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IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

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BUREAU OF FACILITY STANDARDS  
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**CERTIFIED MAIL: 7007 0710 0002 7979 0918**

January 28, 2011

David Orchard, Administrator  
Les Bois Surgery Center  
8950 W Emerald Street, Suite 168  
Boise, ID 83704

RE: Les Bois Surgery Center, Provider #13C0001036

Dear Mr. Orchard:

Based on the survey completed at Les Bois Surgery Center, on January 19, 2011, by our staff, we have determined Les Bois Surgery Center is out of compliance with the Medicare ASC Condition for Coverage on **Governing Body and Management (42 CFR 416.41)**, **Quality Assessment & Performance Improvement (42 CFR 416.43)**, **Medical Records (42 CFR 416.47)**, **Patient Rights (42 CFR 416.50)**, **Patient Admission, Assessment and Discharge (42 CFR 416.52)**. To participate as a provider of services in the Medicare Program, an ASC must meet all of the Conditions for Coverage established by the Secretary of Health and Human Services.

The deficiencies, which caused this condition to be unmet, substantially limit the capacity of Les Bois Surgery Center, to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567).

You have an opportunity to make corrections of those deficiencies, which led to the finding of non-compliance with the Condition for Coverage referenced above by submitting a written Credible Allegation of Compliance/Plan of Correction.

An acceptable Plan of Correction 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;

David Orchard, Administrator  
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- 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 each form.

**Such corrections must be achieved and compliance verified by this office, before March 5, 2011. To allow time for a revisit to verify corrections prior to that date, it is important that the completion dates on your Credible Allegation/Plan of Correction show compliance no later than February 25, 2011.**

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **February 10, 2011.**

Failure to correct the deficiencies and achieve compliance will result in our recommending that CMS terminate your approval to participate in the Medicare Program. If you fail to notify us, we will assume you have not corrected.

We urge you to begin correction immediately.

If you have any questions regarding this letter or the enclosed reports, please contact me at (208) 334-6626.

Sincerely,



GARY GULES  
Health Facility Surveyor  
Non-Long Term Care



NICOLE WISENOR  
Co-Supervisor  
Non-Long Term Care

GG/srm

Enclosures

cc: Debra Ransom, R.N., R.H.I.T., Bureau Chief  
Kate Mitchell, CMS Region X Office

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

PRINTED: 01/28/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13C0001036	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/19/2011
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NAME OF PROVIDER OR SUPPLIER  LES BOIS SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8950 W EMERALD STREET, SUITE 168 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)	(X5) COMPLETION DATE
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Q 000	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the recertification survey of your Ambulatory Surgical Center. The surveyors conducting the review were:</p> <p>Gary Guiles, RN, HFS, Team Leader Aimee Hastriter, RN, HFS Mark Grimes, Supervisor of Facility Fire Safety and Construction Program</p> <p>The following acronyms were used in this report:</p> <p>AOx3 = Alert and Oriented times 3 (person, place, time) ASC = Ambulatory Surgical Center BS = bowel sounds CV = cardiovascular HEENT = head, ears, eyes, nose, throat H&amp;P = History and Physical Examination Hg = mercury IV = intravenous lbs. = pounds min. = minute mm = millimeter MS = Mental Status NT = Non-tender OP = Operative Pulm = pulmonary QAPI = Quality Assessment and Performance Improvement RN = Registered Nurse VAS = Visual Analog Pain Scale</p>	Q 000	<p><b>RECEIVED</b> FEB 11 2011 <b>FACILITY STANDARDS</b></p>	
Q 040	<p><b>416.41 GOVERNING BODY AND MANAGEMENT</b></p> <p>The ASC must have a governing body that assumes full legal responsibility for determining, implementing, and monitoring policies governing</p>	Q 040		<p>Q40 This condition is not met based on the following standards being found deficient; (Q40-1) Q41 and (Q40-2) Q43. It is also evidenced by the deficiencies that were found for condition (Q40-3) Q80 and corresponding standards Q81, Q82 and Q84.</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Office Manager	(X6) DATE 2/10/11
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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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Q 040	<p>Continued From page 1</p> <p>the ASC's total operation. The governing body has oversight and accountability for the quality assessment and performance improvement program, ensures that facility policies and programs are administered so as to provide quality health care in a safe environment, and develops and maintains a disaster preparedness plan.</p> <p>This CONDITION is not met as evidenced by: Based on observation, staff interview and review of medical records, ASC policies, QAPI documents, Governing Board meeting minutes, and personnel files, it was determined the ASC's Governing Body failed to develop, implement, and monitor policies governing the ASC's total operation. This resulted in a lack of direction and oversight of the facility. Findings include:</p> <ol style="list-style-type: none"> <li>1. The Governing Body failed to ensure contracted nursing services were provided in a safe and effective manner by qualified persons. Refer to Q41 as it relates to the lack of qualified personnel.</li> <li>2. The Governing Body failed to ensure the governing body conducted an annual emergency preparedness drill and coordinate the written emergency preparedness plan with State and local authorities for all patients, staff and visitors. Refer to Q43 as it relates to the lack of drills and plans.</li> <li>3. The Governing Body failed to ensure a data driven QAPI program had been developed, implemented, and monitored. Refer to Q80 and related standard deficiencies as they relate to the lack of a comprehensive QAPI program.</li> </ol>	Q 040	<p>The condition (Q40-4) Q160 was also declared deficient due to the standards Q161 and Q162 not being met. The condition Q40 is not met due to the deficiencies found in standards (Q40-5,6) Q181 and Q184. The condition (Q40-7) Q220 was not met due to the standards Q221, Q222, Q223 and Q224. Finally, the condition (Q40-8) Q260 was not met because of deficiencies in standards Q261, Q262, Q264 and Q266. The aforementioned standards will be addressed next to their corresponding deficiency sections. Because the conditions are out of compliance due to the standard's deficiencies, the standards will be addressed for corrections and will in turn bring the conditions back in to compliance.</p>		

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Q 040	Continued From page 2  4. The Governing Body failed to ensure a complete, comprehensive, and accurate medical records system was maintained. Refer to Q160 and related standard deficiencies as they relate to the lack of a coherent medical records system.  5. The Governing Body failed to ensure drugs were provided in a safe and effective manner. Refer to Q181 as it relates to the lack of a system to administer conscious sedation medications in accordance with accepted standards of practice.  6. The Governing Body failed to ensure medications were provided in a safe and effective manner. Refer to Q181 as it relates to ASC's failure to ensure conscious sedation medications were provided in accordance with physician orders.  7. The Governing Body failed to ensure patients were provided information regarding their rights. Refer to Q220 and related standard level deficiencies as they relate to the lack of a system defining patient rights and the lack of a system to inform patients of those rights.  8. The Governing Body failed to ensure appropriate patient assessments were completed before and after procedures. Refer to Q260 and related standard level deficiencies as they relate to the lack of a system to assess patients.  The cumulative effect of these negative systemic practices seriously impeded the ASC's ability to provide quality care to patients.	Q 040		
Q 041	416.41(a) CONTRACT SERVICES	Q 041		

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Q 041	<p>Continued From page 3</p> <p>When services are provided through a contract with an outside resource, the ASC must assure that these services are provided in a safe and effective manner.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of medical records, contracts, and personnel information, it was determined the ASC failed to ensure contracted nursing services were provided in a safe and effective manner by qualified persons. This directly impacted the care of 6 of 6 patients (#10, #15, #16, #18, #19, and #23) who received care from contract nursing personnel and whose records were reviewed. This resulted in the inability of the ASC to ensure staff was competent to perform their assigned duties. Findings include:</p> <p>1. A contract between the ASC and a nurse staffing agency was dated 7/28/09. The contract stated the staffing agency would provide "qualified" temporary nursing personnel as needed. The contract did not specify what qualified meant or what documentation would be provided to the ASC to ensure temporary staff were qualified to perform the duties they were assigned.</p> <p>Medical records for 10/11/10 documented temporary nursing staff provided care for Patients #18 and #19. Medical records for 10/12/10 documented temporary nursing staff provided care for Patient #10. Medical records for 10/13/10 documented temporary nursing staff provided care for Patients #15, #16, and #23. This care included pre and post procedure care as well as assisting with pain intervention</p>	Q 041	<p><b>Q41 Action:</b> After reviewing the Q41 (Contract Services), an addendum to the current contract between the ASC and the temporary nursing staffing company (Progressive Nursing, LLC) will be added to ensure that contracted nursing services will be provided in a safe and effective manner by qualified persons. The contract will specify the documentation that will be provided to the ASC to ensure nurse's qualifications. Also, a list of qualifications for temporary nursing staff will be provided for the staffing company.</p> <p><b>Process improvement:</b> The new contract addendum will ensure that the credentials/ qualification of the temporary nursing staff can be verified by the ASC.</p> <p><b>Implementation Procedure:</b> A member of the ASC committee will contact Progressive Nursing, LLC, and request that an addendum or new contract be made. A copy of the new contract will be kept on file and the certifications of qualifications for the temporary nurses will also be kept for each nurse that works in the ASC.</p> <p><b>Completion Date:</b> February 25, 2011</p> <p><b>Monitoring and Tracking procedure:</b> The new temporary staffing contract will be shown to the Governing Body and placed on file for future reference. The administrator of the ASC will ensure that the certifications will be gathered before any temporary nursing staff begins work.</p>		

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Q 041	Continued From page 4 procedures, including administering conscious sedation medications.  A different temporary nurse provided care to patients on each of the 3 days from 10/11/10 through 10/13/10. Personnel information was not present for the temporary nurses who worked on those dates. The Administrator, interviewed on 1/13/11 beginning at 11:15 AM, stated the ASC did not have documentation of licensure or other qualifications for any of the 3 nurses who worked on those dates. He stated the nurse staffing agency contract promised qualified nurses and he accepted that. He said the ASC did not ask for or maintain information regarding the qualifications and training for temporary nurses.	Q 041	If the ASC uses a different agency in the future, similar requirements will be sought to ensure qualified nursing services and approved by the Governing Body  <u>Person Responsible:</u> David Orchard, MBA	
Q 043	416.41(c) DISASTER PREPAREDNESS PLAN  (1) The ASC must maintain a written disaster preparedness plan that provides for the emergency care of patients, staff and others in the facility in the event of fire, natural disaster, functional failure of equipment, or other unexpected events or circumstances that are likely to threaten the health and safety of those in the ASC. (2) The ASC coordinates the plan with State and local authorities, as appropriate. (3) The ASC conducts drills, at least annually, to test the plan's effectiveness. The ASC must complete a written evaluation of each drill and promptly implement any corrections to the plan.  This STANDARD is not met as evidenced by:	Q 043	Q43 <u>Action:</u> After reviewing Q43 findings the ASC will conduct an annual emergency preparedness drill. The ASC will contact a local authority at the Ada County Emergency Management Dept. Also a hazard vulnerability analysis will be conducted to identify potential dangers.  <u>Process improvement:</u> The coordination of planning with local authorities, hazard analysis and annual emergency preparedness drills will help to effectively deal with the care, health and safety of patients, staff and other individuals.  <u>Implementation Procedure:</u> The administrator for the ASC will contact a local authority and communicate with him/her the desire to coordinate emergency preparedness.	

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Q 043	<p>Continued From page 5</p> <p>Based on interview and record review, it was determined the facility failed to ensure the governing body conducted an annual emergency preparedness drill and coordinate the written emergency preparedness plan with State and local authorities for all patients, staff and visitors. This resulted in the potential for the facility's inability to effectively deal with the care, health and safety of patients, staff and other individuals when a major disruptive event occurred. Findings include:</p> <p>The facility's emergency preparedness plan, undated, was reviewed. This plan did not include documentation of a hazard vulnerability analysis or coordination with state and local authorities and there was no record of an emergency preparedness drill being conducted annually to test the plan's effectiveness. When asked about the plan, on 1/12/11 between 10:00 and 11:00 AM, the facility's Administrator acknowledged the lack of an annual drill and was unaware of the requirements for a hazard vulnerability analysis and coordination with State and local authorities.</p> <p>The facility failed to ensure the emergency preparedness plan addressed all hazards, was coordinated with State and local authorities, and that an emergency preparedness drill was conducted at least annually to test the plan's effectiveness.</p>	Q 043	<p>Anything that is gained from this communication with local authorities will be included in the Disaster Preparedness Policy. An annual drill will be conducted immediately upon completion and annually thereafter and employees will be trained at the time of their hire and on the day of the drill. A hazard analysis will be completed by the ASC committee and included as part of the emergency preparedness plan.</p> <p><b>Completion Date:</b> February 25, 2011</p> <p><b>Monitoring and tracking procedure:</b> The governing body will ensure that an annual emergency preparedness drill has been completed annually by verifying its completion with the drill log. Along with other drills that need to be completed monthly, quarterly or annually, etc. this drill will be placed on a calendaring system that the ASC will use to track their completion. The governing body will review the emergency preparedness plan and talk to a local authority annually.</p> <p><b>Person Responsible:</b> David Orchard, MBA</p>		
Q 080	<p>416.43 QUALITY ASSESSMENT &amp; PERFORMANCE IMPROVEMENT</p> <p>The ASC must develop, implement and maintain an on-going, data-driven quality assessment and performance improvement (QAPI) program.</p>	Q 080	<p>Q80 This condition is not met by the following standards being deficient: (Q80-1) Q81, (Q80-2) Q82 and (Q80-3) Q84. The individual standards will be addressed below and will help meet the conditions of Q80.</p>		

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Q 080	<p>Continued From page 6</p> <p>This <b>CONDITION</b> is not met as evidenced by: Based on staff interview and review of medical records, ASC policies, QAPI documents, incident reports, and Governing Board meeting minutes, it was determined the facility failed to ensure a data driven QAPI program had been developed, implemented, and monitored. This resulted in the inability of the ASC to evaluate its procedures and practices. Findings include:</p> <ol style="list-style-type: none"> <li>1. Refer to Q81 as it relates to the failure of the ASC to ensure the scope of the QAPI program provided sufficient direction to staff to demonstrate measurable improvement in patient health outcomes by using quality indicators and by the identification and reduction of medical errors.</li> <li>2. Refer to Q82 as it relates to the failure of the ASC to ensure the QAPI program incorporated quality indicator data to monitor the effectiveness and safety of its services and to identify opportunities to improve patient care.</li> <li>3. Refer to Q84 as it relates to the failure of the ASC to ensure the Governing Body monitored and maintained the QAPI program.</li> </ol> <p>The cumulative effect of these negative facility practices prevented the ASC from utilizing information to improve its processes.</p>	Q 080		
Q 081	<p>416.43(a), 416.43(c)(1) PROGRAM SCOPE; PROGRAM ACTIVITIES</p> <p>(a)(1) The program must include, but not be limited to, an ongoing program that demonstrates measurable improvement in patient health outcomes, and improves patient safety by using</p>	Q 081	<p>Q81 <b>Action:</b> After reviewing Q81 (a)(1) the ASC committee will determine what quality indicators (QI) will be monitored on an ongoing basis. These QI's will be measured by an assigned member of the staff and reviewed by the committee and submitted to the governing board.</p>	

