IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

February 4, 2013

Carol Lugar, Administrator
Boise Endoscopy Center
425 West Bannock
Boise, ID 83702

RE: Boise Endoscopy Center, Provider #13C0001024

Dear Ms. Lugar:

This is to advise you of the findings of the Medicare survey of Boise Endoscopy Center, which was conducted on January 25, 2013.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicare deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. It is important that your Plan of Correction address each deficiency in the following manner:

An acceptable plan of correction (PoC) contains the following elements:

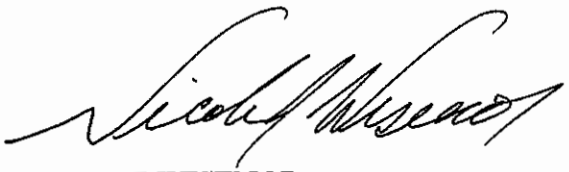
- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the PoC is effective in bringing the ASC into compliance, and that the ASC remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
- The administrator's signature and the date signed on page 1 of the Form CMS-2567.

After you have completed your Plan of Correction, return the original to this office by **February 19, 2013,** and keep a copy for your records.

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

Sincerely,

SUSAN COSTA
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

SC/nw
Enclosures

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

PRINTED: 02/01/2013
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13C0001024		01/25/2013

NAME OF PROVIDER OR SUPPLIER: BOISE ENDOSCOPY CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 425 WEST BANNOCK, BOISE, ID 83702

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 000	INITIAL COMMENTS The following deficiencies were cited during the recertification survey of your Ambulatory Surgery Center. Surveyors conducting the recertification were: Susan Costa, RN, HFS, Team Leader Gary Guiles, RN, HFS Taylor Barkley, REHS Acronyms used in this report include: ASC - Ambulatory Surgical Center CDC - Center for Disease Control EGD - Esophago-gastro-duodenoscopy IV - Intravenous mcg - microgram mg - milligram RN - Registered Nurse QAPI - Quality Assessment and Performance Improvement upper GI endoscopy - upper gastrointestinal endoscopy, an examination of the upper gastrointestinal tract using a scope	Q 000	A study has been initiated on the use of reversal agents in the ASC. Data has been collected on the patients that received reversal agents in 2012. This is intended to be an ongoing study. The data collected will include all patients that received reversal agents in procedure as well as post procedure. MD's will have education on 2/20/13 at the governing body meeting. The education will include: • details of the data collection • use of reversal agents necessitate an adverse event form • documentation of the patients status/reaction that led to the decision to administer a reversal agent is required • the patients response to the reversal agent is to be documented • the steps to be taken to sign off on a post procedure order • medication reconciliation between the nurse and the MD at the end of the procedure • Discharge procedure after the administration of a reversal agent.	Evidence
Q 081	416.43(a), 416.43(c)(1) PROGRAM SCOPE; PROGRAM ACTIVITIES (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 quality indicators or performance measures associated with improved health outcomes and by the identification and reduction of medical errors. (a)(2) The ASC must measure, analyze, and track quality indicators, adverse patient events, infection control and other aspects of	Q 081		

RECEIVED FEB 19 2013 FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Carol Dugan RN — TITLE: Clinical Director — (X6) DATE: 2/15/2013

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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PRINTED: 02/01/2013
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OMB NO. 0938-0391

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	13C0001024	A. BUILDING _____ B. WING _____	01/25/2013

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Q 081	Continued From page 1 performance that includes care and services furnished in the ASC. (c)(1) The ASC must set priorities for its performance improvement activities that - (i) Focus on high risk, high volume, and problem-prone areas. (ii) Consider incidence, prevalence, and severity of problems in those areas. (iii) Affect health outcomes, patient safety, and quality of care. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records, facility policies, and quality improvement documents, it was determined the ASC failed to analyze adverse patient events including 1 of 1 patient (#10) who had an endoscopy and required a reversal agent. This prevented the ASC from implementing and monitoring program changes to prevent further adverse patient events. Findings include: 1. The ASC did not identify all adverse patient events. For example, Patient #10 medical record documented the use of a benzodiazepine antagonist following an upper GI endoscopy on 11/07/12. The drug was used to reverse the sedative effects of the drugs administered to Patient #10 during the procedure. An incident report was not completed and the event was not investigated. This prevented the ASC from tracking and trending adverse patient events. The Assistant Clinical Director was interviewed on	Q 081	The nursing staff meeting is scheduled on 02/28/13 @ 3PM. All the above listed items will be covered. Through education and monitoring physicians and nursing will have an opportunity for [illegible] awareness of when reversal are utilized, improved comm[illegible] of outcomes, improved und[illegible] of policies associated wit[illegible] reversal agents. By reviewin[illegible] steps to be followed for po[illegible] procedure orders, documen[illegible] and signature improveme[illegible] all entries associated [illegible] anesthesia administrat[illegible] be documented. The review of medication reconciliation will improve the accuracy of the record quarterly use of reversal agents will be reviewed by the QI committee. [redacted] will be responsible for the data collection, monitoring and implementing the plan to correct the deficiencies.	Evidence of staff [illegible] 2/15/13 ongoing

