COPY

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
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CERTIFIED MAIL: 7007 3020 0001 4038 8447

September 25, 2012

Julie Lineberger, Administrator
Surgery Center Of Idaho
2855 East Magic View Drive
Meridian, ID 83642

RE: Surgery Center Of Idaho, Provider #13C0001060

Dear Ms. Lineberger:

Based on the survey completed at Surgery Center Of Idaho, on September 21, 2012, by our staff, we have determined Surgery Center Of Idaho is out of compliance with the Medicare ASC Condition for Coverage of **Governing Body and Management (42 CFR 416.41); Quality Assessment & Performance Improvement (42 CFR 416.43); Nursing Services (42 CFR 416.46) and Infecetion Control (42 CFR 416.51)**. 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 Surgery Center Of Idaho, 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.

<u>An acceptable Plan of Correction contains the following elements</u>:

- 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 each form.

Such corrections must be achieved and compliance verified by this office, before November 5, 2012. 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 October 25, 2012.

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **October 9, 2012**.

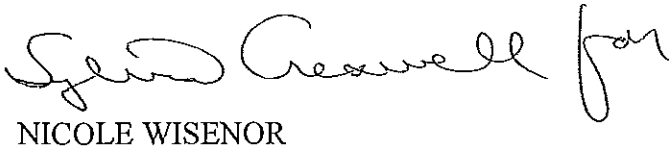
Failure to correct the deficiencies and achieve compliance will result in our recommending that CMS terminate your approval to participate in the Medicare Program. If you fail to notify us, we will assume you have not corrected.

We urge you to begin correction immediately.

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

Sincerely,

GARY GUILES
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

GG/srm
Enclosures
ec: 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: 09/24/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13C0001060		09/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURGERY CENTER OF IDAHO	2855 EAST MAGIC VIEW DRIVE 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 000	INITIAL COMMENTS The following deficiencies were cited during the recertification survey of your Ambulatory Surgical Center. The surveyors conducting the review were: Gary Guiles, RN, HFS, Team Leader Rebecca Lara RN, BA, HFS The following acronyms were used in this report: ASC = ambulatory surgery center MEC = Medical Executive Committee QAPI = quality assessment performance improvement	Q 000	RECEIVED OCT 25 2012 FACILITY STANDARDS	
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 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	Q 040	Alleged date of completion 10-25-2012	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tomas Russell | TITLE: Administrator | (X6) DATE: 10-9-2012

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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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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Q 040	Continued From page 1 operation. This resulted in a lack of guidance and oversight of the facility's staff and programs. Findings include: 1. Refer to Q80 - Condition of Coverage for Quality Assessment and Performance Improvement as it relates to the failure of the ASC to ensure a data driven QAPI program was developed and implemented. 2. Refer to Q140 - Condition of Coverage for Nursing Services it relates to the failure of the ASC to ensure qualified nursing leadership was provided. 3. Refer to Q240 - Condition of Coverage for Infection Control as it relates to the failure of the ASC to ensure a comprehensive infection control program was developed and implemented. The cumulative effect of the lack of governing body involvement resulted in a lack of direction to staff and a lack of structure defining the ASC's processes.	Q 040		
Q 080	416.43 QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT The ASC must develop, implement and maintain an on-going, data-driven quality assessment and performance improvement (QAPI) program. This CONDITION is not met as evidenced by: Based on staff interview and review of policies, medical staff bylaws, meeting minutes, and QAPI documents, it was determined the ASC failed to ensure a data driven QAPI program had been	Q 080		

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Q 080	Continued From page 2 developed, implemented, and monitored. This resulted in the inability of the ASC to evaluate its processes and practices. Findings include: 1. Refer to Q081 as it relates to the failure of the ASC to ensure the scope of the QAPI program provided sufficient direction to staff to allow them to demonstrate measurable improvement in patient health outcomes by using quality indicators. 2. Refer to Q082 as it relates to the failure of the ASC to ensure data, including adverse patient events, was used to monitor the effectiveness and safety of its services. 3. Refer to Q083 as it relates to the failure of the ASC to conduct performance improvement projects. 4. Refer to Q084 as it relates to the failure of the ASC to ensure the Governing Board defined, monitored, and maintained the QAPI program. The cumulative effect of these negative facility practices prevented the ASC from utilizing information to improve its processes.	Q 080		
Q 081	416.43(a), 416.43(c)(1) PROGRAM SCOPE; PROGRAM ACTIVITIES (a)(1) The program must include, but not be limited to, an ongoing program that demonstrates measurable improvement in patient health outcomes, and improves patient safety by using quality indicators or performance measures associated with improved health outcomes and by the identification and reduction of medical errors.	Q 081		