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Q 081	<p>Continued From page 7</p> <p>quality indicators or performance measures associated with improved health outcomes and by the identification and reduction of medical errors.</p> <p>(a)(2) The ASC must measure, analyze, and track quality indicators, adverse patient events, infection control and other aspects of performance that includes care and services furnished in the ASC.</p> <p>(c)(1) The ASC must set priorities for its performance improvement activities that -</p> <ul style="list-style-type: none"> <li>(i) Focus on high risk, high volume, and problem-prone areas.</li> <li>(ii) Consider incidence, prevalence, and severity of problems in those areas.</li> <li>(iii) Affect health outcomes, patient safety, and quality of care.</li> </ul> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of medical records, ASC policies, incident reports, and QAPI documents, it was determined the facility failed to ensure the scope of the QAPI program provided sufficient direction to staff to demonstrate measurable improvement in patient health outcomes by utilizing quality indicators. The ASC also failed to investigate 2 of 2 adverse events (involving Patient #s 20 and 22). This resulted in performance measures that were insufficient to measure the quality of care provided to patients. Findings include:</p> <p>1. The policy "QUALITY IMPROVEMENT PROGRAM," not dated, outlined broad goals and objectives for the agency's QAPI program.</p>	Q 081	<p>The ASC committee will identify QI's based on high risk, high volume and problem-prone areas per the deficiencies found in Q81(a)(3). Of these QI's, the governing body will consider incidence, prevalence and severity of the problems in those areas and also the affected health outcomes, patient safety and quality of care. Per the deficiency found in Q81 (a)(2) the ASC will not only report incidents/adverse patient events that occur in the ASC, but they will be investigated by a member of the governing body. Any corrections that can be made to prevent similar incidents will be given by the governing body. The QAPI policy will be updated to indicate those changes.</p> <p><b>Process improvement:</b> The new QAPI policy will help ensure that the program will provide sufficient direction to staff for measuring improvement in patient health outcomes and identify reductions of medical errors.</p> <p><b>Implementation procedure:</b> The ASC committee will modify the current QAPI policy to be more comprehensive by including a list of high risk, high volume and problem prone areas for the ASC to monitor. They will decide on which QI's to track that is derived from that list. A staff member will be assigned to measure the data. The data will be analyzed and tracked by the committee and shown to the governing body for further direction and correction.</p>	

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Q 081	<p>Continued From page 8</p> <p>However, a comprehensive plan, including specific activities and quality indicators to be measured, had not been developed.</p> <p>The Administrator was interviewed on 1/13/11 at 3:30 PM. He stated a Performance Improvement Project related to low back injections had been completed in December 2010. He stated that, except for the project data, infection log data, and quality control checks on equipment, no quality indicators had been measured in 2010. He stated no new quality indicators had been implemented for 2011. He stated the ASC had not identified high risk, high volume, and problem-prone areas, in order to develop quality indicators based on those items.</p> <p>2. A process to investigate adverse events at the ASC had not been developed and implemented. One "Incident Report Form," dated 11/08/10, was documented in 2010. The report stated Patient #20 had nearly fallen in the parking lot following a procedure. The report gave an account of the incident but it did not describe an investigation into the causes of the event. The report also failed to document whether steps were taken to prevent similar incidents in the future.</p> <p>The Administrator was interviewed on 1/13/11 at 3:30 PM. He stated a policy describing how adverse events would be investigated had not been developed. He stated causes of the above incident were not investigated.</p> <p>3. Patient #22's medical record documented a 57 year old female who had a diagnosis of colon cancer and chronic pain syndrome. Her record stated she had an intercostal nerve block on 12/15/10. The "Interventional Pain Procedure"</p>	Q 081	<p>Part of reporting incidents/adverse patient events in the ASC will also include an investigation by the governing board, with corrections to help reduce similar events from occurring.</p> <p><b>Completion Date:</b> February 25, 2011</p> <p><b>Monitoring and tracking procedure:</b> The governing body will approve the changes to the QAPI policy. The governing body will review at least annually, the QI's that are being monitored for the ASC to ensure they are relevant and include high risk, high volume and problem-prone areas. The incident /adverse patient event reports will be collected and maintained in a log book for completion and investigation by the governing body.</p> <p><b>Person responsible:</b> David Orchard, MBA</p>	

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Q 081	<p>Continued From page 9</p> <p>note by the Physician, dated 12/21/10, stated "...In the recovery room, the patient had some sensitivity reaction and felt like she was short of breath. There was some question about her tongue swelling. I immediately was at the patient's bedside. She was given 25 mg of Benadryl, auscultated, sat up, and percussed. It appears that the patient had some type of obstruction from secretions, and with appropriate pulmonary toilet, dramatically improved. At one point, the patient was given 100% oxygen. IV fluids were given to hydrate the patient, and the crash cart was opened, but only Benadryl was used..." An incident report was not documented regarding this event.</p> <p>Patient #22's Physician was interviewed on 1/14/11 at 11:00 AM. He stated an incident report had not been generated for the 12/15/10 event. He said an investigation of the event, its causes, and the extent that facility policies were followed, had not occurred.</p> <p>The ASC failed to develop and implement a comprehensive QAPI plan including developing quality indicators and a process to investigate the causes of adverse events.</p>	Q 081		
Q 082	<p>416.43(b), 416.43(c)(2), 416.43(c)(3) PROGRAM DATA; PROGRAM ACTIVITIES</p> <p>(b)(1) The program must incorporate quality indicator data, including patient care and other relevant data regarding services furnished in the ASC.</p> <p>(b)(2) The ASC must use the data collected to - (i) Monitor the effectiveness and safety of its services, and quality of its care. (ii) Identify opportunities that could lead to</p>	Q 082	<p>Q82 <u>Action:</u> After reviewing Q82 findings the ASC will incorporate quality indicator data (QI) as part of the QAPI program (Q82 b1). The data will help monitor the effectiveness and safety of its services and to improve patient care (Q82 b2i,ii). The QAPI program will also track adverse patient events, examine their causes, implement improvements and ensure they are sustained over time (Q82 c2). The ASC staff will be educated on strategies for preventing adverse patient events (Q82 c3)</p>	

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Q 082	<p>Continued From page 10 improvements and changes in its patient care.</p> <p>(c)(2) Performance improvement activities must track adverse patient events, examine their causes, implement improvements, and ensure that improvements are sustained over time.</p> <p>(c)(3) The ASC must implement preventive strategies throughout the facility targeting adverse patient events and ensure that all staff are familiar with these strategies.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of ASC policies and QAPI documents, it was determined the facility failed to ensure the QAPI program incorporated quality indicator data, to monitor the effectiveness and safety of its services and to identify opportunities to improve patient care. This resulted in the ASC's inability to measure the quality of the care it provided for all patients receiving care at the facility. Findings include:</p> <p>1. The policy "QUALITY IMPROVEMENT PROGRAM," not dated, did not identify how data would be collected or utilized to improve patient care.</p> <p>The Administrator was interviewed on 1/13/11 at 3:30 PM. He stated a Performance Improvement Project related to low back injections had been completed in December 2010. He stated this data had been forwarded to the ASC's accrediting body for their analysis. He stated no other data had been gathered in 2010.</p> <p>Except for 1 project, the ASC had not gathered or analyzed data specific to the quality of care</p>	Q 082	<p><b>Process Improvement:</b> The addition of QI's that monitor adverse patient events as part of the QAPI program will help in measuring the quality of care that is provided at the ASC and help improve it.</p> <p><b>Implementation procedure:</b> The ASC committee will modify the current QAPI policy to include QI data. The QI data will include adverse patient events that will be analyzed, tracked, investigated and corrections will be made to prevent future events from occurring.</p> <p><b>Completion Date:</b> February 25, 2011</p> <p><b>Monitoring and tracking procedure:</b> The governing body will approve the changes to the QAPI program. The governing body will review at least annually, the QI's that are being monitored for the ASC to ensure they are relevant and include adverse patient events. The incident /adverse patient event reports will be collected and maintained in a log book for completion and investigation by the governing body.</p> <p><b>Person Responsible:</b> David Orchard, MBA</p>		

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Q 082 Q 084	Continued From page 11 provided to patients at the ASC. <b>416.43(e) GOVERNING BODY RESPONSIBILITIES</b>  The governing body must ensure that the QAPI program- (1) Is defined, implemented, and maintained by the ASC. (2) Addresses the ASC's priorities and that all improvements are evaluated for effectiveness. (3) Specifies data collection methods, frequency, and details. (4) Clearly establishes its expectations for safety. (5) Adequately allocates sufficient staff, time, information systems and training to implement the QAPI program.  This STANDARD is not met as evidenced by: Based on staff interview and review of ASC policies and Governing Body meeting minutes, it was determined the ASC's Governing Body failed to ensure the QAPI program was defined and implemented. This impeded the ASC's ability to monitor the quality of the services it provided for all patients receiving care at the facility. Findings include:  The policy "QUALITY IMPROVEMENT PROGRAM," not dated, outlined broad goals and objectives for the agency's QAPI program. However, a comprehensive plan, including specific activities and quality indicators to be measured, had not been developed. The policy did not define the role of the Governing Body, its duties, or the frequency that it would review quality data. The policy did not define the structure of persons tasked to implement the	Q 082 Q 084	<b>Q84 Action:</b> After reviewing Q84 the governing body will ensure that the QAPI program is defined, implemented and maintained. The governing body will ensure that the QAPI program will address the ASC priorities and that all improvements are evaluated for effectiveness. The governing body will be specific about what data is collected and how. The governing body will ensure that the QAPI program clearly establishes its expectation for safety and also allocates sufficient staff, time, information systems and training.  <b>Process improvement:</b> The governing body, through the QAPI program, will ensure that the quality of services provided at the ASC are monitored and improved.  <b>Implementation procedure:</b> The ASC committee will present to the governing body a more detailed QAPI program. The program will include specific activities and quality indicators, the role of the governing body and will designate a specific person for developing and maintaining it. The governing body will discuss these details at least annually in their meetings.  <b>Completion date:</b> February 25, 2011  <b>Monitoring and Tracking procedure:</b> The governing body will ensure that the QAPI program is addressed at least annually by requiring that it be included on their agenda at the first meeting of each new year.	

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Q 084	Continued From page 12 QAPI program, such as the appointment of a Quality Committee or Coordinator and their duties.  Two Governing Body meetings were documented in 2010. No meetings were documented in 2011. Minutes from a Governing Body meeting, dated 2/02/10, stated the ASC would participate in a study by its accrediting body on "low back injections." Governing Body meeting minutes, dated 9/14/10, stated the nurse had gathered information for the first half of the low back injection study and the accrediting body would release a report soon. No other entries related to the ASC's QAPI program were documented in Governing Body Meeting minutes.  The Administrator was interviewed on 1/13/11 at 3:30 PM. He confirmed the lack of documentation of oversight of the ASC's QAPI program. He stated the Governing Body had not defined who was responsible to develop and maintain the QAPI program.	Q 084	During that meeting the specifics of the QAPI program will be discussed and approved. Meeting minutes from each of the governing body meeting will be kept for review.  <u>Person Responsible:</u> David Orchard, MBA	
Q 160	The Governing Body failed to define, implement, and monitor the QAPI program. <b>416.47 MEDICAL RECORDS</b>  The ASC must maintain complete, comprehensive, and accurate medical records to ensure adequate patient care.  This CONDITION is not met as evidenced by: Based on observation, staff interview and review of medical records and facility policies, it was determined the ASC failed to ensure a complete, comprehensive, and accurate medical records system had been developed and implemented.	Q 160	Q160 This condition is not met by the following standards being found deficient: Q161 and Q162. The corrections for each of these standards are found below. The condition Q160 will be met as the standards are corrected for deficiencies and the ASC will ensure that care is justified and can	

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Q 160	Continued From page 13 This resulted in the potential for misinterpretation of information and had the potential to negatively impact the quality and safety of patient care. Findings include:  1. The ASC failed to develop a system for the proper collection of medical record information. Refer to Q161 as it relates to the lack of a system to gather and record patient information.  2. The ASC failed to ensure medical records were accurate and promptly completed. Refer to Q162 as it relates to inaccuracies in the medical record.  The cumulative effect of these negative systemic practices resulted in the inability of the ASC to justify care and to communicate the care that was provided to others.	Q 160		
Q 161	416.47(a) ORGANIZATION  The ASC must develop and maintain a system for the proper collection, storage, and use of patient records.  This STANDARD is not met as evidenced by: Based on observation, staff interview and review of medical records, it was determined the ASC failed to develop a system for the proper collection of medical record information. This incomplete system led to incomplete documentation for 4 of 4 patients (#2, #9, #12, and #22), whose medical records were reviewed specifically for systematic issues involving medical records. It also called into question the accuracy of all patients treated at the ASC. The lack of systems to document complete information resulted in the inability of the ASC to	Q 161	Q161 <b>Action:</b> After reviewing Q161( findings 1-7), a new paper charting system will be implemented to better document the patient work flow of the surgical center. This paper charting system will address the deficiencies found in each finding. The new system specifically will not allow for prefilled templates (1,7), will not allow for multiple versions of the same note to be printed (2), will divide the patient work flow to separate specific forms each with appropriate time and date stamp notations (3) instead of a larger super document will add appropriate nursing notes sections (4) as well as an adverse event log, and will allow appropriate identification of persons documenting specific work flow as well as timing of that documentation (5,6).	

