IDAHO DEPARTMENT OF
HEALTH & WELFARE

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RUSSELL S. BARRON– Director

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BUREAU OF FACILITY STANDARDS
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December 28, 2018

Tracy McGeorge, Administrator
Southwest Idaho Surgery Center
900 North Liberty Street, Suite 400
Boise, ID 83704

RE: Southwest Idaho Surgery Center, Provider #13C0001021

Dear Ms. McGeorge:

This is to advise you of the findings of the Medicare survey of Southwest Idaho Surgery Center, which was conducted on December 13, 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 **January 8, 2019,** 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
	13C0001021	A. BUILDING _____ B. WING _____	12/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST IDAHO SURGERY CENTER	900 NORTH LIBERTY STREET, SUITE 400 BOISE, ID 83704

(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 Medicare recertification survey of your facility conducted on 12/11/18 to 12/13/18. Surveyors conducting the recertification survey were: Brian Osborn, RN, HFS - Team Leader Gary Guiles, RN, HFS Acronyms used in this report include: F - Fahrenheit H&P - History and Physical oz - ounce RN - Registered Nurse SP - Sterile Processing	Q 000		
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	Q 162	SEE ATTACHED	

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

Tracy J Mee | Administrator | 1/3/18

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 informed patient consent. (8) Discharge diagnosis. This STANDARD is not met as evidenced by: Based on medical record review and staff interview, it was determined the facility failed to ensure medical records were complete for 3 of 21 patients (#4, #11, and #17) whose records were reviewed. This resulted in lack of documentation clarity and had the potential to impact understanding of the actual course of patient care. Findings include: 1. Patient #11 was a 12 year old male who was admitted to the facility on 11/02/18, for a tonsillectomy and adenoidectomy. Patient #11's medical record included post-anesthesia standing orders, dated 11/02/18, signed by the anesthesia provider, and noted by an RN. The order form had 18 sections, each with multiple subsections of various standing orders ranging from oxygen administration, to pain management, to discharge criteria. However, the check boxes for these selections were blank. It was unclear what was ordered for Patient #11 and why the order was noted by the RN. The Surgery Center Manager was interviewed on 12/13/18, beginning at 9:52 AM, and Patient #11's medical record was reviewed in her presence. She confirmed the post-anesthesia order was blank and stated her expectation was for the order sheet to be filled out correctly. Patient #11's medical record was not complete. 2. Patient #17 was a 52 year old female who was admitted to the facility on 7/11/17, for a left	Q 162	SEE ATTACHED SEE ATTACHED	

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Q 162	Continued From page 2 paotidectomy. Patient #17's medical record included post-anesthesia standing orders, dated 7/11/17, signed by the anesthesia provider, and noted by an RN. The order form had 18 sections, each with multiple subsections of various standing orders ranging from oxygen administration, to pain management, to discharge criteria. However, the check boxes for these selections were blank. It was unclear what was ordered for Patient #17 and why the order was noted by the RN. The Surgery Center Manager was interviewed on 12/13/18, beginning at 9:52 AM, and Patient #17's medical record was reviewed in her presence. She confirmed the post-anesthesia order was blank and stated her expectation was for the order sheet to be filled out correctly. Patient #17's medical record was not complete. 3. Patient #4 was a 17 year old male who had surgery to reduce a fractured nose on 3/16/18. The progress note by the recovery room nurse, dated 3/16/18 at 4:50 PM, stated Patient #4 coughed his airway out. The note stated he was then unresponsive and biting his teeth together while coughing. The note stated the physician was summoned to the bedside. The note stated the physician gave Patient #4 Narcan, a medication to treat narcotic overdoses, at 4:55 PM. Patient #4 recovered and was discharged at 5:51 PM. Patient #4's physician examined and treated him, but the physician did not document his	Q 162	SEE ATTACHED	

