



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

September 14, 2012

RECEIVED
OCT 01 2012
FACILITY STANDARDS

Jeanette Baker, Administrator
North Idaho Endoscopy Center
1607 Lincoln Way, Suite 100
Coeur D'Alene, ID 83814

RE: North Idaho Endoscopy Center, Provider #13C0001044

Dear Ms. Baker:

This is to advise you of the findings of the Medicare survey of North Idaho Endoscopy Center, which was conducted on September 6, 2012.

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

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

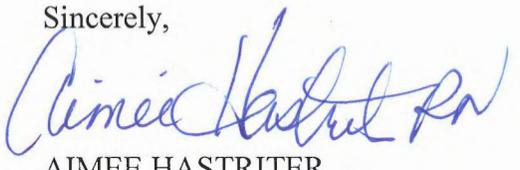
- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date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

Jeanette Baker, Administrator
September 14, 2012
Page 2 of 2

After you have completed your Plan of Correction, return the original to this office by **September 27, 2012**, and keep a copy for your records.

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

Sincerely,



AIMEE HASTRITER
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

AH/srm
Enclosures

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

PRINTED: 09/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/06/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH IDAHO ENDOSCOPY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1607 LINCOLN WAY, SUITE 100 COEUR D'ALENE, ID 83814
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

Q 000	INITIAL COMMENTS The following deficiencies were cited during the recertification survey of your Ambulatory Surgical Center. The surveyors conducting the review were: Aimee Hastriter RN, BS, HFS, Team Lead Rebecca Lara RN, BA, HFS The following acronyms were used in this report: ASC = Ambulatory Surgery Center CDC = Centers for Disease Control and Prevention IV = Intravenous RN = Registered Nurse QA = Quality Assurance	Q 000		
Q 082	416.43(b), 416.43(c)(2), 416.43(c)(3) PROGRAM DATA; PROGRAM ACTIVITIES (b)(1) The program must incorporate quality indicator data, including patient care and other relevant data regarding services furnished in the ASC. (b)(2) The ASC must use the data collected to - (i) Monitor the effectiveness and safety of its services, and quality of its care. (ii) Identify opportunities that could lead to improvements and changes in its patient care. (c)(2) Performance improvement activities must track adverse patient events, examine their causes, implement improvements, and ensure that improvements are sustained over time. (c)(3) The ASC must implement preventive strategies throughout the facility targeting adverse	Q 082	SEE ATTACHED PLAN OF CORRECTION.	



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <i>Medical Director</i>	(X6) DATE <i>9/28/12</i>
---	----------------------------------	-----------------------------

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.

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

PRINTED: 09/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/06/2012
NAME OF PROVIDER OR SUPPLIER NORTH IDAHO ENDOSCOPY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1607 LINCOLN WAY, SUITE 100 COEUR D'ALENE, ID 83814		
(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 082	Continued From page 1 patient events and ensure that all staff are familiar with these strategies. This STANDARD is not met as evidenced by: Based on staff interview and review of QA documentation, it was determined the facility failed to ensure performance improvement activities examined the causes of adverse patient events in order to implement improvements for 4 of 4 incidents reviewed. Failure to analyze adverse events resulted in missed opportunities for the ASC to evaluate processes of care. Findings include: 1. The "Incident Reporting Policy," dated 5/20/02, was reviewed. According to the policy, "All incidents or accidents involving a staff member or patient will be reported in writing within 24 hours after the occurrence...Staff will not attempt to judge whether an occurrence is 'serious' enough to report, but will complete the Incident Report Form on all occurrences involving patients or staff." The policy indicated that real or potential problems would be identified and evaluated and actions implemented to resolve the issue. An incident report form, and/or subsequent evaluation of the event, was not completed as follows: a. The "Quality Management and Improvement Report" for July - September of 2011, was reviewed. Quality indicators included "Use of reversal agents" and "Transfer to hospital." Documentation in the report identified one patient who received reversal agents and was transferred to the hospital as a result of a	Q 082			

