



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  
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**CERTIFIED MAIL: 70073020000140388478**

February 12, 2013

Shane Ricks, Administrator  
Millennium Surgery Center  
1828 South Millennium Way, Suite 100  
Meridian, ID 83642

RE: Millennium Surgery Center, Provider #13C0001011

Dear Mr. Ricks:

Based on the survey completed at Millennium Surgery Center, on January 29, 2013, by our staff, we have determined Millennium Surgery Center is out of compliance with the Medicare ASC Condition for Coverage of **Governing Body and Management (42 CFR 416.41)**. 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 Millennium 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;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;

Shane Ricks, Administrator  
February 12, 2013  
Page 2 of 2

- 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 15, 2013. 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 March 6, 2013.**

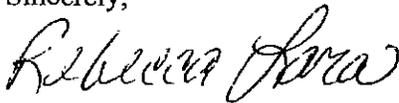
Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **February 22, 2013.**

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,



REBECCA LARA  
Health Facility Surveyor  
Non-Long Term Care



NICOLE WISENOR  
Co-Supervisor  
Non-Long Term Care

RL/nw

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: 02/12/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13C0001011</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/29/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MILLENNIUM SURGERY CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1828 SOUTH MILLENNIUM WAY, SUITE 100 MERIDIAN, ID 83642</b>
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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>Rebecca Lara RN, BA, HFS, Team Leader Libby Doane RN, BSN, HFS Aimee Hastriter RN, BSN, HFS Susan Costa RN, HFS</p> <p>The following acronyms were used in this report:</p> <p>ASC - Ambulatory Surgical Center CDC - Centers for Disease Control CRNA - Certified Registered Nurse Anesthetist CST - Certified Scrub Technician D&amp;C - Dilatation and Curettage- a surgical procedure for cleaning out the lining of the uterus DEA - Drug Enforcement Agency DVT - Deep Vein Thrombosis EGD - Esophagogastroduodenoscopy ER - Emergency Room ET - Endotracheal DNR - Do Not Resuscitate H&amp;P - History and Physical IDAPA - Idaho Administrative Procedures Act IV - Intravenous GMA - General Mask Anesthesia LMA - Laryngeal Mask Airway MAC - Monitored Anesthesia Care OR - Operating Room PACU - Post Anesthesia Care Unit PARSAP - Post Anesthesia Recovery Score for Ambulatory Patients QAPI - Quality Assurance Performance Improvement RN - Registered Nurse</p>	Q 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE

Administrator

(X6) DATE

2/26/2013

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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Q 000	Continued From page 1 TB - Tuberculosis TIVA - Total Intravenous Anesthesia WNL - Within Normal Limits	Q 000		
Q 040	416.41 GOVERNING BODY AND MANAGEMENT  The ASC must have a governing body that assumes full legal responsibility for determining, implementing, and monitoring policies governing 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.  This CONDITION is not met as evidenced by: Based on observation, staff interview, and review of policies, personnel files, staff training records and administrative documents, it was determined the ASC failed to ensure the governing body assumed responsibility for determining, implementing, and monitoring policies governing the ASC's total operation. This failure impacted 20 of 20 patients (Patients #1 - #20) whose records were reviewed and had the potential to impact all patients receiving care at the facility. This failed practice directly impacted 1 of 2 patients whose surgical procedures were observed (Patient #18) and resulted in a lack of guidance and oversight of the facility's staff and programs. Findings include:  1. A policy titled, "CARDIOPULMONARY RESUSCITATION TRAINING REQUIREMENTS,"	Q 040	<p>① CPR Training requirements In 2012 mock codes were not completed.</p> <p>② All <sup>clinical</sup> staff are required to participate in a mock code annually per policy #8032 and Policy 7006 Inservice Education Programs.</p> <p>③ All clinical staff members participated in a pediatric and Adult mock code.</p> <p>④ Feb 21, 2013</p> <p>⑤ A note is in all participants files to note training was completed. This will be tracked and completed annually.</p> <p>⑥ supervised by the Administrator.</p> <p>⑦ Administrator is responsible for the annual completion of mock codes and CPR ACLS and PALS training and monitoring 2/21/13</p>	

Policy 8032 & 7006 Approved  
by governing board 2/26/13

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Q 040	<p>Continued From page 2 last revised 5/12/11, stated "Annual Mock Codes will be conducted."</p> <p>All personnel files were reviewed with the Administrator on 1/24/13. There was no evidence of participation in cardiovascular mock codes for adult or pediatric patients found in any of the personnel files. Additionally, staff inservice/education records were reviewed with the Administrator on 1/24/13. No documentation was found indicating cardiovascular mock codes had occurred in 2012.</p> <p>The Administrator for the ASC was interviewed on 1/28/13, beginning at approximately 1:40 PM. He stated it was the facility's practice to conduct annual pediatric and adult cardiovascular mock codes. The Administrator said pediatric and adult cardiovascular mock codes were conducted in 2011, but neither occurred in 2012. Additionally, no documentation was provided verifying the 2011 mock codes were conducted.</p> <p>The facility failed to ensure cardiovascular mock codes for adult and pediatric patients were conducted on an annual basis in accordance with facility policy.</p> <p>2. An in-service/education manual for staff was reviewed with the Administrator on 1/23/13. The manual was dated 2011 and contained educational reading material/booklets related to various topics, such as hand hygiene and infection control. Staff sign in sheets that corresponded to each topic were also found in the manual. Educational information and evidence of participation could not be found for 2012.</p>	Q 040	<p>② Inservice / Education</p> <p>① Inservice/Edu policy # 7000 Not all training and recording of the training was inadequate</p> <p>① Training by clinical staff is required. See policy</p> <p>① Training will be completed and properly recorded. Required topics, Safety, Infection Control, mock codes, Fire drills, Emergency drill, ETC. Training completed. Mock code Pediatric and Adult Malignant Hyperthermia. Emergency preparedness. Also Infection control MDV. policy review # 3635 3036 patient positioning and safety Strap inservice. Preoperative criteria reviewed policy 2007, 2010 and 2015. Cleaning Audits reviewed. Completed 2/21/13.</p> <p>① Monitored and tracked by Administrator. Record of Training in files.</p> <p>① Administrator Responsible for Compliance</p>	
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Policies

2/21/13

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Q 040	Continued From page 3  The Administrator was interviewed on 1/23/13, beginning at approximately 9:15 AM. He stated it was the practice of the ASC to provide annual in-service/education to employees. The Administrator said staff in-service/education was provided primarily through reading materials in 2011, as evidenced by the education manual dated 2011. He stated the plan for 2012 was to provide on-line access to approved educational material for the staff, but the plan had not worked as expected and therefore had never occurred. The Administrator confirmed an in-service/education program was not implemented for staff in 2012.  The ASC failed to ensure staff was provided annual in-service/education in 2012 in accordance with facility policy.  3. The facility's discharge policies were not sufficiently developed and did not match patient forms as follows:  a. The "POST ENDOSCOPIC PROCEDURE RECOVERY" policy, revised 7/08/11, provided instructions for patients who received moderate sedation. The policy did not define "moderate sedation."  According to the policy, patients were to be transported to the PACU and observed for level of consciousness, discomfort/pain, medication reaction, bleeding, abdominal rigidity, vital signs, and IV site appearance. The policy did not specify what criteria were to be met other than "Patients are discharged to their designated driver via a wheelchair, when alert from the	Q 040	<p>③ Discharge Criteria from PACU Policy # 2332.</p> <p>② Post Endo procedure policy as been removed from Service and combined with Policy 2332</p> <p>① Discharge Criteria is defined and acceptable Discharge Score is noted.</p> <p>④ Staff were in service on better defined discharge criteria.</p> <p>⑤ Completed 2/21/13</p> <p>⑥ Administrator monitors compliance by having chart reviews done quarterly. Completed by nursing staff and followed by Administrator</p> <p>⑦ Administrator is responsible for compliance. 2/21/13</p> <p>Policy 2332 Approved by Governing Board. 2/20/13</p>	

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Q 040	<p>Continued From page 4 recovery unit." The policy did not indicate a discharge order was required.</p> <p>Further, the facility used an endoscopy form with a "POST PROCEDURAL ASSESSMENT" section. The form allowed for the monitoring of vital signs and included a list of items to be assessed such as color, consciousness, circulation, respiration, activity, and pain. The items to be assessed on the form did not match the items to be assessed in the facility's policy.</p> <p>A document titled "PHYSICIAN PROCEDURE RECORD" contained orders for endoscopic procedures. The discharge order indicated, "May discontinue IV and discharge when discharge criteria met." Facility policies did not include discharge criteria that correlated with these orders.</p> <p>The facility's "POST ENDOSCOPIC PROCEDURE RECOVERY" policy, the "POST PROCEDURAL ASSESSMENT" section of the endoscopy form and the "PHYSICIAN PROCEDURE RECORD" were not consistent with each other.</p> <p>b. The "DISCHARGE FROM PACU" policy, revised 7/08/11, stated that all patients "are discharged from the PACU by order of anesthesia provider...when they have achieved a score of eight (8) or greater on the Aldrete Post Anesthesia Recovery Score for Discharge Criteria..." In addition, the policy stated, "Patients receiving straight LOCAL anesthesia or monitored anesthesia care (MAC) may be discharged directly back to the patient care unit, per the discretion of the anesthesia provider."</p>	Q 040	<p>③ b. ① inconsistent PACU Scoring policy 2332. ① policies updated to reflect actual practice and forms. Staff was inserviced and reviewed policy. Completed 2/21/13 ② Administrator is responsible for compliance. 2/21/13</p>	

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Q 040	<p>Continued From page 5</p> <p>The remainder of the policy contained directions for reporting conditions to receiving nursing.</p> <p>The "DISCHARGE CRITERIA - SURGICAL PATIENTS" policy, revised 7/08/11, was reviewed. The policy noted that it applied to patients "receiving any type of anesthesia." According to the policy, "Prior to discharge, patient must, at a minimum, meet all the following discharge criteria:"</p> <ul style="list-style-type: none"> <li>- Vital signs shall remain stable</li> <li>- Be able to swallow fluids or demonstrate a gag reflex</li> <li>- Able to ambulate</li> <li>- Minimal nausea or vomiting</li> <li>- Minimal dizziness</li> <li>- No signs of respiratory distress</li> <li>- Alert and oriented</li> <li>- Pain free or controlled by oral analgesics</li> <li>- Minimal surgical bleeding</li> <li>- Patients who received a spinal or epidural anesthetic will have "returned sensation and movement in the lower extremities and shall be able to support self when standing"</li> <li>- Patients having a D&amp;C, cystoscopy, spinal or epidural anesthetic "shall void prior to discharge."</li> </ul> <p>It was not clear which policy was to be followed for assessing and discharging patients from the facility.</p> <p>Additionally, post-surgical assessment documentation in the medical records included forms titled "PACU Record - Phase I," "PACU Record - Phase II." The discharge policies did not reference either one of these forms or the differences between Phase I and Phase II of recovery.</p>	Q 040	<p>Removed not services provided her</p>	

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Q 040	<p>Continued From page 6</p> <p>The "PACU Record - Phase I" form consisted of two pages. On the first page, the RN documented what type of anesthesia was used. The form was divided into three main sections, "ADMISSION ASSESSMENT," "TREATMENTS," and "DISCHARGE ASSESSMENT." The assessment sections addressed a patient's oxygen requirements, respiratory, integumentary, cardiovascular, and musculoskeletal status, and their response to stimuli. On the second page, the RN recorded vital signs and completed a Modified Aldrete Score assessment for admission and discharge from Phase I recovery. The "PACU Record - Phase II" form allowed the RN to complete a PARSAP score upon admission to recovery and discharge home. The form allowed for documentation of vital signs and comments such as patient activity and medication administration.</p> <p>The facility's discharge policies did not address when a patient was to be monitored using the criteria found in the Phase I form and <u>what criteria were to be met in order to transition to Phase II</u>, recovery. The policies did not address the <u>assessments</u> to be completed in either phase of recovery (such as the Aldrete or PARSAP assessments). The policies did not direct staff regarding the use of the assessment tools to determine when patients met criteria for discharge home.</p> <p>The facility's "DISCHARGE FROM PACU" policy, "DISCHARGE CRITERIA - SURGICAL PATIENTS" policy, and post-surgical assessment documentation forms titled "PACU Record - Phase I," "PACU Record - Phase II" were not</p>	Q 040	<p>b. Criteria and orders updated for Anesthesia and doctors Forms. See policy 2332. Reviewed and Approved by Governing Board.</p>	2/26/13
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Q 040	Continued From page 7 consistent with each other.  c. Further, the medical records contained a standardized "Anesthesiologist Orders" form with a section dedicated to "Discharge (PACU)." There were several options for discharge to choose from, including "Discharge with Modified Aldrete Score 8-10" and "Discharge per Post Anesthesia Standards of Care."  The facility's policies did not address discharging a patient from the facility based on a Modified Aldrete Score or Post Anesthesia Standards of Care.  The Administrator was interviewed on 1/28/13 beginning at 1:30 PM. He confirmed the discharge policies used by the facility did not correspond with the post procedural assessments or the discharge order documentation found in the medical records. He agreed that the policies were not reflective of current practice.  The facility failed to ensure discharge policies were sufficiently developed and consistent with assessment forms and physician orders.  4. The facility's pre-procedure assessment policies were not sufficiently developed and did not match documentation in the medical record as follows:  a. The "AMBULATORY SURGERY PREOPERATIVE ASSESSMENT CRITERIA" policy, revised 7/08/12, stated that "Cases scheduled for general anesthesia will require: A recent patient history and record of physical examination. If the H&P was completed within 30	Q 040	<p>Ⓒ Anesthesia orders corrected to reflect policy and scoring and assessment of discharge of patients. Admin reviewed and approved 2/26/13</p> <p>Ⓓ A. Pre op. assessment criteria #2005.</p> <p>Ⓔ H&amp;P and physical assessment The physical assessment criteria was not being met per CMS requirement.</p> <p>Ⓕ policies were updated 2005, 2007 &amp; 2010 to reflect required assessment criteria. Surgeon or Anesthesia provider will perform a physical assessment minimum of heart and lungs. Policies reviewed and approved by the governing board 2/26/13</p>		

Ⓜ practice monitored by the Administrator for compliance. Policies faxed to CRNAs 2/26/13 Email reply required for records due before March 10<sup>th</sup>.