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Q 162	Continued From page 3 examination, findings, and actions taken. The Surgery Center Manager was interviewed on 12/13/18 at 9:00 AM. She stated there was no note by Patient #4's physician, regarding his treatment of and administration of Narcan. Patient #4's physician failed to document treatment of Patient #4.	Q 162		
Q 222	NOTICE OF RIGHTS - POSTING CFR(s): 416.50(a)(1)(i) (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, patient rights information review, and staff interview, it was determined the facility failed to ensure the posted notice of rights included the name, address, and telephone number of a representative in the State Agency to whom patients could report complaints. This had the potential to interfere with the ability of patients or their surrogates to file a verbal complaint with the State Agency. Findings include: An observation of the facility's waiting room was conducted in the presence of the Receptionist on 12/12/18, beginning at 8:30 AM. The facility had	Q 222	SEE ATTACHED	

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Q 222	Continued From page 4 a posted notice of patient rights, however, the patients rights did not include the name, address, or phone number of the State Agency to whom patients could report complaints. The Surgery Center Manager was interviewed on 12/12/18, beginning at 9:10 AM. She confirmed the posted notice of patients rights did not include the name, address, or phone number of the State Agency. The facility's posted patient rights information did not include the name, address, or phone number of the State Agency.	Q 222		
Q 225	SUBMISSION AND INVESTIGATION OF GRIEVANCES CFR(s): 416.50(d)(4),(5), & (6) 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	Q 225	SEE ATTACHED	

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Q 225	Continued From page 5 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 grievance process was completed. This STANDARD is not met as evidenced by: Based on facility policy review, grievance documentation review, and staff interview, it was determined facility policy did not address all of the requirements for a grievance procedure and failed to ensure grievance documentation was maintained. This resulted in an incomplete grievance process and a lack of clarity as to whether patient complaints and grievances were addressed in accordance with requirements and had the potential to impact all patients and their surrogates. Findings include: A facility policy "SUBMISSION AND INVESTIGATION OF GRIEVANCE," revised 7/2017, stated "Upon completion of the investigation a written response to the complaint/grievance will be prepared...The written decision from the Administrator will be sent to the patient within 15 business days of the received complaint. This will include the name of the contact person at the Center, the steps taken to investigate the grievance, the results of the grievance process, and the date the grievance process was completed." This policy was not followed. The facility grievance/complaint log was requested from the Surgery Center Manager on 12/11/18, at 9:00 AM. One patient grievance, dated 2/22/17, was provided. The grievance had attached information regarding the steps the facility took to investigate the patient's concerns. However, the grievance did not have a written resolution to the patient. It could not be	Q 225		

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Q 225	Continued From page 6 determined if the facility responded to the patient's concerns and in what timeframe. The Surgery Center Manager was interviewed on 12/12/18, beginning at 9:10 AM, and the provided grievance was reviewed in her presence. She confirmed the facility did not provide a written resolution letter to the patient. The facility did not provide patients with written notices of its grievance decisions.	Q 225		
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, review of manufacturers instructions-for-use, and staff interview it was determined the facility failed to maintain a functional and sanitary environment for reprocessing and disinfection of surgical instruments. This had the potential to impact all patients receiving services at the facility and placed patients at an increased risk for infections to occur. Findings include: McKesson enzymatic cleaner manufacturers instructions-for-use stated: - "Use 1/2 to 1 oz per gallon of water or more" - "Optimum temperature [water] 68 - 122 degrees F"	Q 241	SEE ATTACHED	