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Q 081	Continued From page 3 (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. (c)(1) The ASC must set priorities for its performance improvement activities that - (i) Focus on high risk, high volume, and problem-prone areas. (ii) Consider incidence, prevalence, and severity of problems in those areas. (iii) Affect health outcomes, patient safety, and quality of care. This STANDARD is not met as evidenced by: Based on staff interview and review of ASC policies and QAPI documents, it was determined the facility failed to ensure the scope of the QAPI program provided sufficient direction to staff to allow them to demonstrate measurable improvement in patient health outcomes by using quality indicators. This resulted in performance measures that were insufficient to measure the quality of care provided to patients. Findings include: 1. The policy "QUALITY ASSURANCE PLAN," revised 3/10, stated the purpose of the "Quality Assurance Plan." The policy stated the plan "...focuses on the processes and outcome of care given..." The policy did not define what a "Quality Assurance Plan" should include. Consequently, a specific "Quality Assurance Plan," which specified items such as high risk, high volume, problem	Q 081		

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Q 081	Continued From page 4 prone areas of focus, quality indicators to be monitored, a system for gathering data, and performance improvement projects to be studied, had not been developed. The Administrator, who was also the Quality Assurance Coordinator, was interviewed on 9/19/12 beginning at 2:00 PM. She confirmed a "Quality Assurance Plan" that defined the scope of quality improvement activities at the ASC had not been developed. The ASC did not develop a quality plan.	Q 081		
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 patient events and ensure that all staff are familiar with these strategies.	Q 082		

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Q 082	Continued From page 5 This STANDARD is not met as evidenced by: Based on staff interview and review of QAPI documents, it was determined the facility failed to ensure data, including adverse patient events, was used to monitor the effectiveness and safety of its services. This resulted in the inability of the ASC to determine if services were being provided in a safe and effective manner. Findings include: 1. Data was documented on the "Surgery Cancel Tracking" and "Qualitative/Quantitative Quarterly Report Card." These documents listed the number of discrete events, such as the number of procedure cancellations per physician with reasons for the cancellations. However, the ASC did not develop or analyze that data. Quality documents did not include a list of the top reasons for surgery cancellations, percentages, or possible ways to decrease the number of cancellations. Additonally, the number of infections per quarter was listed. These numbers were not broken down further and an infection rate was not calculated. Therefore, infection rates could not be compared to determine if they were increasing or decreasing. Further, incident reports for items such as falls, transfers to acute care facilities, and medication errors were documented. However, an investigation of these events was not documented. No quality data was documented related to incidents except for raw numbers of events. The Administrator, who was also the Quality Assurance Coordinator, was interviewed on	Q 082		

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Q 082	Continued From page 6 9/19/12 beginning at 2:00 PM. She confirmed that, except for raw numbers of events, data was not being gathered or analyzed. The ASC did not utilize data in its QAPI program. 2. Five "QUALITY IMPROVEMENT STUDY[s]" were documented between 11/17/11 and 6/20/12 for items such as the use of laryngeal mask airways and communication between ASC staff. All of the studies were completed. None of the studies included the gathering or analysis of data. The Administrator was interviewed on 9/19/12 beginning at 2:00 PM. She stated data had not been gathered or analyzed for the quality studies. The ASC did not utilize data for quality improvement studies.	Q 082		
Q 083	416.43(d) PERFORMANCE IMPROVEMENT PROJECTS (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 project's results 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 performance improvement	Q 083 Pain / urology		

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Q 083	Continued From page 7 projects were conducted. This resulted in the inability of the ASC to conduct studies to evaluate complex processes. Findings include: 1. The policy "QUALITY ASSURANCE PLAN," revised 3/10, outlined how the ASC was to develop an overall quality plan. The policy did not include performance improvement projects. A quality plan for the ASC, including performance improvement projects, was not documented. The Administrator was interviewed on 9/19/12 beginning at 2:00 PM. She confirmed a quality improvement plan, including performance improvement projects, had not been developed. The ASC did not develop a plan for performance improvement projects. 2. Five documents titled "QUALITY IMPROVEMENT STUDY" were documented between 11/17/11 and 6/20/12 for items such as the use of laryngeal mask airways and communication between ASC staff. None of these "studies" contained documentation that data had been gathered or analyzed or any follow up had been done beyond defining the problem. The Administrator was interviewed on 9/19/12 beginning at 2:00 PM. She stated data had not been gathered or analyzed for the quality studies since at least 8/01/11. The ASC did not utilize data for quality improvement studies.	Q 083		
Q 084	416.43(e) GOVERNING BODY RESPONSIBILITIES	Q 084		

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Q 084	Continued From page 8 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 Medical Staff Bylaws, meeting minutes, and QAPI documents, it was determined the ASC's Governing Board failed to ensure a QAPI program was defined, implemented, and maintained by the ASC. This resulted in a lack of leadership to provide direction of QAPI activities at the ASC. Findings include: 1. "MEDICAL STAFF RULES AND REGULATIONS," dated 12/16/09, stated "The Board shall develop and implement a plan for assessing the quality of care provided to the patients treated in The Surgery Center of Idaho, LLC." A plan for the ASC's QAPI program, including the activities to be conducted and data to be gathered, was not documented. The Administrator was interviewed on 9/19/12	Q 084		