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Q 081	Continued From page 2 1/24/13 beginning at 9:43 AM. She stated an incident report had not been generated regarding the use of the benzodiazepine antagonist for Patient #10. She confirmed that the incident should have been reported and investigated. The ASC did not identify all adverse patient events.	Q 081		
Q 162	416.47(b) FORM AND CONTENT OF RECORD The ASC must maintain a medical record for each patient. Every record must be accurate, legible, and promptly completed. Medical records must include at least the following: (1) Patient identification. (2) Significant medical history and results of physical examination. (3) Pre-operative diagnostic studies (entered before surgery), if performed. (4) Findings and techniques of the operation, including a pathologist's report on all tissues removed during surgery, except those exempted by the governing body. (5) Any allergies and abnormal drug reactions. (6) Entries related to anesthesia administration. (7) Documentation of properly executed informed patient consent. (8) Discharge diagnosis. This STANDARD is not met as evidenced by: Based on review of medical records and staff interview, it was determined the facility failed to ensure medical records were clear and accurate for 2 of 20 patients (#10 and #14) whose records were reviewed. This resulted in lack of clarity	Q 162	See plan included in Q81 response RECEIVED MAR 21 2013 FACILITY STANDARDS	

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Q 162	Continued From page 3 regarding documentation by the physician and nurse of medications given during the procedures. Findings include: Medical records were not clear and accurate as follows: 1. Patient #10 was administered a reversal agent without a physician order, and the record did not contain and indication for why it was used or for the response to the drug. Patient #10's medical record documented a 43 year old female who had an upper GI endoscopy performed on 11/07/12. The procedure began at 2:36 PM. The "GI Nurse Note" documented Patient #10 received 125 mcgs of Fentanyl and 6 mgs of Versed intravenously during the procedure between 2:33 PM and 2:36 PM. In addition, Patient #10 received Phenergan 25 mgs IV for nausea at 2:31 PM. The note stated the procedure ended at 2:38 PM and she was transferred to recovery. At 4:05 PM, Patient #10 received Romazicon 0.2 mgs IV, a benzodiazepine antagonist (a drug used to reverse the sedative effects of the Versed.) Patient #10 was discharged to home at 4:21 PM. Patient #10's medical record did not document why she received the Romazicon approximately an hour and a half after her transfer to recovery. There was no physician order or documentation in Patient #10's record to indicate the physician had approved or was aware of the administration of the reversal agent. Documentation by the nurse who had administered the Romazicon did not indicate the reason for administration, or note the patient response to the drug after it was	Q 162		

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Q 162	Continued From page 4 given. The last set of vital signs for Patient #10 was documented at 3:26 PM on 11/07/12, which was before the drug had been administered. The registered nurse who administered the Romazicon was interviewed on 1/25/13 beginning at 9:05 AM. She reviewed Patient #10's record. She stated she did not remember the patient and could not recall details surrounding the use of the Romazicon. Patient #10's medical record was not complete. 2. Patient #14 was a 23 year old male who was admitted on 12/20/12 for a colonoscopy. The procedure note, written by the physician, documented Patient #14 received Fentanyl 150 mcgs and Versed 8 mgs IV. However, the RN documented the patient received Fentanyl 200 mcgs and Versed 10 mgs. In an interview on 1/25/12 beginning at 10:30 AM, the Clinical Director reviewed the record and confirmed the documentation of medications Patient #14 received was different on each form. The Clinical Director stated the nurse had accurately documented the amounts given. She stated it was the practice of the nurse to enter the amount of medication directly into the computer immediately after administration. The facility failed to ensure the medical records were complete and accurate.	Q 162		
Q 241	416.51(a) SANITARY ENVIRONMENT The ASC must provide a functional and sanitary environment for the provision of surgical services by adhering to professionally acceptable	Q 241	A copy of the handwashing policy/procedure is posted for review. The policy will be circulated at the governing body mtg 2/20/13	