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Q 161	<p>Continued From page 14</p> <p>ensure medical records were complete and accurate. Findings include:</p> <p>1. Nursing notes were written prior to events occurring.</p> <p>Patient #12 was observed from her arrival at 1:20 PM on 1/12/11 until she left the building at 2:15 PM that same day. The RN was observed to greet the patient at 1:23 PM and escort her to the pre-operative holding area. She obtained information from Patient #12 and garnered consent for a caudal epidural steroid injection. The physician examined Patient #12 at 1:25 PM. The RN was observed to complete her nursing notes on the "CONSCIOUS SEDATION FORM" at approximately 1:40 PM, including documenting post-procedure monitoring for the procedure which did not begin until 1:55 PM. Patient #12 was discharged at 2:15 PM.</p> <p>Following Patient #12's discharge, the RN was observed to change the discharge time on her original note to match the actual time. Patient #12's "CONSCIOUS SEDATION FORM," in a section labeled "POST-OP," contained items including "Patient able to tolerate food/fluids: Yes." and "Patient able to void: Yes." However, Patient #12 was not observed to void or eat or drink before leaving. The questions in the "POST-OP" section were completed prior to the start of the procedure. The time the notes were written was not documented.</p> <p>The RN who cared for Patient #12 was interviewed beginning at 2:20 PM on 1/12/11. She stated she routinely entered the post-operative information before the procedure and then changed it later if needed.</p>	Q 161	<p><b>Process improvement:</b> The new medical record system will allow us to more accurately reflect and more easily track specific components of the patient work flow through the surgical center.</p> <p><b>Implementation procedure:</b> The committee will design a new paper charting system consisting of a series of individual work documents to include patient's right and responsibilities, consent form, patient responsibilities, preoperative history and physical, IV and conscious sedation log including nursing notes and discharge criteria, and physician procedure document. The new form will be used in the ASC and staff will receive appropriate training and instruction.</p> <p><b>Completion date:</b> February 25, 2010</p> <p><b>Monitoring and tracking procedure:</b> A member of the ASC committee will review 2 random charts a week for a month after this change is implemented to make sure that the changes that are taking place will fulfill the requirements of this standard. Regular chart reviews will be established and approved by the governing board to guarantee ongoing compliance with this standard.</p> <p><b>Person Responsible:</b> Shane Maxwell D.O.</p>	

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Q 161	<p>Continued From page 15</p> <p>Nursing notes were written prior to events occurring.</p> <p>2. The medical record did not lock at the time progress notes were written. This allowed multiple versions of the same note to be printed.</p> <p>a. Patient #12 was observed from her arrival at 1:20 PM on 1/12/11 until she left the building at 2:15 PM that same day. The surveyor printed copies of her medical record at different times. Copy A of the "CONSCIOUS SEDATION FORM" was obtained at 1:45 PM on 1/12/11, prior to the procedure. Copy B of the same "CONSCIOUS SEDATION FORM" was obtained the following morning after the documentation was completed by the physician.</p> <p>Copy A documented Patient #12's physical examination, including:</p> <p>"Vitals: [blank] Weight: 240 lbs. VAS Pain Score is 6/10. Height 6 [feet] ASC: MS: AOx3 HEENT: normal CV: Regular Rate and Rhythm, no murmurs Pulm: normal Abdomen: Soft and NT, Normal BS Extremities: no edema or cyanosis... Plan: ...no sedation... PROCEDURE MONITORING... Patient able to tolerate food/fluids: Yes. Patient able to bear weight/ambulate safely: Yes. Patient able to void: Yes. Patient given follow up appointment/instructions: Yes. Patient discharged to the care of an adult: Yes. Self...</p>	Q 161		
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Q 161	<p>Continued From page 16</p> <p>Patient discharged to physician's office: No Patient discharged at: 1330. Attending Nurse Signature: (signature graphic present) Attending Doctor Signature: (signature graphic present)"</p> <p>Copy B documented Patient #12's physical examination, including:</p> <p>"Vitals BP: 133/69 mm HG. Pulse: 93 per min. Respiration: 16 breaths per min. Weight: 234 lbs. VAS Pain Score today is 4/10... HEENT: normal CV: Regular Rate and Rhythm, no murmurs Pulm: normal Abdomen: Soft and NT, Normal BS Extremities: no edema or cyanosis... Patient accepts the plan for conscious sedation: yes" [on observation, no sedation was used during the procedure] PROCEDURE MONITORING... Patient able to tolerate food/fluids: Yes. Patient able to bear weight/ambulate safely: Yes. Patient able to void: Yes. Patient given follow up appointment/instructions: Yes. Patient discharged to the care of an adult: Yes. Son... Patient discharged to physician's office: No Patient discharged at: 1415. Attending Nurse Signature: esig: [RN's name] Attending Doctor Signature (signature graphic present)" [This "CONSCIOUS SEDATION FORM" did not state it was closed]</p> <p>The 2 copies of the same form contained different</p>	Q 161		

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Q 161	<p>Continued From page 17</p> <p>information depending on when they were printed. Copy A contained the signature graphic of an RN who no longer worked at the ASC. Copy B contained a line that stated "esig:" followed by the name of the RN who cared for Patient #12.</p> <p>During an interview with Patient #12's Physician on 1/12/11 at 4:00 PM, he stated he did not document on her medical record until after the procedure had been completed at 2:05 PM on 1/12/11. He stated information could be changed on the forms until it was locked.</p> <p>The RN who cared for Patient #12 was interviewed beginning at 2:20 PM on 1/12/11. She stated she routinely entered the post-operative information before the procedure and then changed it later if needed. She stated she entered information that was likely rather than information she knew to be true. For example, she stated she documented patients were able to void after procedures based on the type of procedure rather than actual knowledge the patient could void. She stated the notes were not closed until the physician closed them so it was possible to alter the notes after they were written. She stated no record of the alteration would appear in the medical record.</p> <p>3. Physician and nursing notes were not finalized when they were written. Instead, they remained open which allowed staff to change the original documentation.</p> <p>Patient #22's medical record documented a 57 year old female who had a diagnosis of colon cancer and chronic pain syndrome. Her record stated she had an intercostal nerve block on 12/15/10. Her record stated she had a possible</p>	Q 161		
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Q 161	<p>Continued From page 18</p> <p>complication to the procedure. The "INTERVENTIONAL PAIN PROCEDURE" note and the "CONSCIOUS SEDATION FORM" both stated they were closed by the physician on 12/21/10, 6 days after the procedure was performed. Closing the record locked the information. The electronic medical record notes remained open until they were closed by the physician. This meant they could have been accessed by staff and the documentation could have been altered during the time before they were locked.</p> <p>Patient #22's physician was interviewed on 1/14/11 at 11:00 AM. He confirmed the documentation. He stated the "INTERVENTIONAL PAIN PROCEDURE" and the "CONSCIOUS SEDATION FORM" were not locked for 6 days because they had to be coded. He stated locking the notes finalized them and made them permanent.</p> <p>4. Nursing notes did not allow documentation of events due to constraints of the electronic medical record.</p> <p>Patient #22's medical record documented a 57 year old female who had a diagnosis of colon cancer and chronic pain syndrome. Her record stated she had an intercostal nerve block on 12/15/10. The "INTERVENTIONAL PAIN PROCEDURE" note by the physician, dated 12/21/10, stated "...In the recovery room, the patient had some sensitivity reaction and felt like she was short of breath. There was some question about her tongue swelling. I immediately was at the patient's bedside. She was given 25 mg of Benadryl, auscultated, sat up, and percussed. It appears that the patient had some</p>	Q 161		

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Q 161	<p>Continued From page 19</p> <p>type of obstruction from secretions, and with appropriate pulmonary toilet, dramatically improved. At one point, the patient was given 100% oxygen. IV fluids were given to hydrate the patient, and the crash cart was opened, but only Benadryl was used..."</p> <p>Patient #22's 12/15/10 "CONSCIOUS SEDATION FORM," where the RN documented, was closed on 12/21/10. The form documented Patient #22 was taken "To Surgery..." at 10:30 AM. This form contained the nursing notes. The time the procedure was started was not documented but the form stated Patient #22 was given conscious sedation medication at 12:00 noon and 12:15 PM. The form did not document events between 10:30 AM and 12:00 noon. The form stated Patient #22 was discharged at 12:45 PM. The events involving the sensitivity reaction described in the physician's "INTERVENTIONAL PAIN PROCEDURE" note were not documented in the nursing notes.</p> <p>The RN who cared for Patient #22 was interviewed beginning at 11:15 AM on 1/14/11. She stated the electronic medical record did not allow her to write narrative notes on the "CONSCIOUS SEDATION FORM." She stated the record did not have a place for the RN to document events such as complications following a procedure.</p> <p>5. The medical record did not identify which persons documented specific information.</p> <p>Patient #12 was observed from her arrival at 1:20 PM on 1/12/11 until she left the building at 2:15 PM that same day. The RN was observed to ask her of changes in her recent history. The</p>	Q 161		

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Q 161	<p>Continued From page 20</p> <p>physician was observed to ask her about her recent history and to conduct a physical examination.</p> <p>Patient #12's "CONSCIOUS SEDATION FORM," dated 1/12/11 but not timed, contained an extensive past medical history. This was documented but it was not gathered during the visit on 1/12/11. The "CONSCIOUS SEDATION FORM" then listed current medications, allergies, and a physical examination. The physical examination section of the form included vital signs. The RN was observed to obtain vital signs. The physical examination section of the form also included mental status, HEENT, cardiovascular status, pulmonary status, status of abdomen, and the status of extremities. This section of the form contained a graphic copy of the physician's signature.</p> <p>The second section of the "CONSCIOUS SEDATION FORM" stated the procedure and sedation were explained to the patient and she accepted the plan. This section was followed by another graphic copy of the physician's signature.</p> <p>A section of the form, labeled "INTRA-OP," contained 2 sets of vital signs with the RN's initials. The final section of the form was titled "POST-OP." It documented the condition of the patient and the time of discharge. The RN signed this section but the time she signed was not documented. After the RN's signature was a graphic copy of the physician's signature.</p> <p>Finally, the "CONSCIOUS SEDATION FORM" stated "This document was electronically signed by (the physician.) Note closed by (the physician) 01-12-2011 13:13:47." Except for the RN's</p>	Q 161		

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Q 161	<p>Continued From page 21</p> <p>initials in conjunction with the vital signs in the "INTRA-OP" section, it was not possible to tell which staff member was completing which section of the form, including which staff member had conducted the physical examination.</p> <p>The RN who cared for Patient #12 was interviewed beginning at 11:15 AM on 1/14/11. She stated the electronic medical record combined documentation from both the physician and the RN into 1 form. She confirmed the identity of individual authors of specific information could not be determined.</p> <p>Also, Patient #12's "CONSCIOUS SEDATION FORM," dated 1/12/11 but not timed, was printed at 1:45 PM on 1/12/11. The sections labeled "Physical Examination" and "Procedure Monitoring" contained signature graphics by the physician making it appear the physician had signed the form.</p> <p>Patient #12's physician was interviewed on 1/12/11 at 4:00 PM. He stated he did not document anything on Patient #12's medical record until after her procedure which ended at 2:10 PM.</p> <p>6. The RN could not enter the time she documented on the medical record including the time she signed the document. She also could not enter post-operative vital signs.</p> <p>a. The medical records of Patients #2, #9, and #12 documented they underwent procedures at the ASC on 12/27/10, 1/03/11, and 1/12/11, respectively. The "CONSCIOUS SEDATION FORM" for each patient documented the time the patient was taken "To surgery," a table titled</p>	Q 161		

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Q 161	<p>Continued From page 22</p> <p>"PROCEDURE MONITORING," which documented vital signs during procedures, and a line that documented the time each patient was discharged. None of the 3 medical records contained times the RN signed the forms or other times, such as the time the procedures ended.</p> <p>Additionally, none of the medical records of Patients #2, #9, and #12 contained documentation of post-operative vital signs.</p> <p>The RN who cared for all 3 patients was interviewed beginning at 11:15 AM on 1/14/11. She stated the electronic medical records did not allow her to document the times of signatures and the times other information was entered into the record. She also stated the electronic medical records did not allow her to document post operative vital signs.</p> <p>7. The RN documented events that had not occurred and documented the potential for outcomes instead of the actual outcomes. Examples included:</p> <p>a. Patient #1 was admitted to the facility on 1/12/11 for a left sacroiliac joint injection without sedation. Patient #1's care was observed on 1/12/11 from admission at 10:10 AM through discharge at 10:45 AM. At 10:20 AM the RN was observed to complete her nursing notes on the "CONSCIOUS SEDATION FORM," including documentation in the "POST-OP" template section. At 10:30 AM, the RN documented the first set of vital signs just prior to initiation of the procedure. A second set of vital signs was obtained at 10:35 AM, at the completion of the procedure. The Physician reiterated to Patient #1 how the medication delivered in the injection</p>	Q 161		
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Q 161	<p>Continued From page 23</p> <p>worked, assisted Patient #1 to a sitting position on the procedure table. The Physician then left the room. The RN assisted Patient #1 off the procedure table and asked if she would like any food or drink, which Patient #1 declined. The RN reviewed discharge instructions and asked Patient #1 how her leg felt and if she had any pain. Patient #1 stated her leg was "numb." The RN then escorted Patient #1 to the waiting room. Patient #1 was discharged at 10:45 AM.</p> <p>Patient #1's "CONSCIOUS SEDATION FORM," in the section titled "POST-OP," contained the above template items, including "Patient able to tolerate food/fluids: Yes," and "Patient able to void: Yes." However, Patient #1 was not observed to eat, drink, or void. The RN was observed to ask Patient #1 about her pain level, however this information was not documented in the medical record.</p> <p>b. Patient #21 was admitted to the facility on 1/13/11 for a steroid injection into the lumbosacral region of her spinal cord with conscious sedation. Patient #21's care was observed on 1/13/11 from admission at 1:10 PM through discharge at 1:50 PM. The RN was observed to complete her nursing notes on the "CONSCIOUS SEDATION FORM," including documentation in the "POST-OP" template section at 1:20 PM. The RN documented vital signs at 1:30 PM, 1:35 PM, and 1:40 PM. The RN documented administration of conscious sedation medication at 1:30 PM. At 1:40 PM, the Physician completed the procedure, asked Patient #21 if she was okay, and left the room. He stated he would return to see Patient #21 prior to her discharge. The RN assisted Patient #21 to a sitting position on the procedure table, asked if Patient #21 felt the</p>	Q 161		