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Q 040	Continued From page 8 days of the scheduled procedure, an update documenting any changes in the patient's condition must be completed prior to surgery. History and physical may be brief, however, must describe examination of the area of the body to be affected by surgery, heart, lungs, and orientation." The policy indicated that the anesthesia provider, not the physician/surgeon, was to complete the update to the H&P as well as the physical examination. Anesthetists used several types of anesthesia for various surgeries or procedures yet the policy only addressed completing an assessment on patients who received general anesthesia.  b. The policy, "ASSESSMENT PRIOR TO INDUCTION OF ANESTHESIA/SEDATION," revised 7/27/11, stated "The purpose of this policy is to provide optimum patient care through a comprehensive preanesthesia evaluation, ensuring that the patient is hemodynamically stable to receive administration of anesthetic agents." This policy did not outline what was meant by "comprehensive preanesthesia evaluation." In addition, the policy specified the preanesthesia evaluation was to be completed prior to "a surgical and/or invasive procedure in those instances where anesthesia services are requested." This policy was not congruent with the "AMBULATORY SURGERY PREOPERATIVE ASSESSMENT CRITERIA" policy, which indicated the preoperative assessment was to be completed for patients receiving general anesthesia.  c. The "PRE AND POST ANESTHESIA EVALUATION POLICY," revised 7/08/12, stated "All patients receiving anesthesia or sedation and	Q 040	④ b policy 2039. ① Describes the minimum requirement of assessment prior to anesthesia induction or sedation. ② Policy updated to reflect CMS minimum requirements for physical assessment. Policy is now congruent with policy # 2005 & 2007 pre op policy. CRNA's (Anes. providers) will review and document under standing of policies. Policies approved by the governing board 2/26/13 Monitored compliance by Administrator. Accomplished by peer review and chart reviews done quarterly. To be completed by 3/10/13		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13C0001011</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/29/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MILLENNIUM SURGERY CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1828 SOUTH MILLENNIUM WAY, SUITE 100 MERIDIAN, ID 83642</b>
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Q 040	<p>Continued From page 9</p> <p>analgesia care shall have a preanesthesia evaluation completed and documented by a practitioner qualified and privileged to administer anesthesia, within 48 hours prior to surgery or a procedure requiring anesthesia services." This policy indicated the preanesthesia evaluation was to include, "but is not limited to," documentation of the anesthesia risk, anesthesia history, potential anesthesia problems identified, and the "Patient's condition prior to induction of anesthesia." The policy did not direct anesthesia staff to complete the preanesthesia assessment the day of, but prior to, surgery. The policy did not include completion of a physical examination, such as listening to a patient's heart and lungs with a stethoscope. Contrary to the "AMBULATORY SURGERY PREOPERATIVE ASSESSMENT CRITERIA" policy, the "PRE AND POST ANESTHESIA EVALUATION POLICY" stated a preanesthesia evaluation was also to be completed when a patient received sedation and analgesia, not only when a patient received general anesthesia.</p> <p>d. The "PREANESTHESIA ASSESSMENT" <del>42007</del> policy, dated 7/01/08, stated the anesthetist was to perform a "preanesthesia assessment of each patient prior to ordering preoperative medication." According to the policy the evaluation was to include a review of the patient's chart and an interview with the patients. The policy did not include completion of a physical examination, such as listening to the patient's heart and lungs with a stethoscope, as part of the preanesthesia assessment. According to this policy, "each patient" was to have a preanesthesia assessment. This did not match the "AMBULATORY SURGERY PREOPERATIVE" <del>2005</del></p>	Q 040	<p><del>100</del> policies 2007, 2005, 2309, and 2015 all updated to reflect consistency and completeness and compliance with CMS Guidelines.</p> <p>Reviewed and understood by Anesthesia providers by 3/10/13</p> <p>Policies Approved by Governing Board 2/26/13</p> <p>Monitored by Administrator</p>	
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Q 040	Continued From page 10 ASSESSMENT CRITERIA" policy, which stated the assessment was to be completed on patient's who required general anesthesia. It also did not match the "ASSESSMENT PRIOR TO INDUCTION OF ANESTHESIA/SEDATION" policy, which stated the assessment was to be completed on patients when anesthesia services were required. In addition, it did not quite match the "PRE AND POST ANESTHESIA EVALUATION POLICY" which stated an assessment was to be completed on patients receiving anesthesia or sedation and analgesia.  e. Medical records contained patient H&Ps completed prior to surgery. Preoperative assessment documentation in the medical record included a stamp placed on the H&P which read "H&P Reviewed No Change." The physician was to sign and date the stamped statement the day of surgery. The facility's practice of stamping, signing and dating the H&Ps was not addressed in the preoperative assessment policies. In addition, this practice was not sufficient to ensure the physician had conducted a complete physical examination of the patient (such as listening to the heart and lungs with a stethoscope) prior to the procedure with the exact results as those documented in the H&P. Facility policies did not address the physician's role in completion of a preanesthesia/presurgical assessment with either an update of the H&P or a physical examination.  f. Additionally, patient medical records included a "PREANESTHESIA EVALUATION" form. The form contained space for the CRNA to document a patient's surgical history, current medications and allergies, an assessment of the patient's airway, and results of any laboratory or diagnostic	Q 040	(4E) Policy H&P# 2010 Policy updated for clarity Physician to review and update H&P the day of surgery and assess the location of the procedure. Anesthesia providers can perform a physical assessment immediately prior to surgery. Policy reviewed and approved by Governing board. 2/26/13 Monitored for completion by administrator and RN staff. Staff meeting review for RN's 2/21/13	

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Q 040	<p>Continued From page 11 studies. In addition, the form contained a pre-printed list of body systems including respiratory, cardiovascular, liver/gastrointestinal, neuro/musculoskeletal, and renal/endocrine. A list of common conditions associated with each system was also listed on the form. For example, under the respiratory system were such diagnoses as asthma, pneumonia, productive cough, shortness of breath, etc. In a column next to each body system listed was a box labeled "WNL" and an area for any additional comments to be documented. Facility policies did not address completion of this form. The policies did not define what was to be indicated when "WNL" was marked.</p> <p>The Administrator was interviewed on 1/28/13 at 1:40 PM. He confirmed that the documentation of the preanesthesia assessment was not consistent with facility policies. He stated that there were a couple of physicians who completed their own physical examination but that others defaulted to examinations completed by the CRNAs. He agreed that documentation on the "PREANESTHESIA EVALUATION" form did not specifically indicate when a physical examination, such as listening to a patient's heart and lungs with a stethoscope, had been completed. In addition, the Administrator explained the facility required an H&amp;P, completed within 30 days of the date of the surgery/procedure, to be in every patient's medical record. He explained that each H&amp;P was to contain the stamp mark "H&amp;P Reviewed No Change." He stated the physician was expected to sign and date that the H&amp;P had been reviewed and that no changes were noted. He agreed that based on this documentation it could not be determined the physician had</p>	Q 040	<p>(4) F - pre Anesthesia policy 2015 updated, Defines Stamp H&amp;P update process. It notes that anesthesia providers can perform the physical assessment for the Surgeon. The term WNL is defined in H&amp;P policy #2010. Policy #2007 preanesthesia assessment defines WNL for assessment purposes. Approved by the governing Board 2/26/13 Reviewed by CRNA's documentation due by 3/10/13</p>	
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Q 040	<p>Continued From page 12</p> <p>completed a physical examination of the patient (such as listening to the heart and lungs with a stethoscope) the day of the procedure with the exact results as those documented in the H&amp;P.</p> <p>The facility's pre-procedure assessment policies were not sufficiently developed and did not match documentation in the medical record.</p> <p>5. Patient #18 was a 16 year old female admitted to the facility on 1/24/13 for foot surgery. Her surgical procedure was observed on 1/24/13 beginning at 3:00 PM. Patient #18 was assisted to the OR table from the stretcher and given medication to sedate her. After Patient #18 fell asleep, an RN secured her to the OR table using two soft blue straps. The RN tied the straps in a tight knot over Patient #18's upper legs. The RN continued to prepare for the surgery and then stated she needed to place a catheter in Patient #18. The RN had to remove the straps to reposition the patient but was unable to get the knot untied quickly. A second RN came to assist her and together they were able to untie the knot and place the catheter. After the catheter insertion, the blue straps were again tied in a knot over the patient and the surgery began.</p> <p>The RN who originally tied the straps in the procedure was interviewed on 1/25/13 at 2:30 PM. She stated she would tie the straps together when a patient was smaller framed to ensure the patient was secured on the table but would secure the straps with Velcro for a patient that was larger framed. She stated that the straps had been in that OR as long as she had been employed at the facility. She confirmed that it was sometimes difficult to untie the straps. She</p>	Q 040	<p>⑤ Patient Positioning Policy # 2023. Safety Strap</p> <p>① Velcro safety strap was in use.</p> <p>② New rubberized cleanable belt is on order. When the new belt arrives the velcro strap will be removed from service. The release will be quicker on the New Safety Strap. It will be the same as the other OR No further training is required.</p> <p>③ monitor and tracking of proper use by the Administrator.</p> <p>Completion date pending arrival of new strap. ordered 2/25/13</p>	

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Q 040	<p>Continued From page 13</p> <p>stated that in an emergency situation, where she would have to remove the straps quickly, she would just cut them off.</p> <p>The Administrator was interviewed about the observation on 1/25/13 at 1:30 PM. He stated the blue straps were meant to be "Velcroed" together to secure patients to the OR table. He stated he was unaware the nurses were tying the straps in a knot. The Administrator stated he knew the RNs would secure the straps tightly but would use the Velcro to secure them. He agreed that in an emergency situation it would be difficult to remove the straps quickly. He stated that only one OR contained these blue straps, the other had an adjustable belt that secured the patient and could be easily removed. When requested, the Administrator was unable to produce a policy to outline the facility's expectations of how the straps would be used.</p> <p>The Governing Body failed to ensure a policy was developed, implemented, and monitored necessary to ensure appropriate strap use.</p> <p>6. Refer to Q041 as it relates to the Governing Body's failure to ensure contract services were provided with sufficient monitoring and oversight necessary to ensure staff was competent to perform their assigned duties.</p> <p>7. Refer to Q043 as it relates to the Governing Body's failure to ensure an annual emergency preparedness drill was conducted.</p> <p>8. Refer to Q084 as it relates to the Governing Body's failure to ensure a comprehensive QAPI program was fully defined, implemented, and</p>	Q 040			

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Q 040	<p>Continued From page 14 maintained by the ASC.</p> <p>9. Refer to Q162 as it relates to the Governing Body's failure to ensure 16 of 20 patient medical records (Patients #2, #4 - #8, #10, #11, and #13 - #20) included accurate, comprehensive information.</p> <p>10. Refer to Q181 as it relates to the Governing Body's failure to ensure medication was stored, prepared and administered for 1 of 2 patients (Patient #20) in accordance with acceptable standards of practice.</p> <p>11. Refer to Q202 as it relates to the Governing Body's failure to ensure radiation safety procedures were implemented and monitored for C-Arm use.</p> <p>12. Refer to Q224 as it relates to the Governing Body's failure to ensure comprehensive rights information related to Advance Directives was provided to patients and/or their representatives.</p> <p>13. Refer to Q225 as it relates to the Governing Body's failure to ensure a procedure for identifying and documenting the existence and submission of grievances was developed and implemented.</p> <p>14. Refer to Q245 as it relates to the Governing Body's failure to ensure a plan of action for preventing and identifying infections was provided for 8 of 20 patients (Patients #1, #3, #7, #9, #12, #16, #18, and #19)</p> <p>15. Refer to Q262 as it relates to the Governing Body's failure to ensure 3 of 3 patients (Patients</p>	Q 040			

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Q 040 Q 041	Continued From page 15 #18 - #20) received a pre-surgical assessment that included a physical examination. 416.41(a) CONTRACT SERVICES  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.  This STANDARD is not met as evidenced by: Based on contract review, record review, staff interview, and review of information from the Idaho State Board of Pharmacy and DEA, it was determined the ASC failed to provide oversight and monitoring for 11 of 11 contracted employees (Staff A - K). This lack of oversight of contract services resulted in the inability of the ASC to ensure staff was competent to perform their assigned duties and had the potential to negatively impact all patients. Findings include:  1. Credentialing and personnel files were reviewed with the Administrator on 1/23/13. There was no evidence of DEA registration present in the files for 2 of 6 CRNAs (Staff C and Staff F.) At approximately 2:30 PM on 1/23/13, the Administrator was interviewed and confirmed evidence of DEA registration was not present in the files of Staff C and Staff F. He stated it was his understanding that it was not required.  In a letter dated 5/25/11, the Executive Director of the Idaho State Board of Pharmacy referred to Idaho Code Section 37-2716 (a) Registration Requirements, which states: "Every person who manufactures, distributes, or dispenses any controlled substance within this state or who	Q 040 Q 041	① DEN and CS state Lic. ① The 2 providers that were lacking this requirement have completed and provided the information to MSC their files are now complete 2/26/13 ① Administrator will monitor that all required licenses are up to date in Anesthesia providers files Providers updated Fred Starr and John Kerfoot. 2/26/13	

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Q 041	<p>Continued From page 16</p> <p>proposes to engage in the manufacture, distribution, or dispensing of any controlled substance within this state, must obtain annually a registration issued by the board in accordance with its rules." The letter stated the definition of "dispense" included prescribing and administering according to Idaho Code 37-2701(i). For exemption to the registration requirement, the letter referred to Idaho Code 37-2716, which states: "The following persons need not register and may lawfully possess controlled substances under this act: An agent or employee of any registered manufacturer, distributor, or dispenser, of any controlled substance if he is acting in the usual course of his business or employment." The letter further stated that the Idaho Board of Pharmacy Rule 435 (IDAPA 27.01.01.435) required an applicant for a board of pharmacy controlled substance registration to hold a valid federal DEA registration.</p> <p>In a letter dated 3/22/11, a representative of the DEA to the Idaho State Board of Pharmacy clearly stated that a CRNA could not independently administer, dispense, or prescribe controlled substances without being registered with the DEA.</p> <p>Documentation in records indicated Staff C administered Versed (midazolam), a Schedule IV substance, and/or Fentanyl, a Schedule II substance, to Patient #4. Documentation in records indicated Staff F administered Versed and Fentanyl to Patient #17.</p> <p>The ASC did not ensure DEA registration for CRNA staff.</p>	Q 041			