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

PRINTED: 09/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/06/2012
NAME OF PROVIDER OR SUPPLIER NORTH IDAHO ENDOSCOPY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1607 LINCOLN WAY, SUITE 100 COEUR D'ALENE, ID 83814		
(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 082	<p>Continued From page 2</p> <p>respiratory code. However, there was no incident report form present and there was no documentation to support an analysis of the event for potential improvements in patient care.</p> <p>The Nurse Manager was interviewed on 9/05/12 at 8:40 AM. She explained that while the respiratory arrest was not expected, it was considered a risk with the administration of sedation. She stated that staff discussed the issue but did not review the event to evaluate the care provided both before and after the adverse event.</p> <p>b. The "Quality Management and Improvement Report," for October - December of 2011, was reviewed. One quality indicator monitored was "Unexpected Proc. [Procedure] Comp. [complication]." Documentation in the report indicated one patient suffered a post-procedure bleed, identified after discharge, and received a blood transfusion at a hospital. However, there was no incident report form present and there was no documentation to support an analysis of the event for potential improvements in patient care.</p> <p>c. The "Quality Management and Improvement Report," for January - March of 2012, was reviewed. One quality indicator monitored was, "Unexpected Complication." Documentation in the report identified one patient who suffered a bowel perforation (a tear in the bowel wall), identified after discharge. According to the document, the patient was admitted to the hospital for antibiotic administration. However, there was no incident report form present and there was no documentation to support an</p>	Q 082			

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

PRINTED: 09/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/06/2012
NAME OF PROVIDER OR SUPPLIER NORTH IDAHO ENDOSCOPY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1607 LINCOLN WAY, SUITE 100 COEUR D'ALENE, ID 83814	
(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 082	Continued From page 3 analysis of the event for potential improvements in patient care. d. Another quality indicator noted in the "Quality Management and Improvement Report," for January - March of 2012, was "Medication Error." Additional documentation in this report included an incident report completed for a patient who was administered a medication for which he had a documented allergy. However, there was no documentation to support an analysis of the event for potential improvements in patient care. The Nurse Manager was interviewed on 9/05/12 at 1:35 PM. She reviewed the QA documentation and confirmed that, with the exception of the medication error, no incident report forms had been completed by staff. She stated that she felt staff understood that an "incident" was anything out of the ordinary but confirmed that there was no written definition for incidents and adverse events. She confirmed the lack of analysis of events to ensure that systems and procedures already in place were sufficient, or to determine if there was a need to amend a process in order to improve patient care. Performance improvement activities did not include tracking and analysis of patient adverse events or unexpected outcomes for potential process improvements.	Q 082		
Q 181	416.48(a) ADMINISTRATION OF DRUGS Drugs must be prepared and administered according to established policies and acceptable standards of practice.	Q 181	SEE ATTACHED PLAN OF CORRECTION	

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

PRINTED: 09/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/06/2012
NAME OF PROVIDER OR SUPPLIER NORTH IDAHO ENDOSCOPY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1607 LINCOLN WAY, SUITE 100 COEUR D'ALENE, ID 83814	
(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 181	Continued From page 4 This STANDARD is not met as evidenced by: Based on observation, staff interviews and review of facility policies and logs, it was determined the facility failed to dispose of expired medications in accordance with facility policy and acceptable standards of practice. This had the potential to impact all patients at the facility. Failure to discard expired medications found in the crash cart had the potential to result in unexpected responses to the administered medications. Findings include: 1. A tour of the facility occurred on 9/05/12, beginning at 7:28 AM. During the tour, an RN inspected the crash cart with the surveyor. The inspection was noted to include emergency equipment testing and review of required supplies and medications for expiration dates. During this inspection, the RN found a 500 milliliter bag of sodium chloride (an IV solution used to replace fluid) and a single use vial of Narcan (a medication used to treat narcotic drug overdose) which had expired in June of 2012. The RN was interviewed following the inspection of the crash cart. She stated the crash cart was inspected and medications were reviewed on a daily basis. The log was reviewed and indicated daily inspection of the crash cart and documentation that each medication had been reviewed for expiration dates. However, the RN confirmed the expired IV solution and Narcan had not been removed from the cart and replaced. The "Medication Outdate Policy," developed 5/20/02, documented "If outdated medications	Q 181		