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Q 084	Continued From page 9 beginning at 2:00 PM. She stated a plan for the ASC's QAPI program had not been developed since at least 8/01/11. The ASC's Governing Board did not ensure a QAPI plan had been developed. 2. Medical Staff Bylaws, dated 12/16/09, stated "Quality Assurance Committee: The Committee Chair shall direct the Quality Assurance activities of the Center..." The bylaws stated the objectives of the committee included "B. Assist in the analysis of data to identify opportunities to improve patient care. C. Review and approve the facility Quality Assurance plan...F. Report findings and actions quarterly to the Board. G. Assign quality assurance studies..." No minutes were present that a Quality Assurance Committee had met or participated in quality improvement activities. Eleven Governing Board meetings were documented between 8/24/11 and 8/15/12. None of the meeting minutes contained documentation of Quality Assurance Committee activities or reports to the Board. The Medical Director, who was also a member of the Governing Board, was interviewed on 9/20/12 beginning at 9:10 AM. He stated a formal quality committee had not been appointed by the Governing Board and no official meetings had been held. The ASC's Governing Board did not ensure a quality committee had been appointed and was functioning.	Q 084		

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Q 084	Continued From page 10 3. Documentation of QAPI activities was reviewed dating back to 8/01/11. No analysis of data was documented in relation to the ASC's QAPI program since at least 8/01/11. The Administrator was interviewed on 9/19/12 beginning at 2:00 PM. She stated data that had been gathered for the ASC's QAPI program had not been broken down or analyzed. The ASC's Governing Board did not ensure data was utilized for the QAPI program. 4. No performance improvement projects were documented since at least 8/01/11. The Administrator was interviewed on 9/19/12 beginning at 2:00 PM. She stated no performance improvement projects had been conducted since at least 8/01/11. The ASC's Governing Board did not ensure performance improvement projects were conducted.	Q 084		
Q 140	416.46 NURSING SERVICES The nursing services of the ASC must be directed and staffed to assure that the nursing needs of all patients are met. This CONDITION is not met as evidenced by: Based on staff interview, it was determined the ASC failed to ensure nursing services were directed to meet the nursing needs of patients. This resulted in a lack of qualified leadership for nursing services at the ASC. Findings include:	Q 140		

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Q 140	Continued From page 11 A qualified director of nursing services or equivalent staff member was not employed by the ASC. The Administrator was interviewed on 9/20/12 beginning at 1:30 PM. She stated a director of nursing services had not been employed by the ASC since at least 8/01/11. She stated she directed nursing activities at the ASC. She stated she was not a nurse and did not have a clinical background in nursing. The cumulative effect of this systemic omission resulted in a lack qualified personnel to direct and oversee nursing activities.	Q 140		
Q 240	416.51 INFECTION CONTROL The ASC must maintain an infection control program that seeks to minimize infections and communicable diseases. This CONDITION is not met as evidenced by: Based on interview, and review of policies and infection control documents, it was determined the ASC failed to ensure a comprehensive infection control program was developed, implemented and monitored. This resulted in the increased risk of infection to patients. Findings include: 1. Refer to Q242 as it relates to the lack of infection control policies and procedures. 2. Refer to Q243 as it relates to the lack of professional staff to direct the infection control activities of the ASC.	Q 240		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13C0001060		09/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURGERY CENTER OF IDAHO	2855 EAST MAGIC VIEW DRIVE 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 240	Continued From page 12 3. Refer to Q244 as it refers to the ASC's lack of integration of the infection control program into the QAPI program. 4. Refer to Q245 as it relates to the lack of a surveillance plan for identifying infections. The cumulative effect of these systemic omissions resulted in the inability of the ASC to ensure all reasonable steps had been taken to identify and prevent infections.	Q 240		
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 staff interview and review of policies and infection control documents, it was determined the ASC failed to ensure an ongoing infection control program was maintained. The lack of a clearly defined program prevented the ASC from positively identifying and preventing infections, as well as mitigating the associated risks. Findings include: 1. The ASC failed to develop and maintain a comprehensive and ongoing infection control program as follows: a. The ASC's policy, titled "INFECTION	Q 242		

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	13C0001060		09/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURGERY CENTER OF IDAHO	2865 EAST MAGIC VIEW DRIVE MERIDIAN, ID 83642