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Q 041	<p>Continued From page 17</p> <p>2. Facility contracts were reviewed during the survey. Contractual agreements between the facility and CRNA staff were provided. Contracts were not found for Staff B, Staff C, Staff D, Staff E or Staff F.</p> <p>The Administrator was interviewed on 1/23/13, beginning at 9:15 AM. He confirmed there were no contracts in existence between the facility and CRNA Staff B, Staff C, Staff D, Staff E or Staff F.</p> <p>The ASC did not ensure contracts were implemented for all CRNAs.</p> <p>3. The Administrator for the ASC was interviewed on 1/23/13, beginning at 9:15 AM. He said if a patient became unresponsive and a code was called in the facility, he preferred a CRNA direct the resuscitation procedure.</p> <p>A policy titled, "CARDIOPULMONARY RESUSCITATION TRAINING REQUIREMENTS," last revised 5/12/11, stated "Annual Mock Codes will be conducted."</p> <p>The Administrator was interviewed on 1/28/13, beginning at approximately 1:40 PM. He stated it was the facility's practice to conduct annual pediatric and adult cardiovascular mock codes.</p> <p>Staff inservice/education records for 6 contracted CRNAs (Staff A - F) were reviewed with the Administrator on 1/24/13. No documentation was found indicating cardiovascular mock codes had occurred in 2012.</p> <p>During an interview on 1/28/13 beginning at approximately 1:40 PM, the Administrator said</p>	Q 041	<p>②④ CRNAs work independently at MSC. They are privileged and work under the privileges granted to them. We are in the process of contracting with TVA and Peggy Minnaert CRNA. We will have a contract in place by March 10/2013</p> <p>③④ policy 8032 CPR training Annual training for Clinical Staff.</p> <p>④ Brad Westover CRNA was present at the Staff meeting he assisted in CPR/mock Codes, pediatric, adult, Malignant Hypertension and Emergency/disaster. Completed on 2/21/2013</p> <p>④ mentioned and documented by administration. Admin responsible that it will be completed annually</p> <p style="text-align: right;">2/21/13</p>	
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Q 041	<p>Continued From page 18</p> <p>pediatric and adult cardiovascular mock codes were conducted in 2011, but did not occur in 2012. However, no documentation was provided verifying the 2011 mock codes were conducted.</p> <p>The facility failed to ensure cardiovascular mock codes, that included the contracted CRNAs, were conducted on an annual basis in accordance with facility policy.</p> <p>4. An inservice/education manual for staff was reviewed with the Administrator on 1/23/13. The manual was dated 2011 and contained educational reading material/booklets related to various topics, such as hand hygiene and infection control. Staff sign in sheets that corresponded to each topic were also found in the manual. Documentation was not found indicating contracted staff (Staff A - K) participated in inservice/education. Additionally, educational information and evidence of participation could not be found for 2012.</p> <p>The Administrator was interviewed on 1/23/13, beginning at approximately 9:15 AM. He stated contracted staff were not required to participate in annual inservice/education to employees. The Administrator confirmed an education/inservice program was not implemented for contracted staff in 2012.</p> <p>5. A facility policy titled "Hepatitis B Policy," undated, documented "Millennium Surgery Staff at the time of hire will have evidence of a positive titer or series injection forms."</p> <p>Personnel files for employees of the ASC included evidence of hepatitis B injection series</p>	Q 041	<p>(4) Inservice policy 7006 Participation at review of annual training.</p> <p>(A) All Employees are required to complete annual training Non Physician Staff, Anesthesia providers and Surgeons are required to complete training specific to their duties. This training will start Feb 28, 13 and will be completed by March, 10, 2013. The training will be recorded in their files.</p> <p>(M) Administrator will ensure that all annual training will be completed and documented. completion date March 10/13</p>	

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Q 041	<p>Continued From page 19 and/or current blood titer. However, documentation indicating evidence of positive titer or hepatitis B injection series could not be found in the personnel files of contracted employees.</p> <p>The Administrator was interviewed on 1/24/13, beginning at 9:15 AM. He confirmed though employees of the ASC were required to provide documentation, contracted employees had not been required to submit evidence of hepatitis B injection series or a positive blood titer.</p> <p>The ASC failed to ensure contracted employees had undergone hepatitis series injections and/or provided evidence of blood titer.</p> <p>6. An ASC policy titled "Tuberculosis Respiratory Control Plan," undated, stated "Verification of TB testing for the current year will be required of all new employees at time of hire. TB Testing will be required Semi-annually thereafter."</p> <p>Personnel files for employees of the ASC included evidence of TB testing as stated in the policy. However, documentation indicating evidence of TB testing could not be found in the personnel files of contracted employees.</p> <p>The Administrator was interviewed on 1/24/13, beginning at 9:15 AM. He confirmed though employees of the ASC were required to undergo TB screening/testing, contracted employees had not been required to do so.</p> <p>The ASC failed to ensure contracted employees had undergone TB screening/testing.</p>	Q 041	<p>⑤ Hep B policy updated. All staff, <del>non</del>physician staff, Surgeons, Anesthesia providers etc. Will have documents provided to MSC for proof of Hep B titer or Injection Series.</p> <p>Ⓜ Administrator will insure that all current and future employees have Hep B Status documented.</p> <p>Ⓢ To be completed by March 19</p> <p>⑥ TB control plan policy 2013 Action TB testing will be done or evidence of a TB titer will be recorded in all medical Staff's Files. For a pre employment status verification. Testing there after will only be done if symptoms are present. This is the policy due to the fact that Idaho was a very low incidence of TB, and the patient population at MSC is a</p>	
Q 043	416.41(c) DISASTER PREPAREDNESS PLAN	Q 043		

Very low risk. Clinical Staff was trained on the signs and symptoms of TB on Feb 21 2013  
Ⓜ supervised by the Administrator

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

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13C0001011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/29/2013
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NAME OF PROVIDER OR SUPPLIER  MILLENNIUM SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1828 SOUTH MILLENNIUM WAY, SUITE 100 MERIDIAN, ID 83642
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Q 043	<p>Continued From page 20</p> <p>(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.</p> <p>(2) The ASC coordinates the plan with State and local authorities, as appropriate.</p> <p>(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.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, it was determined the Governing Body failed to ensure an annual emergency preparedness drill was conducted. This resulted in a potential inability of the facility 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>1. The facility's emergency preparedness plan, #4041 undated, was reviewed. There was no record of an emergency preparedness drill being conducted annually to test the plan's effectiveness. When asked about the plan, on 1/23/13 at 10:30 AM, the facility's Administrator acknowledged the last drill was performed on 10/4/11 and an annual drill in 2012 was not conducted.</p> <p>The facility failed to ensure that an emergency</p>	Q 043	<p>① Emergency preparedness Plan. # 4041.</p> <p>② Annual training required not completed in 2012</p> <p>③ Emergency Drill performed at Staff meeting. It was recorded in the Drill File and in all participating Staff files.</p> <p>④ completed Feb, 21, 2013 Supervised by the Administrator</p>	
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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Q 043	Continued From page 21	Q 043		
Q 081	<p>preparedness drill was conducted at least annually to test the plan's effectiveness.</p> <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 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, review of medical records, policies, QAPI documents and meeting minutes, it was determined the facility failed to ensure the development of a comprehensive quality improvement plan which included performance measures that promoted patient</p>	Q 081		

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Q 081	<p>Continued From page 22</p> <p>safety and improved patient outcomes. This prevented the ASC from effectively evaluating delivery of patient care and had the potential to impact all patients receiving care at the facility. Findings include:</p> <p>1. The "ORGANIZATIONAL PERFORMANCE IMPROVEMENT PLAN," effective 7/01/08, stated "...The primary goals of the Organizational Performance Improvement Plan are to continually and systemically plan, design, measure, assess and improve performance of critical focus areas, improve healthcare outcomes, and reduce and prevent medical/health care errors..."</p> <p>QAPI documents stated the ASC conducted 2 performance improvement studies in 2012. One study began in April of 2011 and continued through the time of this survey, 1/28/13. It involved hand hygiene in the facility. A second study involved prevention of DVT's and began in late 2010, with data collection implemented in December of 2011. The DVT prevention project remained a current study at the time of the survey.</p> <p>Except for the "DVT prevention project," the ASC had not implemented any other studies that effectively evaluated delivery of patient care. The facility did not adequately identify methods that could have been used to improve processes resulting in improved patient outcomes.</p> <p>The Administrator was interviewed on 1/23/13 beginning at 2:45 PM. When asked to discuss the facility's current performance improvement projects, he stated they were working on a hand hygiene project. The Administrator said he</p>	Q 081	<p>① PI / Quality Improvement Plan. MSC has failed to Adequately document and perform PI/QI projects</p> <p>② Several projects need to be properly updated and executed.</p> <p>③ Hand Hygiene Study updated and reinvigorated.</p> <p>④ DVT project updated and on maintenance/tracking Now</p> <p>⑤ Surgeon / Surgery Starttimes Started in late 2011 and is still in data collection data and moving towards monitoring study</p> <p>⑥ 2013 project starting March 1, 2013 pediatric pain in PACU and intervention requirements. Retrospective data will be researched and Plan for study will</p>	
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be determined by 3/15/2013

⑦ to be monitored and by the Administrator. Approved and reviewed by the Governing Board 2/26/12

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

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Q 081	<p>Continued From page 23</p> <p>noticed the emphasis on the importance of hand washing being reported by the media and decided to begin monitoring ASC staff for compliance. He confirmed the project did not begin based on quality indicator tracking or negative patient outcomes.</p> <p>He confirmed that except for the DVT study, processes for evaluating delivery of care at the ASC had not been implemented in 2012.</p> <p>The ASC did not adequately evaluate processes of care.</p> <p>2. The "ORGANIZATIONAL PERFORMANCE IMPROVEMENT PLAN," effective 7/01/08, stated the plan would "...Provide for a facilitywide [sic] program that assures the facility designs processes (with special emphasis on design of new or revisions in established services) well and systematically measures, assesses and improves its performance to achieve optimal patient health outcomes in a collaborative, cross-departmental interdisciplinary approach. These processes include mechanisms to assess the needs and expectations of the patients and their families, staff and others."</p> <p>However, a plan for the ASC's QAPI program, including the activities to be conducted and data to be gathered, was not documented. Additionally, monthly Governing Body meeting minutes included quality measures the facility was tracking through 2012. The minutes documented quality measures included the following: timing of preoperative administration of antibiotics, patient burns, patient falls, wrong site surgeries, transfers to a hospital, hair removal and</p>	Q 081	<p>(2) Quality Assurance</p> <p>(A) MSC tracks a lot of data it needs to be done in a more transparent manner. We track cleaning, infection control, data refrigerator temp. Auto Clave proofs, BG and HCG controls, quality measures, ASCA benchmarking criteria etc. If there are variations to what is considered safe practice those issues will either be immediately corrected or they will be studied in a PI OR QI study. Minutes and in staff meetings and governing board will document areas for improvement of the need for a study will be determined.</p> <p>(M) Administrator and Staff will monitor quality assurance indicators to determine areas of need. The governing board</p>		

will participate and  
over see the quality and  
intervention and studies  
are appropriate and effective  
current QA and PI/QI studies  
reviewed and approved 2/26/13

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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Q 081	Continued From page 24 nausea/vomiting requiring medication. Meeting minutes did not discuss how the data was being tracked or how it was used to improve patient care in the ASC. There was no evidence that indicated the ASC was identifying and tracking high risk, high volume and problem-prone areas in order to prioritize a quality plan. Additionally, the minutes did not prioritize performance measures/projects for a 2012 quality plan that resulted in evaluation of patient care processes.  The Administrator was interviewed on 1/22/13, beginning at 10:00 AM. The QAPI program and committee was discussed. When asked about the QAPI committee, he stated QAPI activities were discussed during the monthly Governing Body meetings. When asked, during a subsequent interview on 1/24/13 beginning at 9:15 AM, the Administrator confirmed high risk, high volume, and problem-prone areas had not been adequately or consistently identified or tracked.	Q 081			
Q 083	The ASC failed to ensure a comprehensive quality improvement program was sufficiently developed, implemented and monitored. <b>416.43(d) PERFORMANCE IMPROVEMENT PROJECTS</b>  (1) The number and scope of distinct improvement projects conducted annually must reflect the scope and complexity of the ASC's services and operations.  (2) The ASC must document the projects that are being conducted. The documentation, at a minimum, must include the reason(s) for implementing the project, and a description of the	Q 083			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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Q 083	<p>Continued From page 25 project's results</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of policies and QAPI documents, it was determined the facility failed to ensure annual performance improvement projects were conducted that adequately reflected the scope of services provided in the ASC. This resulted in the inability of the ASC to conduct studies to evaluate complex processes and had the potential to impact all patients receiving care at the facility. Findings include:</p> <p>1. The Administrator was interviewed on 1/23/13, beginning at 9:15 AM. The scope of services provided in the facility was discussed. He stated procedures conducted in the ASC included the following: foot and ankle surgeries, plastic surgeries (facial, breast augmentation and abdominoplasty/tummy tuck), pediatric dentistry, colonoscopies, EGDs, hemorrhoid ablations, vasectomies, hernia repairs and occulo-plastic surgeries.</p> <p>QAPI documents stated the ASC conducted 2 performance improvement studies in 2012. One study began in April of 2011 and continued through the time of this survey, 1/28/13. It involved hand hygiene in the facility. A second study involved prevention of DVT's and reportedly began in late 2010, with data collection implemented in December of 2011. The "DVT prevention project" remained a current study at the time of this survey. The "DVT prevention project," was the only performance improvement project the ASC had implemented that evaluated</p>	Q 083	① see pg 23 for PI Plan of Correction and Action being taken.		

