

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
FAX 208-364-1888

October 11, 2012

Ron Pullen, Administrator
Kootenai Outpatient Surgery Center
707 Ironwood Drive
Coeur D'Alene, ID 83814

RE: Kootenai Outpatient Surgery Ce, Provider #13C0001037

Dear Mr. Pullen:

This is to advise you of the findings of the Medicare survey of Kootenai Outpatient Surgery Center, which was conducted on September 27, 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:

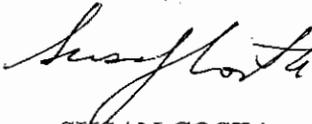
- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date 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.

Ron Pullen, Administrator
October 11, 2012
Page 2 of 2

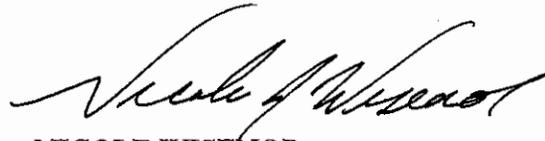
After you have completed your Plan of Correction, return the original to this office by **October 24, 2012**, and keep a copy for your records.

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

Sincerely,



SUSAN COSTA
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

SC/nw
Enclosures

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

PRINTED: 10/11/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001037	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/27/2012
NAME OF PROVIDER OR SUPPLIER KOOTENAI OUTPATIENT SURGERY CE			STREET ADDRESS, CITY, STATE, ZIP CODE 707 IRONWOOD DRIVE 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 9/27/12 Medicare re-certification survey of your Ambulatory Surgical Center. Surveyors conducting the survey were: Susan Costa, RN, HFS, Team Leader Aimee Hastriter, RN, HFS Acronyms used in this report include: ASC - Ambulatory Surgery Center CRNA - Certified Registered Nurse Anesthetist CST - Certified Surgical Technician FSBS - Fasting Serum Blood Sugar H&P - History and Physical IV - Intra Venous kg - kilogram MAR - Medication Administration Record mcg - microgram mg - milligram OR - Operating Room PACU - Post Anesthesia Care Unit PAR - Post Anesthesia Recovery post-op - post-operative pre-op - pre-operative prn - as needed RN - Registered Nurse	Q 000	<p style="text-align: center;">RECEIVED NOV 09 2012</p> <p style="text-align: center;">FACILITY STANDARDS</p> <p>The PAR box in the lower right hand corner of the Anesthesia record will have an area for the RN who is documenting to sign.</p> <p>The signature line for MD or anesthesia will be removed as this box is to indicate the patient has met discharge criteria.</p> <p>The change to this form will be made by 11/12/12 at which time the new form will be implemented. The changes will be made by Anesthesia lead.</p>	11/12/12
Q 162	416.47(b) FORM AND CONTENT OF RECORD The ASC must maintain a medical record for each patient. Every record must be accurate, legible, and promptly completed. Medical records must include at least the following: (1) Patient identification. (2) Significant medical history and results of physical examination. (3) Pre-operative diagnostic studies (entered	Q 162		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *R. Pulla* TITLE *Director* (X6) DATE *10/26/12*

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Q 162	<p>Continued From page 1 before surgery), If performed. (4) Findings and techniques of the operation, including a pathologist's report on all tissues removed during surgery, except those exempted by the governing body. (5) Any allergies and abnormal drug reactions. (6) Entries related to anesthesia administration. (7) Documentation of properly executed informed patient consent. (8) Discharge diagnosis.</p> <p>This STANDARD is not met as evidenced by: Based on observation, review of medical records and facility policies and staff interview, it was determined the facility failed to ensure medical records were complete and accurate for 22 of 22 patients (#1 - #22) whose records were reviewed. This failure impacted the clarity of the medical record and had the potential to impede continuity of patient care. Findings include:</p> <p>Medical records were not clear and accurate as follows:</p> <p>1. Documentation added to forms on the medical records was not properly authenticated as follows:</p> <p>a. Medical records contained a documented labeled "ANESTHESIA INTRA-OP RECORD." In the bottom left corner of this form was a box dedicated to "PAR Documentation." The box was designed for documentation to indicate where the patient was discharged to after recovering from anesthesia, such as if the patient was discharged</p>	Q 162	<p>A monthly chart audit of a random pull of 42 charts will be audited by an RN monthly.</p> <p>Any chart found to be non-compliant will be given to the PACU Supervisor for follow up.</p> <p>PI Coordinator will oversee chart audit on a monthly basis.</p>	