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Q 161	<p>Continued From page 24</p> <p>effects of the sedation medication and if she was okay to stand. Patient #21 was then escorted to the recovery area. The Patient #21 accepted the offer of fluids and recovered in a chair for several minutes. At 1:48 PM, the Physician asked Patient #21 how she was doing and assessed her left leg for strength. At 1:50 PM, the RN was asked Patient #21 how her legs felt and if she had any pain. Patient #21 stated her legs felt "heavier, but okay." The RN was observed to escort Patient #21 out of the recovery area.</p> <p>Patient #21's "CONSCIOUS SEDATION FORM," in the section titled "POST-OP," contained the above template items, including "Patient able to void: Yes." However, Patient #1 was not observed to void. The RN was observed to ask Patient #1 about her pain level, however this information was not documented in the medical record.</p> <p>The RN was interviewed on 1/12/11 at 10:45 AM. She stated she documented the discharge data during the admission process and amended the information as needed. For example, if a patient was discharged at a time other than which she originally entered, she amended this. She explained her process of evaluating a patient for discharge. She stated she always offers a patient fluids to drink. She stated if a patient was able to ambulate, there was no interruption to the nerves for the bowel and bladder and therefore a patient had the ability to void. If the patient complained of being numb in an area related to these specific nerves, she evaluated the patient more closely and if needed, had them stay until this was resolved.</p> <p>Physician B was interviewed on 1/14/11 at 11:00</p>	Q 161			

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Q 161	Continued From page 25 AM. He stated he believed because the facility had the opportunity to amend the medical record, it was not a significant issue for the RN to complete the "POST-OP" section prior to the procedure. He also stated indicating a patient could void when this was not witnessed was inaccurate.	Q 161			
Q 162	416.47(b) FORM AND CONTENT OF RECORD  The facility failed to ensure medical records were complete, accurate, and secure.  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: <ul style="list-style-type: none"> <li>(1) Patient identification.</li> <li>(2) Significant medical history and results of physical examination.</li> <li>(3) Pre-operative diagnostic studies (entered before surgery), if performed.</li> <li>(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.</li> <li>(5) Any allergies and abnormal drug reactions.</li> <li>(6) Entries related to anesthesia administration.</li> <li>(7) Documentation of properly executed informed patient consent.</li> <li>(8) Discharge diagnosis.</li> </ul> This STANDARD is not met as evidenced by: Based on review of facility policies and medical records, and staff interview it was determined the facility failed to ensure medical records were complete and accurate for 23 of 23 patients (#1 -	Q 162	Q162 <u>Action:</u> After reviewing Q162 (findings 1-3), a new paper charting system will be implemented as described in Q161 to better document the patient work flow of the surgical center. This paper charting system will address the deficiency from each finding. The new system will allow for more accurate time stamping of the patient in procedure work flow from the time of admission to the time of discharge (1,3), correct the conscious sedation portion of the nursing record to have accurate descriptions of the medication and concentration of medication to be used (2), will not allow for template driven medical record notations that may lead to inaccurate data(3).  <u>Process improvement:</u> The new medical record system will allow us to more accurately reflect and more easily track specific components of the patient work flow through the surgical center. It was noted in reviewing our previous Internet based electronic medical record system that our server was set to Pacific Standard Time and made our time stamps incorrect.		

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Q 162	<p>Continued From page 26</p> <p>#23) whose records were reviewed. Failure to ensure completeness and clarity in the medical record had the potential to negatively impact patient care. Findings include:</p> <p>1. The facility failed to document properly executed informed consents were obtained. The electronic medical record did not automatically attach a time to a patient's signature on the consent form. Medical records for Patients #1 - #23 were reviewed. It could not be determined if the Patients' informed consents were signed prior to the procedure, or prior to the administration of conscious sedation if this applied.</p> <p>During an interview on 1/12/11 at 8:30 AM, the Administrator confirmed the time consents were signed was not present in the medical record. He stated this was not something the electronic medical record automatically added, nor was it written in by the patient or the RN.</p> <p>The facility failed to ensure a complete and proper informed consent was obtained prior to the procedure.</p> <p>2. In addition to the electronic medical record version, a paper version of the "CONSCIOUS SEDATION FORM" was used when a contract nurse was used to provide care in the facility, or when the computer was not working. A portion of this form was used to document the conscious sedation medication administered during a procedure. The name of the medication (Versed or Fentanyl) was written at the top of a column, and rows were used to document the time of the medication administration. However, the concentration of the medication was not noted, and the dose of the medication was indicated only</p>	Q 162	<p><b>Implementation procedure:</b> The committee will design a new paper charting system consisting of a series of individual work documents to include patient's right and responsibilities, consent form, patient responsibilities, preoperative history and physical, IV and conscious sedation log including nursing notes and discharge criteria, and physician procedure document. The new form will be used in the ASC and staff will receive appropriate training and instruction.</p> <p><b>Completion date:</b> February 25, 2010</p> <p><b>Monitoring and tracking procedure:</b> A member of the ASC committee will review 2 random charts a week for a month after this change is implemented to make sure that the changes that are taking place will fulfill the requirements of this standard. Regular chart reviews will be established and approved by the governing board to guarantee ongoing compliance with this standard.</p> <p><b>Person Responsible:</b> Shane Maxwell D.O.</p>	

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Q 162	<p>Continued From page 27</p> <p>as a "1." The following are examples of unclear documentation of medication administration:</p> <p>a. Patient #14 was admitted to the facility for a procedure on 12/01/10. The paper version of the "CONSCIOUS SEDATION FORM," dated 12/01/10, contained a column for Versed and a column for Fentanyl. At 10:05 AM, under the column "Fentanyl," the RN documented "1 ml (milliliter), 1 ml." At 10:10 AM, and again at 10:15 AM, under the columns "Versed" and "Fentanyl," the RN indicated 1 dose of each of these medications was administered. Documentation on the "CONSCIOUS SEDATION FORM" also indicted Patient #14 received Normal Saline via IV during the procedure. The total volume of IV solution given was not documented.</p> <p>b. Patient #19 was admitted to the facility for a procedure on 10/11/10. The paper version of the "CONSCIOUS SEDATION FORM," dated 10/11/10, indicated the RN administered 1 dose of Versed and one dose of Fentanyl at 10:53 AM, and again at 11:04 AM.</p> <p>c. Patient #18 was admitted to the facility for a procedure on 10/11/10. The paper version of the "CONSCIOUS SEDATION FORM," dated 10/11/10 indicated the RN administered 1 dose of Versed and 1 dose of Fentanyl at 3:30 PM.</p> <p>Physician B was interviewed on 1/14/11 at 11:03 AM. He stated the concentration of Versed was 2 mg (milligram) in 1 ml. The concentration of Fentanyl was 50 mcg (micrograms) in 1 ml. He stated the documentation of "1" and "1" indicated 1 ml of each medication was given. He agreed that without this description on the paper version of the "CONSCIOUS SEDATION FORM," it was</p>	Q 162		

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Q 162	<p>Continued From page 28</p> <p>not clear exactly what dosage of the medications were administered.</p> <p>3. Documentation in the medical record was inaccurate. The following examples indicated inaccuracies in the medical record which prevented clear and accurate documentation of events:</p> <p>a. Patient #12's medical record documented a 53 year old female who had a caudal epidural steroid injection performed on 1/12/11. Patient #12's "CONSCIOUS SEDATION FORM," dated 1/12/11, did not document the time she was admitted to the pre-operative holding area, the time she was examined by the physician, the time of the procedure, or the time she returned to the recovery area. The "CONSCIOUS SEDATION FORM" contained an untimed set of vital signs as well as vital signs at 2:00 PM and 2:05 PM. The "CONSCIOUS SEDATION FORM" stated the note was closed by the physician at 1:13 PM even though it referred to events at 2:15 PM.</p> <p>The administrator was interviewed on 1/14/11 at 10:45 AM. He confirmed the documentation.</p> <p>b. Patient #5's medical record documented a 49 year old male who had a transforaminal epidural steroid injection performed on 12/28/10. Patient #5's "CONSCIOUS SEDATION FORM," dated 12/28/10, did not document the time he was admitted to the pre-operative holding area, the time he was examined by the physician or the time he returned to the recovery area. Patient #5's "CONSCIOUS SEDATION FORM" did not include documentation of vital signs. The "CONSCIOUS SEDATION FORM" stated the note was closed by the physician at 11:08 AM</p>	Q 162		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13C0001036</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/19/2011</b>
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NAME OF PROVIDER OR SUPPLIER  <b>LES BOIS SURGERY CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>6950 W EMERALD STREET, SUITE 166 BOISE, ID 83704</b>
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Q 162	<p>Continued From page 29</p> <p>even though it stated Patient #5 was taken to surgery at 11:30 AM and was discharged at 12:00 noon.</p> <p>The administrator was interviewed on 1/14/11 at 10:45 AM. He confirmed the documentation.</p> <p>c. Patient #2's medical record documented a 61 year old female who had a sacro-iliac joint injection performed on 1/04/11. Patient #2's "CONSCIOUS SEDATION FORM," dated 1/12/11, did not document the time she was admitted to the pre-operative holding area, the time she was examined by the physician, or the time she returned to the recovery area. The "CONSCIOUS SEDATION FORM" stated the note was closed by the physician at 8:12 AM even though it stated Patient #2 was administered conscious sedation medication at 8:55 AM and was discharged at 9:10 AM. The note stated the side rails were up even though Patient #2 was not placed on a gurney with side rails.</p> <p>The administrator was interviewed on 1/14/11 at 10:45 AM. He confirmed the documentation.</p> <p>d. Patient #21's medical record documented a 40 year old female who had a left sacroiliac joint injection performed on 1/13/11. Patient #21's "CONSCIOUS SEDATION FORM," dated 1/13/11, did not document the time she was admitted to the pre-operative holding area, the time she was examined by the physician, or the time she returned to the recovery area. The "CONSCIOUS SEDATION FORM" indicated the note was closed by the physician at 1:04 PM even though it indicated Patient #21 was administered conscious sedation at 1:30 PM and was discharged at 1:55 PM. The note also indicated</p>	Q 162		

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NAME OF PROVIDER OR SUPPLIER  LES BOIS SURGERY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 8950 W EMERALD STREET, SUITE 168 BOISE, ID 83704	
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Q 162	Continued From page 30 there was a possibility Patient #21 was pregnant and that no pregnancy test had been done. Further, the note indicated the side rails were up even though Patient #21 was not placed on a gurney with side rails.  Patient #21's Physician, Physician B, was interviewed on 1/14/11 11:00 AM. He reviewed Patient #21's medical record and stated documentation related to things such as the possibility of being pregnant, and side rails being up was not accurate and did not convey clear documentation of events. He confirmed the physician had the ability to close a record, and this was confirmed with an electronic signature. He reviewed the times documented in Patient #21's "CONSCIOUS SEDATION FORM" and stated the time documented was inaccurate. He stated he did not complete documentation until after the procedure was complete.  Physician A was interviewed on 1/14/11 at 9:00 AM. He stated the medical record contained many default templates (including the one which asked about pregnancy and side rails) that required human intervention in order to make an accurate record.	Q 162		
Q 181	Medical records were not complete and accurate. 416.48(a) ADMINISTRATION OF DRUGS  Drugs must be prepared and administered according to established policies and acceptable standards of practice.  This STANDARD is not met as evidenced by:	Q 181	Q181 <u>Action:</u> After review of the deficiencies noted in Q181 the following changes will occur including: an update to the "Conscious sedation for adults" policy to include that no sedation medications will be given to the patient until the nurse receives a verbal order which is repeated back to the physician, all verbal orders will be verified and signed by the physician with our updated medical record system (see Q161).	

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Q 181	<p>Continued From page 31</p> <p>Based on observation, review of facility policies and medical records, and staff interview it was determined the agency failed to administer conscious sedation medications in accordance with accepted standards of practice for 1 of 1 patients (#21) who received conscious sedation and whose procedure was observed. The lack of a clear defined procedure had the potential to affect all patients who received conscious sedation. Failure to adhere to acceptable standards of practice resulted in the potential for patients to receive incorrect doses of medication during a procedure, and increased the potential for negative patient outcomes. Findings include:</p> <p>1. According to the Textbook of Basic Nursing, published by Wolters Kluwer Health/Lippincott Williams and Wilkins in 2008, upon receipt of a verbal order, the nurse must verify the order by reading back/repeating the order to the physician. This accepted standard of practice was not noted during the period of observation as follows:</p> <p>Patient #21 was admitted to the facility on 1/13/11 for a steroid injection into the lumbosacral region of her spinal cord with Physician B. Patient #21's care was observed on 1/13/11 from admission at 1:10 PM through discharge at 1:50 PM. AT 1:30 PM, Patient #21 was positioned and the site was cleansed for the injection. Once this was completed, and before the physician began to numb the site for the procedure, the RN was observed to administer IV medication from two different syringes. No communication was observed between the physician and the RN. Approximately two minutes later the RN asked Patient #21 if she noticed any affect from the medications. Patient #21 replied, "a little." The RN then administered another dose of IV</p>	Q 181	<p>All nurses performing conscious sedation in the ASC will have verification of competency and training in administering and monitoring conscious sedation. This will include all current and temporary nursing staff.</p> <p><b>Process improvement:</b> A clearly defined procedure will improve the safety of our conscious sedation, reducing the likelihood that the wrong dose of medication is given during the procedure.</p> <p><b>Implementation procedure:</b> The policy will be changed as noted above and all current nursing and physician staff will be trained to follow basic nursing standards that upon receipt of a verbal order, the nurse will verify the order by repeating it back. Validation of nurse competency in administering and monitoring conscious sedation would be kept in the individual's personnel file.</p> <p><b>Completion date:</b> February 25, 2011</p> <p><b>Monitoring and tracking procedure:</b> A member of the ASC committee will review 2 random charts a week for a month after this change is implemented to make sure that the changes that are taking place will fulfill the requirements of this standard. Regular chart reviews will be established and approved by the governing board to guarantee ongoing compliance with this standard.</p> <p><b>Person Responsible:</b> Shane Maxwell D.O.</p>	