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Q 242	Continued From page 13 CONTROL PROGRAM," not dated, included "...Surveillance: The program will include ongoing monitoring for infections among the patients, staff and visitors to detect changes in infection trends. Patients will be contacted within 72 hours of surgery for assessment. Surgeons will be contacted 30 days post op to monitor post op infections." The Administrator and RN, who was designated by the ASC to oversee infection control, were interviewed on 9/19/12, beginning at 1:00 PM. The ASC's infection control program was discussed. The Administrator and RN stated the facility had chosen to follow CDC and APIC infection control guidelines, including a process required for surveillance. They said patients were contacted by phone the day after they underwent surgery in order to monitor patients for potential post operative infections, including signs and symptoms of post operative infection. They stated patients were asked questions, some of which were related to signs and symptoms of infection. The "POSTOPERATIVE PATIENT FOLLOW UP PHONE CALL-Surgery Center of Idaho" document was reviewed. The document asked patients to respond to questions about their general condition, fluid tolerance, effectiveness of pain meds, nausea, status of the surgical site if applicable, status of the IV site, unexpected problems and how patients rated their overall experience in the ASC. There was no information included on the form that would have consistently and specifically addressed signs and symptoms of infection.	Q 242		

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Q 242	Continued From page 14 Additionally, when asked during an interview on 9/19/12, beginning at 1:00 PM, the Administrator and RN confirmed the information derived from the form was not tracked and included in infection control surveillance data. The ASC did not perform ongoing, active surveillance and failed to accurately track infection control data. b. The Administrator and RN stated, during an interview on 9/19/12 beginning at 1:00 PM, a letter was sent on a quarterly basis, to physicians who performed procedures in the ASC. The letter asked physicians to review all cases they had performed during the past quarter and submit any incidents of post operative infection. The Administrator and RN confirmed they had no way of validating the accuracy of the data. They confirmed the agency was not performing routine, active and ongoing surveillance. The ASC failed to maintain a fully developed infection control program that accurately identified all incidents of infection, monitored for compliance, evaluated program effectiveness and revised the program when indicated.	Q 242		
Q 243	416.51(b)(1) INFECTION CONTROL PROGRAM - DIRECTION The program is - Under the direction of a designated and qualified professional who has training in infection control. This STANDARD is not met as evidenced by:	Q 243		

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Q 243	Continued From page 15 Based on staff interviews and review of facility policies and personnel files, it was determined the ASC failed to ensure the infection control program functioned under the direction of a qualified professional who had training in infection control. This prevented the ASC from utilizing the knowledge base of a trained professional to develop and monitor the infection control program. Findings include: On 9/18/12, beginning at 9:00 AM, the Administrator was interviewed. She explained one of the RNs in the facility was designated by the ASC to oversee infection control. The RN, who was designated to oversee infection control, was interviewed on 9/18/12, beginning at 1:00 PM. She stated she had been overseeing infection control since early 2012. The RN said she had since attended one APIC conference, but had received no formal training and possessed no specific qualifications to assume responsibility for the infection control program. She said she was new to the position and was still in the process of learning and building an infection control program. The Administrator was interviewed on 9/19/12, beginning at 2:15 PM. She confirmed the RN had no formal training or certification to oversee the infection control program. She stated the RN had other responsibilities in the ASC and possessed no title that indicated she was overseeing infection control. Additionally, the Administrator stated the RN's time that was dedicated to infection control was not being tracked or monitored.	Q 243		

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Q 243	Continued From page 16 Personnel files were reviewed. The RN's job description was titled "Registered Nurse - Operating Room, Infection Control, Float." However, the job description did not include any job duties specific to directing an infection control program. Additionally, the job description failed to include qualifications or requirements specific to overseeing an infection control program. Facility policies were reviewed. A policy and/or job description outlining the qualifications and responsibilities of the individual directing the infection control program was not found. The facility failed to ensure the infection control program functioned under the direction of a qualified professional who had training in infection control.	Q 243		
Q 244	416.51(b)(2) INFECTION CONTROL PROGRAM - QAPI [The program is -] An integral part of the ASC's quality assessment and performance improvement program This STANDARD is not met as evidenced by: Based on staff interview and review of quality assurance and infection control documentation, it was determined the facility failed to ensure the ASC's infection control program was integrated into a QAPI program. This failure impacted all patients receiving care at the facility and had the potential to inhibit the ASC's ability to identify infections and improve infection control practices at the ASC. Findings include:	Q 244		

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Q 244	Continued From page 17 1. The ASC's quality assurance documentation was reviewed. Information relevant to the collection, analysis and monitoring of infection control data was not found. The Administrator of the ASC was interviewed on 9/19/12, beginning at 2:15 PM. She confirmed infection control program was not a component of the QAPI program. The ASC failed to ensure infection control data and activities were integrated into a QAPI program.	Q 244		
Q 245	416.51(b)(3) INFECTION CONTROL PROGRAM - RESPONSIBILITIES 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. This STANDARD is not met as evidenced by: Based on staff interview and review of policies and infection control documentation, it was determined the ASC failed to ensure it had developed and implemented a plan of action for preventing, identifying, and managing infections for all patients and staff at the ASC. This resulted in the ASC's inability to ensure the risk of transmitting infections was minimized and interfered with infection prevention and control efforts. Findings include: The ASC's policy, "INFECTION CONTROL PROGRAM," not dated, documented the ASC	Q 245		

