IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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September 5, 2018

Carol Lugar, Administrator
Meridian Endoscopy Center
2235 E Gala Street
Meridian, ID 83642

RE: Meridian Endoscopy Center, Provider #13C0001057

Dear Ms. Lugar:

This is to advise you of the findings of the Medicare survey of Meridian Endoscopy Center, which was conducted on August 28, 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 **September 17, 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
	13C0001057	A. BUILDING _____ B. WING _____	08/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN ENDOSCOPY CENTER	2235 E GALA STREET MERIDIAN, ID 83642

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Q 000	INITIAL COMMENTS The following deficiencies were cited during the Medicare recertification survey of your ambulatory surgical center, conducted on 8/23/18 to 8/28/18. Surveyors conducting the recertification were: Gary Guiles, RN, HFS Nancy Bax, RN, BSN, HFS Weslianne Lewis, RN, BSN, HFS Acronyms used in this report include: ASA - American Society of Anesthesiologists, an ASA Grade Assessment classifies patients according to their risk of recieving anesthesia ASC - Ambulatory Surgery Center BP - Blood Pressure CDC - Centers for Disease Control D5LR - Dextrose 5% in Lactated Ringers solution D5NS - Dextrose 5% in Normal Saline solution EGD - Esophagogastroduodenoscopy (Upper Endoscopy) EMR - Electronic Medical Record GI - Gastrointestinal IDAPA - Idaho Administrative Procedures Act IV - Intravenous LPN - Licensed Practical Nurse MD - Doctor of Medicine mg - Milligrams mL - Milliliter mmHg - Millimeters of Mercury NS - Normal Saline pt - patient TKO - To Keep Open (IV fluids)	Q 000	RECEIVED SEP 18 2018 FACILITY STANDARDS	
Q 162	FORM AND CONTENT OF RECORD CFR(s): 416.47(b) The ASC must maintain a medical record for	Q 162		

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

Clinical Director 9/17/18

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 162	Continued From page 1 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. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records, it was determined the ASC failed to ensure 2 of 20 patient medical records (#6 and #16) reviewed were accurate and promptly completed. This impeded the ability of readers to understand events that occurred. Findings include: 1. Patient #6 was a 71 year old female who presented for a colonoscopy on 6/28/18 at 11:49 AM. She also had a history of diabetes which was controlled with diet. Patient #6's first documented heart rate was 174 at 12:00 noon. The American Heart Association website, queried on 8/28/18, stated a normal heart rate is between 60 and 100 beats per minute. The website stated a "...rapid heartbeat	Q 162	This case was discussed at the Quality Improvement meeting. The MD described being at the bedside. He examined the patient. The physician discussed with the patient and the family the caridac condition. After a lengthy discussion the patient and family reluctantly accepted that the procedure would be cancelled and the patient would be transported by EMS to St. Luke's Meridian. The physician contacted the Emergency Room physician regarding the patient and their condition. These details were not documented by the physician. The lack of documentation of the event was reviewed by the medical director with the physician who was present at the meeting. The nurse contacted EMS for transport of the patient. After description of the patient to the paramedic, the paramedic instructed the nurse to administer oral glucose as the patient had "diet controlled" diabetes. The paramedic also instructed nursing to give three aspirin. Both the glucose and the aspirin administration were discussed with the physician but were not documented as a verbal order. The nurse was present at the Quality	