11/7/12
RP

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Q 162	<p>Continued From page 2</p> <p>home or transferred to the hospital. In addition, there were lines prompting documentation of the patient's date and time of discharge, if the patient's vital signs were stable, and the patient's oxygen saturation level on room air or with supplemental oxygen. At the bottom of the box was a line for a signature and boxes to mark to indicate whether the signature was a physician or a CRNA.</p> <p>i. Patient #1 was a 28 year old female admitted to the facility on 9/25/12 for laser lithotripsy of a stone in her right ureter. The surveyor followed Patient #1 from the admission process at 11:50 AM through the surgical procedure, her recovery and on to her discharge at 4:00 PM. Patient #1 was moved from the operating room to the post-operative recovery area at 2:42 PM, at that time the CRNA signed the "ANESTHESIA INTRA-OP RECORD" on the line in the box on the lower right side. The remaining information remained blank and the CRNA left the recovery area. When Patient #1 was discharged at 4:00 PM, the RN who was providing care for her at that time completed the remaining details in the lower right hand corner box, which included discharge to home, vital signs stable, patient was on room air, and the date and time. The RN who discharged Patient #1 did not initial or sign her entry on the "ANESTHESIA INTRA-OP RECORD."</p> <p>During an interview on 9/27/12 at 1:00 PM, an Anesthesiologist reviewed the "ANESTHESIA INTRA-OP RECORD" for Patient #1 and stated when he or a member of the anesthesia team signed the line on lower right of the page, it was to indicate a verbal report had been given to the</p>	Q 162		
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Q 162	<p>Continued From page 3</p> <p>post-operative recovery nurse, and the anesthesia team was signing off on their care for the patient. The Anesthesiologist stated the recovery nurse would complete the remaining details in that box upon patient discharge.</p> <p>ii. Patient #22 was admitted to the facility on 9/26/12 for laparoscopic removal of her fallopian tubes. Her care at the facility was observed from 11:00 AM through 3:15 PM. Patient #22 was moved from the operating room to the post-operative recovery area at 2:15 PM. At 2:25 PM, the CRNA signed her name to the box dedicated to the PAR documentation. The rest of the information in the box remained blank and the CRNA left the recovery area.</p> <p>On 9/26/12 at 3:00 PM, the post-operative recovery RN was interviewed. She explained that except under special conditions, once the CRNA or anesthesiologist turned the patient over to recovery room personnel, they did not routinely return to evaluate the patient prior to discharge. She stated that the CRNAs and physicians were always available as resources if nursing staff had any questions regarding a patient's post-operative recovery course.</p> <p>Patient #22's medical record was reviewed. The section of the "ANESTHESIA INTRA-OP RECORD" for PAR documentation indicated Patient #22 was discharged home, with stable vital signs and an oxygen saturation of 98% on room air, on 9/26/12 at 5:00 PM. The author of this added documentation was not clear.</p> <p>The Perioperative Manager was interviewed on 9/27/12 at 9:00 AM. She stated the facility</p>	Q 162			