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Q 181	<p>Continued From page 32</p> <p>medication from each of the two syringes. No communication was noted between the physician and the RN.</p> <p>The RN was interviewed on 1/13/11 at 1:50 PM. She stated used her assessment skills (a patient's age, size, medical history, medication history, risk factors for sedation, etc.) to determine how much medication to initially administer, as well as for subsequent doses. She stated she typically told the physician what she planned to give and they either agreed or altered the dose. This was not observed. She stated she was becoming more familiar with specific physician styles regarding sedation and took this into consideration during the procedures.</p> <p>Physician B was interviewed on 1/14/11 at 11:03 AM. He stated he usually talked with the RN in the morning before procedures regarding each patient and what amount of conscious sedation medication might be needed for the scheduled procedure. The amount discussed was based on the patient's medical history, age, size, past amounts of sedation required for procedures, etc. He stated he did not recall specifically providing the RN with verbal orders for the conscious sedation medication administered during the observed procedure.</p> <p>Physician A was interviewed on 1/14/11 at 9:00 AM. He stated the RN was getting better at anticipating the appropriated amount of medication to administer based on the patient's medical history, etc. He stated he typically asked the RN what was given, and provided additional recommendations based on the patient's response.</p>	Q 181		

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Q 181	<p>Continued From page 33</p> <p>The "Administration of Drugs" policy, not dated, was reviewed. The policy addressed verbal orders and indicated the "Nurse will read-back and verify the orders given by the physician, who will confirm their correctness." This policy was not followed in the observation described above.</p> <p>The "Conscious Sedation for Adults" policy, updated August 2010, indicated specific criteria for RNs who provided conscious sedation. According to the policy, only RNs who were trained in Advanced Cardiac Life Support and had validated current competency in administering and monitoring conscious sedation would be permitted to perform this task. However, the facility did not maintain documentation to indicate these criteria had been met by RNs who administered conscious sedation.</p> <p>The Administrator was interviewed on 1/13/11 at 11:15 AM. He stated the facility did not maintain documentation which verified training and competency for RNs who administered conscious sedation medication.</p> <p>The "Conscious Sedation for Adults" policy, updated August 2010, also indicated the RN would, "Administer pharmacological agents under direct supervision of responsible physician. Begin administration of sedative or analgesic drugs only when responsible physician is present." This policy did not contain a procedure for the verbal order of specific doses of medication to be administered.</p> <p>The facility failed to implement the policy addressing verbal orders and proper communication related to medication administration during procedures. The facility</p>	Q 181		

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Q 181	Continued From page 34	Q 181			
Q 184	<p>failed to ensure that communication related to verbal orders was performed in accordance with accepted standards of practice.</p> <p><b>416.48(a)(3) VERBAL ORDERS</b></p> <p>Orders given orally for drugs and biologicals must be followed by a written order signed by the prescribing physician.</p> <p>This STANDARD is not met as evidenced by: Based on review of medical records and facility policy and staff interview it was determined the facility failed to ensure verbal orders for conscious sedation were signed by the ordering physician for 7 of 7 patients (#10, #14, #15, #16, #18, #19, and #23) whose records were reviewed and contained a paper version of the "CONSCIOUS SEDATION FORM." Failure to obtain a physician signature for verbal orders impeded the verification of medication administration per physician order. Findings include:</p> <p>The medical records for Patients #14, #18, and #19 were reviewed. Each medical record contained a paper version of the "CONSCIOUS SEDATION FORM." The RN documented on this form which conscious sedation medication she administered and the time it was given. The medical record did not contain a physician signature for the individual orders of medications administered during the procedures. Examples included:</p> <p>a. Patient #14 was admitted to the facility for a procedure on 12/01/10. The paper version of the "CONSCIOUS SEDATION FORM," dated</p>	Q 184	<p><b>Q184 Action:</b> After review of the deficiencies noted in Q184 the following changes will occur including: all verbal orders will followed by a written and signed order by the physician.</p> <p><b>Process improvement:</b> These actions will improve the safety of our patients by ensuring that the medications administered during a procedure were verified by the physician.</p> <p><b>Implementation procedure:</b> The policy will be changed and a new paper charting form will be used so that the orders can be verified and signed by the physician. All current nursing and physician staff will be trained to verify and sign for verbal orders.</p> <p><b>Completion date:</b> February 25, 2011</p> <p><b>Monitoring and tracking procedure:</b> A member of the ASC committee will review 2 random charts a week for a month after this change is implemented to make sure that the changes that are taking place will fulfill the requirements of this standard. Regular chart reviews will be established and approved by the governing board to guarantee ongoing compliance with this standard.</p> <p><b>Person Responsible:</b> Shane Maxwell D.O.</p>		

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Q 184	<p>Continued From page 35</p> <p>12/01/10, contained a column for Versed and a column for Fentanyl. At 10:05 AM, under the column "Fentanyl," the RN documented "1 ml (milliliter), 1 ml." At 10:10 AM, and again at 10:15 AM, under the columns "Versed" and "Fentanyl," the RN indicated 1 dose of each of these medications was administered. Documentation on the "CONSCIOUS SEDATION FORM" also indicted Patient #14 received Normal Saline via IV during the procedure. The medical record did not contain a physician signature for the order of these medications.</p> <p>b. Patient #19 was admitted to the facility for a procedure on 10/11/10. A paper version of the "CONSCIOUS SEDATION FORM" indicated the RN administered two doses of Versed and two doses of Fentanyl. The medical record did not contain a physician signature for these medications.</p> <p>c. Patient #18 was admitted to the facility for a procedure on 10/11/10. A paper version of the "CONSCIOUS SEDATION FORM" indicated the RN administered one dose of Versed and one does of Fentanyl. The medical record did not contain a physician signature for these medications.</p> <p>d. Patient #10's medical record documented a 58 year old male who had a lumbar epidural steroid injection performed on 10/12/10. A handwritten "CONSCIOUS SEDATION FORM," dated 10/12/10, stated Patient #10 was given "1" Versed and "1" Fentanyl at 3:20 PM. An order for the medications was not present in the medical record.</p> <p>An interview with the Administrator, on 1/14/11 at</p>	Q 184			

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Q 184	<p>Continued From page 36 10:45 AM, confirmed the documentation.</p> <p>e. Patient #15's medical record documented a 76 year old male who had a lumbar epidural steroid injection performed on 10/13/10. A handwritten "CONSCIOUS SEDATION FORM," dated 10/13/10, stated Patient #15 was given 1 mg (milligram) of Versed and 1 ml of Fentanyl at 9:30 AM. An order for the medications was not present in the medical record.</p> <p>f. Patient #16's medical record documented a 56 year old female who had a spinal cord stimulator trial performed on 10/13/10. A handwritten "CONSCIOUS SEDATION FORM," dated 10/13/10, stated Patient #16 was given 1/2 mg of Versed and 1/2 ml of Fentanyl at 1:55 PM. An order for the medications was not present in the medical record.</p> <p>g. Patient #23's medical record documented a 68 year old male who had a spinal cord stimulator trial performed on 10/13/10. A handwritten "CONSCIOUS SEDATION FORM," dated 10/13/10, stated Patient #23 was given 1/2 mg of Versed and 1 ml of Fentanyl at 10:30 AM, 1/2 mg of Versed at 10:40 AM and 1/2 mg of Versed and 1/2 ml of Fentanyl at 10:45 AM. An order for the medications was not present in the medical record.</p> <p>The "Administration of Drugs" policy, not dated, documented, "If any orders are given orally for drugs, they must be followed by a written order and signed by the prescribing physician...The prescribing physician will sign date and time the written order as soon as possible after the verbal order is given." This policy was not followed.</p>	Q 184		

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Q 184	Continued From page 37 An interview with the Administrator, on 1/25/11 at 10:00 AM, confirmed the documentation and lack of physician signature for the medications administered.	Q 184			
Q 220	416.50 PATIENT RIGHTS  The facility failed to ensure all medications administered by the RN were co-signed by a physician.  The ASC must inform the patient or the patient's representative of the patient's rights, and must protect and promote the exercise of such rights.  This CONDITION is not met as evidenced by: Based on staff interview, observation, review of patient rights information, ASC policies and medical records it was determined the ASC failed to provide patients or their representatives with complete information regarding their rights. This failure had the potential to interfere with patients' ability to make fully informed decisions for their care. Findings include:  1. Refer to Q221 as it relates to the failure of the ASC to provide patients or their representatives, in advance of the date of the procedure, with information regarding their rights.  2. Refer to Q222 as it relates to the failure of the ASC to post a written notice of the complete list of patient rights, and to ensure patient rights information included the name, phone number, and address of the state representative in the event patients wished to report complaints.  3. Refer to Q223 as it relates to the failure of the ASC to disclose, in writing and in advance of the	Q 220	Q220 This condition is not met because the following standards were found deficient: Q221, Q222, Q223 and Q224. The corrections for each of these standards are found below. The condition Q220 will be met as the standards are corrected for deficiencies and the ASC will ensure that patient rights are communicated and upheld.		

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Q 220	Continued From page 38 date of the procedure, physician ownership of the facility.	Q 220		
Q 221	4. Refer to Q224 as it relates to the failure of the ASC to provide complete information regarding advanced directives in advance of the procedure and document in the medical record whether an advance directive had been executed.  The cumulative effect of these systemic practices resulted in an inability of the facility to ensure patient rights were communicated and upheld. 416.50(a)(1) NOTICE OF RIGHTS  The ASC must provide the patient or the patient's representative with verbal and written notice of the patient's rights in advance of the date of the procedure, in a language and manner that the patient or the patient's representative understands.  This STANDARD is not met as evidenced by: Based on staff interview, review of patient rights information and ASC policies, and observation it was determined the ASC failed to provide patients or their representatives with information regarding their rights in advance of the date of the procedure. This impacted 3 of 3 patients (#1, #12, and #21) whose procedures were observed and had the potential to impact all patients receiving services at the facility. This resulted in patients not being notified of their rights prior to the date of the procedure, which had the potential to interfere with patients' ability to make informed decisions. Findings include:  1. On 1/12/11 at 8:20 AM, the Administrator stated prior to initiation of the survey on 1/11/11,	Q 221	Q221 <u>Action:</u> All patients or representatives of patients will receive written and verbal notice of the patient rights, prior to the date of the procedure in a language and manner that can be understood. If the patient is physically present in the office when a procedure is scheduled, a copy the patient rights will be given to the patient at that time. If the patient is not in the office at the time of scheduling, a copy will be mailed to the patient prior to admission to the ASC.  <u>Process improvement:</u> Implementation of the above policy will improve the patient's safety by allowing them to make fully informed decisions regarding their care.  <u>Implementation procedure:</u> All persons involved in scheduling patient procedures will be provided with a copy of the new policy and will be verbally instructed on the new policy and how to deliver the patient rights in a timely manner.  <u>Completion date:</u> February 25, 2011	

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NAME OF PROVIDER OR SUPPLIER  <b>LES BOIS SURGERY CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>6950 W EMERALD STREET, SUITE 166 BOISE, ID 83704</b>	
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Q 221	<p>Continued From page 39</p> <p>patient rights information was not provided in advance of the procedure. Instead, the RN reviewed the information upon the patient's admission the date of the procedure. A written copy of patient rights information was distributed to the patient at that time.</p> <p>In the following examples patients were observed to receive and review patient rights documentation just prior to their scheduled procedures:</p> <p>a. Patient #1 was admitted to the facility on 1/12/11 for a left sacroiliac joint injection. Patient #1's care was observed on 1/12/11 from admission at 10:10 AM through discharge at 10:45 AM. The RN was observed, at 10:15 AM, reviewing patient rights information with Patient #1. The RN told Patient #1 a patient had the right to refuse treatment, the facility was physician owned, and the patient had the right to confidentiality. The RN asked if Patient #1 had any questions, asked Patient #1 to review the patient rights documentation, and sign the form. Patient #1 was given a copy of the patient rights information to take home after the procedure.</p> <p>b. Patient #12 was observed from her arrival at 1:20 PM on 1/12/11 until she left the building at 2:15 PM that same day. A caudal epidural steroid injection was performed. The RN was observed to hand a copy of patient rights to Patient #12, have her sign the form, and send a copy home with her after the procedure.</p> <p>The RN who cared for Patient #12 was interviewed beginning at 2:20 PM on 1/12/11. She stated patients were not routinely given copies of patient rights prior to their procedures.</p>	Q 221	<p><u>Monitoring and tracking procedure:</u> A member of the ASC committee will review 2 random charts a week for a month after this change is implemented to make sure that the changes that are taking place will fulfill the requirements of this standard. Regular chart reviews will be established and approved by the governing board to guarantee ongoing compliance with this standard.</p> <p><u>Person Responsible:</u> Shane Maxwell D.O.</p>	

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NAME OF PROVIDER OR SUPPLIER  LES BOIS SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8950 W EMERALD STREET, SUITE 168 BOISE, ID 83704
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Q 221	Continued From page 40  c. Patient #21 was admitted to the facility on 1/13/11 for a steroid injection into the lumbosacral region of her spinal cord. Patient #21's care was observed on 1/13/11 from admission at 1:10 PM through discharge at 1:50 PM. The RN was observed, on 1/13/11 at 1:10 PM, reviewing patient rights information with Patient #21. The RN told Patient #21 a patient had the right to participate in care or refuse treatment and had the right to confidentiality. The RN asked Patient #21 to review the patient rights documentation and sign the form. Patient #21 was given a copy of the patient rights information to take home after the procedure.  The ASC failed to provide patients with patient rights information in advance of the date of the procedure.	Q 221		
Q 222	4166.50(a)(1)(i) NOTICE - POSTING  In addition, the ASC must - Post the 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, review of patient rights information, and interview, it was determined the facility failed to post a written notice of the complete list of patient rights and failed to ensure patient rights information included the name,	Q 222	<b>Q222 Action:</b> A copy of our updated patient's writes notice will be posted in easily accessible locations. The patient rights will include the name, address and telephone number of a representative in the State agency to whom patients can report complaints, the Web site for the Office of the Medicare Beneficiary Ombudsman, disclosure of physician ownership, the right to submit a grievance to the facility and the facilities policy related to Advance Directives.  <b>Process improvement:</b> Posting accurate and detailed information about patient rights will ensure that patients or their representatives are fully informed of their rights.	