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Q 241	Continued From page 7 - "Soak time of 2 minutes" These manufacturers instructions-for-use were not followed. An observation of the facility's reprocessing and sterilization room was conducted with the SP Tech on 12/12/18, beginning at 12:36 PM. The facility failed to maintain a sanitary environment. Examples include: 1. The SP Tech was observed to use McKesson enzymatic solution for initial decontamination of surgical instruments. He applied the enzymatic, 3 pumps, into a prefilled plastic basin; approximately 3/4 full of water. When asked what his ratio of enzymatic to water was, the SP Tech stated "3 pumps in 3/4 full container of water." When asked if the 3/4 of water placed into the plastic basin was 1 gallon, the SP Tech stated he did not know. Additionally, he stated he did not measure the water amount prior to adding the enzymatic solution. 2. During the observation, a device to monitor solution temperature was not seen. When asked if he monitored the enzymatic solution's temperature, the SP Tech stated no. 3. During the observation, the SP Tech submerged the surgical instruments into the enzymatic solution briefly, manually decontaminated the instruments, and rinsed them with water. When asked how long he soaked surgical instruments in the enzymatic solution prior to manual decontamination, the SP Tech stated "there's no real soak time."	Q 241	SEE ATTACHED SEE ATTACHED SEE ATTACHED	

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Q 241	Continued From page 8 The SP Tech and Surgery Center Manager were interviewed together on 12/12/18, beginning at 12:52 PM. They confirmed the McKesson enzymatic manufacturers instructions-for-use were not followed. The facility failed to ensure a sanitary environment for reprocessing and disinfection of surgical instruments.	Q 241		
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 facility failed to ensure changes in the patient's condition since completion of the most recently documented H&P was documented for 1 of 21 patients (Patient #16), whose records were reviewed. This had the potential to result in unrecognized patient needs and for patients to suffer complications from surgery and anesthesia. Findings include: Patient #16 was a 3 year old male who presented	Q 262	SEE ATTACHED	

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Q 262	Continued From page 9 to the facility for a tonsillectomy on 12/07/17. Patient #16's untimed operative note, dated 12/07/18, stated "...during induction [of anesthesia], the patient was noted to be markedly bronchospastic and there was some difficulty in maintaining his [oxygen] saturations. He was treated with Albuterol inhaler and finally stabilized without significant desaturations. However, it was felt it was not in the patient's best interest to proceed with tonsillectomy in this setting..." Patient #16's surgery was canceled, and he was discharged. Patient #16's "NURSING ADMISSION ASSESSMENT," dated 12/07/17 at 6:40 AM, stated his temperature was 101 degrees. The "PRE-OPERATIVE ANESTHESIA EVALUATION," dated 12/07/18 at 7:15 AM, listed Patient #16's vital signs and an evaluation for anesthesia. However, the anesthesiologist's evaluation did not mention the elevated temperature, nor did it state the type of infection the child had. Patient #16's H&P, dated 12/04/17, did not document vital signs, including a fever. The H&P stated the child was recovering from an ear infection and said he had been taking an antibiotic. The H&P stated the child had normal breath sounds. A stamp on the H&P, dated 12/07/17 but not timed, stated the H&P had been reviewed and there were no changes. The stamp was signed by the surgeon. Again, there was no mention of the child's fever and whether the surgeon felt it was safe to proceed with the surgery. Patient #16's surgeon reviewed the medical record on 12/12/18 at 9:05 AM. He stated there	Q 262	SEE ATTACHED	

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Q 262	Continued From page 10 was no documentation that he was aware of the child's elevated temperature and decided to proceed with the surgery anyway. Patient #16's anesthesiologist reviewed the medical record on 12/12/18 at 3:10 PM. He stated there was no documentation to show he considered the child's infection and decided to proceed with anesthesia anyway. The facility did not note changes in Patient #16's condition since his H&P and document that it was safe to proceed with his surgery.	Q 262	SEE ATTACHED	