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Q 162	<p>Continued From page 4</p> <p>viewed the signature in the PAR discharge box and the CRNA's or Anesthesiologist's authorization to follow the signed orders regarding discharge. She stated the discharge order indicated that a patient may be discharged from the facility when certain criteria had been met. She explained that because of this process, the facility felt the RN was authorized to write in the discharge disposition and vital signs in the box already containing the practitioner's signature. She confirmed that the RN did not authenticate the addition of the documentation.</p> <p>The facility's policy, "THE MEDICAL RECORD," dated 3/2004, was reviewed. According to the policy "Documentation or care given, treatments, procedures, and instructions shall be entered into the patient's record at the time it occurs. To document "ahead of time" is a falsification of records and is strictly prohibited." The policy included an examples of documenting ahead of time, such as documenting assessments prior to their completion.</p> <p>The facility failed to ensure that information added the post-anesthesia recovery record, after the practitioner signed, was authenticated by the RN.</p> <p>b. Staff added information to order sets and assessments without properly documented who added the information and when.</p> <p>i. Patient #1 was a 28 year old female admitted to the facility on 9/25/12 for laser lithotripsy (a medical procedure that uses shock waves to break up stones in the kidney, bladder, or ureter) of a stone in her right ureter. The surveyor</p>	Q 162	<p><i>In accordance with policy all entries shall include first initial, last name, title, time + date.</i></p> <p><i>Any additional orders will be clearly marked by either circle or drawing an arrow to the new order with first initial, last name, title time + date.</i></p> <p><i>Anesthesia lead will communicate to all anesthesia providers by 11/15/12.</i></p> <p><i>All charts will be verified following the day of surgery 24 hours to include pre-op orders.</i></p>	11/15/12

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Q 162	<p>Continued From page 5</p> <p>followed Patient #1 from the admission process at 11:50 AM through the surgical procedure, her recovery and on to her discharge at 4:00 PM. A CRNA entered the pre-op room at 12:35 PM to speak with Patient #1. He identified himself to the patient and stated he would not be providing her anesthesia but would be reviewing her chart, and discussed the plans for anesthesia. After Patient #1 signed a consent for anesthesia, the CRNA left the area.</p> <p>Review of Patient #1's "ANESTHESIA PRE-OP ORDERS," timed 12:35 PM, noted the pre-printed order sheet had a check mark next to the medication order for Midazolam.</p> <p>A second CRNA came in to speak with Patient #1 at 1:00 PM. She identified herself as the Anesthetist who would be taking care of Patient #1 during the procedure. She asked Patient #1 if she had any questions, reviewed the information on the clipboard, and assessed her mouth for airway and mobility. The second CRNA left Patient #1's room at 1:15 PM and checked additional boxes next to medications on the "ANESTHESIA PRE-OP ORDERS" sheet as follows:</p> <ul style="list-style-type: none"> - Ondansetron, - Dexamethasone, - Promethazine, - Diphenhydramine. <p>In an interview on 9/25/12 at 1:25 PM, the RN who was providing care for Patient #1 in the Pre-op area reviewed the "ANESTHESIA PRE-OP ORDERS" sheet, and confirmed the addition of medication orders by the second</p>	Q 162	<p>Any orders not found to be compliant will be given to anesthesia lead for follow up and completion.</p> <p>PACU supervisor will oversee the verification process.</p>	
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Q 162	<p>Continued From page 6</p> <p>CRNA. She stated the second CRNA initialed and dated the entries, but did not write the time on the sheet. The RN stated it was difficult to know which CRNA had written the orders; and the orders should have been written on a separate sheet by the second CRNA.</p> <p>ii. Patient #5 was a 66 year old female admitted to the facility on 7/23/12 for sinus surgery. Her medical record contained a form titled, "ANESTHESIA EVALUATION NOTE." The form was completed by the evaluating CRNA on 7/23/12. On the form, in a different hand writing, were notes regarding Patient #5's alcohol intake and a note indicating a possible alternative to the anesthesia plan. It was not clear who added this information or when.</p> <p>The Perioperative Manager reviewed Patient #5's record on 9/27/12 at 9:00 AM. She confirmed that someone besides the evaluating CRNA added information to the assessment without proper authentication.</p> <p>The facility's policy, "THE MEDICAL RECORD," dated 3/2004, was reviewed. According to the policy, "Entries shall include the time, first initial and last name, and title...of the appropriate care provider."</p> <p>The facility failed to ensure that all entries into the medical record were clearly authenticated.</p> <p>2. The accurate date of completion of the H&P was not clear as follows:</p> <p>a. Patient #1 was a 28 year old female admitted to the facility on 9/25/12 for laser lithotripsy of a</p>	Q 162		