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Q 245	Continued From page 18 would "...provide the highest quality of patient care including a safe and effective system for the surveillance prevention and control of infections." However, on 9/19/12, beginning at 2:15 PM, the Administrator and RN, who was designated to oversee infection control were interviewed. Both confirmed the ASC did not have an active infection control surveillance program. The ASC failed to ensure a plan of action for preventing, identifying, and managing infections had been implemented.	Q 245		

CMS Conditions of Coverage Summary Statement of Deficiencies

Pg 1. **Q000** – Introduction

Q040 (416.41) - Governing body: Surgery Center of Idaho (SCI) Board is the designated Governing Body that will oversee and assume responsibility by monitor policies governing the Ambulatory Surgery Center(ASC's)'s total operation. The Governing Body has accountability for the quality assurance, infection control and process improvement programs as well as the development and implementation of a disaster plan to ensure the facility administers quality health care. The Governing body is also responsible for but not limited to;

a. Implement and review annually the Ambulatory Surgery Center (ASC's) policies and revising when applicable.
b. Safety of the Ambulatory Surgery Center (ASC's) environment
c. Credentialing process
d. monthly meetings

The Governing body will meet once (1) a month to discuss any pertinent issues and address the following:

a. Quality assurance
b. Process improvement
d. Infection control

The Governing body will be responsible for maintaining meeting minutes on a monthly basis with assistance from the Administrator.

Authority:

The Governing body has delegated the following individuals with operational responsibilities;

Administrator:

a. Assisting in developing and enforcing the policies of the center in all areas of service provided by the center
b. Determining the center's compliance with federal, State, and local laws
c. Organizing the center's ongoing function
d. Employing qualified personnel
e. Ensuring continuing medical staff education for all employees. The Administrator will ensure that the employees have regular inservice education, make arrangements for employees to attend meetings in the medical staff member's field of expertise and ensure medical staff members of the center are members of their respective professional societies/organizations.
f. Maintain as the liaison with the Governing Body and the Medical Staff.
g. Ensure an effective budgeting and accounting system.
h. Assist the Medical Director in managing the daily operations and business affairs of the facility.
i. Enforcing and monitoring policies established by the Governing Body

j. Working with the Infection Control Coordinator (ICC) on staffing problems and issues
k. Addressing patient problems and complaints
l. Negotiating with suppliers and equipment manufacturers
m. Responsible for all financial matters such as insurance, banking, and legal matters
n. Maintaining all financial records and all meeting minutes per committee.
o. Negotiating managed care contracts in conjunction with the Medical Director
p. Supervising all billing and payment matters
q. Supervising training of office personnel.
r. Managing the Medical Staff credentialing and granting of privileges with assistance from the Medical Director.
s. Management of the Ambulatory Surgery Center (ASC's) physical plant with assistance from the Facilities Coordinator

Nurse Educator / Infection Control Coordinator is responsible for the following with oversight from the Administrator:

Hiring and Supervision of all nursing and clinical technician personnel ("clinical staff").

a. Scheduling and assigning duties to the clinical staff
b. Providing PRN nurses when absences or shortages of clinical staff arise
c. Holding regularly scheduled clinical staff meetings
d. Compliance with OSHA
e. Schedule training and inservice education for clinical staff
f. Communicating any problems to the Medical Director
g. Delegate responsibilities as needed, such as purchasing supplies
h. Working in conjunction with the medical staff to provide quality, efficient care
i. Coordinating State health audits and other regulatory checks
j. Coordinating Bio-Med technician to service and maintain equipment.

Infection Control Coordinator (ICC) is responsible for the following with assistance from the Administrator and Medical Director:

a. Infection Control presentation, data collection, monitoring and implementing QAPI program. Responsible for educating staff and Medical staff with assistance from Medical Director. Reporting information to the board.
b. Quality Assurance presentation, data collection, monitoring, implementing, analyzing report findings and assist in conducting root cause analysis of events to assist in developing and implementing plans to address such adverse outcomes. Reporting information to the board.
c. Process Improvement presentation, data collection, analysis, reporting, ongoing monitoring, identifying and implementing change of insufficient processes related to healthy outcomes for patients.
d. Oversee the pharmacy with assistance from RN staff member.