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Q 162	Continued From page 2 keeps the heart's chambers from filling completely between contractions, which compromises blood flow to the rest of the body." Patient #6's heart rate stayed above 160 beats per minute until 12:43 PM, when it was 158 beats per minute. Her blood pressure dropped to 83/55 at 12:10 PM but then it came back up to 125/97 at 12:15 PM. The first note of Patient #6's Procedure Log, timed 12:43 PM, stated the nurse told the physician about Patient's #6's elevated heart rate at that time and the physician visited with Patient #6. At 12:53 PM, the log stated she was given oral glucose. At 12:56 PM, the log stated the physician spoke with Patient #6's family. At 1:02 PM, the log stated Patient #6 complained of acid reflux and tightness in her chest. At 1:13 PM, she complained of pain "...radiating from chest to shoulders and neck." At 1:17 PM, the log stated the decision was made to transport her to an emergency room. The fire department arrived at 1:31 PM and she was taken to the hospital by ambulance. No documentation was present between 12:00 and 12:43 PM, of an examination by a physician or nurse in response to Patient #6's increased heart rate. No documentation was present that the physician was informed of the increased heart rate until 12:43 PM. A note by the physician, dated 7/12/18, 16 days after the date of the incident, stated Patient #6 was anxious, had a regular cardiac rate and rhythm, and her breath sounds were clear. The note stated, "Patient has been assessed and found to be a suitable candidate for the planned procedure." No other documentation by the physician was present.	Q 162	Improvement meeting. Documentation was reviewed regarding verbal orders. It was reviewed with the four physicians and five nurse on the QI committee that all events even when a procedure does not occur need clear documentation. Additional follow up with nursing and physicians is scheduled on September 19, 2018 to review the procedure for verbal orders and documentation. The clinical director will provide education to the nursing staff and the medical director will provide education to the physicians.	9/19/18

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Q 162	Continued From page 3 A Procedure log note by the RN, at 12:53 PM on 6/26/18, stated Patient #6 was given "...oral glucose 15." No order for this was documented. A log note at 1:25 PM, stated "non emergent transport ordered to give [Aspirin] x3 at this time" and said the medication was given (by the ASC nurse). The note did not define non emergent transport or say if the physician was involved in this decision. This occurred before the paramedics arrived to take Patient #6 to the hospital. No orders for the glucose or the Aspirin were documented. Patient #6's physician was interviewed on 8/23/18 beginning at 3:45 PM. He confirmed he did not document on Patient #6's record except for the 7/12/18 entry. He stated he did not document a physical examination or write orders. The nurse who gave Patient #6 the Aspirin was interviewed on 8/24/18 beginning at 3:24 PM. She confirmed a physical assessment of the Patient #6's condition was not documented. She stated the Aspirin was ordered by "dispatch." She stated there was no written order. The ASC did not document events surrounding the care of Patient #6. Patient #16 was a 68 year old female admitted on 7/03/18, for an EGD. Her record stated she had stage 4 chronic kidney disease. The American Heart Association website, accessed on 8/29/18, defined the following blood pressure categories: Normal - less than 120/80 Elevated - Systolic 120-129, and Diastolic less than 80	Q 162		

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Q 162	Continued From page 4 Hypertension Stage 1 - Systolic 130-139 or Diastolic 80-89 Hypertension Stage 2 - Systolic greater than 140 or Diastolic greater than 90 Hypertensive Crisis - Systolic greater than 180 or Diastolic greater than 120 Patient #16's record documented an initial BP of 140/97 mmHg at 3:05 PM. The next BP documented was 193/119 mmHg at 3:21 PM, 2 minutes before insertion of the endoscope at 3:23 PM. Her BP remained elevated at 179/108 mmHg at 3:23 PM, and 171/99 mmHg at 3:28 PM. Patient #16 was taken to recovery at 3:31 PM. There was no documentation related to her elevated BP. It could not be determined if the physician was aware of her elevated BP prior to and during her procedure. Patient #16's record included a procedure note signed by her physician on 7/03/18. It included a "Pre-Anesthesia Assessment" that stated her cardiovascular assessment was normal. It did not address her elevated BP prior to her procedure. The note stated her BP was monitored throughout the procedure, and she tolerated the procedure well. It did not address her elevated BP during the procedure. During an interview on 8/27/18 at 1:20 PM, the RN who assisted the physician during Patient #16's procedure was asked if the physician was notified of her elevated BP. She stated "Absolutely." She confirmed there was no documentation her physician was notified or aware of Patient #16's elevated BP. The ASC failed to document Patient #16's elevated BP.	Q 162	Nursing staff will discuss how to better document conversations with patients and physicians regarding elevated blood pressure to include- has the patient taken their antihypertensive today? What is their "normal" BP? Nurisng will document patient and physician conversation in the medical record of elevated BP preprocedure, during procedure and post procedure. Based on the patients reponse a plan will be initiated by the nurse, doctor and patient and documented by the nurse. Staff and physicians to be educated by the clinical director at meetings scheduled for 09/19/2018. After education the charge nurse will review 10 charts per month to insure compliance of documentation of vital sign abnormalities to the physician and verify that a plan was initiated.	9/19/18