Rough draft attached to be sent 11/5/12

A letter drafted by the KOS Director to all Physicians indicating the all H&P's need to document the date of assessment and completion of the assessment.

poc @ 162

09 70838

November 2, 2012

Dear

As a result of our recent Medicare tour and audit it is a requirement for the pre-surgical History and Physical to include the actual date that you assessed your patient. This change is being mandated by Medicare and will be followed by Kootenai Outpatient Surgery.

Please be aware that as of Nov. 15th 2012 our staff will be auditing charts for this date on your H&P's.

Thank you for your cooperation in this requirement

Sincerely,

Ron Pullen RN
Director of Kootenai Outpatient Surgery

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Q 162	<p>Continued From page 7</p> <p>stone in her right ureter. The surveyor followed Patient #1 from the admission process at 11:50 AM through the surgical procedure, her recovery and on to her discharge at 4:00 PM.</p> <p>In an interview on 9/25/12 beginning at 12:00 PM, Patient #1 stated she had gone in to the hospital on 9/17/12 with right sided pain and found out she had a stone in her ureter. She stated the stone was blocking the flow of urine and caused the right kidney to enlarge. Patient #1 stated her physician had placed a stent at that time to allow the urine to drain around the blockage. Patient #1 stated she had met with her physician on 9/17/12, and had not seen him since that date. She stated his office had contacted her by phone on 9/20/12 informing her of the scheduled surgical procedure to be done 9/25/12.</p> <p>A clipboard for Patient #1 contained a history and physical from 9/17/12, when Patient #1 was hospitalized the previous week. At 12:32 an additional History and Physical was placed on Patient #1's clipboard by the Pre-op RN. There was no date on the H&P to indicate when it had been performed. The new H&P included date of admission as 9/25/12, and was dictated 9/25/12 at 10:29 AM. The H&P contained a note in the present tense, which included a conversation held with Patient #1 that day regarding the surgical plan, risks, and post operative expectations. Patient #1 had stated she had not seen her physician since 9/17/12.</p> <p>At 1:10 PM the Physician came in to the Pre-op area, reviewed the clipboard for Patient #1, signed the H&P, and went in to speak with Patient #1. He reviewed the plan for the procedure then</p>	Q 162	<p><i>if short form is used it will indicate date of assessment.</i></p> <p><i>42 charts will be pulled on a random pull and audited for compliance by RN on a monthly basis.</i></p> <p><i>1:1 follow-up with each physician found non-compliant by ROS Director.</i></p>	