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

PRINTED: 09/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/06/2012
NAME OF PROVIDER OR SUPPLIER NORTH IDAHO ENDOSCOPY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1607 LINCOLN WAY, SUITE 100 COEUR D'ALENE, ID 83814	
(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 181	Continued From page 5 are found, they will be removed from the area and new or replacement medication will be stocked." The facility failed to ensure expired medications were not on the crash cart and available for patient use.	Q 181		
Q 224	416.50(a)(2) ADVANCE DIRECTIVES The ASC must comply with the following requirements: (i) Provide the patient or, as appropriate, the patient's representative in advance of the date of the procedure, with information concerning its policies on advance directives, including a description of applicable State health and safety laws, and, if requested, official State advance directive forms. (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. (iii) Document in a prominent part of the patient's current medical record, whether or not the individual has executed an advance directive. This STANDARD is not met as evidenced by: Based on observation, staff interview and review of medical records, 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. This resulted in a lack of information related to provision of life sustaining measures provided during respiratory and/or cardiac arrest. Findings include:	Q 224	SEE ATTACHED PLAN OF CORRECTION. SEE EXHIBIT (A) SEE EXHIBIT (B)	

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

PRINTED: 09/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/06/2012
NAME OF PROVIDER OR SUPPLIER NORTH IDAHO ENDOSCOPY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1607 LINCOLN WAY, SUITE 100 COEUR D'ALENE, ID 83814		
(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 224	Continued From page 6 1. The "Living Wills and Advance Directives Policy," developed 5/20/02, documented "It is the policy of the [facility name] to coordinate with the patients and their families, when there is a desire for a living will and/or an advanced directive to be noted for their care." The policy did not indicate how the facility would incorporate an Advance Directive into emergency care provided to patients. The policy did not indicate the process for documenting and/or obtaining an Advance Directive if a patient had one. The policy did not indicate the process for providing information to patients regarding Advance Directive formulation upon a patient's request. The "Patient Rights and Responsibilities" information, undated, provided to patients prior to a procedure was reviewed. According to this document, patients had "the right to know that Advance Directive information is available for you at our facility if you request it." In addition, the document specified the patient had the responsibility of providing the facility with a copy of any Advance Directives. This information was also posted in the waiting room for patients and/or their representatives to view. The patients' rights information did not clearly indicate that if a patient had an emergency while at the facility, the patient would be stabilized and transported to the hospital. The Nurse Manager was interviewed on 9/05/12 at 8:05 AM. She stated in the event of an emergent situation with a patient in the facility, the patient would be stabilized and transported to the nearest hospital. Additionally, she said the facility staff explained this practice during the time they	Q 224			

SEE EXHIBIT (B)

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

PRINTED: 09/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/06/2012
NAME OF PROVIDER OR SUPPLIER NORTH IDAHO ENDOSCOPY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1607 LINCOLN WAY, SUITE 100 COEUR D'ALENE, ID 83814		
(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 224	Continued From page 7 were establishing contact with patients prior to procedures. The Nurse Manager confirmed that neither the facility's "Living Wills and Advance Directives Policy" or "Patient's Rights and Responsibilities" information explained this practice in writing.	Q 224			
Q 225	The ASC failed to ensure comprehensive rights information related to Advance Directives was provided to patients and/or their representatives. 416.50(a)(3)(i), (v), (vi), (vii) SUBMISSION AND INVESTIGATION OF GRIEVANCES (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. (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. (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. This STANDARD is not met as evidenced by: Based on review of facility policies and staff interview, it was determined the facility failed to	Q 225	SEE PLAN OF CORRECTION * SEE EXHIBIT (c)		