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Q 181	ADMINISTRATION OF DRUGS CFR(s): 416.48(a) Drugs must be prepared and administered according to established policies and acceptable standards of practice. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records and facility policies, it was determined the ASC failed to ensure IV solutions were administered according to established policies and acceptable standards of practice. This affected the care for 20 of 20 patients (#1 - #20), whose records were reviewed. This resulted in a lack of direction for nurses by the Medical Staff. Findings include: 1. The records of 20 patients (#1 - #20) contained the statement, "DOCTOR'S ORDERS. IV fluids (500 ml or 100 ML): D5LR, Normal Saline, D5NS or Lactated Ringers at TKO." These are all IV solutions containing different doses of electrolytes and/or glucose. The different solutions can impact patients with different diagnoses in various ways. Since the physician did not specify which solution to administer, it was up to the registered nurse to choose. Idaho Board of Nursing administrative rules, IDAPA 23.01, states Licensed Professional Nurses (RNs) administer medications and treatments prescribed by legally authorized persons. Those legally authorized persons are physicians and Advance Practice Nurses, such as	Q 181		

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Q 181	Continued From page 6 Nurse Practitioners and Registered Nurse Anesthetists. Choosing which IV solution to administer is beyond the scope of practice for the RN. The ASC did not have a policy that addressed IV solution choice. The Clinical Director was interviewed on 8/28/18 beginning at 3:00 PM. She stated the medical records did not include specific orders for IV solutions. She also stated the ASC did not have policies that addressed IV solution selection. The ASC did not provide direction to nurses regarding IV solutions through orders and policies. 2. Patient #16 was a 68 year old female admitted on 7/03/18 for an EGD. Her record stated she had stage 4 chronic kidney disease. Patient #16's record included a "GI Pre-call Note" dated 6/26/18, signed by an LPN. The note stated, "use NS [Normal Saline IV fluid] pt has stage 4 kidney disease." Patient #16's record included a "GI MD Pre-evaluation Note" signed by the physician on 7/03/18 at 3:13 PM. The note stated, "use NS pt has stage 4 kidney disease." Additionally, it stated, "DOCTOR'S ORDERS IV fluids (500 mL or 1000 mL): D5LR, Normal Saline, D5NS or Lactated Ringers at TKO." It was unclear what IV fluids Patient #16 should receive. Patient #16's record stated an IV of D5LR was started at 3:15 PM. There was no documentation her physician was contacted to determine what IV	Q 181	After discussion at the Quality Improvement meeting the IV policy was revised to specify the specific solution to be used for all patients. Nursing and physicians will have education on the IV policy update at their respective meetings on 09/19/2018. The IV policy was revised by the Quality Improvement committee to instruct nursing to administer normal saline for patients with renal disease. This policy will be reviewed with nursing and physcians at their meetings scheduled on 09/19/18.	9/19/18 9/19/18

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Q 181	Continued From page 7 fluids she should receive. During an interview on 8/27/18 at 1:37 PM, the RN who started Patient #16's IV reviewed her record and stated she did not remember her. She confirmed the pre-evaluation note stated she should receive NS IV fluids due to her kidney disease. She confirmed Patient #16's record stated she received D5LR. The RN stated normally a patient with kidney disease was given NS IV fluids but this was not written in a policy. She stated she did not remember if Patient #16's physician was consulted regarding IV fluids, but stated the physician is not usually involved in determining what fluids should be infused. Patient #16 was given IV fluids that may have been contraindicated without a physician order.	Q 181		
Q 184	VERBAL ORDERS CFR(s): 416.48(a)(3) Orders given orally for drugs and biologicals must be followed by a written order signed by the prescribing physician. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records, it was determined the ASC failed to ensure verbal orders for drugs and biologicals were followed by a written order for 2 of 20 patients (#6 and #8) whose records were reviewed. This resulted in a lack of accountability for the verbal orders. Findings include: 1. Patient #6 was a 71 year old female who presented for a colonoscopy on 6/28/18 at 11:49	Q 184	The procedure for verbal orders will be reviewed with nursing and physicians at the staff meetings scheduled for 09/19/2018. The clinical director will review with nursing that orders suggested by the paramedics will be discussed with the MD and documented as a verbal order from the MD. The medical director will review this procedure with the MD.	9/19/18