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

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Q 083	Continued From page 26 delivery of care in the facility.  The Administrator was interviewed on 1/23/13 beginning at 2:45 PM. He confirmed the ASC had not conducted distinct improvement projects annually that reflected the scope of services provided in the facility.	Q 083			
Q 084	The facility did not adequately identify performance improvement projects annually that reflected the scope and complexity of the ASC's services.  <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 bylaws, meeting minutes, and QAPI documents, it was determined the ASC's Governing Body failed to ensure a comprehensive QAPI program was fully defined, implemented, and maintained by the ASC. This resulted in a lack of leadership to provide direction of QAPI activities at the ASC	Q 084			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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Q 084	<p>Continued From page 27 and had the potential to impede the development of a comprehensive QAPI program. Findings include:</p> <p>1. A policy titled "Quality Improvement Plan Statement of Philosophy," (without an effective or approval date) was provided by the ASC. When asked about the policy, during an interview on 1/22/13 beginning at 10:00 AM, the Administrator state the policy was approved by the Governing Body sometime in 2011. However, he was unable to provide verifying documentation.</p> <p>Additionally, the "ORGANIZATIONAL PERFORMANCE IMPROVEMENT PLAN," effective 7/01/08, stated "The Governing Body has the responsibility to evaluate the effectiveness of the performance improvement activities performed throughout the facility and the Organizational Performance Improvement Program as a whole." Additionally, medical staff bylaws, signed by medical staff members on 2/25/04, stated "The medical staff shall actively participate in quality assurance." The bylaws stated the quality improvement committee "will be comprised of one member of the Governing Board and two registered nurses. The purpose of the committee will be to ensure that the objectives and goals of the surgery center are carried out and met."</p> <p>However, no documentation was present to establish that a quality improvement committee had met or participated in quality improvement activities.</p> <p>The Administrator was interviewed on 1/22/13, beginning at 10:00 AM. The QAPI program was</p>	Q 084	<p>① Quality improvement Plan Action &amp; Policy update All clinical staff and the governing board are members of the QI committee. Notes for the meetings and plans and projects and included in the Staff meeting and Governing Board meeting minutes.</p> <p>② QI plan will be supervised by the administrator and overall approval and review done by the governing board. Meetings held. Staff QI meeting 2/21/13 Governing Board 2/26/13</p>		

These meetings will be held quarterly per policy.

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

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Q 084	Continued From page 28 discussed. He stated QAPI activities were discussed during the monthly Governing Body meetings. He confirmed a QAPI committee had not been appointed and therefore had not met to discussed quality improvement activities.	Q 084	(2) (3) see pg 23 PI Plan For studies and pg 24 QI/QA tracking 2/26/13	
Q 162	2. Refer to Q081 as it relates to the Governing Body's failure to ensure the development of a comprehensive quality improvement plan which included performance measures that promoted patient safety and improved patient outcomes.  3. Refer to Q083 as it relates to the Governing Body's failure to ensure annual performance improvement projects were conducted that adequately reflected the scope of services provided in the ASC.  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.	Q 162		

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

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Q 162	Continued From page 29  This STANDARD is not met as evidenced by: Based on observation, policy and record review, and staff interview it was determined the facility failed to ensure medical records were accurate for 16 of 20 patients (Patients #2, #4 - #8, #10, #11, and #13 - #20) whose records were reviewed. This failure resulted in a lack of clarity in the medical records related to allergies, anesthesia administration and the completion of pre-surgical physical examinations. Findings include:  1. The preoperative assessments of 3 patients were observed. The patients' medical records did not accurately reflect the assessments, as follows:  - Patient #18 was a 16 year old female admitted to the facility on 1/24/13 for foot surgery. On 1/24/13 at approximately 2:30 PM, CRNA B was observed while performing Patient #18's preoperative anesthesia assessment. He reviewed her medical history, discussed the upcoming surgical procedure and the type of anesthesia he planned to administer. He also evaluated Patient #18 for prior problems with anesthesia and asked if she had been ill or if her health status had changed since she was last seen by the physician. CRNA B did not examine Patient #18. He did not listen to her heart and lungs with a stethoscope.  However, Patient #18's medical record included a "PREANESTHESIA EVALUATION" form, signed by CRNA B on 1/24/13. CRNA B documented the	Q 162	① Preanesthesia Assessment Policy and practice.  ② Pre Anes. Assess. # 2007 updated to required physical assessment. Minimum heart and lung evaluation will be done and documented on every patient. CRNA's informed of required assessment on Feb 26 2013 compliance required after confirmation of understanding of the policy this will be recorded in their file.  ③ Approved by Administrator and the governing board Clinical Staff will report any non compliance.  2/26/2013	

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13C0001011</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/29/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>MILLENNIUM SURGERY CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1828 SOUTH MILLENNIUM WAY, SUITE 100 MERIDIAN, ID 83642</b>		
(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 162	<p>Continued From page 30</p> <p>anesthesia plan for Patient #18 included a popliteal block with IV sedation, listed Patient #18's prior surgeries, and documented an assessment of her airway. CRNA B made a line through the "WNL" boxes next to each of the body systems. Patient #18's medical record also included an H&amp;P dated 1/21/13. On 1/24/13, the physician signed the stamp to indicate the H&amp;P had been reviewed and no changes were noted.</p> <p>Patient #18's record did not reflect the lack of a complete preoperative examination (failure to listen to her heart and lungs with a stethoscope).</p> <p>- Patient #20 was a 3 year old female admitted to the facility on 1/25/13 for dental surgery. On 1/25/13 at approximately 9:30 AM, CRNA B was observed while performing Patient #20's preoperative anesthesia assessment. CRNA B reviewed Patient #20's medical history, discussed the upcoming surgical procedure and the type of anesthesia he planned to administer. CRNA B also evaluated Patient # 20 for prior problems with anesthesia and asked if she had been ill or if her health status had changed since seeing the physician. CRNA B did not examine Patient #20. He did not listen to her heart and lungs with a stethoscope.</p> <p>However, Patient #20's medical record included a "PREANESTHESIA EVALUATION" form, signed by CRNA B on 1/25/13. CRNA B documented the anesthesia plan for Patient #20 included general anesthesia. CRNA B noted that Patient #20 had bilateral breath sounds, documented Patient #20's airway assessment and marked a line through the "WNL" box next to each of the systems listed. Patient #20's medical record also</p>	Q 162			

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

PRINTED: 02/12/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13C0001011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/29/2013
NAME OF PROVIDER OR SUPPLIER  MILLENNIUM SURGERY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1828 SOUTH MILLENNIUM WAY, SUITE 100 MERIDIAN, ID 83642	
(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 162	<p>Continued From page 31</p> <p>included an H&amp;P dated 1/22/13. On 1/25/13, the physician signed the stamp to indicate the H&amp;P had been reviewed and no changes were noted.</p> <p>Patient #20's record did not reflect the lack of a complete preoperative examination (failure to listen to her heart and lungs with a stethoscope).</p> <p>CRNA B, who cared for Patients #18 and #20, was interviewed on 1/25/13 at approximately 1:15 PM. The preoperative examination was discussed. CRNA B stated "If there has been a problem, I will listen to heart and lungs. If not, I won't listen. I always listen in the OR before we get started. Usually, the physician has already examined the patient and I don't need to."</p> <p>However, Patient #20's physician was interviewed at 1:20 PM on 1/25/13. He stated his practice was to verbally review the H&amp;P, allergies, the last time the patient ate or drank and home medications with the patient and/or family prior to the procedure. He explained that if there were changes in the patient's condition, he relied on anesthesia and nursing staff to perform a physical assessment to determine the patient's eligibility for surgery. He stated that he did not actually listen to a patient's heart or lungs because as a dentist, he was "not really qualified" to assess a patient for surgery.</p> <p>The facility failed to ensure Patient #18 and #20's preoperative assessments were accurately documented.</p> <p>- Patient #19 was a 50 year old male admitted to the facility on 1/25/13 for a colonoscopy. On 1/25/13 at approximately 8:05 AM, CRNA A was</p>	Q 162		

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

PRINTED: 02/12/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13C0001011</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/29/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>MILLENNIUM SURGERY CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1828 SOUTH MILLENNIUM WAY, SUITE 100 MERIDIAN, ID 83642</b>		
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Q 162	<p>Continued From page 32</p> <p>observed while performing Patient #19's preoperative anesthesia assessment. CRNAA reviewed Patient #19's medical history, discussed the upcoming surgical procedure and the type of anesthesia she planned to administer. She also evaluated Patient #19 for prior problems with anesthesia and asked if he had been ill or if his health status had changed since seeing the physician. CRNAA did not examine Patient #19. She did not listen to his heart and lungs with a stethoscope.</p> <p>However, Patient #19's medical record contained a "PREANESTHESIA EVALUATION" form, signed by CRNAA on 1/25/13. CRNAA documented the anesthesia plan for Patient #19 included TIVA, listed Patient #19's prior surgery, and documented an assessment of his airway. CRNAA made a line through the "WNL" boxes next to the respiratory, liver/gastrointestinal, neuro/musculoskeletal, and renal/endocrine systems. The box next to the cardiovascular system was not marked but underneath the system "Hypertension" was circled and the CRNAA documented Patient #19 had elevated cholesterol. Patient #19's medical record also included an H&amp;P dated 11/13/12. On 1/25/13, the physician signed the stamp to indicate the H&amp;P had been reviewed and no changes were noted.</p> <p>CRNAA was interviewed on 1/25/13 at approximately 10:00 AM. The preoperative examination was discussed. CRNAA stated if patients received "deep general anesthesia," she listened to heart and lungs. She also said if she was working with Dr. [physician's name], he tells her not to perform the preoperative exam because he has already done so.</p>	Q 162			

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

PRINTED: 02/12/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13C0001011</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/29/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MILLENNIUM SURGERY CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1828 SOUTH MILLENNIUM WAY, SUITE 100 MERIDIAN, ID 83642</b>
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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 162	<p>Continued From page 33</p> <p>The facility failed to ensure Patient #19's preoperative assessment included complete, comprehensive information.</p> <p>2. The type of anesthesia administered to patients during surgeries/procedures included various forms, as follows:</p> <ul style="list-style-type: none"> <li>- On the "Operative Record" the "Primary Anesthesia" choices available to mark were General, Regional, and Local. The "Type" included ET, Mask, LMA, Epidural, Spinal, and MAC.</li> <li>- The "ANESTHESIA RECORD" contained a section for "ANESTHETIC TECHNIQUE" which was divided into General, Regional, and Other. Under the "General" section was another list of options, one of which was "TIVA." Under the "Other" category was "MAC" and "TIVA."</li> <li>- The "POSTOPERATIVE FOLLOW-UP EVALUATION" form allowed the RN to choose "General," "Local," "TIVA," or "Regional Anesthesia."</li> </ul> <p>The type of anesthesia administered to patients during surgeries/procedures was not documented in a clear and consistent manner, as follows:</p> <p>a. Patient #4 was a 79 year old female admitted to the facility on 1/3/13 for foot surgery. The anesthesia used during her surgery was documented throughout her record, as follows:</p> <ul style="list-style-type: none"> <li>- On the "Operative Record," completed by the circulating RN, anesthesia was not documented.</li> </ul>	Q 162	<p>② Documentation of Anesthesia type. There were multiple discrepancies in the documentation of Anesthesia type.</p> <p>① Staff were informed of the inconsistencies and were educated of keeping the documentation consistent. They agreed to improve their practice during our meeting. CRNA's will be informed as part of their 2/28/13 training. Governing board and Surgeons will be informed of Anesthesia type during Governing board 2/26/13</p> <p>③ Administrator and RN's will insure consistency is maintained. Monitoring by quarterly chart review - 2/26/13</p>	
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by quarterly chart review - 2/26/13

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

PRINTED: 02/12/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13C0001011</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/29/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MILLENNIUM SURGERY CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1828 SOUTH MILLENNIUM WAY, SUITE 100 MERIDIAN, ID 83642</b>
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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 162	<p>Continued From page 34</p> <ul style="list-style-type: none"> <li>- On the "PREANESTHESIA EVALUATION" form, completed by the CRNA, the CRNA documented the anesthesia plan was MAC.</li> <li>- On the "ANESTHESIA RECORD," completed by the CRNA, under "ANESTHETIC TECHNIQUE" the CRNA selected MAC.</li> <li>- On the "POSTOPERATIVE FOLLOW-UP EVALUATION" form, the RN marked TIVA.</li> <li>- In the "OPERATIVE REPORT" the physician dictated MAC as the type of anesthesia used.</li> </ul> <p>The type of anesthesia administered to Patient #4 during her surgery was not documented in a clear and consistent manner.</p> <p>b. Patient #11 was a 66 year old female admitted to the facility on 11/29/12 for foot surgery. The anesthesia used during her surgery was documented throughout her record, as follows:</p> <ul style="list-style-type: none"> <li>- On the "Operative Record" completed by the circulating RN, "TIVA" was written in the section related to anesthesia.</li> <li>- On the "PREANESTHESIA EVALUATION" form, completed by the CRNA, the CRNA documented the anesthesia plan as a popliteal block with TIVA.</li> <li>- On the "ANESTHESIA RECORD," completed by the CRNA, under "ANESTHETIC TECHNIQUE" the CRNA selected several options under "Regional" and marked "TIVA" in the "Other" category.</li> </ul>	Q 162		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/12/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13C0001011</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/29/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>MILLENNIUM SURGERY CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1828 SOUTH MILLENNIUM WAY, SUITE 100 MERIDIAN, ID 83642</b>		
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Q 162	<p>Continued From page 35</p> <ul style="list-style-type: none"> <li>- On the "Post Operative Note/Orders" the physician documented "Anesthetic: Popliteal."</li> <li>- On the "POSTOPERATIVE FOLLOW-UP EVALUATION" form, the RN marked TIVA.</li> <li>- In the "OPERATIVE REPORT" the physician dictated "Intravenous sedation" as the type of anesthesia used.</li> </ul> <p>The type of anesthesia administered to Patient #11 during her surgery was not documented in a clear and consistent manner.</p> <p>c. Patient #14 was a 61 year old female admitted to the facility on 12/11/12 for foot surgery. The anesthesia used during her surgery was documented throughout her record, as follows:</p> <ul style="list-style-type: none"> <li>- On the "Operative Record," completed by the circulating RN, the RN documented Patient #14 received general anesthesia via a mask.</li> <li>- On the "PREANESTHESIA EVALUATION" form, completed by the CRNA, the CRNA documented the anesthesia plan was "Local/MAC [with] IV sedation."</li> <li>- On the "ANESTHESIA RECORD," completed by the CRNA, under "ANESTHETIC TECHNIQUE" the CRNA selected MAC.</li> <li>- On the "Post Operative Note/Orders" the physician documented "Anesthetic: MAC."</li> <li>- On the "POSTOPERATIVE FOLLOW-UP EVALUATION" form, the RN marked TIVA.</li> </ul>	Q 162			