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Q 222	<p>Continued From page 41</p> <p>phone number, and address of the state representative in the event patients wished to report complaints. This impacted 1 of 1 facilities toured and had the potential to impact all patients who received care at that facility. These failures had the potential to result in patients and their representatives not being fully informed of their rights. Findings include:</p> <p>1. A tour of the facility was conducted with the RN on 1/11/11 from 1:20 PM to 2:05 PM. A document titled "Patient Rights and Responsibilities" was located on the wall in the waiting room. This form did not contain the following required patient rights information:</p> <ul style="list-style-type: none"> <li>a. Disclosure of physician ownership.</li> <li>b. The patient's right to submit a grievance to the facility.</li> <li>c. The the name, address, and telephone number of the state representative with whom complaints could be filed or the web site for the Office of the Medicare Beneficiary Ombudsman.</li> <li>d. The patient's right to formulate an advance directive or the facility's policy related to Advance Directives.</li> </ul> <p>The Administrator was interviewed on 1/11/11 at 4:03 PM. He stated the agency was in the process of updating patient rights information as the current information was missing some required documentation.</p> <p>2. On 1/12/11 at 8:20 AM the Administrator provided a new version of the patient rights information. He stated staff had received training on the new policy and the documentation was utilized beginning with patients seen in the facility on 1/12/11.</p>	Q 222	<p><u>Implementation procedure:</u> Changes will be made to the patient rights form and it will be posted in the ASC where it is likely to be noticed.</p> <p><u>Completion date:</u> February 25, 2011</p> <p><u>Monitoring and tracking procedure:</u> The director of the ASC will review the new form and ensure current copies of the patient's rights are posted. Annually, the governing body will review the patient rights and approve the information that is in it.</p> <p><u>Person Responsible:</u> Shane Maxwell D.O.</p>	

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Q 222	Continued From page 42  On 1/13/11 at 10:13 AM, the Receptionist for the facility verified the copy of the "Patient Rights and Responsibilities" document posted on the facility wall in the waiting room. This document was different than the one observed on 1/11/11.  This form did not contain the following information:  a. Disclosure of physician ownership. b. The the name or the correct address and telephone number of the state representative with whom complaints could be filed. c. The form indicated a patient could voice a grievance regarding treatment of care but did not indicate who in the facility should be notified or how they could be contacted. d. The form indicated the facility acknowledged the patient's right to have an Advance Directive and asked the patient to notify the facility if they had an Advance Directive in place. The form indicated additional documentation related to Advance Directives would be provided to the patient upon request. However, it was unclear if the facility would, in fact, honor the Advance Directive should the need arise while the patient received care in the facility in accordance with their policy.  The facility failed to ensure a complete and accurate written notice of patient rights was posted in the facility.	Q 222			
Q 223	416.50(a)(1)(ii) NOTICE - PHYSICIAN OWNERSHIP  The ASC must also disclose, where applicable, physician financial interests or ownership in the ASC facility in accordance with the intent of Part	Q 223	Q223 <u>Action:</u> A copy of our updated patient's rights notice will be posted in easily noticed location and will include a disclosure of the ownership information.		

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Q 223	Continued From page 43 420 of this subchapter. Disclosure of information must be in writing and furnished to the patient in advance of the date of the procedure.  This STANDARD is not met as evidenced by: Based on staff interview and review of patient rights information and medical records, it was determined the ASC failed to disclose, in writing and in advance of the date of the procedure, physician ownership of the facility. This impacted all patients receiving services at the ASC, including 23 of 23 patients (#1 - #23) whose records were reviewed. This failure had the potential to interfere with patients' ability to make fully informed decisions. Findings include.  The medical records for Patients #1 - #23 included copies of a document titled, "Patient Rights and Responsibilities," signed by the patient. This document did not contain information disclosing the physician ownership of the facility.  The Administrator stated, during an interview on 1/11/10 at 4:03 PM, the agency was in the process of updating patient rights information as the current information was missing some required documentation. He confirmed the information found in the medical records was the patient rights information provided to patients at the time of their procedure.  The ASC failed to disclose in writing physician ownership of the facility.	Q 223	<b>Process improvement:</b> Disclosing the ownership information of the ASC will eliminate the potential to interfere with the patient's ability to make a fully informed decision regarding their health care.  <b>Implementation procedure:</b> An updated copy of the patient rights will be posted in a conspicuous location in the ASC, to include the ownership information.  <b>Completion date:</b> February 25, 2011  <b>Monitoring and tracking procedure:</b> The director of the ASC will review the new form and ensure current copies of the patient's rights are posted. Annually, the governing body will review the patient rights and approve the information that is in it.  <b>Person Responsible:</b> Shane Maxwell D.O.	
Q 224	416.50(a)(2) ADVANCE DIRECTIVES  The ASC must comply with the following requirements:	Q 224		

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Q 224	<p>Continued From page 44</p> <p>(i) Provide the patient or, as appropriate, the patient's representative in advance of the date of the procedure, with information concerning its policies on advance directives, including a description of applicable State health and safety laws, and, if requested, official State advance directive forms.</p> <p>(ii) Inform the patient or, as appropriate, the patient's representative of the patient's rights to make informed decisions regarding the patient's care.</p> <p>(iii) Document in a prominent part of the patient's current medical record, whether or not the individual has executed an advance directive.</p> <p>This STANDARD is not met as evidenced by: Based on review of policies and patient rights information, record review, and staff interview, it was determined the ASC failed to provide complete information regarding advanced directives prior to the date of the procedure and document in the medical record whether an advance directive had been executed. This impacted all patients receiving services at the facility, including 23 of 23 patients (#1 - #23) whose records were reviewed. As a result, patients were not informed of the advance directive information or the facility's policy and missed the opportunity to execute advance directives and/or have them honored. Findings include:</p> <p>1. The facility failed to ensure patients were provided information related to advance directives and the facility's policy regarding advance directives prior to the date of the procedure as evidenced by the following:</p>	Q 224	<p>Q224 <u>Action:</u> After reviewing the standards for Q224 the ASC will make sure patients receive complete information regarding advanced directives prior to the date of the procedure. It will be clearly documented in the medical records whether an advance directive had been executed. Complete information includes a description of applicable state health and safety laws and, if requested, official state advance directive forms.</p> <p><u>Process improvement:</u> Providing complete information for patients will ensure that that are informed of their advanced directive rights and have an opportunity to execute and/or honor their directives.</p> <p><u>Implementation procedure:</u> The ASC committee will make sure that complete information regarding advance directives is included in the patient rights information. The patient will receive a copy of their rights at least one day prior to their procedure. This will be done either the day they are in the doctor's office and are scheduled an appointment or it will be mailed to them well in advance of their procedure. This delivery of information will be indicated in the patients chart or in the clinic billing software as having been given to them prior to their procedure. The notice of advance directives will be asked about by a member of the staff on the day of the procedure. If there are any directives provided by the patient, it will be included in the patient's records.</p> <p><u>Completion date:</u> February 25, 2011</p>	

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Q 224	<p>Continued From page 45</p> <p>The medical records for Patients #1 - #23 included copies of a document titled, "Patient Rights and Responsibilities," signed by the patient. This document did not contain information related to advance directives, including a description of the various types of advance directives (such as Living Will or Durable Power of Attorney for Health Care) available as a result of State laws. There was no evidence in the medical record that Patients #1 - #23 were provided with the facility policy regarding advance directives.</p> <p>On 1/12/11 at 8:20 AM the Administrator provided a new version of the "Patient Rights and Responsibilities" form to be distributed to patients. He stated staff received training on the new policy and the document was utilized beginning with patients seen in the facility on 1/12/11.</p> <p>This form contained documentation related to advance directives. It noted State law provided an individual ways to ensure their wishes concerning their healthcare could be carried out in the event the individual was unable to speak for themselves. Facility patients were directed to notify the facility if they had advance directives in place. Patients were provided with additional written documentation or forms related to advance directives if requested, and the web site for additional State information regarding advance directives was noted.</p> <p>This form did not include a description the various types of advance directives (such as Living Will or Durable Power of Attorney for Health Care) available as a result of State laws. The form did not clearly indicate if the facility would, in fact,</p>	Q 224	<p><u>Monitoring and tracking procedure:</u> A member of the ASC committee will review 2 random charts a week for a month after this change is implemented to make sure that the changes that are taking place will fulfill the requirements of this standard. Regular chart reviews will be established and approved by the governing board to guarantee ongoing compliance with this standard.</p> <p><u>Person Responsible:</u> David Orchard, MBA</p>		

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Q 224	<p>Continued From page 46</p> <p>honor the advance directive should the need arise while the patient received care in the facility. The facility's policy related to advance directives was not provided in this form.</p> <p>The "Advance Directives" policy, dated January 2010, was reviewed. It noted "In the event that a patient becomes incapacitated or not able to speak for themselves then the healthcare providers in the ASC will follow their wishes according the patients [sic] Advance Directives." However, during an interview on 1/19/11 beginning at 11:45 AM, Staff A stated in the unlikely event a patient needed resuscitation effort, those would be provided by facility staff regardless of the patient's advance directive.</p> <p>On 1/12/11 at 8:20 AM, the Administrator provided a policy titled, "Dissemination of Patient Rights and Responsibilities," which was approved by the Governing Body on 1/11/11. He indicated that prior to this new policy, patient rights information was not provided in advance of the procedure, but was discussed by the RN at the time of the procedure. Patients were provided with a copy of the patient rights information at that time.</p> <p>During an interview on 1/19/11 at 11:00 AM, the Administrator confirmed information related to advance directives, and the facility's policy regarding advance directives, was not part of the patient rights information provided to patients prior to the survey initiated on 1/11/11.</p> <p>The "Advance Directives," policy, dated January 2010, indicated, "Before the date of a procedure the patient will be notified of their rights for designating Advance Directives." This policy was</p>	Q 224		

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Q 224	<p>Continued From page 47 not followed.</p> <p>The facility failed to ensure the required documentation related to advance directives was provided to patients in advance of the date of their procedure.</p> <p>2. There was no evidence in the medical records for Patients #1 - #23 to indicate whether an advance directive had been executed or not.</p> <p>The Administrator was interviewed on 1/19/11 at 11:00 AM. He stated the facility had the capability of prominently documenting whether or not a patient had executed an advance directive. He stated that prior to the survey initiated on 1/11/11, the issue of advance directives was not addressed with patients and this information was not documented in the medical record.</p> <p>The "Advance Directives" policy, dated January 2010, noted the following:</p> <ul style="list-style-type: none"> <li>- "If the patient has indicated that they have an Advance Directive, it will be put in the patients chart."</li> <li>- "In the event that a patient becomes incapacitated or not able to speak for themselves then the healthcare providers in the ASC will follow their wishes according to the patients [sic] Advance Directives."</li> <li>- "On the day of the procedure the form will be printed and kept on hand, for immediate reference and for delivery with the patient if they are transferred to another facility."</li> <li>- "The ASC will notify the patient if there are any</li> </ul>	Q 224		

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Q 224	Continued From page 48. limitations in carrying out the advance directives specified by the patient."	Q 224			
Q 260	416.52 PATIENT ADMISSION, ASSESSMENT AND DISCHARGE  The ASC must ensure each patient has the appropriate pre-surgical and post-surgical assessments completed and that all elements of the discharge requirements are completed.  This CONDITION is not met as evidenced by: Based on observation, review of facility policies and medical records, and staff interview, it was determined the facility failed to ensure appropriate assessments were completed before and after the procedure and the patient was discharged from the facility with a physician order. These failures had the potential to result in negative patient outcomes. Findings include:  1. Refer to Q261 as it relates to the facility's failure to ensure a current and comprehensive H&P was included in the medical records.  2. Refer to Q262 as it relates to the facility's failure to ensure a physician examined patients prior to procedures.  3. Refer to Q264 as it relates to the facility's failure to ensure patients were properly assessed prior to discharge.	Q 260	Q260 This condition is not met due to the following deficient standards: Q261, Q262, Q264 and Q266. The corrections for each of these standards are found below. The condition Q260 will be met as the standards or corrected and the ASC will ensure that good patient care and safety is maintained.		

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NAME OF PROVIDER OR SUPPLIER  <b>LES BOIS SURGERY CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>8950 W EMERALD STREET, SUITE 168 BOISE, ID 83704</b>		
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Q 260	Continued From page 49	Q 260			
Q 261	<p>4. Refer to Q266 as it relates to the facility's failure to ensure patients were discharged per physician's orders.</p> <p>The cumulative effect of these systemic failures had to the potential to impact patient care and safety.</p> <p><b>416.52(a)(1) ADMISSION ASSESSMENT</b></p> <p>Not more than 30 days before the date of the scheduled surgery, each patient must have a comprehensive medical history and physical assessment completed by a physician (as defined in section 1861(r) of the Act) or other qualified practitioner in accordance with applicable State health and safety laws, standards or practice, and ASC policy.</p> <p>This STANDARD is not met as evidenced by: Based on observation, review of medical records and facility policies, and staff interview it was determined the facility failed to ensure a current and comprehensive H&amp;P was included in the medical records for 5 of 15 patients (#1, #8, #15, #18, and #19) whose records were reviewed for the comprehensive H&amp;P. This failure led to the potential for patient to receive inadequate care during and after the procedure. Findings include:</p> <p>1. The ASC had not developed a policy defining H&amp;Ps and providing direction to staff to ensure comprehensive examinations were documented in the medical record prior to surgery.</p> <p>Two policies addressed H&amp;Ps at the ASC. The policy "MEDICAL RECORDS POLICY FOR LES BOIS SURGERY CENTER," not dated, stated a</p>	Q 261	<p>Q261 <u>Action:</u> After reviewing the standards of Q261 the ASC will ensure that a comprehensive H&amp;P will be performed no more than 30 days prior to the patient's procedure. What is included in a comprehensive H&amp;P will be defined.</p> <p><u>Process improvement:</u> Completing a comprehensive H&amp;P no more than 30 days prior to a surgery will help ensure patient's safety in the ASC.</p> <p><u>Implementation Procedure:</u> The committee will design a new intake form (paper charting) that will be used by the nurse and the physician that will ask for confirmation of a comprehensive H&amp;P having been performed on the patient prior to surgery. If none was performed then there will be space available for the physician to complete one at that time. A definition of what is included in that comprehensive H&amp;P will be approved by the governing body.</p> <p><u>Completion date:</u> February 25, 2011</p>		