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Q 184	Continued From page 8 AM. A Procedure log note by the RN, at 12:53 PM on 6/26/18, stated Patient #6 was given "...oral glucose 15" after being seen by a physician. No order for this was documented. Another log note at 1:25 PM stated, "non emergent transport ordered to give [Aspirin] x3 at this time" and said the medication was given (by the ASC nurse). The note did not define non emergent transport or specifically say who gave the order. No orders for the glucose or the Aspirin were documented. The nurse who gave Patient #6 the Aspirin was interviewed on 8/24/18 beginning at 3:24 PM. She stated there were no written orders for the glucose and Aspirin. The ASC did not include written confirmation of verbal orders for Patient #6. 2. Patient #8 was a 41 year old male admitted on 8/16/18 for an EGD. a. Patient #8's record documented IV medications given during his procedure, including Versed and Propofol. His record did not include a physician's order for the medications. b. Patient #8's record included a verbal order from his physician stating, "Give 8 mg Zofran IV now. The order was signed by the RN. The order did not include the time it was received by the RN. Patient #8's record was not signed by his physician as of 8/27/18, 11 days after his procedure.	Q 184	see above The clinical director will provide education for nursing on correct documentation of all verbals orders to include a time stamp. Education will occur on September 19, 2018 at the staff meeting. Additionally, a content change will be submitted to the EHR vendor to add a preprocedure and post procedure tab to allow better documentation of medications given throughout these phases of care. This will be reviewed at the staff meeting on 9/19/2018	9/19/18 content change vendor de-pendent

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Q 184	Continued From page 9 During an interview on 8/24/18 at 2:35 PM, the Director stated that during a procedure, medications are administered by the RN per the physician's verbal order. The medications administered are documented in the EMR by the RN. The physician electronically signs the patient's record after the procedure is completed, and that is the physician signature for the verbal orders taken by the RN during the procedure. During an interview on 8/27/18 at 10:05 AM, the RN who took the verbal order for Zofran reviewed Patient #8's record and confirmed it did not include the time the order was taken. She confirmed Patient #8's record was not signed by his physician. The ASC failed to ensure verbal orders included the time received, and were signed by the physician as soon as possible after the order was given.	Q 184	The medical records policy was reviewed by the Quality Improvement committee. The policy has been changed to require that verbal orders are signed within 24 hours after the order is given. All verbal orders to be time stamped as to when the order is received. The policy change will be reviewed with nursing at the staff meeting on 9/19/18 by the clinical director and with the physicians by the medical director. The charge nurse will audit 10 charts per month to verify if verbal orders have been documented appropriately and follow up with education to staff and notification to the clinical director.	9/19/18
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 observations, policy review, and staff interview, it was determined the ASC failed to ensure a sanitary environment for patients receiving care at the facility. This directly impacted 1 of 2 patients (Patient #19) whose care was observed and had the potential to impact all patients receiving services at the ASC. This	Q 241		

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Q 241	Continued From page 10 resulted in patients being placed at an increased risk for infections. Findings include: 1. The CDC "Guidelines for Hand Hygiene in Health-Care Settings," dated 10/25/02, was reviewed. According to the guidelines, hand washing is recommended when hands are visibly soiled. Otherwise, hand hygiene, either hand washing or decontamination with an alcohol-based hand sanitizer, is recommended including when: hands are not visibly soiled, before direct contact with patients, after contact with patient's intact skin, when moving from a contaminated body site to clean body site, after contact with inanimate objects in the immediate vicinity of the patients, and after removing gloves. 2. An ASC policy "STANDARD PRECAUTIONS FOR ALL PATIENT CARE," dated 1/18/18, stated "Wash hands before and after patient contact." Staff did not follow professional standards of practice as follows: Patient #19 was a 24-year-old female admitted on 8/24/18 for an EGD. Patient #19's care was observed on 8/24/18, beginning at 7:45 AM. During the observation, an RN entered Patient #19's pre-op room in response to her activating her call light. The RN pulled back Patient #19's privacy curtain, touched her bed rail, reset her call light, handled her chart, and retouched her privacy curtain. The RN exited Patient #19's room, touched a desk and papers at the nurse's station, touched a different bed rail, linens, and clean gown in an unoccupied room. The RN did not perform hand hygiene before or after these observed events.	Q 241	The infection control nurse will provide an educational inservice on handwashing the morning of 9/19/2018. She will review the handwashing policy/procedure with nursing staff, scope techs and medical assistants. The inservice will include a review of the patient and environmental encounters that require the use of hand sanitizer or handwashing.	9/19/18

