as evidenced by: Based on observation, infection control policies and guidelines, medical record review, and staff interview, it was determined the ASC failed to ensure appropriate glove change and handwashing occurred during 1 of 2 procedures that were observed, which impacted 1 patient (Patient #20). This had the potential to compromise infection prevention. Findings include: The ASC Infection Control policies included "Guidelines Utilized in the Creation of this Infection Prevention Plan," dated 10/02/17. The guideline listed the World Heath Organization (WHO) as the reference for hand hygiene. The WHO website (www.who.int), was accessed 7/30/18. It described "5 Moments for Hand Hygiene," including: 1) before touching a patient; 2) before a clean/aseptic procedure; 3) after fluid exposure risk; 4) after touching a patient; and 5) after touching patient surroundings. Hand hygiene guidelines were not followed. An example includes:	Q 241	Q 241 Ambulatory Surgery Center of Burley has obtained a personnel file for evidence of education and training of staff that accompany Physicians and Dentists. The ASC of Burley will educate the assistants of Physician or Dentist in infection control and good Hand Hygiene.	8/10/18 Implemented by Charge RN nurse manager

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Q 241	Continued From page 10 Patient #20 was a 23 month old female admitted on 7/26/18 for full dental rehabilitation. Surgery was observed from 7:45 AM until 8:30 AM. Surveyors observed a Dental Assistant, with gloved hands, assisting the Dentist, providing instruments and dental supplies and taking dental x-rays. The Dental Assistant shifted from assisting the Dentist to obtaining a sani-wipe with her gloved hands, and wiping down the portable x-ray equipment, a table, a computer, and some cords. The Dental Assistant was then observed to return to assisting the Dentist, including handing the Dentist crowns that were subsequently placed in Patient #20's mouth. The Dental Assistant was not observed to remove gloves and wash her hands after handling the disinfectant and cleaning equipment, and to re-apply fresh gloves prior to assisting the Dentist. The Nurse Manager was interviewed on 7/26/18 at 10:30 AM. She stated the Dental Assistant came to the ASC with the Dentist. She was not an employee of the ASC. When asked to review her personnel file for evidence of infection control training, the Nurse Manager stated she did not keep a file on the Dental Assistant, nor did she train the Dental Assistant in infection control. The Nurse Manager stated she was not sure of the Dental Assistant's training. She confirmed it would have been appropriate to change gloves after cleaning equipment before returning to assisting the Dentist. Hand hygiene did not occur in accordance with WHO infection control standards.	Q 241		
Q 261	ADMISSION ASSESSMENT	Q 261		

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Q 261	Continued From page 11 CFR(s): 416.52(a)(1) Not more than 30 days before the date of the scheduled surgery, each patient must have a comprehensive medical history and physical assessment completed by a physician (as defined in section 1861(r) of the Act) or other qualified practitioner in accordance with applicable State health and safety laws, standards or practice, and ASC policy. This STANDARD is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the facility failed to ensure an H&P was comprehensive for 1 of 1 patient (Patient #4) whose procedure was performed by an ophthalmologist and whose records were reviewed. This had the potential to interfere with the physician's ability to assess patient readiness for surgery. Findings include: ASC policy, "APPROPRIATENESS OF PROCEDURE," dated 10/01/17, stated "A comprehensive history and physical shall be completed within 30 days prior to surgery ..." The term "comprehensive" was not defined to reflect minimum expectations by the ASC for a comprehensive H&P. Patient #4 was a 79 year old male admitted on 5/29/18, for surgery on both eyelids. The physical examination portion of the H&P, dated 5/22/18, was limited to the eyes. The examination was focused, rather than comprehensive. The Nurse Manger was interviewed on 7/26/18 at 11:20 AM. She reviewed Patient #4's medical record and confirmed the H&P was not	Q 261	Q 261 A comprehensive history and physical shall be mandatory for all Surgery patients. Ophthalmology (local with sedation) History and Physical will include comprehensive history and physical to include assessment of heart and lungs.	8/1/18 implemented by Charge nurse manager

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13C0001028	A. BUILDING _____ B. WING _____	07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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Q 261	Continued From page 12 comprehensive.	Q 261		