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Q 261	<p>Continued From page 50</p> <p>complete medical record included "Significant and up to date History and Physical (less than 30 days old) by the provider at the time of service or an addendum to a previous H&amp;P with the wording (no changes since last seen) or appropriate changes added to it on the day of service and so noted."</p> <p>The policy "Guidelines and admission protocol to the ASC," not dated, stated "Upon arrival to the ASC the patient will be identified and an initial assessment will be performed which will include review of History and Physical, medications, and allergies."</p> <p>While the policies referenced H&amp;Ps, no policy defined what an H&amp;P included and how it was documented. Physician B was interviewed on 1/14/11 at 11:00 AM. He stated follow-up visits served as H&amp;Ps at the ASC.</p> <p>The follow ups were visits patients made to physician's offices a week or two after having a pain procedure. They utilized a common template which included information that was automatically populated by the computer as well as new information gathered during the visit. This made it impossible to tell which information was automatically populated by the computer and which specific information was gathered at the time of the visit. Follow up visits were not labeled as H&amp;Ps. They included an extensive assessment of patients' pain problems but did not evaluate more general problems, such as cardiovascular problems, pulmonary problems, diabetes, and other issues that could affect patients' health during procedures and the administration of conscious sedation medications.</p>	Q 261	<p><u>Monitoring and tracking procedure:</u> A member of the ASC committee will review 2 random charts a week for a month after this change is implemented to make sure that the changes that are taking place will fulfill the requirements of this standard. Regular chart reviews will be established and approved by the governing board to guarantee ongoing compliance with this standard.</p> <p><u>Person responsible:</u> Shane Maxwell D.O.</p>		

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Q 261	<p>Continued From page 51</p> <p>The lack of a policy defining H&amp;Ps was confirmed by interview with the Administrator on 1/25/11 at 10:00 AM. He also stated follow up office visits prior to the procedures served as H&amp;Ps.</p> <p>Examples of the facility's failure to ensure H&amp;P assessments were completed within 30 days of the procedure date included:</p> <p>a. Patient #1's medical record documented a 62 year old female admitted to the facility on 1/12/11 for a left sacroiliac joint injection. Patient #1 was observed on 1/12/11, from arrival to the facility at 9:45 AM through discharge at 10:45 AM. During the admission process, at 10:18 AM, the RN asked Patient #1 about her cardiopulmonary status. Patient #1 informed the RN she had emphysema, COPD (Chronic Obstructive Pulmonary Disease), and CHF (Congestive Heart Failure). Patient #1 stated she used inhalers as needed to control breathing symptoms. The most recent follow up in the medical record was dated 12/06/10. The Physician was not observed completing an updated H&amp;P.</p> <p>An updated H&amp;P, completed within 30 days of the procedure was not located in Patient #1's medical record.</p> <p>b. Patient #18's medical record documented a 71 year old male admitted to the agency on 10/11/10 for right sacroiliac radio frequency denervation with conscious sedation. Documentation of an H&amp;P completed within 30 days was not present in the medical record. The last follow up office visit prior to the procedure was documented on 7/09/10. At this visit the physician noted, "No real changes are noted in the patient's physical examination at this follow-up visit." However, the</p>	Q 261			

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Q 261	<p>Continued From page 52</p> <p>physician also documented in the "Respiratory" section under the "Review of Systems" Patient #18 was experiencing difficulty breathing. There was no documentation the Physician further examined this breathing difficulty by listening to his lungs with a stethoscope. There was no documentation in the follow up visit to explain a potential cause for the difficulty breathing.</p> <p>Documentation on the "CONSCIOUS SEDATION FORM," completed by the RN on 10/11/10, indicated Patient #18 had a history of throat cancer, a cardiac history of "3x bypass," and was on home oxygen for COPD. This information was not found in the past medical history documentation on the follow up visit from 7/09/10.</p> <p>A current and comprehensive H&amp;P was not found in Patient #18's medical record.</p> <p>c. Patient #19's medical record documented a 49 year old female admitted to the facility on 10/11/10 for a right ilioinguinal/genital femoral radio frequency denervation with conscious sedation. Her medical record contained documentation from a follow up office visit on 10/06/10. This follow up visit contained extensive documentation related to Patient #19's past medical and surgical histories. Patient #19's medical history included asthma, allergies, and sleep apnea. Patient #19 was noted to use several medications, including inhalers to control symptoms. The physician documented "No real changes are noted in the patient's physical examination at this follow-up visit." It was not clear when the last physical examination was, or what the results of that physical examination were.</p>	Q 261		

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Q 261	<p>Continued From page 53</p> <p>Patient #19's medical record did not contain a comprehensive H&amp;P completed within 30 days of procedure on 10/11/10.</p> <p>d. Patient #15's medical record documented a 76 year old male who had left epidural steroid injections performed at the facility on 10/13/10 and 11/22/10. Prior to the procedures, follow up visits were documented on 10/05/10 and 11/02/10. Neither note documented Patient #15's overall health status at the time of the visits. Both follow up notes stated Patient #15 was taking Coumadin, an anticoagulant medication. Neither note documented how much Coumadin he was taking or if laboratory tests had been performed to check its effectiveness. Neither note documented an examination or questioning to determine if Patient #15 was taking too much Coumadin and his risk of excessive bleeding. Neither note documented instructions to the patient regarding how much Coumadin to take prior to the procedures.</p> <p>A "CONSCIOUS SEDATION FORM," dated 11/22/10, also stated Patient #15 was taking Coumadin but did not provide further information. A different form was used for the 10/13/10 procedure which did not mention medications. Neither form documented how much Coumadin Patient #15 had taken prior to the procedure, which led to the potential to place Patient #15 at increased risk of bleeding during the procedure.</p> <p>e. Patient #8's medical record documented a 39 year old female who had bilateral medial branch radio frequency denervation performed on 11/16/10. A "Pain Clinic Follow Up" note, dated 10/19/10 and used as the H&amp;P, stated Patient #8 had a history of diabetes, chronic pancreatitis,</p>	Q 261			

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Q 261	<p>Continued From page 54</p> <p>and arterial embolism. The medication list stated she was taking Coumadin. The note did not document Patient #8's overall health status. The note did not document how much Coumadin she was taking or if laboratory tests had been performed. The note did not note document an examination or questioning to determine if Patient #8 was taking too much Coumadin which would indicate her risk for excessive bleeding. The note did not document instructions to the patient regarding how much Coumadin to take prior to the procedure.</p> <p>On 1/14/11 at 9:00 AM, Physician A was interviewed. He stated he looked at the information from a patient's last follow up visit, and compared it with the procedure that was scheduled to ensure the proper procedure was indeed being performed. He stated if it had been a while since the patient was in the office he spoke with them to obtain updated information. He stated he was not doing a full physical examination with each procedure, except if it was a new patient for him. He stated he often treated patients for long periods of time and was well acquainted with their medical history. He stated if they had medical problems or were ill (i.e., cancer) at the time of the procedure, they were examined and given the appropriate attention.</p> <p>Physician B was interviewed on 1/14/11 at 11:00 AM. He stated if it was more than 30 days between an office visit and a procedure, office staff were to flag the chart and alert him that an examination was due prior to the procedure. He stated examinations were not performed as often as they should be and physicians could be more consistent with this.</p>	Q 261		

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Q 261	Continued From page 55 The facility failed to ensure a comprehensive H&P, completed 30 days or less from the date of the procedure, was present in the medical record prior to the procedure.	Q 261		
Q 262	416.52(a)(2) PRE-SURGICAL ASSESSMENT  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 observation, interview, and review of medical records and policies, it was determined the facility failed to ensure a physician examined patients prior to procedures for 1 of 3 patients (#1) whose procedures were observed. Failure to perform this pre-surgical assessment had the potential to impact patient safety during and after the procedure. Findings include:  1. The policy "Guidelines and admission protocol to the ASC," not dated, stated "Upon arrival to the ASC the patient will be identified and an initial assessment will be performed which will include review of History and Physical, medications, and allergies." The policy did not state who would perform the assessment or what the assessment would include, i.e. listening to a patient's heart or lungs, etc. The policy also did not state how the	Q 262	Q262 <u>Action:</u> After reviewing the standards for Q262 the ASC will ensure that a pre-surgical assessment is done immediately prior to a procedure being performed at the ASC.  <u>Process improvement:</u> By performing a pre-surgical assessment immediately prior to a procedure performed in the ASC, will help ensure the patient's safety during and after the procedure.  <u>Implementation procedure:</u> The ASC committee will develop a new intake form (paper charting) that will be used by the nurse and the physician that will provide a location for documenting the performance of a pre-surgical assessment. The physician will perform the assessment along with the nurse and document their findings. The assessment will include, at minimum, a review of medical history and a physical assessment for changes since their last exam and also documentation of any patient allergies.  <u>Completion date:</u> February 25, 2011	

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Q 262	<p>Continued From page 56</p> <p>assessment would be documented. This was confirmed by interview with the Administrator on 1/26/11 at 10:05 AM.</p> <p>During an interview with Physician A on 1/14/11 at 9:00 AM, the Physician explained how information was compiled and populated into the "CONSCIOUS SEDATION FORM." He stated information such as the surgical history, social history, medication list, and allergies were automatically populated into the form. He stated the "Past Medical History" section in this form was automatically populated based on the diagnosis codes used at the last follow up office visit. He further explained the "Physical Examination" section was a template but could be altered as needed. He stated the RN entered in the vital signs and updated information in the template if indicated. The portion of the template directly related to the physical exam was as follows:</p> <p>"Vitals: [blank] Weight: [blank] VAS Pain Score is [blank] Height [blank] ASC: MS: AOx3 HEENT: normal CV: Regular Rate and Rhythm, no murmurs Pulm: normal Abdomen: Soft and NT, Normal BS Extremities: no edema or cyanosis..."</p> <p>Physician A stated the physician should be looking at what the RN documented in this section.</p> <p>Physician B was interviewed on 1/14/11 at 11:00 AM. He stated if he performed a physical examination on a patient, it was documented in the "Physical Examination" section of the</p>	Q 262	<p><u>Monitoring and tracking procedure:</u> A member of the ASC committee will review 2 random charts a week for a month after this change is implemented to make sure that the changes that are taking place will fulfill the requirements of this standard. Regular chart reviews will be established and approved by the governing board to guarantee ongoing compliance with this standard.</p> <p><u>Person responsible:</u> Shane Maxwell D.O.</p>	

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Q 262	<p>Continued From page 57 "CONSCIOUS SEDATION FORM."</p> <p>The RN was interviewed on 1/12/11 at 10:45 AM. She stated prior to the procedure she asked patients questions about their medical history, most of them pertinent to cardiovascular or pulmonary status. She stated she did not listen to a patient's heart, lungs, or abdomen with a stethoscope. She stated she depended on the monitors for blood pressure, pulse, and oxygen saturation level, and patient responses to questions to assess the patient. She stated she documented the findings based on her assessment in the "Physical Examination" section.</p> <p>Both the RN and the physician had the ability to document in the "Physical Examination" section of the medical record. In addition, the template, which automatically populated in the medical record, made it difficult to determine if the patient was actually examined, and if so, by whom.</p> <p>The RN was interviewed beginning at 11:15 AM on 1/14/11. She stated the electronic medical record combined documentation from both the physician and the RN into 1 form. She confirmed the identity of individual authors of specific information could not be determined.</p> <p>The physician failed to perform a physical examination prior to a procedure in the following example:</p> <p>Patient #1's medical record documented a 62 year old female admitted to the facility on 1/12/11 for a left sacroiliac joint injection. Patient #1 was observed from admission through discharge on 1/12/11 from 9:45 AM through 10:45 AM. During</p>	Q 262			

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Q 262	<p>Continued From page 58</p> <p>the admission process, at 10:18 AM, the RN asked Patient #1 about her cardiopulmonary status. Patient #1 informed the RN she had emphysema, COPD (Chronic Obstructive Pulmonary Disease), and CHF (Congestive Heart Failure). Patient #1 told the RN she used inhalers. The RN was observed entering this data into the "Physical Examination" section in the computer. Patient #1's physician entered the procedure room at 10:30 AM and asked Patient #1 if there were any changes since the last time she was seen. The physician failed to perform an examination prior to Patient #1's procedure.</p> <p>Physician A was interviewed on 1/14/11 at 9:00 AM. He stated he does not perform a complete physical examination of patients prior to procedures unless it is the first time he is seeing the patient.</p> <p>Physician B was interviewed on 1/14/11 at 11:00 AM. He stated he typically performed a physical examination on patients who had not been seen in the office within 30 days of the scheduled procedure. He stated that pre-procedure assessments were not completed as often as they should be and the physicians could be more consistent with this.</p> <p>The facility RN was interviewed on 1/12/11 at 2:20 PM. She stated Physician A did not normally perform pre-operative assessments of patients. She stated Physician B performed pre-operative assessments if an H&amp;P had not been completed in the prior 30 days. She said if an H&amp;P had been completed in that time, Physician B did not perform a pre-operative assessment.</p> <p>The facility failed to ensure patients were</p>	Q 262			

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NAME OF PROVIDER OR SUPPLIER  LES BOIS SURGERY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 8950 W EMERALD STREET, SUITE 168 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 262 Q 264	Continued From page 59 examined by a physician prior to the procedure. 416.52(b) POST-SURGICAL ASSESSMENT :  (1) The patient's post-surgical condition must be assessed and documented in the medical record by a physician, other qualified practitioner, or a 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 observation, review of medical records and facility policy, and staff interview it was determined the facility failed to ensure patients were properly assessed prior to discharge which directly impacted 5 of 23 patients (#1, #12, #14, #20, and #21) whose records were reviewed, and had the potential to impact all patients who received care at the facility. Failure to adequately assess a patient prior to discharge had the potential to result in premature discharge and subsequent negative patient outcomes. Findings include:  1. Two policies related to discharge criteria to be met before a patient was released from the facility were reviewed. The "Anesthetic risk, evaluation, and recovery" policy, not dated, indicated, "Prior to discharge from the surgical center the patient will demonstrate the ability to maintain normal respiratory function (normal rate and oxygen saturation greater than 92%) without the aid of oxygen (unless the patient is previously on home required oxygen therapy), normal cardiovascular	Q 262 Q 264	Q264 <u>Action:</u> After reviewing the standards for Q264 the treating physician or registered nurse will asses and document the post-surgical condition of the patient prior to discharge. Any post-surgical needs will be addressed and included in the discharge notes.  <u>Process improvement:</u> Assessing and documenting the post-surgical condition and needs of the patients in the ASC, will help reduce the possibility of premature discharge and subsequent negative patient outcomes.  <u>Implementation procedure:</u> The ASC committee will design a new post-surgical charting form that will provide a location for documenting the post-surgical assessment for each patient that undergoes surgery at the ASC. Any post-surgical needs will be addressed and documented on that form. The nurse will assess the patients per a clearly defined discharge policy that is approved by the governing body.  <u>Completion date:</u> February 25, 2011  <u>Monitoring and tracking procedure:</u> A member of the ASC committee will review 2 random charts a week for a month after this change is implemented to make sure that the changes that are taking place will fulfill the requirements of this standard. Regular chart reviews will be established and approved by the governing board to guarantee ongoing compliance with this standard.	

