

COPY



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1686

January 19, 2012

Steven Farro, Administrator
Idaho Endoscopy Center
6259 West Emerald Street
Boise, ID 83704

RE: Idaho Endoscopy Center, Provider #13C0001010

Dear Mr. Farro:

This is to advise you of the findings of the Medicare complaint survey of Idaho Endoscopy Center, which was conducted on January 13, 2012.

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.

Steven Farro, Administrator
January 20, 2012
Page 2 of 2

After you have completed your Plan of Correction, return the original to this office by **February 1, 2012**, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,



GARY GUILLES
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

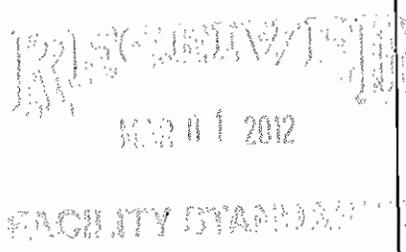
GG/srm
Enclosures

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

PRINTED: 01/18/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001010	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/13/2012
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NAME OF PROVIDER OR SUPPLIER IDAHO ENDOSCOPY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 9289 WEST EMERALD STREET BOISE, ID 83704
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(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)	(X6) COMPLETION DATE
Q 000	INITIAL COMMENTS The following deficiencies were cited during the complaint survey of your ASC. Surveyors conducting the investigation included: Gary Gulles, RN, HFS, Team Leader Karen Robertson, RN, BSN, HFS Acronyms used in this report include: ASC - ambulatory surgery center CT - computed tomography, a radiology procedure DON - Director of Nursing EGD - esophagoduodenoscopy, an examination of the esophagus, stomach, and small bowel with a small camera pm - as needed	Q 000		
Q 162	416.47(b) FORM AND CONTENT OF RECORD The ASC must maintain a medical record for each patient. Every record must be accurate, legible, and promptly completed. Medical records must include at least the following: (1) Patient identification. (2) Significant medical history and results of 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.	Q 162		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE	(X6) DATE 02.28.2012
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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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NAME OF PROVIDER OR SUPPLIER

IDAHO ENDOSCOPY CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

6260 WEST EMERALD STREET

BOISE, ID 83704

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Q 162	<p>Continued From page 1 (8) Discharge diagnosis.</p> <p>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 complete medical records were maintained, including physician progress notes, for 2 of 2 patients (#7 and #16) who had documented adverse events following procedures. This resulted in the lack of complete information regarding treatment of patients. Findings include:</p> <p>1. Patient #7's medical record documented a 59 year old male who had a colonoscopy performed on 8/04/11. Following the procedure, a "NURSING NOTES ADDENDUM," dated 8/04/11 at 8:33 AM, stated Patient #7 became pale, diaphoretic [sweaty], and unresponsive to sternal rubs. An incident report, dated 8/04/11 at 8:33 AM, stated a "Code" was called, indicating an emergency situation for Patient #7. Nursing notes documented the physician examined Patient #7 at 8:38 AM. Patient #7 responded to emergency treatment and was discharged home from the ASC at 10:15 AM on 8/04/11. A progress note by the physician who examined and treated Patient #7 was not documented.</p> <p>The physician who examined and treated Patient #7 was interviewed on 1/12/12 beginning at 3:50 PM. He stated he thought he had written a progress note. The DON searched for the missing progress note at 4:00 PM on 1/12/12 with the Health Information Manager. The DON stated the physician progress note could not be</p>	Q 162	<p>The Discharge, Safety and Transportation to Hospital policies, and the Incident Report form were updated to clearly identify physician responsibilities. The physician will be responsible to document the occurrence in his visit report or in an addendum to his visit report which will include the occurrence, plan of care, and transfer order. These policies and form were approved by the medical staff which includes all physicians on 1/31/2012.</p> <p>The incident report of the occurrence will include verification that physician documentation has occurred. The Quality Improvement Chairman will be informed immediately to monitor reporting compliance. The Quality Improvement Chairman keeps a log of all occurrence reports and monitors compliance on a weekly basis.</p>	

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NAME OF PROVIDER OR SUPPLIER