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

PRINTED: 09/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/06/2012
NAME OF PROVIDER OR SUPPLIER NORTH IDAHO ENDOSCOPY CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1607 LINCOLN WAY, SUITE 100 COEUR D'ALENE, ID 83814		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 225	<p>Continued From page 8</p> <p>ensure the grievance process specified time frames for investigation and resolution of grievances and that written notices were provided for 1 of 1 grievances reviewed. This had the potential to result in incomplete communication regarding the investigation and resolution of patients' grievances. Findings include:</p> <p>1. The facility's policy, "Patient Complaint Response and Resolution Policy," dated 5/20/02, was reviewed. The policy indicated that if a concern was not able to be immediately addressed and resolved then staff were to complete a "Quality Management Reporting Form" and forward it on to the manager to coordinate resolution. The policy also indicated that information regarding the concern would be gathered and analyzed and "all individuals involved should be notified of the results or outcome." The policy did not specify a time frame for investigating and resolving a grievance. The policy did not specify the complainant was to receive a written notice of the resolution which included 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 was resolved.</p> <p>The Nurse Manager was interviewed on 9/05/12 at 8:40 AM. She stated that the facility had only one current grievance. She explained that on 8/30/12, a patient complained that staff misappropriated money from his wallet. The Nurse Manager stated she spoke with the patient, the patient's physician, staff members, and the patient's brother who was responsible for transporting the patient home after the procedure. She stated that in the interest of patient relations,</p>	Q 225		

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

PRINTED: 09/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/06/2012
NAME OF PROVIDER OR SUPPLIER NORTH IDAHO ENDOSCOPY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1607 LINCOLN WAY, SUITE 100 COEUR D'ALENE, ID 83814	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 225	Continued From page 9 the facility did not admit guilt but reimbursed the patient for the missing money. As a result of this incident, a new sign was posted notifying patients that the facility was not responsible for a patient's valuables in the facility. The Nurse Manager confirmed that the grievance, the investigation, and the resolution were not documented. She confirmed that the patient did not receive a written notice of the resolution. In addition, the Nurse Manager stated the "Quality Management Reporting Form" was typically used for incident reports, not grievances, and that the policy did not reflect current practice. She confirmed the policy did not direct staff to provide a written notice to the complainant with the required information. The facility failed to ensure the grievance process specified time frames for investigation and resolution of grievances and that written notices were provided upon completion resolution of the concern.	Q 225		
Q 242	416.51(b) INFECTION CONTROL PROGRAM The ASC must maintain an ongoing program designed to prevent, control, and investigate infections and communicable diseases. In addition, the infection control and prevent program must include documentation that the ASC has considered, selected, and implemented nationally recognized infection control guidelines. This STANDARD is not met as evidenced by: Based on observation, interview, and review of policies and infection control documentation, it was determined the facility failed to maintain an ongoing program to prevent, control, and	Q 242	SEE ATTACHED PLAN OF CORRECTION SEE EXHIBIT (D) (E)	

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

PRINTED: 09/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/06/2012
NAME OF PROVIDER OR SUPPLIER NORTH IDAHO ENDOSCOPY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1607 LINCOLN WAY, SUITE 100 COEUR D'ALENE, ID 83814	
(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 242	Continued From page 10 investigate infections. This directly impacted 1 of 2 patients (#16) whose procedures were observed and had the potential to impact all patients cared for at the facility. The failure to adequately maintain an infection control program resulted in lack of surveillance for infections and improper hand hygiene during procedures. Findings include: 1. The facility's "Infection Monitoring and Log Policy," dated 5/20/02, was reviewed. According to the policy, the facility was to monitor for unexpected outcomes from patient procedures, including post procedure infections. The policy indicated, "Patients that have had a procedure at the Endoscopy Center will typically receive some kind of procedure follow-up through the physician's office. The physician will be responsible to self-report the unexpected outcomes including infections post procedure." According to the policy, the information would then be documented on an infection log by the Nurse Manager. The Nurse Manager was interviewed on 9/05/12 at 3:12 PM. She stated there was not a system in place to actively identify infections potentially related to procedures performed at the facility. She confirmed that occasionally discharge instructions included instructions to contact the physician if the patient experienced a fever or chills, but this was not consistent. She explained that each patient received a follow up phone call by an RN the morning after the procedure. She stated part of this conversation included questions about any potential infections, either from the IV line or the procedure. She explained that the follow up phone call was documented by	Q 242		