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Q 264	<p>Continued From page 60</p> <p>function including rate and blood pressure, alert and appropriate mental status, controlled pain, and absence of nausea and vomiting."</p> <p>A second policy, the "Conscious Sedation for Adults" policy, updated August 2010, contained information related to discharge criteria for patients who received conscious sedation. According to the policy, "Patients who have received conscious sedation/analgesia may be discharged if all of the established discharge criteria are met." The list of discharge criteria was as follows:</p> <ul style="list-style-type: none"> <li>- "Patient is as alert and orient [sic] as baseline</li> <li>- Presence of protective reflexes (swallow and gag)</li> <li>- Stable vital signs</li> <li>- Oxygen saturation on room air at least 95% or at baseline</li> <li>- Cardiac rhythm consistent with baseline</li> <li>- BP (blood pressure) and heart rate within normal limits</li> <li>- Pain rating &lt; or = to baseline</li> <li>- When applicable, no visible site drainage or excessive swelling</li> <li>- Patient is able to ambulate as well as he/she was able to ambulate prior to the procedure</li> <li>- Responsible adult is present to drive patient home and remain with patient..."</li> </ul> <p>Not all of the criteria addressed in the policies related to discharge criteria were evaluated or documented prior to patient discharge. For example:</p> <ul style="list-style-type: none"> <li>-Patient's mental status was not documented at discharge.</li> <li>-Vital signs were not always obtained prior to</li> </ul>	Q 264	<u>Person responsible:</u> Shane Maxwell D.O.	

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Q 264	<p>Continued From page 61 discharge.</p> <ul style="list-style-type: none"> <li>-Pain rating was not documented post-procedure.</li> <li>-The patient did not always drink fluids (to evaluate protective reflex) or void prior to discharge yet these were marked "Yes."</li> <li>-No documentation related to nausea and vomiting at discharge. The template was populated and the RN completed entering information, including the name of the driver and the approximate discharge time, prior to the procedure taking place.</li> </ul> <p>The Administrator was interviewed on 1/25/11 at 10:00 AM. He reviewed the above policies. He confirmed the discrepancies between the two policies related to criteria required for discharge. He confirmed the facility did not have a policy related to discharge criteria for patients who did not receive conscious sedation. He stated he believed the above criteria were assessed, however due to the format of the electronic medical record were not properly documented.</p> <p>The facility failed to ensure criteria outlined in discharge policies was evaluated and documented in the medical record.</p> <p>2. The medical record contained a "CONSCIOUS SEDATION FORM," which had a section titled, "POST-OP." Discharge assessment information was documented in this section. The assessment criteria was formatted as a template and automatically populated with answers to all but the last two lines. The template was as follows:</p> <ul style="list-style-type: none"> <li>- "Patient able to tolerate food/fluids: Yes.</li> <li>- Patient able to bear weight/ambulate safely: Yes</li> <li>- Patient able to void: Yes</li> <li>- Patient given a follow-up</li> </ul>	Q 264		

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Q 264	<p>Continued From page 62 appointment/instructions: Yes - Patient discarded to the care of an adult: Yes (area to insert name/relationship of this adult) - Patient discharged at:"</p> <p>The RN was interviewed on 1/12/11 at 10:45 AM. She stated she documented the discharge data during the admission process and amended the information as needed. For example, if a patient was discharged at a time other than which she originally entered, she amended this. She explained her process of evaluating a patient for discharge. She stated she always offered a patient fluids to drink. She stated if a patient was able to ambulate, there was no interruption to the nerves for the bowel and bladder and therefore a patient had the ability to void. She stated if the patient complained of being numb in an area related to these specific nerves, she evaluated the patient more closely and if needed, had them stay until this was resolved.</p> <p>During an interview on 1/14/11 at 9:00 AM, Physician A reviewed this section and explained how it was used by the RN. He stated while the electronic medical record automatically populated this portion of the record, the RN had to fill in the name of the individual who was driving the patient home and the discharge time. Therefore, the RN reviewed all of the discharge criteria and amended data as needed.</p> <p>He reviewed the discharge criteria evaluated in the medical record and stated most patients are taking fluids prior to discharge and the facility's accrediting organization required documentation that a patient was able to void prior to discharge.</p> <p>Physician B was interviewed on 1/14/11 at 11:00 AM. He stated he believed because the facility</p>	Q 264		

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Q 264	<p>Continued From page 63</p> <p>had the opportunity to amend the medical record, it was not a significant issue for the RN to complete the "POST-OP" section prior to the procedure. He also stated indicating a patient could void when this was not witnessed was inaccurate.</p> <p>Examples of patients not adequately assessed prior to discharge included:</p> <p>a. Patient #20's medical record documented an 82 year old female who had a lumbar epidural steroid injection on 11/08/10. Nursing notes on the "CONSCIOUS SEDATION FORM," not timed, included a post-surgical assessment. The note stated Patient #20 was given conscious sedation medication at 1:45 PM and 1:50 PM. The note did not state when the procedure ended. The note stated Patient #20's blood pressure was 203/93 at 1:45 PM and was 186/90 at 2:00 PM when she was discharged. An assessment of her status in relation to her elevated blood pressure was not documented, i.e. if she was dizzy or had visual problems. The note stated Patient #20 was "able to bear weight/ambulate safely."</p> <p>An "Incident Report Form," written by the RN and dated 11/08/10, stated Patient #20's husband and the nurse "assisted pt [patient] from x-ray to w/c [wheel chair]-pt was able to partially assist. After 15-20 minutes in recovery pt wheeled to car. With spouse &amp; myself for assist, pt was ready for transfer to car. Pt leaned forward to stand &amp; legs wouldn't hold her weight. Pt stated can't feel my legs. Husband on left side, me right, couldn't get pt in w/c again. Husband supported pt, pt held herself @ door jam...With the help of 4 people, pt was lifted the remaining way back into w/c. Pt never went to the ground. Black and blue</p>	Q 264			

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Q 264	<p>Continued From page 64</p> <p>bruising on [right] shin noticed after back in recovery." This incident was not documented on Patient #20's medical record.</p> <p>The RN who cared for Patient #20 was interviewed beginning at 11:15 AM on 1/14/11. She confirmed the documentation and stated there was no way to document a post-surgical assessment besides the pre-printed questions listed on the form.</p> <p>b. Patient #1 was admitted to the facility on 1/12/11 for a left sacroiliac joint injection without sedation. Patient #1's care was observed on 1/12/11 from admission at 10:10 AM through discharge at 10:45 AM. At 10:20 AM the RN was observed to complete her nursing notes on the "CONSCIOUS SEDATION FORM," including documentation in the "POST-OP" template section. At 10:30 AM, the RN documented the first set of vital signs just prior to initiation of the procedure. A second set of vital signs was obtained at 10:35 AM, at the completion of the procedure. The Physician reiterated to Patient #1 how the medication delivered in the injection worked, assisted Patient #1 to a sitting position on the procedure table. The Physician then left the room. The RN assisted Patient #1 off the procedure table and asked if she would like any food or drink, which Patient #1 declined. The RN reviewed discharge instructions and asked Patient #1 how her leg felt and if she had any pain. Patient #1 stated her leg was "numb." The RN then escorted Patient #1 to the waiting room. Patient #1 was discharged at 10:45 AM.</p> <p>Patient #1's "CONSCIOUS SEDATION FORM," in the section titled "POST-OP," contained the above template items, including "Patient able to</p>	Q 264		

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Q 264	<p>Continued From page 65</p> <p>tolerate food/fluids: Yes," and "Patient able to void: Yes." However, Patient #1 was not observed to eat, drink, or void. The RN was observed to ask Patient #1 about her pain level, however this information was not documented in the medical record.</p> <p>c. Patient #21 was admitted to the facility on 1/13/11 for a steroid injection into the lumbosacral region of her spinal cord with conscious sedation. Patient #21's care was observed on 1/13/11 from admission at 1:10 PM through discharge at 1:50 PM. The RN was observed to complete her nursing notes on the "CONSCIOUS SEDATION FORM," including documentation in the "POST-OP" template section at 1:20 PM. The RN documented vital signs at 1:30 PM, 1:35 PM, and 1:40 PM. The RN documented administration of conscious sedation medication at 1:30 PM. At 1:40 PM, the Physician completed the procedure, asked Patient #21 if she was okay, and left the room. He stated he would return to see Patient #21 prior to her discharge. The RN assisted Patient #21 to a sitting position on the procedure table, asked if Patient #21 felt the effects of the sedation medication and if she was okay to stand. Patient #21 was then escorted to the recovery area. Patient #21 accepted the offer of fluids and recovered in a chair for several minutes. At 1:48 PM, the Physician asked Patient #21 how she was doing and assessed the left leg for strength. At 1:50 PM, the RN was asked Patient #21 how her legs felt and if she had any pain. Patient #21 stated her legs felt "heavier, but okay." The RN was observed to escort Patient #21 out of the recovery area.</p> <p>Patient #21's "CONSCIOUS SEDATION FORM," in the section titled "POST-OP," contained the</p>	Q 264		

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Q 264	<p>Continued From page 66</p> <p>above template items, including "Patient able to void: Yes." However, Patient #1 was not observed to void. The RN was observed to ask Patient #1 about her pain level, however this information was not documented in the medical record.</p> <p>d. Patient #14 was admitted to the facility on 12/06/10 for a right lumbar sympathetic block (#2 in a series of 3). The "CONSCIOUS SEDATION FORM" contained documentation of the first set of vital signs and administration of Versed and Fentanyl at 1:25 PM. Vital signs and the second doses of Versed and Fentanyl were documented at 1:30 PM. At 1:35 PM, the RN documented a third set of vital signs and third doses of Versed and Fentanyl. The medical record contained no additional vital signs taken after the last doses of medication were administered. The medical record did not indicate who was driving Patient #14 home, and indicated Patient #14 was discharged at 2:00 PM.</p> <p>The RN was interviewed on 1/19/11 at 11:15 AM. She stated vital signs are obtained during the procedure, however once the patient was in the recovery room, she did not routinely obtain vital signs. She stated she used her judgment to decide if additional vital signs needed to be obtained prior to discharge, for example if the patient remained extremely drowsy she might check their vital signs or their oxygen saturation level. She stated, however, she did not have a place in the medical record to document vital signs obtained in the recovery area.</p> <p>e. Patient #12 was observed from her arrival at 1:20 PM on 1/12/11 until she left the building at 2:15 PM that same day. A caudal epidural steroid</p>	Q 264		

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Q 264	<p>Continued From page 67</p> <p>injection was performed. The RN was observed to complete her nursing notes on the "CONSCIOUS SEDATION FORM" at approximately 1:40 PM, including documenting post-procedure monitoring for the procedure which did not begin until 1:55 PM. The procedure was complete and Patient #12 was taken to the recovery room at 2:10 PM. She changed into her street clothes and was discharged at 2:15 PM. The RN did not obtain a set of vital signs following the procedure. A post-surgical assessment was not performed.</p> <p>Patient #12's "CONSCIOUS SEDATION FORM," in a section labeled "POST-OP," contained items including "Patient able to tolerate food/fluids: Yes." and "Patient able to void: Yes." However, Patient #12 was not observed to void or eat or drink before leaving.</p> <p>The RN who cared for Patient #12 was interviewed beginning at 2:20 PM on 1/12/11. She stated she did not routinely take post-surgical vital signs.</p> <p>The facility failed to ensure patients were properly assessed prior to discharge in accordance with facility policy.</p>	Q 264		
Q 266	<p>416.52(c)(2) DISCHARGE - ORDER</p> <p>[The ASC must -] Ensure each patient has a discharge order, signed by the physician who performed the surgery or procedure in accordance with applicable State health and safety laws, standards of practice, and ASC policy.</p> <p>This STANDARD is not met as evidenced by:</p>	Q 266	<p>Q266 <b>Action:</b> After reviewing the standards for Q266 the ASC will ensure each patient has a discharge order, signed by the physician who performed the surgery.</p> <p><b>Process improvement:</b> Having a discharge order for each patient that is signed by the physician will reduce the possibility of a premature discharge.</p>	

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Q 266	<p>Continued From page 68</p> <p>Based on review of medical records and facility policies and staff interview it was determined the agency failed to ensure patients were discharged with a physician's order for 23 of 23 patients (#1 - #23) whose records were reviewed. Failure to ensure a discharge order was obtained had the potential to result in premature discharge of patients. Findings include:</p> <p>Two facility policies, "Anesthetic risk, evaluation, and recovery" policy, not dated, and the "Conscious Sedation for Adults" policy, updated August 2010, contained a list of criteria patients must have met prior to discharge. It did not indicate that a patient was to be discharged upon the order of a physician.</p> <p>Medical records for Patients #1 - #23 were reviewed and did not contain documentation of a specific discharge order written by the physician.</p> <p>During an interview on 1/19/11, beginning at 11:45 AM, Physicians A and B confirmed the lack of a complete and accurate discharge assessment and a specific discharge order signed by the physician.</p> <p>Medical records did not contain a physician order for patient discharge.</p>	Q 266	<p><b>Implementation procedure:</b> The ASC committee will design a new post-surgical charting form that will provide a location for documenting the discharge order for each patient that undergoes surgery at the ASC. The physician who performed the surgery will sign the discharge order.</p> <p><b>Completion date:</b> February 25, 2011</p> <p><b>Monitoring and tracking procedure:</b> A member of the ASC committee will review 2 random charts a week for a month after this change is implemented to make sure that the changes that are taking place will fulfill the requirements of this standard. Regular chart reviews will be established and approved by the governing board to guarantee ongoing compliance with this standard.</p> <p><b>Person responsible:</b> Shane Maxwell D.O.</p>	