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

PRINTED: 02/12/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13C0001011</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/29/2013</b>
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Q 162	<p>Continued From page 36</p> <ul style="list-style-type: none"> <li>- In the "OPERATIVE REPORT" the physician dictated "Local with IV sedation" as the type of anesthesia used.</li> <li>The type of anesthesia administered to Patient #14 during her surgery was not documented in a clear and consistent manner.</li> <li>d. Patient #2 was an 81 year old female admitted to the facility on 1/22/13 for foot surgery. The anesthesia used during her surgery was documented throughout her record, as follows: <ul style="list-style-type: none"> <li>- On the "Operative Record," completed by the circulating RN, the RN documented Patient #2 received general anesthesia via a mask.</li> <li>- On the "PREANESTHESIA EVALUATION" form, completed by the CRNA, the CRNA documented the anesthesia plan was a popliteal block with IV sedation.</li> <li>- On the "ANESTHESIA RECORD," completed by the CRNA, under "ANESTHETIC TECHNIQUE" the CRNA selected options under "Regional" and noted Patient #2 received supplemental oxygen via a nasal cannula.</li> <li>- On the "Post Operative Note/Orders" the physician documented "Anesthetic: MAC - pop [popliteal block]."</li> <li>- On the "POSTOPERATIVE FOLLOW-UP EVALUATION" form, the RN marked "General."</li> <li>- In the "OPERATIVE REPORT" the physician dictated "Monitored anesthesia care with a</li> </ul> </li> </ul>	Q 162			

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

PRINTED: 02/12/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13C0001011</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/29/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MILLENNIUM SURGERY CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1828 SOUTH MILLENNIUM WAY, SUITE 100 MERIDIAN, ID 83642</b>
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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 162	<p>Continued From page 37 popliteal block..." as the type of anesthesia used.</p> <p>The type of anesthesia administered to Patient #2 during her surgery was not documented in a clear and consistent manner.</p> <p>e. Patient #10 was a 66 year old male admitted to the facility on 11/28/12 for foot surgery. The anesthesia used during his surgery was documented throughout his record, as follows:</p> <ul style="list-style-type: none"> <li>- On the "Operative Record," completed by the circulating RN, the RN wrote "TIVA."</li> <li>- On the "PREANESTHESIA EVALUATION" form, completed by the CRNA, the CRNA documented the anesthesia plan was "TIVA."</li> <li>- On the "ANESTHESIA RECORD," completed by the CRNA, under "ANESTHETIC TECHNIQUE" the CRNA selected "TIVA" in the "General" section.</li> <li>- On the "POSTOPERATIVE FOLLOW-UP EVALUATION" form, the RN marked "TIVA."</li> <li>- In the "OPERATIVE REPORT" the physician dictated "IV sedation with local block..." as the type of anesthesia used.</li> </ul> <p>The type of anesthesia administered to Patient #10 during his surgery was not documented in a clear and consistent manner.</p> <p>f. Patient #8 was a 53 year old female admitted to the facility on 10/5/12 for surgery on her eyelids. The anesthesia used during her surgery was documented throughout her record, as follows:</p>	Q 162		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/12/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13C0001011</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/29/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MILLENNIUM SURGERY CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1828 SOUTH MILLENNIUM WAY, SUITE 100 MERIDIAN, ID 83642</b>
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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 162	<p>Continued From page 38</p> <ul style="list-style-type: none"> <li>- On the "Operative Record," completed by the circulating RN, the RN marked MAC.</li> <li>- On the "PREANESTHESIA EVALUATION" form, completed by the CRNA, the CRNA documented the anesthesia plan was "GA [general anesthesia] - GA backup."</li> <li>- On the "ANESTHESIA RECORD," completed by the CRNA, under "ANESTHETIC TECHNIQUE" the CRNA selected MAC.</li> <li>- On the "POSTOPERATIVE FOLLOW-UP EVALUATION" form, the RN marked "TIVA."</li> <li>- In the "OPERATIVE REPORT" the physician dictated "MAC with local" as the type of anesthesia used.</li> </ul> <p>The type of anesthesia administered to Patient #8 during her surgery was not documented in a clear and consistent manner.</p> <p>g. Patient #19 was a 50 year old male admitted to the facility on 1/25/13 for a colonoscopy. The anesthesia used during his procedure was documented throughout his record, as follows:</p> <ul style="list-style-type: none"> <li>- On the "PREANESTHESIA EVALUATION" form, completed by the CRNA, the CRNA documented the anesthesia plan was TIVA.</li> <li>- On the "ANESTHESIA RECORD," completed by the CRNA, under "ANESTHETIC TECHNIQUE" the CRNA selected "TIVA" under the "General" section.</li> </ul>	Q 162		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/12/2013  
FORM APPROVED  
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER  <b>MILLENNIUM SURGERY CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1828 SOUTH MILLENNIUM WAY, SUITE 100 MERIDIAN, ID 83642</b>
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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 162	<p>Continued From page 39</p> <ul style="list-style-type: none"> <li>- On the "POSTOPERATIVE FOLLOW-UP EVALUATION" form the anesthetic used was not documented.</li> <li>- In the "OPERATIVE REPORT" the physician dictated anesthesia was provided "per anesthesia record."</li> </ul> <p>The type of anesthesia administered to Patient #19 during his procedure was not documented in a clear and consistent manner.</p> <p>h. Patient #15 was a 51 year old female admitted to the facility on 12/4/12 for foot surgery. The anesthesia used during her surgery was documented throughout her record, as follows:</p> <ul style="list-style-type: none"> <li>- On the "Operative Record," completed by the circulating RN, the RN documented Patient #15 received general anesthesia with a mask.</li> <li>- On the "PREANESTHESIA EVALUATION" form, completed by the CRNA, the CRNA documented the anesthesia plan was MAC and popliteal block.</li> <li>- On the "ANESTHESIA RECORD," completed by the CRNA, under "ANESTHETIC TECHNIQUE" the CRNA selected MAC. The CRNA also selected "Popliteal" under the "Regional" section.</li> <li>- On the "POSTOPERATIVE FOLLOW-UP EVALUATION" form, the anesthetic provided was not documented.</li> <li>- In the "OPERATIVE REPORT" the physician dictated "Local with IV sedation and popliteal nerve block..." as the type of anesthesia used.</li> </ul>	Q 162		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/12/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13C0001011</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/29/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MILLENNIUM SURGERY CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1828 SOUTH MILLENNIUM WAY, SUITE 100 MERIDIAN, ID 83642</b>
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Q 162	<p>Continued From page 40</p> <p>The type of anesthesia administered to Patient #15 during her surgery was not documented in a clear and consistent manner.</p> <p>i. Patient #13 was a 55 year old male admitted to the facility on 3/15/12 for general surgery. The anesthesia used during his surgery was documented throughout his record, as follows:</p> <ul style="list-style-type: none"> <li>- On the "Operative Record," completed by the circulating RN, the RN documented Patient #13 received general anesthesia with a mask.</li> <li>- On the "PREANESTHESIA EVALUATION" form, completed by the CRNA, the CRNA documented the anesthesia plan was "GMA [sic]."</li> <li>- On the "ANESTHESIA RECORD," completed by the CRNA, under "ANESTHETIC TECHNIQUE" the CRNA selected "TIVA."</li> <li>- On the "POSTOPERATIVE FOLLOW-UP EVALUATION" form, the RN marked "General."</li> <li>- In the "OPERATIVE REPORT" the physician dictated "General" as the type of anesthesia used.</li> </ul> <p>The type of anesthesia administered to Patient #13 during his surgery was not documented in a clear and consistent manner.</p> <p>j. Patient #7 was a 46 year old female admitted to the facility on 3/8/12 for foot surgery. The anesthesia used during her surgery was documented throughout her record, as follows:</p> <ul style="list-style-type: none"> <li>- On the "Operative Record," completed by the</li> </ul>	Q 162		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/12/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13C0001011</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/29/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>MILLENNIUM SURGERY CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1828 SOUTH MILLENNIUM WAY, SUITE 100 MERIDIAN, ID 83642</b>		
(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 162	<p>Continued From page 41</p> <p>circulating RN, the RN documented Patient #7 received general anesthesia with a mask.</p> <ul style="list-style-type: none"> <li>- On the "PREANESTHESIA EVALUATION" form, completed by the CRNA, the CRNA documented the anesthesia plan was general anesthesia.</li> <li>- On the "ANESTHESIA RECORD," completed by the CRNA, the CRNA selected "Pre-Oxygenation" under the general section and noted that an LMA was used.</li> <li>- On the "Post Operative Note/Orders" the physician documented "Anesthetic: ankle block."</li> <li>- On the "POSTOPERATIVE FOLLOW-UP EVALUATION" form, the RN marked "General."</li> <li>- In the "OPERATIVE REPORT" the physician dictated "Intravenous sedation" as the type of anesthesia used.</li> </ul> <p>The type of anesthesia administered to Patient #7 during her surgery was not documented in a clear and consistent manner.</p> <p>k. Patient #6 was an 80 year old male admitted to the facility on 12/6/12 for surgical removal of growths from his arm. The anesthesia used during his surgery was documented throughout his record, as follows:</p> <ul style="list-style-type: none"> <li>- On the "Operative Record," completed by the circulating RN, the RN documented Patient #6 received general anesthesia with a mask.</li> <li>- On the "PREANESTHESIA EVALUATION" form, completed by the CRNA, the CRNA documented</li> </ul>	Q 162			

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

PRINTED: 02/12/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13C0001011</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/29/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>MILLENNIUM SURGERY CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1828 SOUTH MILLENNIUM WAY, SUITE 100 MERIDIAN, ID 83642</b>		
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Q 162	<p>Continued From page 42 the anesthesia plan was TIVA.</p> <ul style="list-style-type: none"> <li>- On the "ANESTHESIA RECORD," completed by the CRNA, the CRNA selected "TIVA" in the "General" section and documented a mask with an airway was used.</li> <li>- On the "POSTOPERATIVE FOLLOW-UP EVALUATION" form, the RN marked "General."</li> <li>- In the "OPERATIVE REPORT" the physician dictated "General" as the type of anesthesia used.</li> </ul> <p>The type of anesthesia administered to Patient #6 during his surgery was not documented in a clear and consistent manner.</p> <p>I. Patient #16 was a 68 year old male admitted to the facility on 1/17/12 for foot surgery. The anesthesia used during his surgery was documented throughout his record, as follows:</p> <ul style="list-style-type: none"> <li>- On the "Operative Record," completed by the circulating RN, did not include documentation regarding anesthesia.</li> <li>- On the "PREANESTHESIA EVALUATION" form, completed by the CRNA, the CRNA did not document a plan for anesthesia.</li> <li>- On the "ANESTHESIA RECORD," completed by the CRNA, the CRNA selected "TIVA" in the "General" section and that a popliteal block was given. In addition, the CRNA documented a mask was used.</li> <li>- On the "POSTOPERATIVE FOLLOW-UP</li> </ul>	Q 162			

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

PRINTED: 02/12/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13C0001011</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/29/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>MILLENNIUM SURGERY CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1828 SOUTH MILLENNIUM WAY, SUITE 100 MERIDIAN, ID 83642</b>		
(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 162	<p>Continued From page 43 EVALUATION" form, the RN marked "TIVA."</p> <p>- In the "OPERATIVE REPORT" the physician dictated "Local" as the type of anesthesia used.</p> <p>The type of anesthesia administered to Patient #16 during his surgery was not documented in a clear and consistent manner.</p> <p>m. Patient #17 was a 62 year old male admitted to the facility on 12/18/12 for foot surgery. The anesthesia used during his surgery was documented throughout his record, as follows:</p> <p>- On the "Operative Record," completed by the circulating RN, the RN documented "TIVA.</p> <p>- On the "PREANESTHESIA EVALUATION" form, completed by the CRNA, the CRNA documented the plan was for local anesthetic with MAC.</p> <p>- On the "ANESTHESIA RECORD," completed by the CRNA, the CRNA selected "MAC" and "TIVA" in the "Other" section. In addition, the CRNA marked that an "Oral/Nasal Airway" was used.</p> <p>- On the "POSTOPERATIVE FOLLOW-UP EVALUATION" form, the RN marked "TIVA."</p> <p>- In the "OPERATIVE REPORT" the physician dictated "Local with IV sedation" as the type of anesthesia used.</p> <p>The type of anesthesia administered to Patient #17 during his surgery was not documented in a clear and consistent manner.</p> <p>n. Patient #5 was a 63 year old male admitted to</p>	Q 162			

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

PRINTED: 02/12/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13C0001011</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/29/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>MILLENNIUM SURGERY CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1828 SOUTH MILLENNIUM WAY, SUITE 100 MERIDIAN, ID 83642</b>		
(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 162	<p>Continued From page 44</p> <p>the facility on 12/27/12 for surgery on his eyelids. The anesthesia used during his surgery was documented throughout his record, as follows:</p> <ul style="list-style-type: none"> <li>- On the "Operative Record" document, completed by the circulating RN, the "Type" was marked "MAC" and the RN wrote beneath this "TIVA."</li> <li>- On the "PREANESTHESIA EVALUATION" form, completed by the CRNA, the CRNA documented the anesthesia plan as "TIV [total intravenous] gen [general]."</li> <li>- On the "ANESTHESIA RECORD," completed by the CRNA, under "ANESTHETIC TECHNIQUE" the CRNA marked "TIVA" in the section for general anesthesia.</li> <li>- On the "Post Operative Note/Orders" the physician documented "Anesthetic: MAC [with] local."</li> <li>- On the "POSTOPERATIVE FOLLOW-UP EVALUATION" form, the RN marked TIVA.</li> <li>- In the "OPERATIVE REPORT" the physician dictated "MAC with local" as the type of anesthesia used.</li> </ul> <p>The type of anesthesia administered to Patient #5 during his surgery was not documented in a clear and consistent manner.</p> <p>o. Patient #18 was a 16 year old female admitted to the facility on 1/24/13 for foot surgery. The anesthesia used during her surgery was documented throughout her record, as follows:</p>	Q 162			

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

PRINTED: 02/12/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13C0001011</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/29/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>MILLENNIUM SURGERY CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1828 SOUTH MILLENNIUM WAY, SUITE 100 MERIDIAN, ID 83642</b>	
(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 162	<p>Continued From page 45</p> <ul style="list-style-type: none"> <li>- On the "Operative Record," completed by the circulating RN, the "Primary Anesthesia" was documented as "General" and the "Type" was marked as "Mask."</li> <li>- On the "PREANESTHESIA EVALUATION" form, completed by the CRNA, the CRNA documented the anesthesia plan was a popliteal block with IV sedation.</li> <li>- On the "ANESTHESIA RECORD," completed by the CRNA, under "ANESTHETIC TECHNIQUE" the CRNA only selected options under the "Regional" section.</li> <li>- On the "Post Operative Note/Orders" the physician documented "Anesthetic: Popliteal Block."</li> <li>- In the "OPERATIVE REPORT" the physician dictated "Intravenous sedation" as the type of anesthesia used.</li> </ul> <p>The type of anesthesia administered to Patient #18 during her surgery was not documented in a clear and consistent manner.</p> <p>CRNA A who provided anesthesia services for Patient #18 was interviewed at 3:30 PM on 1/24/13. He stated that the anesthesia used for Patient #18 was popliteal block with IV sedation. He stated the popliteal block was the main anesthetic and the IV sedation was to keep Patient #18 comfortable. He stated he used a mask to deliver oxygen but Patient #18 was breathing on her own, so he did not consider her under general anesthesia. He stated there was</p>	Q 162		