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Q 162	<p>Continued From page 8</p> <p>left the patient area without performing an assessment of her heart and lungs or reviewing with her any changes that may have occurred since the previous H&P had been obtained.</p> <p>During an interview on 9/25/12 beginning at 1:25 PM, the RN providing pre-op care for Patient #1, who had placed the additional H&P on the clipboard, reviewed the record and stated it appeared as if the H&P had been performed that morning.</p> <p>It was not clear when the second H&P had been performed.</p> <p>b. Patient #22 was admitted to the facility on 9/26/12 for laparoscopic removal of her fallopian tubes. Her care at the facility was observed from 11:00 AM through 3:15 PM. At 11:10 AM, the Pre-op RN reviewed documentation present in Patient #22's medical record. He noted an H&P completed by Patient #22's surgeon. At the top of the H&P, the date of the surgery was documented. At the end of the H&P, the date and time the report was dictated was documented. According to this information, the report was dictated 9/25/12 at 7:51 AM. The pre-operative RN stated he interpreted the date to be the date the medical history and physical examination were completed by the physician.</p> <p>On 9/26/12 at 11:30 AM, Patient #22 was interviewed. She stated she saw her physician on 9/21/12 for her pre-operative appointment. She stated during that visit the surgeon reviewed all of her medical history and completed her physical examination. She confirmed she did not see her physician on 9/25/12.</p>	Q 162		
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Q 162	<p>Continued From page 9</p> <p>c. Patient #6 was a 65 year old female admitted to the facility on 8/23/12 for hernia repair. Her medical record contained an H&P signed by the physician on 8/22/12. At the top of the H&P, the date of surgery was documented. At the end of the report were the date and time the physician dictated the H&P. The report was dictated on 8/06/12 at 2:25 PM. The document did not indicate when the medical history and physical examination were completed.</p> <p>The Perioperative Manager reviewed Patient #6's medical record on 9/27/12 at 9:15 AM. She confirmed the H&P was missing the date the examination actually occurred. She explained that some of the physicians used the transcription service provided at the facility. She stated that the omission of the date of service was likely missing on all of those H&P's dictated and transcribed through the system.</p> <p>d. Patient #17 was a 62 year old male admitted to the facility on 7/26/12 for surgery on his left thumb. His medical record contained an H&P signed by the physician on 8/11/12 at 10:44 PM. At the top of the H&P in Patient #17's medical record was the date of his admission for surgery, 7/26/12. At the end of the report were the date and time the physician dictated the H&P. The report was dictated on 7/23/12 at 7:25 AM (a Monday). The document did not indicate when the medical history and physical examination were completed.</p> <p>The Perioperative Manager reviewed Patient #17's medical record on 9/27/12 at 9:15 AM. She confirmed the H&P was missing the date the</p>	Q 162		
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NAME OF PROVIDER OR SUPPLIER KOOTENAI OUTPATIENT SURGERY CE	STREET ADDRESS, CITY, STATE, ZIP CODE 707 IRONWOOD DRIVE COEUR D'ALENE, ID 83814
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Q 162	<p>Continued From page 10 examination actually occurred.</p> <p>e. Patient #1 was a 28 year old female admitted to the facility on 9/25/12 for a urologic procedure. Her medical record contained an H&P, unsigned. At the top of the H&P in Patient #1's medical record was the date of her admission for surgery, 9/25/12. At the end of the report were the date and time the physician dictated the H&P. The report was dictated on 7/23/12 at 10:29 AM. The document did not indicate when the medical history and physical examination were completed.</p> <p>f. Patient #3 was a 67 year old male admitted to the facility on 7/19/12 for the removal of his gall bladder. His medical record contained an H&P that was unsigned. At the top of the H&P in Patient #3's medical record was the date of his admission for surgery, 7/19/12. At the end of the report were the date and time the physician dictated the H&P. The report was dictated on 6/28/12 at 4:03 PM. The document did not indicate when the medical history and physical examination were completed.</p> <p>g. Patient #10 was a 79 year old female admitted to the facility on 8/17/12 for removal of a bladder tumor. Her medical record contained an H&P that was unsigned. At the top of the H&P in Patient #10's medical record was the date of her admission for surgery, 8/17/12. At the end of the report were the date and time the physician dictated the H&P. The report was dictated on 8/14/12 at 12:03 PM. The document did not indicate when the medical history and physical examination were completed.</p> <p>h. Patient #12 was a 69 year old female admitted</p>	Q 162		
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Q 162	<p>Continued From page 11</p> <p>to the facility on 9/17/12 for an orthopedic procedure on her right hand. Her medical record contained an H&P that was signed 9/17/12 at 10:10 AM. At the top of the H&P in Patient #12's medical record was the date of her admission for surgery, 9/17/12. At the end of the report were the date and time the physician dictated the H&P. The report was dictated on 9/12/12 at 2:02 PM. The document did not indicate when the medical history and physical examination were completed.</p> <p>i. Patient #14 was a 60 year old male admitted to the facility on 8/29/12 for an appendectomy. His medical record contained an H&P that was signed but undated. At the top of the H&P in Patient #14's medical record was the date of his admission for surgery, 8/29/12. At the end of the report were the date and time the physician dictated the H&P. The report was dictated on 8/28/12 at 3:06 PM. The document did not indicate when the medical history and physical examination were completed.</p> <p>Documentation on the H&P did not clearly indicate when the medical history and physical examination were completed by the surgeon.</p> <p>The facility failed to ensure documentation of the H&P in the medical record clearly indicated the date the H&P was completed.</p> <p>3. The medical record failed to accurately document the need to transfer a patient from the facility to the hospital.</p> <p>a. Patient #2 was a 21 year old male, admitted to the facility for surgical repair of his left shoulder related to frequent dislocations. He was moved</p>	Q 162	<p>Refer to POC Tag Q162 Pg. 7 + 8 of 38.</p> <p>A physicians order will be part of the transfer documentation.</p> <p>See attached Policy.</p>	
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Q 162	<p>Continued From page 12 from the operating room to recovery at 2:24 PM. The following notes in Patient #2's record indicate he was transferred to the hospital, but it was unclear as to the receipt of orders for his transfer:</p> <ul style="list-style-type: none"> - 4:32 PM: "Family updated on pt's status-possibility of admission for pain control." "Dr [name] notified of pt's status-uncontrollable pain." - 4:59 PM: "Report called to [name], RN." - 5:10 PM: "Transferred to 2 North, Room #212-2." <p>Patient #2's "POST-OP ORDERS," dated 8/22/12 and untimed, did not indicate a transfer was to take place, and the pre-printed order set included "Discharge home when stable."</p> <p>"DOCTOR'S ORDERS" written as a RBVO (read back verbal order) by the RN who provided post-operative care for Patient #2, dated 8/22/12 at 4:30 PM, contained orders for antibiotics, intravenous fluids, a pain pump, lab specimens to be drawn, diet and activity orders. The "DOCTOR'S ORDERS" were not authenticated by the physician.</p> <p>In an interview on 9/27/12 at 10:25 AM, the Perioperative Manager reviewed Patient #2's record and stated the verbal order described above was actually a transfer order although it did not state "transfer patient." The Perioperative Manager confirmed the record did not contain a narrative of the physician having been informed of and ordered the transfer of Patient #2.</p> <p>The facility failed to ensure the medical record accurately documented events surrounding</p>	Q 162	<p><i>Educational Training and review of Policy has been provided to staff.</i></p> <p><i>All medical records to be verified 24 hrs to 72 hrs post original date.</i></p> <p><i>Non-compliance will be addressed with KOS Director.</i></p> <p><i>PACU Supervisor to oversee verification process.</i></p>	10/24/12
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Q 162	Continued From page 13 Patient #2's transfer to the hospital. 4. Orders were not timed, and therefore resulted in a lack of clarity related to the timing of physician's orders compared with the RN's notation of the receipt of the orders. a. Patient #4 was a 68 year old female admitted to the facility on 2/07/12 for sinus surgery. Her medical record contained a form with pre- and post-operative orders. The physician signed and dated the form 2/07/12. The time of the orders was not documented. The pre-op RN noted the pre-operative orders on 2/07/12 at 7:48 AM. The post-op RN noted the post-operative orders on 2/07/12 at 3:00 PM. The Perioperative Manager was interviewed on 9/27/12 at 9:00 AM. She reviewed Patient #4's medical record and confirmed that none of the physician's pre-printed order forms contained a line for the time of the physician. She confirmed that a physician may occasionally document the time the orders were signed, but this was not a facility requirement. She agreed that without the time a physician signed orders it could not clearly be determined that the orders were issued prior to the time the RN noted them. b. Patient #6 was a 65 year old female admitted to the facility on 8/23/12 for hernia repair. Her medical record contained pre-printed "ANESTHESIA POST-OP ORDERS" signed and dated by the CRNA on 8/23/12. The line to indicate the time the orders were written was blank. The post-op RN noted the orders on 8/23/12 at 12:00 PM.	Q 162	"Time" Line will be added to all standing order sheets by 11/15/12 PACU RN will complete following day of surgery Chart to be audited & verified. Any charts found to be non-compliant will be followed up with by PACU supervisor.	11/15/12