SOUTHWEST IDAHO SURGERY CENTER
900 N. LIBERTY STE 450
BOISE, ID 83704

CCN#: 13C0001021

DATE OF SURVEY: 12/13/18

PLAN OF CORRECTION

Q 162 #1

- The updated "Pre-Printed Physician Orders" policy *(see attached)* has corrected the deficiency. Instruction and education will be provided to both nursing staff and physicians regarding policy update. Update includes "All pre-written orders shall contain the following information: #3. Specific orders marked appropriately from list options." The Post-Anesthesia Care Orders form was updated *(see attached)* to better support nursing staff and physicians' document according to policy and CMS guidelines.
- These actions will improve clarity regarding post-anesthesia care orders.
- Policy updates were reviewed with the executive director, [redacted], the administrator, [redacted], the director of anesthesia, [redacted], and the Director of Nursing, [redacted]. Approval for the policy change was granted.
- Instruction and education will be presented to physicians and staff January 3rd 2019, policy implementation to immediately follow.
- 416.47b guideline criteria added to quarterly chart review. "Medication boxes appropriately marked?" will be reviewed with 5 % of each physician's total case volume each quarter. Compliance with regulatory requirements will be reviewed quarterly in the Chart Review Quality Improvement project.
- [redacted], Director of Nursing is responsible for implementing the acceptable plan of correction.

NOTE: Patient #11 did not receive any Post Anesthesia Order medications. Thus, none of the medication boxes were marked in this instance. The reason why the order sheet was noted by the RN was because she noting the multiple other nursing care orders on the form directed by the signed physician. During the interview with the surgery center manager regarding patient #11's chart, it was made clear that no medications were administered in this instance, not requiring any boxes to be checked. It was also made clear that it was not the expectation of the physician or nursing staff to mark each box for each order they decided to carryout. All orders stated on the order form with the physician's signature were available based on nursing assessment and judgement. After discussion with governing body members, it was determined to change our practice in order to best uphold regulatory compliance standards and enhance clarity.

Q162 #2

- The updated "Pre-Printed Physician Orders" policy *(see attached)* has corrected the deficiency. Instruction and education will be provided to both nursing staff and physicians regarding policy update. Update includes "All pre-written orders shall contain the following information: #3. Specific orders marked appropriately from list options." The Post-Anesthesia Order form was updated *(see attached)* to better support nursing staff and physicians' document according to policy and CMS guidelines.
- These actions will improve clarity regarding post-anesthesia care orders.
- Policy updates were reviewed with the executive director, [redacted], the administrator, [redacted], the director of anesthesia, [redacted], and the Director of Nursing, [redacted]. Approval for the policy change was granted.
- Instruction and education will be presented to physicians and staff January 3rd 2019, policy implementation to immediately follow.
- 416.47b guideline criteria added to quarterly chart review. "Medication boxes appropriately marked?" will be reviewed with 5 % of each physician's total case volume each quarter. Compliance with regulatory requirements will be reviewed quarterly in the Chart Review Quality Improvement project.
- [redacted], Director of Nursing is responsible for implementing the acceptable plan of correction.

NOTE: Patient #17 did not receive any Post Anesthesia Order medications. Thus, none of the medication boxes were required to be marked in this instance. The RN noted the Post Anesthesia Order sheet because again, she was carrying out the multiple care orders denoted on the order sheet. During the interview with the surgery center manager regarding patient # 17's chart, it was again made clear that the reason the boxes were not checked was because no medications were administered, and it was not the expectation to do so. After discussion with governing body members, it was determined to change our practice in order to best uphold regulatory compliance standards and enhance clarity.

Q162 #3

- The updated "Post-Operative Evaluation and Documentation" policy *(see attached)* has corrected the deficiency. Instruction and education will be provided to both nursing staff and physicians regarding the policy update. Update includes "The Anesthesiologist is responsible for: Any post-operative complication documentation and any accompany care or treatments provided" statement. The Post-Operative Order form was also updated *(see attached)* to better support anesthesiologist's documentation according to policy and CMS guidelines.
- These actions will help guide our anesthesiologist to document properly, uphold policy, and improve upon patient safety.
- The policy update was reviewed with the executive director, Dr. [redacted], the administrator, [redacted], the director of anesthesia, Dr. [redacted], and the Director of Nursing, [redacted]. Approval for the policy change was granted.