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

PRINTED: 02/12/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13C0001011</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/29/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>MILLENNIUM SURGERY CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1828 SOUTH MILLENNIUM WAY, SUITE 100 MERIDIAN, ID 83642</b>	
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Q 162	<p>Continued From page 46</p> <p>some confusion among the CRNAs about what the types of anesthesia meant to each of them. He stated it was sometimes hard to differentiate between MAC and TIVA, and that he always felt TIVA indicated general anesthesia but that was not always the case. He explained that some of the difference had to do with billing issues, insurance would not pay for MAC anesthesia in some procedures but would pay for TIVA.</p> <p>The Administrator was interviewed on 1/28/12 at 1:30 PM. He reviewed Patient #18's and Patient #5's medical records. He explained that "MAC" was rarely used as a type of anesthesia. He stated that any time Propofol was used for sedation in a procedure it was considered "general anesthesia." He also stated that he would have considered general anesthesia to mean that the patient required management of the airway (such as an endotracheal tube). He stated that at times, the details of documentation of anesthesia/sedation were for billing purposes. He agreed that there was a lack of consistency in documentation of the anesthesia, or sedation and analgesia, used.</p> <p>The facility failed to ensure the type of anesthesia administered to patients was documented in a clear and consistent manner.</p> <p>3. Medication allergies were not documented in the medical record, as follows:</p> <p>a. Patient #15 was a 51 year old female who was admitted to the facility on 12/4/12 for left foot surgery. Her medical record contained an H&amp;P dated 11/26/12. The H&amp;P documented Patient #15 was allergic to "penicillin resulting in rash,</p>	Q 162	<p>③ Allergy reporting. There were inconsistencies in the Allergy documentation.</p> <p>④ Policy Documentation of patient Allergies #2004</p> <p>During the preoperative assessment the admitting RN will review all allergies and check for consistency if there are inconsistencies they will be corrected by the appropriate personnel.</p> <p>This policy was reviewed and education on this practice was done in the 2/21/13 staff meeting documentation of training is in the nurses Files. Governing board approval 2/26/13</p>	

④ Chart Reviews done quarterly to review compliance supervised by the administrator.

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

PRINTED: 02/12/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13C0001011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/29/2013
NAME OF PROVIDER OR SUPPLIER  MILLENNIUM SURGERY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1828 SOUTH MILLENNIUM WAY, SUITE 100 MERIDIAN, ID 83642	
(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 162	<p>Continued From page 47</p> <p>Motrin resulting in respiratory complications."</p> <p>The "Consent for Place of Surgery," signed by a facility employee and dated 12/4/12, listed an allergy to penicillin, but did not include Patient #15's allergy to Motrin.</p> <p>The Administrator was interviewed on 1/28/13, beginning at 1:40 PM. He reviewed Patient #15's medical record and confirmed the allergies were incorrectly documented on the consent form.</p> <p>The ASC failed to accurately document Patient #15's allergies throughout the medical record.</p> <p>b. Patient #18 was a 16 year old female admitted to the facility on 1/24/13 for right foot surgery. Her medical record contained an H&amp;P dated 1/21/13. The H&amp;P documented patient #18 was allergic to penicillin and nickel.</p> <p>An orange sticker was located on the outside of Patient #18's medical record. The sticker documented Patient #18 was allergic to penicillin and nickel.</p> <p>Patient #18 and her mother were interviewed on 1/24/13, beginning at 1:20 PM. During the interview, Patient #18's mother said her daughter experienced a difficult time with pain medication after left foot surgery at the ASC in 2012 and developed an allergy to hydrocodone. She said she stopped the medication and contacted the surgeon because her daughter was nauseated and experienced a generalized rash after hydrocodone was administered.</p> <p>During Patient #18's preoperative nursing</p>	Q 162		

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

PRINTED: 02/12/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13C0001011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  01/29/2013
NAME OF PROVIDER OR SUPPLIER  MILLENNIUM SURGERY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1828 SOUTH MILLENNIUM WAY, SUITE 100 MERIDIAN, ID 83642		
(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 162	<p>Continued From page 48</p> <p>evaluation on 1/24/13 at approximately 1:30 PM, the RN identified the patient and verified the type of surgery and surgical site. Afterwards, the RN placed an identification band and an allergy band on Patient #18's left wrist. The allergy band listed penicillin and nickel, but did not include hydrocodone. The RN did not question Patient #18 or her mother about the accuracy of the allergies listed on the wrist band. The surveyor prompted Patient #18's mother to inform the RN about the hydrocodone allergy. The RN added hydrocodone to the allergy band and updated the medical record to include hydrocodone as well.</p> <p>The ASC failed to accurately document Patient #18's allergies throughout the medical record.</p> <p>c. Patient #13 was a 55 year old male admitted to the facility for outpatient general surgery on 3/15/12. Patient #13's record was reviewed and the following discrepancies in documentation of allergies were found:</p> <p>The form "Consent for Place of Surgery" contained the name of the procedure, the patient's allergies and a place for the patient to sign. Under allergies "None Known" was written in red ink. Next to that, in black ink was written "cyclobenzaprine/tramadol." The form was signed and dated by Patient #13 in black ink on 3/15/12. The Administrator reviewed the record and was interviewed beginning at 1:30 PM on 1/28/12. He stated the staff member that checks patients into the facility would write the allergy in red and put a red "X" next to the portion of the form that the patient needs to sign. He concluded that "cyclobenzaprine/tramadol" was written on the allergy line by Patient #13.</p>	Q 162			

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

PRINTED: 02/12/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13C0001011</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/29/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MILLENNIUM SURGERY CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1828 SOUTH MILLENNIUM WAY, SUITE 100 MERIDIAN, ID 83642</b>
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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 162	<p>Continued From page 49</p> <p>The form "Medical/Surgical History" was signed and dated by Patient #13 on 3/12/12. The form contained Patient #13's medical history, surgical history, history of alcohol and tobacco use and allergies. Under "Allergies:" Patient #13 documented cyclobenzaprine and tramadol. The Administrator reviewed the record and was interviewed beginning at 1:30 PM on 1/28/13. He stated this form was mailed to patients prior to their surgery to be filled out and brought with them on the day of their procedure. He confirmed Patient #13 had documented his allergies as cyclobenzaprine and tramadol on this form.</p> <p>The form "Pre-Op Checklist" was completed and signed by an RN but was not dated. The form contained documentation stating Patient #13 had no known drug allergies.</p> <p>The form "PACU RECORD - Phase I" was signed by an RN and dated 3/15/12 at 8:54 AM. The form contained documentation stating Patient #13 had no known allergies.</p> <p>The form "PREANESTHESIA EVALUATION" was completed and signed by a CRNA on 3/15/12 at 8:35 AM. The form contained documentation stating Patient #13 had no known drug allergies.</p> <p>The Administrator reviewed the record and was interviewed beginning at 1:30 PM on 1/28/13. He agreed that Patient #13's allergies were inconsistent with what had been documented by the staff at the facility. He agreed these discrepancies had the potential for Patient #13 to experience adverse drug reactions.</p>	Q 162		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/12/2013  
FORM APPROVED  
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER  <b>MILLENNIUM SURGERY CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1828 SOUTH MILLENNIUM WAY, SUITE 100 MERIDIAN, ID 83642</b>
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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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<p>Q 162</p> <p>Q 181</p>	<p>Continued From page 50</p> <p>The medical records did not contain accurate documentation related to pre-surgical examinations, anesthesia administration or patient allergies.</p> <p>416.48(a) ADMINISTRATION OF DRUGS</p> <p>Drugs must be prepared and administered according to established policies and acceptable standards of practice.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interviews, and review of policies, it was determined the facility failed to ensure medication was stored, prepared and administered in accordance with acceptable standards of practice. This failure directly impacted 1 of 2 patients (Patient #20) whose surgeries were observed and had the potential to impact all patients receiving care after Patient #20. Failure to adhere to acceptable standards of practice had the potential to result in all patients receiving medication and experiencing adverse drug reactions. Findings are as follows:</p> <p>1. The policy "USE OF MULTIPLE DOSE VIALS (MDVs)," revised 7/12/11 stated "The healthcare provider shall write the expiration date on the vial, when opened." The policy went on to state "The beyond-use date (BUD) for an opened or entered (i.e., needle punctured) multiple dose container with antimicrobial preservatives shall be 28 days, unless otherwise specified by the manufacturer." However, the policy also stated a multidose vial would be discarded "When the manufacturer's</p>	<p>Q 162</p> <p>Q 181</p>	<p>① DD MSC has used single dose vials for multiple patients with aseptic technique. This is primarily due to the fact that many drugs are in a shortage.</p> <p>② Policy use of MDV# 3035 and Safe medication practices # 3036. were updated to reflect safe medication practices. MDUs will be dated to expire 28 days after opening. This policy was reviewed by the Clinical Staff during the 2/21/13 Staff meeting they expressed understanding. Training and Education will be documented in Nurses personal files.</p>	
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Policy will be reviewed by CRNAs and respond to show understanding. by 3/10/13 Governing Board reviewed and Approved updated policies.

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

PRINTED: 02/12/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13C0001011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/29/2013
NAME OF PROVIDER OR SUPPLIER  MILLENNIUM SURGERY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1828 SOUTH MILLENNIUM WAY, SUITE 100 MERIDIAN, ID 83642	
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Q 181	<p>Continued From page 51</p> <p>established expiration date is reached..." The policy was unclear as to when a multiple dose vial would be considered expired and would then be discarded.</p> <p>A tour of the facility was conducted on 1/22/13 at 2:45 PM with the Administrator. He confirmed medications were expired or undated, as follows:</p> <p>a. An open multiple dose vial of lidocaine with the expiration date 1/22/13 was observed. The Administrator stated he considered the lidocaine expired and stated it should have been discarded.</p> <p>b. An open multiple dose vial of normal saline was observed with an expiration date of 10/12/12.</p> <p>c. A multiple dose bottle of oral Versed was observed in a medication drawer. There was no expiration date written on the bottle. The Administrator stated because the medication was used so frequently, an expiration date was not needed.</p> <p>d. Two syringes labeled "LIDOCAINE" were observed in baskets containing equipment to start IV sites. The labels were undated. The Administrator confirmed it was difficult to tell when the medication was drawn up. He stated nursing staff prepared several syringes at the start of the day and discarded the unused syringes at the end of the day. He confirmed that at the time of the tour that the lidocaine would no longer be required and should have been discarded.</p> <p>e. On 1/23/12 at 10:45 AM, a syringe labeled "LIDOCAINE" was observed in a basket</p>	Q 181	<p>① Continued</p> <p>Ⓐ Staff were Educated to discard unused drawn up medication <del>the day of</del> draw. The Staff was Educated on proper labeling of Syringes and noted under standing during 2/21/13 Staff meeting</p>	

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

PRINTED: 02/12/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13C0001011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/29/2013
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Q 181	<p>Continued From page 52</p> <p>containing equipment to start IV sites. The label was undated. An RN working in the preoperative area was interviewed. She stated she did not know when the medication was prepared. She explained she was the only RN to start IV sites on 1/23/13 and did not use lidocaine. She stated she believed the syringe was left from the previous day. She confirmed the medication should have been discarded on 1/22/13.</p> <p>f. An open multiple dose vial of insulin was observed in the refrigerator on 1/23/13 at 10:45 AM. The expiration date written on the vial was 7/25/12. An RN in the preoperative area was present at this time and confirmed the insulin was expired and should have been discarded.</p> <p>The facility failed to ensure medications were appropriately labeled and discarded.</p> <p>2. The policy "PHARMACY DRUG STORAGE AND PREPARATION AREA," effective 1/01/08, stated medications should be "inaccessible to unauthorized individuals." The facility failed to adhere to this policy, as follows:</p> <p>a. A tour of the perioperative area was conducted with the Administrator on 1/22/13 at 2:45 PM. A refrigerator containing paralytic medications used for anesthesia, antibiotics, eye drops, lipids, insulin and respiratory medication was sitting on a counter top. The refrigerator was accessible to patients' families and/or housekeeping staff. However, the refrigerator did not have a lock on it. The Administrator confirmed the refrigerator was not locked and had never been locked. He agreed the medication was not secured from unauthorized persons.</p>	Q 181	<p>② Storage of Pharmacy drugs # 2020. Medication refrigerator Not Locked.</p> <p>① Refrigerator lock installed 2/26/2013.</p> <p>③ supervised by administrator completed _____ 2/26/2013</p>	

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

PRINTED: 02/12/2013  
FORM APPROVED  
OMB NO. 0938-0391

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Q 181	<p>Continued From page 53</p> <p>b. A tour of the perioperative area was conducted with the Administrator on 1/22/13 at 2:45 PM. Two syringes marked "LIDOCAINE" were observed in baskets containing equipment to start IV sites. The baskets were located on a counter near the restroom used by patients and families. The Administrator confirmed the medication was not stored in a secure location.</p> <p>The facility failed to ensure medications were kept secure.</p> <p>3. The policy "USE OF MULTIPLE DOSE VIALS (MDVs), revised 7/12/11, was reviewed. There was no language in the policy about prohibiting the use of single dose vials for multiple patients.</p> <p>Patient #20 was a three year old female admitted to the facility for a dental procedure. Her surgery was observed from 9:52 AM to 10:20 AM on 1/25/13. The CRNA medication cart was noted to contain a vial of propofol labeled "SINGLE USE." A 10 cc vial of normal saline with a 1 cc vial of morphine taped to it was also observed. Each of these vials were labeled "SINGLE USE." At 10:05 AM CRNA B was observed to prepare morphine for administration.</p> <p>Patient #20's "ANESTHESIA RECORD" indicated 50 mg of propofol was administered at 10:00 AM and 0.5 mg of morphine was administered at 10:15 AM.</p> <p>CRNA B was interviewed on 1/25/13 at 10:13 AM. He confirmed the propofol, normal saline and morphine vials were labeled for single patient use. He explained that on days with multiple</p>	Q 181	<p>③ policy # 30 35 updated CRNA and RN have reviewed and understand the policy. Info sent to CRNA's 2/26/12 Policy approved by Governing board. Compliance supervised by Administrator. Full implementation by 3/10/13</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/12/2013  
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OMB NO. 0938-0391