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Q 162	<p>Continued From page 14</p> <p>The Perioperative Manager was interviewed on 9/27/12 at 9:15 AM. She confirmed that the post-op orders were not timed.</p> <p>c. Patient #19 was a 74 year old female admitted to the facility on 8/13/12 for creation of a upper arm fistula for dialysis use. Her medical record contained hand-written physician orders for wound care and pain medication signed and dated by the physician on 8/13/12. The time the orders were written was not documented. An RN noted the orders on 8/13/12 at 3:30 PM.</p> <p>The Perioperative Manager was interviewed on 9/27/12 at 9:15 AM. She confirmed that the post-op orders were not timed.</p> <p>d. Patient #20 was a 67 year old male admitted on 8/22/12 for right knee surgery. His medical record contained a form of pre-printed "Routine Outpatient Orders." The physician signed and dated, but did not time, the orders on 8/22/12. A post-op RN noted the orders on 8/22/12 at 11:38 AM.</p> <p>The Perioperative Manager was interviewed on 9/27/12 at 9:15 AM. She confirmed the orders for Patient #20 were not timed.</p> <p>e. Patient #21 was a 50 year old male admitted to the facility on 3/08/12 for implantation of a bone-anchored hearing aide. His medical record contained hand-written physician orders for monitoring, medicating, and transferring Patient #21 from the facility to the hospital. The physician signed and dated the orders on 3/08/12. The orders were not timed. An RN noted the orders on 3/08/12 at 11:35 AM.</p>	Q 162		
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Q 162	Continued From page 15 The Perioperative Manager reviewed Patient #21's medical record on 9/27/12 at 9:15 AM. She confirmed the orders for Patient #21 were not timed. f. Patient #16 was a 79 year old male admitted to the facility on 7/26/12 for surgery on his right foot. His medical record contained hand-written physician orders for post-operative care. The physician signed and dated the orders 7/26/12. The orders were not timed. The orders were not noted by an RN. Patient #16's medical record also contained "ANESTHESIA PRE-OP ORDERS." The orders were signed and dated by the CRNA on 7/26/12. The orders were not timed but were noted by the pre-op RN on 7/26/12 at 2:10 PM. The Perioperative Manager reviewed Patient #16's medical record on 9/27/12 at 9:15 AM. She confirmed the orders for Patient #16 were not timed. g. Patient #5 was a 66 year old female admitted to the facility on 7/23/12 for sinus surgery. Her medical record contained pre-printed "Routine Post-op Orders: Endoscopic Sinus Surgery," signed and dated by the physician on 7/23/12. The orders were not timed. The pre-op RN noted orders for pre-op care on 7/23/12 at 9:00 AM. The post-op RN noted orders on 7/23/12 at 1:26 PM. The Perioperative Manager reviewed Patient #5's medical record on 9/27/12 at 9:00 AM. She confirmed the pre-printed orders were not timed.	Q 162		