- Instruction and education will be presented January 3rd 2019, policy implementation to immediately follow.
- 416.47b guideline criteria added to quarterly chart review. "Anesthesia discharge completed, including any complications if applicable?" question will be reviewed with 5 % of each physician's total case volume each quarter. Compliance with regulatory requirements will be reviewed quarterly in the Chart Review Quality Improvement project.
- [redacted], Director of Nursing is responsible for implementing the acceptable plan of correction.

Q222

- The regional contact information was removed and replaced with Idaho state agency contact information, correcting the deficiency. The following has been updated in the Patient Rights and Responsibilities posted in the waiting room as well as in the Patient Rights and Responsibilities policy *(see attached)*. "Idaho Department of Health and Welfare Bureau of Facility Standards Non-Long Term Care Co-Supervisor c/o Dennis Kelly RN PO Box 83720 Boise, ID 83702-0036 Phone: 208 334 6626 Option 4." Staff and physicians will be educated on updated contact information.
- Having the correct state agency contact information for complaints and comments posted in the waiting room meets the regulatory requirement.
- The policy update was reviewed with the executive director, Dr. [redacted], the administrator, [redacted], the director of anesthesia, Dr. [redacted], and the Director of Nursing, [redacted]. Approval for the policy change was granted.
- Updated contact information will be presented to staff and physicians January 3rd 2019, implementation to immediately follow. A new sign has been placed in the waiting room.
- The Director of Nursing will monitor CMS regulations and ensure compliance.
- [redacted], Director of Nursing is responsible for implementing the acceptable plan of correction.

Q225

- Southwest Idaho surgery center does have a "Submission and Investigation of a Grievance" policy, put into effect July of 2017 *(see attached)*. The grievance in question was dated 2/22/17, at that time a formal and substantial grievance policy was not in place at the surgery center. This deficiency was noted by the surgery center manager during the time of the grievance submission, thus the center began formulating a policy to ensure compliance. The grievance investigation did not include all required components due to the lack of policy in place. Due to the fact this subject has been brought to our attention, education and instruction will be provided to staff and physicians regarding our grievance policy. Please see attached current grievance policy and accompanying grievance form.
- Reviewing the policy with physicians and staff will encourage understanding and increase awareness.
- Policy was completed and put into effect in July of 2017. Policy will be reviewed on January 3rd 2019 with staff and physicians.

- The policy will be reviewed at the next annual governing body meeting as scheduled to ensure updates have been made to reflect compliance with the most recent regulatory guidelines.
- [redacted], Director of Nursing is responsible for implementing the acceptable plan of correction.

NOTE: During the surgery center manager interview regarding the grievance policy, it was made clear that at the time of the grievance submission, there was not a policy on place. However, a copy of our grievance policy taking effect as of July 2017, was offered.

Q241 #1

- The McKesson Enzymatic cleaner Instructions for use state to use ½ to 1 ounce of cleanser per one gallon of water for general purpose cleaning. Additional amounts may be required for hard-to-remove matter. Education and instruction will be provided to the SP (Sterile Processing) Tech regarding IFU measurements. "3 pumps" does in fact equal 1 ounce, but SP Tech should be able to correctly state ratios as written on IFU. Education and instruction will be provided to SP tech regarding water measurement. New tubs were recently purchased for SP sinks and "1 gallon" markers had yet to be drawn on the new bins. "¾ full" does in fact equal one gallon, but the SP tech should have been able to correctly state ratios. "1 Gallon" lines are now marked on the tubs to ensure measurement is correct. Signs are now posted above the sink area stating the appropriate mixture, "1 ounce (3 pumps) with 1 gallon of water."
- These actions will help guide our SP Tech in following IFU recommendations.
- Instruction and education will be provided to the SP Tech on January 3rd, implementation to immediately follow.
- SP surveillance questions regarding appropriate mixing were added to the survey. SP surveillance frequency was also increased from once annually to once quarterly in efforts to ensure compliance.
- [redacted], Director of Nursing is responsible for implementing the acceptable plan of correction.