IDAHO ENDOSCOPY CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

6268 WEST EMERALD STREET
BOISE, ID 83704

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Q 162	Continued From page 2 found. The physician failed to document emergency care provided to Patient #7. 2. Patient #16's medical record documented an 81 year old female who had an endoscopy and colonoscopy performed on 3/22/11. Following the procedures, nursing notes documented Patient #16 was transferred to a local hospital from the ASC for evaluation of abdominal pain. A physician progress note at the time of the procedure was not documented. An addendum written by the physician was dated 8/04/11, over 4 months after the event. It stated, "Following the procedures, the patient had significant and accelerating abdominal pain with increased blood pressure. With concerns of possible complication, I elected to have the patient transferred to [a local hospital] by ambulance for CT scan of the abdomen and pelvis with subsequent admission for observation." The physician who wrote the addendum was interviewed on 1/12/12 beginning at 3:30 PM. He stated he had not written a progress note for Patient #16 at the time he had examined and treated the patient. He stated he had later written the addendum at the request of medical records personnel. The physician failed to document emergency care and transfer provided to Patient #16 in a timely manner.	Q 162		
Q 225	416.50(a)(3)(i), (v), (vi), (vii) SUBMISSION AND INVESTIGATION OF GRIEVANCES (i) The ASC must establish a grievance	Q 225		

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NAME OF PROVIDER OR SUPPLIER IDAHO ENDOSCOPY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8259 WEST EMERALD STREET BOISE, ID 83704
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Q 228	<p>Continued From page 3</p> <p>procedure for documenting the existence, submission, investigation, and disposition of a patient's written or verbal grievance to the ASC.</p> <p>(v) The grievance process must specify timeframes for review of the grievance and the provisions of a response.</p> <p>(vi) The ASC, in responding to the grievance, must investigate all grievances made by a patient or the patient's representative regarding treatment or care that is (or fails to be) furnished.</p> <p>(vii) The ASC must document how the grievance was addressed, as well as provide the patient with written notice of its decision. The decision must contain the name of an ASC contact person, the steps taken to investigate the grievance, the results of the grievance process, and the date the grievance process was completed.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of medical records, policies, and administrative documents, it was determined the ASC failed to ensure a comprehensive grievance process had been developed and implemented. This affected the rights of 2 of 2 patients (#1 and #6) who complained about patient care and it had the potential to impact the rights of all patients treated at the ASC. The lack of grievance processes resulted in the inability of the ASC to identify and respond to patient grievances. Findings include:</p> <p>1. The policy "PATIENT RIGHTS AND RESPONSIBILITIES," dated 5/13/09, stated patients had a right to express "complaints" and to ask questions about their care. The policy</p>	Q 225	<p>The Patient Rights and Responsibilities and Incident Report policies were both revised and clarified to differentiate between a complaint and a substantive complaint/grievance. The Quality Improvement Chairman will be informed of any substantive complaint or grievance immediately to monitor reporting compliance. These policies were approved by the medical staff which includes all physicians on 1/31/2012.</p> <p>A letter to the patient will be initiated within 10 working days of a substantive complaint/grievance which will include the steps taken to review the complaint and the results of the review. The Quality Improvement Chairman keeps a log of all occurrence reports and monitors compliance on a weekly basis.</p>	

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NAME OF PROVIDER OR SUPPLIER IDAHO ENDOSCOPY CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 0259 WEST EMERALD STREET 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 225	<p>Continued From page 4</p> <p>stated, "If a complaint is voiced, then initiate an incident report as per policy." The policy stated patients would receive responses to complaints, either in writing or verbally, which would be documented through the incident report. The policy did not mention the term grievance or define the term complaint. The policy did not require a written response to grievances.</p> <p>A document titled "PATIENT RIGHTS AND RESPONSIBILITIES," which was given to patients prior to their procedures, was included with the policy. It stated patients would "...have the opportunity to raise questions or voice complaints without compromising your future care...You and your representative have a right to file a complaint, in writing to: a. an ASC Manager..." The rights form did not state patients could file verbal complaints or define time frames and responses.</p> <p>The policy "INCIDENT REPORTS," dated 8/11/09, stated an incident report would be filled out "...following any incident involving a complaint, angry patient, adverse experience, or incident in the Company." The report stated incident reports would be used to report adverse experiences including "substantive patient grievances (i.e. patient care, scheduling, bills, etc)." The policy also stated, "Patient grievances documented in accordance with this policy will receive a written response." A specific definition of a grievance and a procedure to investigate the grievance, including time frames, were not present.</p> <p>The DON was interviewed on 1/12/12 beginning at 2:40 PM. She confirmed a specific policy,</p>	Q 225		