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Q 162	<p>Continued From page 16</p> <p>h. Patient #2 was a 21 year old male admitted to the facility on 8/22/12 for the surgical correction of a recurrent dislocated shoulder. His medical record contained a form with pre- and post-operative orders. The physician signed and dated the form 8/22/12. The time of the orders was not documented. The pre-op RN noted the pre-operative orders on 8/22/12 at 9:00 AM. The post-op RN noted the post-operative orders on 8/22/12 at 2:25 PM.</p> <p>i. Patient #7 was a 9 year old male admitted to the facility on 8/21/12 for urologic surgery. His medical record contained a form with post-operative orders. The physician signed and dated the form 8/21/12. The time of the orders was not documented. The post-op RN noted the post-operative orders on 8/21/12 at 8:00 AM.</p> <p>j. Patient #8 was a 2 year old male admitted to the facility on 8/17/12 for dental restoration of multiple teeth. His medical record contained a form with pre and post-operative orders. The physician signed and dated the form 8/17/12. The time of the orders was not documented. The pre-op RN noted the pre-operative orders on 8/17/12 at 8:50 AM. The post-op RN noted the post-operative orders on 8/17/12 at 10:54 AM.</p> <p>k. Patient #9 was a 78 year old male admitted to the facility on 7/24/12 for a throat biopsy. His medical record contained a form with post-operative orders. The physician signed and dated the form 7/24/12. The time of the orders was not documented. The post-op RN noted the post-operative orders on 7/24/12 at 11:10 AM.</p> <p>l. Patient #10 was a 79 year old female admitted</p>	Q 162		