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MERIDIAN ENDOSCOPY CENTER	2235 E GALA STREET MERIDIAN, ID 83642

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Q 241	Continued From page 11 Patient #19's procedure was observed from 9:00 AM to 9:25 AM. During the procedure, surveyors observed lapses in hand hygiene by the RN who was assisting the physician. Examples include: a. The RN placed an oxygen cannula in Patient #19 nostrils with bare hands. She then used the keyboard in the procedure room to document without performing hand hygiene. b. The RN prepared syringes of medication for the procedure, returned to the patient and repositioned the gurney, then returned to the counter and prepared additional syringes of medication without performing hand hygiene. c. The RN repositioned Patient #19 on the gurney and administered medication with bare hands. She placed a bite block in Patient #19's mouth then used the keyboard in the procedure room to document, without performing hand hygiene. d. The RN donned gloves before the physician started the procedure. She did not perform hand hygiene prior to donning gloves. During an interview on 8/27/18 beginning at 1:30 PM, the Infection Control Officer stated the facility followed CDC guidelines for hand hygiene. She confirmed the RN did not perform hand hygiene as required by CDC guidelines. The RN failed to perform hand hygiene per professional standards of practice resulting in the potential to increase infection risk for all patient treated at the ASC.	Q 241	The infection control nurse will provide an educational inservice on handwashing the morning of 9/19/2018. She will review the handwashing policy/procedure with nursing staff, scope techs and medical assistants. The inservice will include a review of the patient and environmental encounters that require the use of hand sanitizer or handwashing. The infection control nurse will perform periodic observations of handwashing throughout the patient care process and provide feedback to staff as appropriate. The infection control nurse will provide feedback to the Quality Improvment committee.	9/19/18

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Q 262	Continued From page 12	Q 262		
Q 262	PRE-SURGICAL ASSESSMENT CFR(s): 416.52(a)(2) Upon admission, each patient must have a pre-surgical assessment completed by a physician or other qualified practitioner in accordance with applicable State health and safety laws, standards of practice, and ASC policy that includes, at a minimum, an updated medical record entry documenting an examination for any changes in the patient's condition since completion of the most recently documented medical history and physical assessment, including documentation of any allergies to drugs and biologicals. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records, it was determined the ASC failed to ensure a complete and accurate pre-surgical assessment was completed for 2 of 20 patients (#13 and #20), whose records were reviewed. The lack of information interfered with the ability of the ASC to make health care decisions regarding patients. Findings include: 1. Patient #13 was a 64 year old female who had a colonoscopy and EGD performed on 8/02/18. Patient #13's "HEALTH HISTORY," dated 8/02/18 but not timed, stated she had a history of abnormal cardiac rhythm, myocardial infarction (heart attack), and had a stent placed in her heart. Patient #13's "Pre-Anesthesia Assessment," dated 8/02/18 but not timed, stated she was an "ASA Grade Assessment I - A normal, healthy	Q 262		

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Q 262	Continued From page 13 patient." This was not accurate. The Acting Medical Director was interviewed on 8/27/18 beginning at 11:00 AM. He stated the ASA classification system was used to determine whether patients were safe to undergo their procedures at the ASC or whether the procedures should be done in a hospital. He reviewed Patient #13's medical record. He stated her ASA classification was not accurate. Patient #13's pre-procedure assessment was not accurate. 2. Patient #20 was a 58 year old male who had a colonoscopy performed on 7/16/18. Patient #20's "HEALTH HISTORY," dated 7/16/18 but not timed, stated he had a history of bowel resection. A history of bowel resection could affect the decision to perform colonoscopy in the ASC. Patient #20's pre-procedure assessment by the physician did not mention the bowel resection. The Assistant Clinical Director was interviewed on 8/27/18 at 2:10 PM. She reviewed Patient #20's medical record and stated the history of bowel resection was not addressed. Patient #13's pre-procedure assessment was not complete.	Q 262	The physicians on the Quality Improvement committee reviewed the documentation of the medical history and the ASA scoring. The medical director will review with the physicians the ASA scoring criteria and the importance of incorporating the patients medical history in the score. Education will occur on September 19, 2018.	9/19/18
Q 264	POST-SURGICAL ASSESSMENT CFR(s): 416.52(b) (1) The patient's post-surgical condition must be assessed and documented in the medical record by a physician, other qualified practitioner, or a	Q 264		