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

PRINTED: 09/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/06/2012
NAME OF PROVIDER OR SUPPLIER NORTH IDAHO ENDOSCOPY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1607 LINCOLN WAY, SUITE 100 COEUR D'ALENE, ID 83814	
(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 242	<p>Continued From page 11</p> <p>a stamp on the discharge instructions and the RN marked "yes" or "no" regarding if any problems were identified. She confirmed this documentation did not clearly outline the information obtained to rule out any post procedure infection. She stated the facility mainly relied on patients' primary providers to report any infections or complications that may have been related to the procedure. She confirmed the facility did not actively attempt to follow up with these primary providers regarding post procedure infections. She confirmed the facility did not maintain an infection control log.</p> <p>The facility failed to maintain an ongoing program with active surveillance to track and investigate infections and communicable diseases.</p> <p>2. The facility's "Hand Washing Policy," dated 5/20/02, was reviewed. The policy contained a list of when employees and medical staff should wash their hands. This list included, "as soon as possible after removal of gloves or other personal protective equipment." The policy did not address the use of the alcohol-based hand rub available in the facility.</p> <p>According to the CDC "Guideline for Hand Hygiene in Health-Care Settings," dated 10/25/02, indications for hand washing or hand antisepsis include, "Decontaminate hands after removing gloves."</p> <p>Hand hygiene was not promoted in accordance with nationally recognized guidelines as follows:</p> <p>a. Patient #16 was a 79 year old male admitted to the facility on 9/05/12 for upper and lower</p>	Q 242	SEE EXHIBIT (E)	

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

PRINTED: 09/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/06/2012
NAME OF PROVIDER OR SUPPLIER NORTH IDAHO ENDOSCOPY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1607 LINCOLN WAY, SUITE 100 COEUR D'ALENE, ID 83814		
(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 242	<p>Continued From page 12</p> <p>endoscopies. His procedures were observed from 9:00 AM through 9:32 AM. At 9:12 AM the Endoscopy Technician assisted with the collection of tissue samples. She was then observed to remove her gloves and immediately don a new pair of gloves. After replacing her gloves she assisted the physician and the RN to reposition Patient #16 for the colonoscopy. At 9:23 AM, the Endoscopy Technician again assisted with collection of a tissue sample. She was observed to change gloves but was not observed to perform hand hygiene between the old and new pair of gloves. At 9:29 AM, the RN was observed to remove her gloves and document in Patient #16's medical record. She was not observed to use hand hygiene following the removal of her gloves and prior to moving to the next task.</p> <p>An RN in the facility was interviewed on 9/05/12 at 9:45 AM. She confirmed that hand hygiene between glove changes while in the procedure room was not routinely practiced.</p> <p>The Nurse Manager was interviewed on 9/05/12 at 1:35 PM. She stated the facility followed CDC hand hygiene guidelines but she was not aware of the requirement to perform hand hygiene between glove changes during the procedure.</p> <p>The facility failed to maintain an ongoing infection control program to prevent infections by promoting hand hygiene in accordance with recommended guidelines.</p>	Q 242			

NORTH IDAHO ENDOSCOPY CENTER
MEDICARE PLAN OF CORRECTION

September 25, 2012

he
OCT 03 2012
FACILITY

Q082: 416.43(b), 416.43 (c) (2), 416.43 (c) (3), PROGRAM DATA; PROGRAM ACTIVITIES

NIEC will ensure that performance improvement activities examine the causes of adverse patient events by immediately forming a QA Committee comprised of the Medical Director, Nurse Manager and Assistant Nurse Manager who will analyze and track on a tracking log sheet, each event and determine whether there are potential improvements that could be implemented for each reported event. This activity of the committee will take place within 1 week of each event to assure that any process improvements can be implemented in a timely manner. On October 5th, 2012, there will be a staff meeting to train all staff on the definition of an adverse event and the incident reporting policy will be reviewed to assure understanding of the reporting process by all staff. The Nurse Manager will be responsible for implementing this corrective measure.