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Q 181	Continued From page 54 pediatric cases, he would open a vial of single use propofol at the beginning of the day, and use it throughout the day.  CRNA B also stated that he drew up the morphine and diluted it in the normal saline at the start of the day to use throughout the day. He stated at the end of the day, the remaining medication was wasted. He explained he did this because he was giving very small doses to pediatric patients and because of a shortage of medication, he did not want to waste such large amounts on each case.	Q 181		
Q 202	The facility failed to ensure single use vials were administered to a single patient. <b>416.49(b) RADIOLOGIC SERVICES</b>  (1) The ASC must have procedures for obtaining radiological services from a Medicare approved facility to meet the needs of patients.  This STANDARD is not met as evidenced by: Based on observation, staff interview, review of manufacturer's guidelines for safety precautions for radiation exposure of a C-Arm (a type of x-ray imaging scanner intensifier, so named because of its configuration) and facility policies, and an interview with Idaho Bureau of Laboratories staff, it was determined the facility failed to implement and monitor procedures for radiation safety from C-Arm use. These failures had the potential to adversely impact the health and safety of all patients and personnel at the facility. Findings include:	Q 202		

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

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FORM APPROVED  
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Q 202	Continued From page 55  1. The facility's policies regarding radiation and x-ray use were reviewed. The policies did not address the use of dosimeters or protective covering to be used in the event of exposure to radiation.  The OR designated Room #2 was toured on 1/24/13 at 3:00 PM. A mini C-arm was observed in the room. A CST was interviewed and explained that the full-time CSTs who assisted the physicians during surgeries requiring the mini C-arm used dosimeters. She stated the physicians and the circulating RN did not wear dosimeters. She stated she believed lead aprons were available but were not required to be used.  Upon request, the Administrator provided the operator's guide for the FluoroScan Premier Imaging System. In the section "Introduction," under the heading of "General," the document stated "Although PREMIER is a low dose device, this does not mean that the X-ray beam is not potentially harmful. It should be noted that X-ray exposures are cumulative and that it may be possible to receive significant exposures if strict safety procedures are not observed at all times." Another portion of the Introduction was titled, "X-Ray Shielding" and stated, "The best protection against radiation exposure is a shield that will attenuate or block X-rays. The protection most commonly used by the operator and staff is the lead apron. Radiation attenuating gloves may also be worn. The scattered radiation from PREMIER is quite low as compared to other devices, and the choice to wear protective aprons is governed by applicable state laws and policy."	Q 202	① The Radiation Control Policy was been updated. All Scrubbed in Staff will wear dosimetry badges. All other occupants in the OR Suite will either leave the room, wear shielding or seek cover in the room that would provide a significant safety barrier behind the Anesthesia machine. MSC will request a waiver from Idaho dept of health and Welfare, Radiological program. We have 5 year + of No exposure dosimetry badges. We will continue our current practice until		

We receive a waiver  
if not we will continue to  
follow our Radiation policy  
Supervised by the Administrator  
Approved by the governing board  
2/26/2013

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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/12/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13C0001011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  01/29/2013
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Q 202	Continued From page 56 The Manager of the Laboratory Improvement & X-ray Certification Sections of the Idaho Bureau of Laboratories was consulted and provided a response on 2/5/13 at 8:48 AM. According to the Manager, the Idaho Radiation Control regulations require dosimetry badges be worn whenever there is actual or potential exposure to radiation unless the facility demonstrated that under normal usage there was zero exposure to the operators of the equipment. He explained that in some circumstances, if a facility used dosimeters for a one-year period of time and recorded no exposure, then an exemption may be issued in writing and would be kept on file at the facility.  The Administrator was interviewed on 1/28/13 at 1:40 PM. He explained that the full-time CST staff wore dosimeters. He explained that for years all staff involved in procedures using x-ray equipment were monitored and for years he had documentation of no measurable radiation exposure. He stated the decision was made to only continue monitoring on the staff members who risked the most prolonged and repeated exposure. He confirmed that the facility had not requested a waiver of exemption related to dosimeter use.  The ASC had not been granted an exemption and did not develop policies and procedures for radiation safety, provide shielding from radiation exposure to employees and patients, or provide radiation monitoring.	Q 202			
Q 224	416.50(a)(2) ADVANCE DIRECTIVES  The ASC must comply with the following requirements: (i) Provide the patient or, as appropriate, the	Q 224			

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

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Q 224	<p>Continued From page 57</p> <p>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 observation, interview, and review of ASC policies and patient rights information, it was determined the ASC failed to ensure comprehensive rights information related to Advance Directives was provided to patients and/or their representatives. This impacted all patients cared for at the facility and resulted in a lack of information related to the provision of life sustaining measures provided during respiratory and/or cardiac arrest. Findings include:</p> <p>1. The "Patient Bill of Rights" information, undated, provided to patients prior to a procedure was reviewed. According to this document, patients had the right to "Formulate advance directives regarding his or her healthcare, and to have facility staff and practitioners who provide care in the facility comply with these directives..." The "Patient and Family Responsibilities" information, undated, stated the patient had the responsibility to inform his/her provider about any "living will, medical power of attorney or other</p>	Q 224	<p>① Advance Directives policy # 1034 and DNR policy 1017 updated Reviewed and Approved by the governing board 2/26/13</p> <p>② All documents with information on Advance Directives have been updated to reflect MSC DNR Statement to provide resuscitative efforts until a patient can be transferred to a facility that can honor their wishes. Clinical Staff were Educated on this Statement and how to communicate this policy to patients during our staff</p>	

meeting 2/21/13

③ Supervise by the Administrator.

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

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FORM APPROVED  
OMB NO. 0938-0391

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Q 224	<p>Continued From page 58</p> <p>directive that could affect his/her care." This information was also observed to be posted in the waiting room of the ASC.</p> <p>However, the "DO NOT RESUSCITATE (DNR)" policy, revised 7/12/11, was reviewed. According to the policy, "It will therefore be the general policy of the Department of Anesthesia in all cases...to institute resuscitative measures in those requiring them under the assumption that these therapies are short-term by the nature of operating room arrests. Anesthesia recognizes that, despite careful explanation of the facts and principles outlined above, some patients may insist on the continuation of their DNR status into the operative setting. In the spirit of emphasizing patient rights in structuring the medical treatment plan it is therefore also recognized that exceptions to the above-stated policy may occur. Such exceptions will allow for the continuation of a patient's DNR status into the operating room..."</p> <p>The Administrator was interviewed on 1/24/13 at 12:45 PM. He stated that while in the facility, a patient would be resuscitated and transferred to the local hospital for emergency care. He stated that this was explained to patients if they indicated they had an Advance Directive with a DNR order. He confirmed this information was not provided to the patient in writing.</p> <p>The Administrative Assistant was interviewed on 1/25/13 at 1:20 PM. She explained her process for checking a patient into the facility. She stated patients were questioned about an Advance Directive at the time of admission. If an Advance Directive was provided, a copy was placed in the patient's medical record. She stated if a patient</p>	Q 224			

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

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Q 224	Continued From page 59 had not completed an Advance Directive and wanted information, this would be provided. The Administrative Assistant stated she did not ask what was contained in a patient's Advance Directive (such as if the patient requested DNR status) and stated she believed this would be discussed with the RN during the preoperative phase.  An RN caring for patients in the perioperative area was interviewed on 1/25/13 at 1:30 PM. She explained she verified the consents and Advance Directive information was signed. She stated she did not discuss the contents of patient's Advance Directives and would not know if a patient requested DNR status. She stated she did not think the ASC performed surgery on patients who requested DNR status and in an emergency, patients would be resuscitated and transferred to a hospital for care. The RN confirmed she did not discuss this with her patients during the preoperative phase but believed this was part of the pre-admission paperwork provided to the patient.	Q 224		
Q 225	The ASC failed to ensure comprehensive rights information related to Advance Directives was provided to patients and/or their representatives. <b>416.50(a)(3)(i), (v), (vi), (vii) SUBMISSION AND INVESTIGATION OF GRIEVANCES</b>  (i) The ASC must establish a grievance procedure for documenting the existence, submission, investigation, and disposition of a patient's written or verbal grievance to the ASC. (v) The grievance process must specify timeframes for review of the grievance and the provisions of a response.	Q 225		

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

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Q 225	<p>Continued From page 60</p> <p>(vi) The ASC, in responding to the grievance, must investigate all grievances made by a patient or the patient's representative regarding treatment or care that is (or fails to be) furnished.</p> <p>(vii) The ASC must document how the grievance was addressed, as well as provide the patient with written notice of its decision. The decision must contain the name of an ASC contact person, the steps taken to investigate the grievance, the results of the grievance process, and the date the grievance process was completed.</p> <p>This STANDARD is not met as evidenced by: Based on review of policies and interview, it was determined the facility failed to ensure a procedure for identifying and documenting the existence and submission of grievances was developed and implemented. This impacted all patients who received care at the facility and had the potential to result in unidentified and unresolved grievances. Findings include:</p> <p>1. The facility's policy, "GRIEVANCE/PATIENT COMPLAINTS," revised 5/18/09, was reviewed. The policy did not define the difference between a grievance and a complaint. The policy stated "Any complaint received from a patient while in the facility or after discharge will be immediately reported to the Administrator (Complete Grievance Form)" and that the "Administrator is responsible for 'On-The-Spot' resolving of patient problems where possible, and for documenting complaints communicated to them or to their staff (Complete Patient Complaint Form)." The policy directed the Administrator to provide a written</p>	Q 225	<p>① Grievance policy # 1043 was not clearly defined</p> <p>Ⓐ policy was updated to better define grievances and complaints.</p> <p>Reviewed by the administrator and approved by the Governing Board 2/26/13</p> <p>The Administrator will be more proactive and is better prepared to address complaints and grievances.</p> <p>Supervised by the administrator and medical director.</p>	
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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Q 225	<p>Continued From page 61</p> <p>notice to the patient with the name of a contact person, steps taken to investigate the grievance, the results of the grievance process and the date the process was completed. Beyond this, the policy did not mention "grievances" but routinely referred to the management of "complaints." According to the policy, a record of complaints was to be maintained.</p> <p>The Administrator was interviewed on 1/28/13 at 1:40 PM. He explained his process for grievances. He stated a concern would start out as a complaint and not a grievance. He agreed that the policy did not clearly define when an issue was to be handled as a grievance and not a complaint. The Administrator explained that if a complaint was voiced while the patient was in the facility he would speak with the patient/representative as soon as possible to try and resolve the issue. He stated that if he was alerted to a concern after a patient was discharged from the facility, he contacted the patient/representative to obtain details of the concern and attempted to resolve the issue. The Administrator explained that if he was not able to resolve a concern, he offered the patient/representative an option to file a formal grievance to address the problem. He stated the concern would be further evaluated and responded to within the timeframe established in the policy and followed up with a letter of resolution. He stated there had been no grievances within the last 12 months and that he did not maintain a record of complaints.</p> <p>The facility failed to ensure a procedure for identifying and documenting the existence and submission of grievances was thoroughly</p>	Q 225			

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

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NAME OF PROVIDER OR SUPPLIER  MILLENNIUM SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1828 SOUTH MILLENNIUM WAY, SUITE 100 MERIDIAN, ID 83642
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<p>Q 225</p> <p>Q 245</p>	<p>Continued From page 62 developed and implemented.</p> <p>416.51(b)(3) INFECTION CONTROL PROGRAM - RESPONSIBILITIES</p> <p>The program is - Responsible for providing a plan of action for preventing, identifying, and managing infections and communicable diseases and for immediately implementing corrective and preventive measures that result in improvement.</p> <p>This STANDARD is not met as evidenced by: Based on staff interviews, observations, and review of policies, infection control documentation and records, it was determined the facility's infection control program failed to provide a plan of action for preventing and identifying infections. This failure directly impacted 8 of 20 patients (Patients #1, #3, #7, #9, #12, #16, #18, and #19) whose medical records were reviewed and had the potential to impact all patients receiving care at the facility. These failures had the potential to impede the mitigation and investigation of infections. Findings include:</p> <p>1. The policy "INFECTION CONTROL PROGRAM," undated, stated "Patients will be contacted within 72 hours of surgery for assessment. Surgeons will be contacted 30 days post op [operation] to monitor post op infections."</p> <p>The Administrator was interviewed on 1/28/13 at 11:20 AM. He explained the primary method of identifying postoperative infections was a surgical site infection report completed by each physician. He stated that every two months a list of patients each physician treated was generated. The</p>	<p>Q 225</p> <p>Q 245</p>	<p>① Infection Control Program. Infection Surveillance, Annual Education, and tracking infections.</p> <p>② A policy reviewed MSC will follow the policy <del>more implicit</del> <sup>better</sup> Surgeons will be contacted 30 days after the Surgery date to report infections and other complications. If the Surgeon discovers an infection he is required/requested to report the infection ASAP for MSC to do an immediate investigation. All complications</p>	
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② monitored by the Administrator  
All infections and complications reviewed by the Clinical Staff and the governing Board every quarter.  
Compliant 2/26/13

and ~~inves~~ complications will be fully investigated until resolution or a conclusion is met. MSC was not completing the circle of investigation. We will...