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Q 241	Continued From page 5 standards of practice. This STANDARD is not met as evidenced by: Based on observations, review of facility policies, and staff interview, it was determined the ASC failed to ensure staff followed established policies to reduce the possibility of spreading infectious diseases for 2 of 2 patients (#1 and #2) whose surgery was observed, and had the potential to affect all patients receiving care at the facility. Failure to follow facility policies had the potential to compromise safety and increase infection risk for all patients treated at the facility. Findings include: The CDC "Guidelines for Hand Hygiene in Health-Care Settings," dated 10/25/02, was reviewed. According to the guidelines, hand washing is recommended when hands are visibly soiled. Otherwise, hand hygiene, either hand washing or decontamination with an alcohol based hand sanitizer, is recommended including when hands are not visibly soiled, before direct contact with patients, after contact with patient's intact skin, when moving from a contaminated body site to clean body sire, after contact with inanimate objects in the immediate vicinity of the patients, and after removing gloves. 1. The facility's policy, "Policy for Control of Infection," dated 7/2011, indicated that hand washing or hand hygiene was to occur "when entering and leaving the area, after glove removal, and between each procedure, patient contact, and after performing any personal hygiene." In the following examples staff failed to perform hand hygiene after contact with	Q 241	Discussion of handwashing procedure to include use of hand sanitizer between change of gloves and between patient contact. Additional hand sanitizers have been ordered for the procedure rooms as well as the patient bays and will be installed on 2/19/13. At the February 28th Nsg staff meeting education on the handwashing policy will occur. Compliance to the policy will be monitored by [redacted] and [redacted]. Observation of physicians and staff will occur after the staff meeting. Spot checks will be done quarterly by assistant clinical director and infection control nurse to ensure compliance.	2/28/13 ongoing

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Q 241	Continued From page 6 contaminated objects or after removing gloves: a. Patient #2 was admitted to the facility on 1/24/13 for an EGD and colonoscopy. Care for Patient #2 was observed from admission at 1:15 PM through post-procedural recovery until 3:30 PM. - At 1:55 PM after speaking with Patient #2 then using a computer, the physician put gloves on without performing hand hygiene. He then started the EGD procedure. - From 1:58 PM until 2:12 PM, the nurse assisting with the procedure was noted to change her gloves 3 times without using hand sanitizer or washing her hands between glove changes. - The colonoscopy was started at 2:15 PM. During the procedure, the nurse was noted to change her gloves 6 times without using hand sanitizer or washing her hands between glove changes. The room had a sink as well as a waterless hand sanitizer dispenser. However, the hand sanitizer dispenser was located on a wall close to the computer desk that was not easily accessible for the staff to use when needed. The Clinical Director was interviewed on 1/25/13 beginning at 10:30 AM regarding expectations related to hand hygiene. She stated it was an expectation for staff to perform hand hygiene after removing gloves.	Q 241		

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Q 241	Continued From page 7 b. Patient #1 was admitted to the facility on 1/23/13 for upper GI endoscopy. Care for Patient #1 was observed from admission at 12:25 PM through post-procedural recovery until discharge at 3:00 PM. Patient #1 was taken to the procedure room at 1:53 PM. After speaking with Patient #1 and physically examining her, the physician wiped her stethoscope down, typed on the computer, put gloves on, and then started the EGD procedure. The physician did not perform hand hygiene during this time. From 1:53 PM until 2:11 PM, when the procedure was finished, the nurse assisting with the procedure was noted to change her gloves 2 times without using hand sanitizer or washing her hands between glove changes. During this time, the nurse positioned Patient #1, administered IV medication, placed a bite block in her mouth, administered more IV medication, and repositioned Patient #1. The room had a sink. However, a trash receptacle was positioned directly in front of the sink making it difficult to use. The Clinical Director was interviewed on 1/25/13 beginning at 10:30 AM regarding expectations related to hand hygiene. She stated it was an expectation for staff to perform hand hygiene after touching the patient and before putting on gloves. Hand hygiene was not performed in accordance with standards of practice and facility policy to	Q 241		

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Q 241	Continued From page 8 ensure a sanitary environment for patient care.	Q 241		