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Q 264	Continued From page 14 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 the post-surgical condition of 3 of 20 patients (#8, #14, and #16), whose records were reviewed, was assessed and/or addressed by a physician, other qualified practitioner, or an RN. The lack of a post-surgical assessment had the potential to result in undiagnosed complications. Findings include: The facility's policy, "POST PROCEDURE DISCHARGE POLICY AND CRITERIA," revised June 2017, stated "The following will be a policy for discharge criteria: A monitoring/discharge scoring system (0-10) will be used to assesses the patient's condition. Vital signs and assessments will be made every 5 minutes for 15 minutes. After 15 minutes patient may be discharged with a discharge score of 9 or 10...Patients will not be discharged with a score of 8 or less unless approved by a physician." The policy stated the scoring system included a score of 0, 1, or 2 for each of 5 areas - activity, respiratory, circulatory, level of consciousness, and color. 1. Patient #14 was a 62 year old female admitted on 8/13/18 at 10:13 AM for a colonoscopy. She was discharged at 11:05 AM.	Q 264		

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Q 264	Continued From page 15 Patient #14's record stated she was taken to the procedure room at 10:35 AM, to recovery at 11:05 AM, and discharged at 11:40 AM. Her record included 2 assessments of the 5 areas noted above, with a score of 10 at 10:30 AM, and a score of 8 at 11:50 AM, when she was taken to recovery. No additional score was documented prior to her discharge at 11:05 AM. During an interview on 8/27/18 at 3:00 PM, the Assistant Director reviewed Patient #14's record and confirmed that it did not include an assessment with a score of 9 or 10 to determine she met criteria for discharge. Patient #14's status was not assessed to determine she met discharge criteria. 2. Patient #8 was a 41 year old male admitted on 8/16/18 at 1:26 PM for an EGD. He was discharged at 2:43 PM. Patient #8's record stated his BP was 108/63 at the time of admission. The last BP documented was 135/110 at 2:22 PM. No additional BP was documented prior to his discharge at 2:43 PM. There was no documentation his physician was notified of his elevated BP. His record did not state his elevated BP was addressed prior to his discharge from the ASC. During an interview on 8/27/18 at 10:05 AM, the discharging RN reviewed Patient #8's record and confirmed his BP was significantly higher than his baseline BP at admission. She stated he experienced pain after his procedure and that caused his elevated BP. The RN stated his pain level improved and she should have checked his	Q 264	The discharge policy to include the discharge criteria will be reviewed with nursing staff. The importance of clear, complete and concise documentation will be emphasized. Education to include documentation of the patient instructions upon discharge regarding BP elevations and any discussions held with the MD regarding the patients condition. Discussion to include documentation of notification of the md of vital sign abnormalities pre, during and post procedure and any orders received. The review of the discharge criteria to include that an md must approve the discharge of any patient with a discharge score of eight or less.	9/19/18

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Q 264	Continued From page 16 BP again prior to discharge. She confirmed Patient #8's physician was not notified of his elevated BP. Patient #8's elevated BP was not addressed prior to his discharge from the ASC. 3. Patient #16 was a 68 year old female admitted on 7/03/18 for an EGD. She was discharged at 3:58 PM. Patient #16's record stated her BP was 140/97 at the time of admission. The last BP documented was 187/109 at 3:49 PM. There was no documentation her physician was notified of her elevated BP. Her record did not state her elevated BP was addressed prior to her discharge from the ASC. During an interview on 8/24/18 at 3:45 PM, the discharging RN reviewed Patient #16's record. She stated her BP was high upon admission and may have been due to anxiety. She confirmed it was higher at the time of discharge. The RN confirmed Patient #16's elevated BP was not addressed prior to her discharge. Patient #16's elevated BP was not addressed prior to her discharge from the ASC.	Q 264	see above RECEIVED SEP 10 2018 FACILITY STANDARDS	