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NAME OF PROVIDER OR SUPPLIER IDAHO ENDOSCOPY CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 6258 WEST EMERALD STREET 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 225	<p>Continued From page 5</p> <p>which fully defined grievances and a procedure for how they would be investigated and responded to, had not been developed. She also stated the ASC performed 700 cases a month, but said no grievances had been filed in 2011 or 2012.</p> <p>Policies did not define grievances or a grievance process.</p> <p>2. Patient #1's medical record documented a 64 year old female who had an endoscopy on 11/21/11. An administrative report stated Patient #1 called the ASC on 11/28/11 and "expressed concerns" that she was discharged on a medication she was sensitive to, that she needed a wheelchair in the facility but was denied the use of one, and that she was concerned about how sedated she was following the procedure. The report did not state it was a grievance. The report stated the incident was investigated, but the report also stated the patient was not notified of the results of the investigation.</p> <p>The DON was interviewed on 1/12/12 beginning at 2:40 PM. She stated the complaints from Patient #1 were not treated as a grievance.</p> <p>The Clinic Nurse Manager was interviewed on 1/13/11 beginning at 3:10 PM. She stated she had spoken with Patient #1 about her complaint. She stated the complaint by Patient #1 should have been treated as a grievance.</p> <p>The ASC did not treat Patient #1's complaints as a grievance.</p> <p>3. Patient #6's medical record documented a 57</p>	Q 225		

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NAME OF PROVIDER OR SUPPLIER IDAHO ENDOSCOPY CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 6269 WEST EMERALD STREET 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 225	<p>Continued From page 8</p> <p>year old male who had an endoscopy with dilation of his esophagus on 9/15/11. A "TELEPHONE MESSAGE," dated 9/16/11, stated Patient #6 called the DON on 9/16/11 with "...concerns re: sedation during exam yesterday and concerns re: continued inability to swallow liquids, pain. Plan: refer to [the physician]." Another "TELEPHONE MESSAGE," dated 9/19/11, stated Patient #6 called back. It said "...Patient expressing his displeasure about not being sleepy enough during his EGD. Plan: patient to call prn." A third "TELEPHONE MESSAGE," dated 9/20/11, stated "reviewed. pt on narcotic and benzodiazepine. any future endoscopy should be with propofol and anesthesia."</p> <p>The DON was interviewed on 1/12/12 beginning at 2:40 PM. She stated the telephone messages were not treated as a grievance and an incident report was not generated from the complaint.</p> <p>The Clinic Nurse Manager was interviewed on 1/13/11 beginning at 3:10 PM. She stated she had spoken with Patient #6 about his complaint. She stated the complaint by Patient #6 should have been treated as a grievance.</p> <p>The ASC did not treat Patient #6's complaints as a grievance.</p>	Q 225		

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DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

January 20, 2012

Steven Farro, Administrator
Idaho Endoscopy Center
6259 West Emerald Street
Boise, ID 83704

Provider #13C0001010

Dear Mr. Farro:

On **January 13, 2012**, a complaint survey was conducted at Idaho Endoscopy Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00005230

Allegation #1: A patient's request to stop a procedure due to pain and lack of sedation was not honored,. This resulted in the patient needing to be physically restrained during the procedure.

Findings #1: An unannounced visit was made to the ambulatory surgery center (ASC) from 1/12/12 to 1/13/12. Observations were conducted. Staff and patients were interviewed. Sixteen medical records, administrative records, and ASC policies were reviewed.

Sixteen medical records were reviewed of patients who had procedures performed from March 2011 through December 2011. None of these records documented patients who experienced significant pain or difficulty with sedation during procedures. None of these patients documented the use of restraint during procedures.

For example, one medical record documented a 57 year old male who had endoscopy with dilation performed on 9/15/11. The procedure report, written by the physician on 9/15/11, stated the procedure was performed without complication. Nursing notes also did not mention problems with pain or the need for restraint. The documented patient's vital signs (blood pressure, pulse, respirations) did not significantly change during the procedure.

The physician and the registered nurse who participated in the endoscopy of the above patient were interviewed separately on 1/12/12. Both stated no complications of the procedure had occurred. Both stated restraint had not been used. The physician stated if a patient experienced significant discomfort during a procedure, the procedure would be stopped. The nurse stated the use of restraint was very unusual. She stated, to her knowledge, no restraint had been used during procedures in 2011.