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED  
OMB NO. 0938-0391

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Q 245	<p>Continued From page 63</p> <p>physicians were instructed to identify any patient who developed an infection, a complication, or required an emergency room visit or hospitalization subsequent to care at the facility. The Administrator also stated that pediatric dental surgery patients did not follow up with the dental surgeon until 6 months postoperatively. He stated he assumed the dental surgeon would be contacted by parents regarding signs or symptoms of infection and the dental surgeon would report these cases via the surgical site infection report. The Administrator confirmed that there was the possibility a patient would not follow up with the ASC physician and the ASC physician would therefore not be aware of a postoperative infection. The Administrator stated that the facility conducted follow up phone calls to patients and would be alerted to signs and symptoms of infections at that time. The Administrator explained that all patients received discharge instructions. He stated he believed discharge instructions included signs and symptoms of infection to report to the physician.</p> <p>The "POSTOPERATIVE FOLLOW-UP EVALUATION" form was reviewed. The form prompted staff to ask patients or their representatives about dressings, circulation, pain, nausea/vomiting, bleeding/drainage, concerns with following discharge instructions, and response to regional anesthesia. The form did not contain questions related to signs and symptoms of an infection.</p> <p>An RN was interviewed on 1/23/13 at 10:10 AM. She stated she did not ask questions regarding signs or symptoms of an infection when making the follow up phone call. She stated it was not</p>	Q 245	<p><i>Post op Evaluation</i></p> <p><i>All discharge orders have been updated to include signs and symptoms of infection and who to contact.</i></p> <p><i>Nurses were educated to review discharge instructions with an emphasis on identifying postoperative infections</i></p> <p><i>Post operative phone call sheet updated to better ask infection type infections questions covered in our 2/1/13 staff meeting.</i></p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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Q 245	<p>Continued From page 64</p> <p>uncommon for patients to run a low grade temperature after surgery. She stated most patients followed up with their physician within a few days after surgery. She confirmed the follow up phone calls, often made within 24 hours of surgery, were not an effective means of collecting infection data as a postoperative infection would not be present so soon after surgery.</p> <p>Discharge instructions provided to patients were reviewed. Signs and symptoms of an infection were not included in the following patients' discharge instructions:</p> <ul style="list-style-type: none"> <li>- Patient #19 was a 50 year old male admitted to the facility on 1/25/13 for a colonoscopy.</li> <li>- Patient #3 was a 15 month old female admitted to the facility on 1/18/13 for dental surgery.</li> <li>- Patient #12 was a 3 year old female admitted to the facility on 12/7/12 for dental surgery.</li> <li>- Patient #1 was a 76 year old female admitted to the facility on 9/5/12 for a colonoscopy.</li> </ul> <p>The Administrator was interviewed on 1/28/13 at 11:20 AM. He reviewed the discharge instructions provided to Patients #1, #3, #12, and #19. He confirmed that not all patients received information related to infections and when to report signs and symptoms of an infection. He confirmed that the facility did not have a way to ensure all infections would be reported to the facility.</p> <p>The facility failed to implement a process to identify postoperative infections.</p>	Q 245			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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Q 245	Continued From page 65  b. The "REVIEW OF HEALTHCARE ASSOCIATED INFECTIONS (HAIs)" policy, revised 5/25/11, was reviewed. According to the policy, "Every infection is investigated."  The Administrator was interviewed at 11:20 AM on 1/28/13. He explained that every two months a list of patients each physician treated was generated. He stated physician's were instructed to identify any patient who developed an infection, a complication, or required an emergency room visit or hospitalization subsequent to care at the facility. He stated any issues identified on these forms were investigated by him and discussed with the physician and at Governing Body and staff meetings. He stated he assessed for causative factors, reviewed policies and procedures, and completed a "Surgical Site Infection (SSI)" form.  The "Surgical Site Infection (SSI)" form, undated, was reviewed. The form contained sections to describe the specific event, signs and symptoms exhibited, laboratory data, and documentation of physician involvement in diagnosis and treatment. The form allowed for documentation of how the infection was detected and the extent of the infection (such as a secondary blood stream infection or death).  Infection control documentation from 1/2012 - 1/25/13 was reviewed. Forms to identify infections, complications, or ER/hospital visits for each patient treated at the facility were present. Five patients with postoperative infections were identified. However, the documentation did not include an investigation of the infection source for	Q 245	(3) HAI policy # 4000 reviewed and updated to reflect current practice. MSC Admin. will improve the documentation of the SSI report and do a better job of closing the circle and complete investigations. Review and approved by the Governing Board 2/26/13	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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Q 245	<p>Continued From page 66</p> <p>3 of the 5 patients (Patients #7, #9, and #16) with infections, as follows:</p> <p>- Patient #7 was a 46 year old female admitted to the facility on 3/8/12, 3/24/12 and 4/24/12 for a non-healing surgical wound after foot surgery on 1/13/12. Infection control documentation for Patient #7 included an "Infection and Complication Log Summary" and an undated "Incident report Summary." The Administrator documented on the "Incident report Summary" that Patient #7 had a complex surgery requiring a "long healing time." He documented Patient #7 was noncompliant, had several comorbidities and that the facility and the surgeon had done "everything in our power to help her." The Administrator noted that Patient #7 was no longer being treated by the facility physician.</p> <p>The "Infection and Complication Log Summary," signed by the Administrator on 7/28/12, documented Patient #7 had a non-healing wound with an infection, and she had been admitted to a long term care facility for wound care and antibiotic treatment.</p> <p>The documentation did not include a "Surgical Site Infection (SSI)" form. Additionally, there was no documentation of an investigation for the cause of the postoperative infection, review of policies and procedures, or discussion with staff members.</p> <p>- Patient #9 was a 65 year old male admitted to the facility on 2/16/12 for a ventral hernia repair. Infection control documentation included an undated and unsigned "Surgical Site Infection (SSI)" form. The form included a handwritten</p>	Q 245			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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Q 245	<p>Continued From page 67</p> <p>note that stated "Resolve Drain and Health Status Likely Factors." The H&amp;P from Patient #9's hospital admission on 2/27/12 was included in the infection control documentation. The H&amp;P was dictated by Patient #9's ASC physician. The physician documented that he believed an abdominal drain (placed during Patient #9's surgery on 2/16/12) was the "source of infection..." However, there was no documentation of an investigation for the cause of the postoperative infection, review of policies and procedures, or discussion with staff members.</p> <p>- Patient #16 was a 68 year old male admitted 1/17/12 for ankle surgery. Infection control documentation did not include a "Surgical Site Infection (SSI)" form. Additionally, there was no documentation of an investigation for the cause of the post operative infection, review of policies and procedures, or discussion with staff members.</p> <p>The Administrator was interviewed on 1/28/13 at 11:20 AM. He reviewed the infection control documentation related to Patients #7, #9, and #16 and confirmed that investigations were not completed to rule out facility acquired infections.</p> <p>The facility failed to implement a process to investigate post-operative infections.</p> <p>2. The policy "EDUCATION," undated, stated the facility would provide an "ongoing educational program" in "identification, prevention, control and reporting of infections." The policy stated this education would be provided annually in addition to new hire training. However, there was no</p>	Q 245	<p>② Annual infection Control Education ongoing Education will be done. The infection Control program was reviewed and the Administrator Educated the Staff on discharge instructions with an Emphasis on infection identification. Post OP phone calls will focus on Education of infection related questioning, and Education on what to do if there is a suspected infection done during the 2/21/13</p>	
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Staff Meeting.  
Monitoring by the Administrator  
Approved by Governing Board  
2/26/13

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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Q 245	<p>Continued From page 68</p> <p>documentation to indicate infection control training had been completed for any staff in 2012.</p> <p>The Administrator was interviewed on 1/28/13 at 11:00 AM. He confirmed staff were not provided with infection control education in 2012. He stated that staff were given some infection control training during staff meetings but this training was not documented.</p> <p>3. Patient #18 was a 16 year old female admitted to the facility on 1/24/13 for foot surgery. Her surgical procedure was observed on 1/24/13 beginning at 3:00 PM. In preparation for surgery the circulating RN was observed to secure Patient #18 to the OR table using two blue straps tied together. The straps were a soft, porous fabric with Velcro on the ends.</p> <p>The Administrator was interviewed on 1/25/13 at 1:30 PM. He stated he was unsure of the process for cleaning the straps. He added that he was unsure if the straps had ever been cleaned.</p> <p>The circulating RN was interviewed on 1/25/13 at 2:30 PM. She stated she cleaned the straps by wiping them with a sanicloth. She acknowledged that because the straps were fabric, it was not possible to ensure they were actually clean.</p> <p>The facility failed to provide non-porous cleanable straps.</p> <p>4. The "HAND HYGIENE - CDC GUIDELINES" policy, last reviewed in January of 2011, indicated the facility followed CDC guidelines related to hand hygiene. The policy stated staff were to</p>	Q 245	<p>(3) pt with velcro strap on. How is the strap cleaned it was wiped with Sani Wipes.</p> <p>(A) This practice is not in line with proper infection control practices a new belt has been purchased and when it arrives the velcro belt will be discarded.</p> <p>(M) supervised and monitored by the administrator for completion.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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Q 245	Continued From page 69 perform hand hygiene using non-antimicrobial soap and water, antimicrobial soap and water, or an alcohol-based hand rub, as follows: "...Before each patient encounter... and...Before applying gloves and inserting indwelling catheters, peripheral vascular catheters, and other invasive devices that do not require a surgical procedure..." However, hand hygiene was not observed to be completed in accordance with facility policy, as follows:  Patient #18 was a 16 year old female admitted to the facility on 1/24/13 for foot surgery. Patient #18's preoperative process was observed on 1/24/13 beginning at 1:20 PM. Her surgical procedure was observed on 1/24/13 beginning at 3:00 PM.  During the preoperative process, the RN was observed preparing to start an IV on Patient #18. In preparation for the procedure, the RN failed to wash her hands before donning gloves.  The CRNA met with Patient #18 during the preoperative process on 1/24/13, beginning at approximately 2:30 PM. In preparation to come in contact with the patient and administer IV sedation, the CRNA failed to wash his hands.  At 3:05 PM, the circulating RN was observed to don sterile gloves before inserting a urinary catheter. At 3:10 PM she removed the gloves and continued to prepare Patient #18 for surgery. She did not perform hand hygiene after removing her gloves and before moving on to the next task.  The facility failed to perform hand hygiene per facility policy and in accordance with CDC	Q 245	(A) Hand Hygiene CDC protocol & policy # 4008 (A) Incidents of failure to perform proper hand hygiene was discussed with the staff during our 2/21/13 Staff meeting staff in addition will review the policy and sign off on the education. This will be kept in their file CRNA's will review and sign off on the policy as well. it will be noted in their file. (M) Supervised by the Administrator.	

Approved by the governing board 2/26/13.

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Q 245 Q 262	Continued From page 70 guidelines. 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 patients received a pre-surgical assessment for 3 of 3 patients (Patients #18, #19 and #20) whose preoperative process was observed. Failure to perform this pre-surgical assessment had the potential to impact patient safety during and after the procedure. Findings include:  1. Pre-surgical assessments were not comprehensive, as follows:  a. Patient #19 was a 50 year old male admitted to the facility on 1/25/13 for a colonoscopy. On 1/25/13 at approximately 8:05 AM, CRNA was observed performing Patient #19's preoperative anesthesia assessment. The CRNA reviewed Patient #19's medical history, discussed the upcoming surgical procedure and the type of	Q 245 Q 262	① presurgical Assessment Policy # 2005 and Assessment prior to induction #2309. updated  ② All Anesthesia providers have been informed to perform a minimum a heart and Lungs physical assessment and to document findings. Policies noted above have been sent to the CRNAs for review and documentation of understanding will be placed in their files. Documentation is due by	

IF assessments are missed or not documented the CRNA will be re-educated. Policies updated by the Administrator and Approved by the governing Board 7/26/15.

March 10<sup>th</sup> 2013.  
③ Administrator will supervise compliance by Auditing Charts by the Nurses and Anesthesia.

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Q 262	<p>Continued From page 71</p> <p>anesthesia she planned to administer. She also evaluated Patient #19 for prior problems with anesthesia and asked if he had been ill or if his health status had changed since seeing the physician. The CRNA did not examine Patient #19. She did not listen to his heart and lungs with a stethoscope.</p> <p>The CRNA was interviewed on 1/25/13 at approximately 10:00 AM. The preoperative examination was discussed. The CRNA stated if patients received "deep general anesthesia," she listened to heart and lungs. She also said if she was working with Dr. [physician's name], he tells her not to perform the preoperative exam because he has already done so.</p> <p>b. Patient #20 was a 3 year old female admitted to the facility on 1/25/13 for dental surgery. On 1/25/13 at approximately 9:30 AM, CRNA B was observed performing Patient #20's preoperative anesthesia assessment. The CRNA reviewed Patient #20's medical history, discussed the upcoming surgical procedure and the type of anesthesia he planned to administer. The CRNA also evaluated Patient #20 for prior problems with anesthesia and asked if she had been ill or if her health status had changed since seeing the physician. The CRNA did not examine Patient #20. He did not listen to her heart and lungs with a stethoscope.</p> <p>c. Patient #18 was a 16 year old female admitted to the facility on 1/24/13 for right foot surgery. On 1/24/13 at approximately 2:30 PM, CRNA B was observed performing Patient #18's preoperative anesthesia assessment. He reviewed her medical history, discussed the upcoming surgical</p>	Q 262			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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Q 262	<p>Continued From page 72</p> <p>procedure and the type of anesthesia he planned to administer. He also evaluated Patient #18 for prior problems with anesthesia and asked if she had been ill or if her health status had changed since she was last seen by the physician. The CRNA did not examine Patient #18. He did not listen to her heart and lungs with a stethoscope.</p> <p>The CRNA who cared for Patients #18 and #20 was interviewed on 1/25/13 at approximately 1:15 PM. The preoperative examination was discussed. The CRNA stated "If there has been a problem, I will listen to heart and lungs. If not, I won't listen. I always listen in the OR before we get started. Usually, the physician has already examined the patient and I don't need to."</p> <p>However, Patient #20's physician was interviewed at 1:20 PM on 1/25/13. He stated his practice was to verbally review the H&amp;P, allergies, the last time the patient ate or drank and home medications with the patient and/or family prior to the procedure. He explained that if there were changes in the patient's condition, he relied on anesthesia and nursing staff to perform a physical assessment to determine the patient's eligibility for surgery. He stated that he did not actually listen to a patient's heart or lungs because as a dentist, he was "not really qualified" to assess a patient for surgery.</p> <p>Additionally, the facility's policy titled, "ASSESSMENT PRIOR TO INDUCTION OF ANESTHESIA/SEDATION," revised 7/27/11 was reviewed. The policy stated that "The patient will be evaluated by the anesthesiologist/anesthetist prior to provision of anesthesia services, with the results of the evaluation documented on the</p>	Q 262			

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

PRINTED: 02/12/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13C0001011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  01/29/2013
NAME OF PROVIDER OR SUPPLIER  MILLENNIUM SURGERY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1828 SOUTH MILLENNIUM WAY, SUITE 100 MERIDIAN, ID 83642		
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Q 262	Continued From page 73 preanesthesia evaluation record." The policy did not define the extent of the evaluation to include listening to the hear and lungs with a stethoscope.  The facility failed to ensure policies were sufficiently developed and implemented necessary to ensure patients received a comprehensive preoperative physical examination.	Q 262			