Human resources are delegated to Human Resource Management, LLC by the Governing Body.

j. Working with the Infection Control Coordinator (ICC) on staffing problems and issues
k. Addressing patient problems and complaints
l. Negotiating with suppliers and equipment manufacturers
m. Responsible for all financial matters such as insurance, banking, and legal matters
n. Maintaining all financial records and all meeting minutes per committee.
o. Negotiating managed care contracts in conjunction with the Medical Director
p. Supervising all billing and payment matters
q. Supervising training of office personnel.
r. Managing the Medical Staff credentialing and granting of privileges with assistance from the Medical Director.
s. Management of the Ambulatory Surgery Center (ASC's) physical plant with assistance from the Facilities Coordinator

The Administrator is responsible for the following with assistance from the Nurse Educator / Infection Control Coordinator

Hiring and Supervision of all nursing and clinical technician personnel ("clinical staff").

a. Scheduling and assigning duties to the clinical staff
b. Providing PRN nurses when absences or shortages of clinical staff arise
c. Holding regularly scheduled clinical staff meetings
d. Compliance with OSHA
e. Schedule training and inservice education for clinical staff
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g. Delegate responsibilities as needed, such as purchasing supplies
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b. Quality Assurance presentation, data collection, monitoring, implementing, analyzing report findings and assist in conducting root cause analysis of events to assist in developing and implementing plans to address such adverse outcomes. Reporting information to the board.
c. Process Improvement presentation, data collection, analysis, reporting, ongoing monitoring, identifying and implementing change of insufficient processes related to healthy outcomes for patients.
d. Oversee the pharmacy with assistance from RN staff member.

Human resources are delegated to Human Resource Management, LLC by the Governing Body.

Q80 – Q83 (416.43) Quality Assessment (QA) and Performance Improvement (PI): The Medical Director shall direct the Quality Assurance Activities of the center with assistance from the Infection Control Coordinator and/or other person(s) appointed by the Board or the Administrator and clinical staff.

The Quality Assessment and Performance Improvement program is developed and implemented to review quality assurance studies, assist in the analysis of data to identify opportunities to improve health care in all departments. Review and approve the Quality assurance plan, identify trends or significant events that are high volume, high risk, or problem prone. Report findings and actions monthly to the Board with assistance from the Medical Director. Assign quality assurance studies and identify the appropriate unit to problem solve. Assist in conducting and reviewing root cause analysis of events requiring such analysis and assist in developing and implementing plans to address such adverse outcomes. Following and monitoring the implementation to collect data for review making sure all adverse outcomes can be resolved and prevented or to continue the analysis until problematic events can be remedied.

Authority:

The Medical Director: shall have the final authority and responsibility for the assurance of a flexible, comprehensive, and integrated QAPI program. The Medical Director accepts the responsibility for assuring the public of the optimal quality of all care delivered by professionals within the facility. The Medical Director protects the confidentiality of QA assessment. Infection Prevention and Quality Data shall be presented and reviewed monthly with the QAPI committee.

The Infection Control Coordinator and Administrator: monitor the quality and appropriateness of all direct patient ancillary services provided by the facility, including:

a. holding and documenting monthly meetings
b. assembling, integrating and disseminating information relative to QA and monitoring activities
c. identifying, screening and monitoring ongoing potential clinical situations that may reflect risk to both patient welfare and Facility liability.
d. disseminating relevant QA findings as appropriate to the staff and the Board
e. provide and recommend continuing education needs in accordance with the findings of QA activities.
f. prioritize / set criteria for problems that need assessment
g. conducting annual evaluation of QA program with oversight from the Medical Director.

Committee Membership: Medical Director, President of Medical Staff, Administrator, Infection Control Coordinator, and other designated committee members.

Functions:

Infection Control Coordinator reviews QAPI activities monthly, collects data, provides report for the committee review and prepares written report as needed for the Medical

Director. The Infection Control Coordinator takes appropriate action when indicated and monitors activities to assess improvement.
Medical Director / Governing Authority reviews problems identified through QAPI mechanisms and takes appropriate corrective action to safeguard the patient when indicated.

Problem Resolution:

Corrective action: Appropriate action shall be implemented to eliminate or reduce an identified or potential problem. Such action may include, but is not limited to:

a. educational training
b. implementation of new or reviewed policies and procedures
c. staffing changes
d. equipment changes
e. counseling or guidance

A 30 day follow-up to the correction will take place by the Committee Membership. Making sure the identified problem has been eliminated; satisfactorily reduced and potential problems have been prevented. A summary of the corrective action will be reviewed and approved by the Committee Membership.

Quality Assessment/Performance Improvement Activities and Mechanisms

Activities designed to ensure high – quality patient care shall include but not be limited to:

Appropriate credentialing / reappointment evaluation, Orientation for all Employees, continuing education-ongoing and due to results of activities, functional, infection prevention and control, sanitation and safety programs. Policies and procedures that are reviewed no less than annually and revised when new standards, equipment, or procedures are implemented.

Methods that are utilized to evaluate quality of patient care include but not limited to:

Ongoing review of patient surveys, review of medical records, review of peri-operative patient contact information (post-op) call, monitoring and evaluating anesthesia services, medication utilization, admission to hospitals, patient dissatisfaction with their experience as a patient. Monitoring post operative and post procedure infections, sterilization and high level disinfectants, employee health requirements. Adverse patient events.
Review of all peri-operative occurrences documented on appropriate form (incident report), collected and reported to the Quality committee.