Q181: 416.48 (a) ADMINISTRATION OF DRUGS

On October 5, 2012, the "Medication Outdate Policy" will be reviewed with all nursing staff to assure understanding that all expired drugs MUST be removed and discarded from the facility. On the last working day of each month, the Nurse Manager will make a visual inspection of all areas that contain drugs to determine if any have expired and will remove if indicated by expiration dates.

Q224 416.50 (a) (2) ADVANCE DIRECTIVES

On September 10, 2012 the "Living Wills and Advance Directives Policy" was revised to include information on how the facility will incorporate the Advance Directive into emergency care provided at the facility. The "Patient Rights and Responsibility" statement was also revised to include this statement on how the policy will be implemented at the facility. Also included in the revision is a statement on the process of documenting and/or obtaining an Advance Directive if a patient has one and providing information to patients regarding Advance Directive formulation upon a patient's request. This activity will be monitored through quarterly chart audits by the Nurse Manager. Staff will be informed of the policy change on October 5, 2012. The Nurse Manger completed this task.

Q225 416.50 (a) (3)(i), (v), (vii) SUBMISSION AND INVESTIGATION OF GRIEVANCES

On September 25, 2012 the "Patient Complaint Response and Resolution Policy" was reviewed and revised to include a timeframe described herein as "If resolution cannot take place within 24 hours, then information will be gathered from those individuals involved including employees, physicians and patients. The complaint or grievance will be received by the Nurse Manager who will investigate the circumstances and a determination will be made whether it can be resolved or not. A response will be

given to the complainant within 5 business days that includes the steps taken during the investigation and the outcome. Also included in the notification will be a facility contact person. This revised policy will be reviewed with staff by the Nurse Manager on October 5, 2012.

Q242 416.51 (b) INFECTION CONTROL PROGRAM

To provide active surveillance in regards to Infection Control, by October 5, 2012, the "Infection Monitoring and Log Policy" will be revised to include a definition of all elements that will be inquired about during the post call encounter. If a patient identifies that they have any symptoms that are consistent with a post procedure infection, they will be advised to seek medical attention and the patients information will be investigated by performing a chart review and documented on a post procedure infection log as well as notifying the physician that performed the procedure. Follow up with the patient will be made within 3 working days to determine the outcome. An additional activity to provide ongoing surveillance will be to develop an electronic reporting system that primary care providers can utilize to report any suspected procedure related infections within 30 days of procedure date. Any reports that are submitted will be investigated within 1 working day of submission and a response of the findings will be given to the reporting physician within 1 working day or as soon as all information can be gathered and analyzed. Each report will be tracked on an Infection Log. An initial introductory letter will be sent to each provider in the community instructing them on how to utilize this new reporting system. A follow up contact will occur bi-annually. The initial contact will be completed by October 30, 2012 and the Medical Director and Nurse Manager will be responsible for this activity.

Discharge instructions will be given to every patient with information that includes all criteria that would prompt contact to the facility regarding suspected infection.

NIEC's Hand Washing policy was revised on Sept 26, 2012 to include the use of alcohol-based hand rub as an alternative to hand decontamination. This policy will be reviewed on October 5, 2012 and will place emphasis on decontamination after removing gloves including intra-procedure. The CDC guidelines will be re-addressed at this time same time. Additional alcohol-based rub units will be placed at each end of the procedure room to provide easy access to this product for hand decontamination. To monitor compliance, peer review of hand washing activity will be implemented by observing 2 procedures involving various staff at least one time each quarter. This will begin Nov.2012. The Nurse Manager will be responsible for implementing these activities.

Overall compliance with this plan will take place on October 5, 2012

Lori Schroder 10/3/12

Lori Schroder, Nurse Manager