Incident reports were reviewed for 2011. No incidents of extraordinary pain, the use of restraint during procedures, or problems achieving adequate sedation, were documented.

Two patients were observed during the pre-procedure process on 1/13/12. One was preparing for a colonoscopy and one was preparing for endoscopy. Physicians informed both patients that they would receive medication to make them comfortable. Neither physician told the patients they would be anesthetized for the procedures.

It could not be determined that the facility failed to provide appropriate care to patients who experienced complications during procedures. Therefore, the allegation was not substantiated.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: The ASC did not respond to patient grievances.

Findings #2: An unannounced visit was made to the ambulatory surgery center (ASC) from 1/12/12 to 1/13/12. Observations were conducted. Staff and patients were interviewed. Sixteen medical records, administrative records including grievances, and ASC policies were reviewed.

The policy "PATIENT RIGHTS AND RESPONSIBILITIES," dated 5/13/09, stated patients had a right to express "complaints" and to ask questions about their care. The policy stated, "If a complaint is voiced, then initiate an incident report as per policy." The policy stated patients would receive responses to complaints, either in writing or verbally, which would be documented through the incident report. The policy did not mention the term grievance or define the term complaint. The policy did not require a written response to grievances.

A document titled "PATIENT RIGHTS AND RESPONSIBILITIES," which was given to patients prior to their procedures, was included with the policy. It stated patients would "...have the opportunity to raise questions or voice complaints without compromising your future care... You and your representative have a right to file a complaint, in writing to: a. an ASC Manager..." The rights form did not state patients could file verbal complaints or define time frames and responses.

The policy "INCIDENT REPORTS," dated 8/11/09, stated an incident report would be filled out "...following any incident involving a complaint, angry patient, adverse experience, or incident in the Company." The report stated incident reports would be used to report adverse experiences including "substantive patient grievances (i.e. patient care, scheduling, bills, etc.)." The policy also stated, "Patient grievances documented in accordance with this policy will receive a written response." A specific definition of a grievance and a procedure to investigate the grievance, including time frames, were not present.

The DON was interviewed on 1/12/12 beginning at 2:40 PM. She stated the ASC performed 700 cases a month, but said no grievances had been filed in 2011 or 2012.

Two patient complaints that qualified as grievances were documented. One Patient's medical record documented a 64 year old female who had endoscopy on 11/21/11. An administrative report stated the patient called the ASC on 11/28/11 and "expressed concerns" that she was discharged on a medication she was sensitive to, that she needed a wheelchair in the facility but was denied the use of one, and that she was concerned about how sedated she was following the procedure. The report did not state it was a grievance. The report stated the incident was investigated but the report also stated the patient was not notified of the results of the investigation.

The DON was interviewed on 1/12/12 beginning at 2:40 PM. She stated the complaint was not treated as a grievance.

The Clinic Nurse Manager was interviewed on 1/13/11 beginning at 3:10 PM. She stated she had spoken with the patient about her complaint. She stated the complaint should have been treated as a grievance.

Another patient's medical record documented a 57 year old male who had an endoscopy with dilation of his esophagus on 9/15/11. A "TELEPHONE MESSAGE," dated 9/16/11, stated the patient called the Director of Nursing on 9/16/11 with "...concerns re: sedation during exam yesterday and concerns re: continued inability to swallow liquids, pain. Plan: refer to the physician." Another "TELEPHONE MESSAGE," dated 9/19/11, stated the patient called back. It said "...Patient expressing his displeasure about not being sleepy enough during his procedure. Plan: patient to call prn.(as needed)"

The Director of Nursing was interviewed on 1/12/12 beginning at 2:40 PM. She stated the telephone messages were not treated as a grievance.

The Clinic Nurse Manager was interviewed on 1/13/11 beginning at 3:10 PM. She stated she

Steven Farro, Administrator
January 20, 2012
Page 4 of 4

had spoken with the patient about his complaint. She stated the complaint by the patient should have been treated as a grievance.

The ASC's policies did not define complete and specific processes for patient grievances. In addition, two complaints that should have been treated as grievances were not investigated. Therefore, the allegation was substantiated and a deficiency was cited at 42 CFR Part 416.50(a,3) related to the lack of a complete grievance process.

Conclusion: Substantiated. Federal deficiencies related to the allegation are cited.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it was addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,



GARY GUILLES
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

GARY GUILLES/srm