Performance Improvement Program: is developed to provide and improve its delivery of quality medical care by ongoing, active, integrated, monitored and relevant data to services provided by the ASC. This program can provide a long-term overview of patient quality care that is delivered daily within the ASC.
Functions:

The Infection Control Coordinator collects data that meets the criteria of performance improvement allowing research, ongoing, analysis and implementing corrective action when needed by taking the following actions. Such actions may include but are not limited to the following:

a. educational training

b. implementation of new or reviewed policies and procedures
c. staffing changes
d. equipment changes
e. counseling or guidance

The PI program will include the following items:

a. activity
b. does this include an adverse patient event?
c. data collected
d. implement improvement
e. % of compliance
f. outcome
g. reevaluate
h. reporting
i. benchmarking
h. education
j. staff involvement
k. re-measurement

Researching Process Improvement projects could include a time frame of 4 months or greater depending on the event. The Infection Control Coordinator takes appropriate action when indicated and monitors activities to assess improvement.
Medical Director / Governing Authority reviews problems identified through QAPI mechanisms and takes appropriate corrective action to safeguard the patient when indicated. Process Improvement projects will be reviewed monthly and minutes will be provided to the committee and Governing Body.

Reporting of QAPI includes the following but not limited to; quarterly reporting with data and summary, medical record review with data and summary, incident report with data and summary.

Page 7 - Addressing concern regarding: Five Quality Improvement Study (s) was documented between 11.17.11 and 6.20.12. Due to the process change in the handling of quality assurance these will not be addressed since they fall out of the new process.

Q84 pg 9

Governing body: Surgery Center of Idaho (SCI) Board is the designated Governing Body that will oversee and assume responsibility by monitor policies governing the Ambulatory Surgery Center (ASC's)'s total operation. The Governing Body has accountability for the quality assurance, infection control and process improvement programs as well as the development and implementation of a disaster plan to ensure the facility administers quality health care. The Governing body is also responsible for but not limited to;

a. implement and review annually the Ambulatory Surgery Center (ASC's) policies and revising when applicable.
b. safety of the Ambulatory Surgery Center (ASC's) environment
c. credentialing process
d. monthly meetings

The Governing body will meet once (1) a month to discuss any pertinent issues and address the following:

a. quality assurance
b. process improvement
d. infection control

The Governing body will be responsible for maintaining meeting minutes on a monthly basis with assistance from the Administrator.

Authority:

The Governing body has delegated the following individuals with operational responsibilities;

Administrator:

t. assisting in developing and enforcing the policies of the center in all areas of service provided by the center
u. determining the center's compliance with federal, State, and local laws
v. organizing the center's ongoing function
w. employing qualified personnel
x. ensuring continuing medical staff education for all employees. The Administrator will ensure that the employees have regular in-service education, make arrangements for employees to attend meetings in the medical staff member's field of expertise and ensure medical staff members of the center are members of their respective professional societies/organizations.
y. maintain as the liaison with the Governing Body and the Medical Staff.
z. ensure an effective budgeting and accounting system.
aa. assist the Medical Director in managing the daily operations and business affairs of the facility.
bb. enforcing and monitoring policies established by the Governing Body
cc. working with the Nurse Educator / Infection Control Coordinator on staffing problems and issues
dd. patients problems and complaints

ee. maintaining the physical plant
ff. negotiating with suppliers and equipment manufacturers
gg. responsible for all financial matters such as insurance, banking, and legal matters
hh. maintaining all financial records and all meeting minutes per committee.
ii. negotiate managed care contracts in conjunction with the Medical Director
jj. supervise all billing and payment matters
kk. supervise training of office personnel.
mm.managing the Medical Staff credentialing and granting of privileges with assistance from the Medical Director.
mn.management of the Ambulatory Surgery Center (ASC's) physical plant with assistance from the Facilities Coordinator

The Administrator is responsible for the following with assistance from the Nurse Educator / Infection Control Coordinator

Hiring and Supervision of all nursing and clinical technician personnel ("clinical staff").

k. scheduling and assigning duties to the clinical staff
l. providing PRN nurses when absences or shortages of clinical staff arise
m. holding regularly scheduled clinical staff meetings
n. compliance with OSHA
o. schedule training and in-service education for clinical staff
p. communicating any problems to the Medical Director
q. delegate responsibilities as needed, such as purchasing supplies
r. working in conjunction with the medical staff to provide quality, efficient care
s. coordinating State health audits and other regulatory checks
t. coordinating Bio-Med technician to service and maintain equipment.