Q241 # 2

- The McKesson Enzymatic cleaner Instructions for use state it is recommended to that these (Mckesson) products be used between 68F-122F. Weekly water temperatures are measured and documented in SP and throughout the center to ensure temperatures remain less than 120F at all times. During the interview, the SP Tech did indicate water temperature measurements were not taken at the time of water fill, but he did "feel it to make sure it is warm." Warm to the touch water would be greater than 68F, and since we routinely test our water temps to ensure they are not higher than 120, we are within the recommended water temperature range. We understand it is best practice to measure the water temperatures, ensuring the temperature is between 68-122F, thus we will implemented a policy change. Prior to the start of gross contamination removal and disinfection, water temperatures will be taken assessed. Education and instruction on the

new process will be provided to the SP Tech. Signs are posted above the sink area to ensure compliance, stating the 68-122F water temperature requirement.

- These actions will help guide our SP Tech in following IFU recommendations.
- Instruction and education will be provided to the SP Tech on January 3rd, implementation to immediately follow.
- SP surveillance questions regarding water temperatures were added to the survey. SP surveillance frequency was also increased from once annually to once quarterly in efforts to ensure compliance.
- [redacted], Director of Nursing is responsible for implementing the acceptable plan of correction.

Q241 #3

- The Mckesson Enzymatic cleanser instructions for use state it "will begin breaking down organic matter immediately." The 2 minute minimum soak time is a recommendation not a requirement. Moving forward we understand it is best practice to meet all requirements and recommendations, thus will institute a 2 minute minimum soak time per recommendation. Instruction and education will be provided to the SP Tech regarding gross debris removal of instruments. Signs are posted above sink area to ensure compliance, stating the accurate 2 minute soak time requirement.
- These actions will help guide our SP Tech in following IFU recommendations.
- Instruction and education will be provided to the SP Tech January 3rd, implementation to immediately follow.
- SP surveillance questions regarding water temperatures, appropriate mixing, and soak length were added to the survey. SP surveillance frequency was also increased from once annually to once quarterly in efforts to ensure compliance.
- [redacted], Director of Nursing is responsible for implementing the acceptable plan of correction.

Q262

- The updated "Pre-Anesthesia Care Requirements and Pre-Anesthesia Evaluation" policy *(see attached)* has corrected the deficiency. Update includes an added statement to the pre-anesthesia evaluation requirements "review of vital signs". Education and instruction regarding the importance of thorough and compete documentation will be provided to both physicians and nursing staff. Nursing staff and physicians will be made aware of the requirement to document all abnormal findings, and all communications made regarding abnormal findings. Patient #16's scenario will be presented in detail including non-compliant findings to nursing staff and physicians. Paper charting documents have been modified and revised to better accommodate compliance. Extra space has been added to organize notes, and explanation of complications or abnormal vital signs.
- These actions will help guide our anesthesiologist's, physicians, and nursing staff to document properly, uphold policy, and improve upon patient safety.

- The policy update was reviewed with the executive director, Dr. [redacted], the administrator, [redacted], the director of anesthesia, Dr. [redacted], and the Director of Nursing, [redacted]. Approval for the policy change was granted.
- Instruction and education will be provided to staff and physicians on January 3rd 2019. Expectation of compliance will immediately follow.
- 416.52(a) (2) guideline criteria added to quarterly chart review. "Are abnormal vital signs found day of surgery noted on H&P under changes?" will be reviewed with 5 % of each physician's total case volume each quarter. Compliance with regulatory requirements will be reviewed quarterly in the Chart Review Quality Improvement project.
- [redacted], Director of Nursing is responsible for implementing the acceptable plan of correction.