Nurse Educator / Infection Control Coordinator is responsible for the following with assistance from the Administrator and Medical Director:

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b. quality Assurance presentation, data collection, monitor, implement, analyze, report findings and assist in conducting root cause analysis of events to assist in developing and implementing plans to address such adverse outcomes. Reporting information to the board.
c. process Improvement presentation, data collection, analysis, reporting, ongoing monitoring, identifying and implementing change of insufficient processes related to healthy outcomes.
d. oversee pharmacy with assistance from RN staff member.

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Q140 (416.46) pg 11

The nursing services will be directed from the Nurse Educator who is an RN.

Q240 – Q245 (416.51) pg. 12 – Infection Control

The Infection Control Program is designed to reduce the number of health care associated infections (HAI's) and to take measures to prevent and control the spread of infections and communicable diseases at the Surgery Center of Idaho, LLC. To provide the highest quality of patient care, including a safe and effective system for the surveillance prevention and control of infections.
The scope of our Infection Control program is to provide an ongoing process that monitors infection prevention and control practices as it relates to patients and all health care personnel including employees, surgeons, anesthesiologist, contract personnel, vendors, as well as visitors.
The Infection Prevention Program is comprehensive in that it addresses detection, prevention and control of infections among patients, visitors, and personnel. The program is consistent with and reflects national evidence based guidelines and regulations such as those from:

- Accreditation Association for Ambulatory Health Care (AAAHC)
- Association for Professionals in Infection Control and Epidemiology (APIC)
- Association of peri-Operative Registered Nurses (AORN)
- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare and Medicaid Services (CMS)
- State and Local Health Departments
- World Health Organization (WHO)

Authority:

The Governing body has delegated the following individuals with operational responsibilities:

The Medical Director: shall have the final authority and responsibility for the assurance of the Infection Control Program. The Medical Director will review Infection Prevention and Quality Data monthly with the Infection Control Committee.
The Infection Control Coordinator: will receive specific training in Infection Control with a goal to have this individual certified as an Infection Control Practitioner. Registered to attend APIC Training Courses for Infection Control – October2012
Infection Control Committee Membership: Medical Director, President of Medical Staff, Administrator, Infection Control Coordinator, and other designated committee members.

Function:

Infection Control Coordinator is responsible for the following with assistance from the Administrator; these responsibilities may include but are not limited to;

a. performs on-going monitoring of healthcare-associated infections.

b. identifies infection prevention areas for improvement and makes recommendations for corrective action.

c. prepares the agenda for the Infection Prevention Committee including the meeting minutes.

d. monitors infection prevention practices and employee compliance.

e. serves as a resource for all departments and personnel.

f. initiates, reviews, and revises infection prevention policies and procedures.

g. conducts outbreak investigation and initiates control measures.

h. reports communicable diseases to the local, state and federal agencies as required by law.

i. provides educational offerings for orientation and on-going inservices.

j. consults with Medical Director, President of Medical Staff, Administrator and physicians as needed to improve care.

k. initiates follow-up on employee/patient exposures to infectious and communicable diseases.

l. participates in quality improvement activities.

m. interacts with employee health on issues related to exposures to communicable diseases and to bloodborne exposures.

n. participates in short and long range planning for the infection prevention department.

Medical Director / Governing Authority reviews problems identified through Infection Control Coordinator mechanisms and takes appropriate corrective action to safeguard the patient when indicated.

Infection Control Program Activities and Mechanisms

Surveillance of infections with implementation of control measures and prevention of infections, outbreak investigation, policy and procedure review and revisions, staff education, quality assurance, and consultation.

Infection Prevention Reporting Mechanisms:

1. Patient infection cases are monitored by the Infection Control Coordinator (ICC). The Infection Control Coordinator investigates the reported infections, completes the monthly report forms and:
    a. reports to the Infection Prevention Committee
    b. reports to the Administrator and others as directed
    c. provides feedback to staff as needed
2. Employee infections and exposures to bloodborne pathogens or communicable diseases are reported by the employee to the Administrator, then to the ICC. The ICC completes the employee infection report form, analyzes the information for outbreaks or trends and reports a summary:
    a. to the Infection Prevention Committee
    b. to the Administrator and others as directed.
3. Compliance with infection prevention practices is monitored and documented by:
    a. staff evaluation
    b. observation of practices

Infection Control Process:

1. Surveillance
    a. methodology
        1. active and Passive
        2. patient-based and Laboratory-based
    b. data collection
        1. numerator
        2. denominator
2. Analysis for identifying potential positive factors
3. Implementation with re-evaluation as needed.

All potential SSi' will be reported by physician on a monthly basis to Infection Control Coordinator. Clinical staff and laboratory personnel will report all positive cultures related to SCI patients to the Infection Control Coordinator.

Infection Control Committee Membership: Medical Director, President of Medical Staff, Administrator, Infection Control Coordinator, and other designated committee members will meet once a month to review and analyze the Infection Control Program. The Infection Prevention Plan will be reviewed annually and changes made as needed.