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Q 162	<p>Continued From page 17</p> <p>to the facility on 8/17/12 for urologic surgery. Her medical record contained a form with post-operative orders. The physician signed and dated the form 8/17/12. The time of the orders was not documented. The post-op RN noted the post-operative orders on 8/17/12 at 10:50 AM.</p> <p>m. Patient #11 was a 69 year old female admitted to the facility on 9/17/12 for orthopedic surgery. Her medical record contained a form with post-operative orders. The physician signed and dated the form 9/17/12. The time of the orders was not documented. The post-op RN noted the post-operative orders on 9/17/12 at 11:48 AM.</p> <p>n. Patient #14 was a 60 year old male admitted to the facility on 8/29/12 for an appendectomy. His medical record contained a form with post-operative orders. The physician signed and dated the form 8/29/12. The time of the orders was not documented. The post-op RN noted the post-operative orders on 8/29/12 at 7:50 AM.</p> <p>The Perioperative Manager reviewed the records for Patients #2, #7, #8, #9, #10, #11, and #14 on 9/27/12 at 10:30 AM. She confirmed the physician orders were not timed.</p> <p>The facility failed to ensure that orders were complete and included physician signature, date, and time.</p> <p>5. Pre-printed standing orders indicated a blood glucose test was to be completed on all patients. However, not all patients required blood glucose tests prior to surgery. Non-diabetic patients (Patients #2, #3, #5, #8, #9, #11 - #15, #18, #20 and #22) had unclear orders related to whether</p>	Q 162	<p>Refer to previous plan Tag Q 162 Pg. 14 of 38</p> <p>Pre checked box for FSBS will be removed from anesthesia standing order by Anesthesia Lead.</p>	<p>11/15/12</p> <p>11/12/12</p>

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Q 162	<p>Continued From page 18 or not this test should be done prior to surgery.</p> <p>The Perioperative Manager was interviewed on 9/27/12 at 9:00 AM and again at 10:30 AM. She confirmed that the pre-printed "ANESTHESIA PRE-OP ORDERS" contained a pre-marked order for "FSBS on arrival to Pre-op." She stated the order forms were the same forms used at their affiliated hospital and the decision was made to leave this order pre-marked. She confirmed that it was not the practice at the facility to routinely check blood sugar levels prior to surgery for all patients. She stated that when the decision was made to leave the order marked, the expectation was that the CRNA or anesthesiologist who completed and signed the orders was to cross out the order if the test was not warranted. She reviewed the above medical records and confirmed that a blood sugar level was not needed but that the order had not been crossed out by the ordering CRNA or anesthesiologist.</p> <p>In an interview on 9/27/12 at 1:00 PM, the Anesthesiologist representing his department, reviewed the pre-printed anesthesia forms. The Anesthesiologist stated the pre-printed forms were used for the hospital as well as for the ASC and the Chief of Anesthesiology had requested that all his patients admitted for surgery at the hospital have a fasting serum blood sugar test as a pre-operative screening. He stated it was the responsibility of the anesthesiologist or the CRNA that completed the form to cross through the order if it was not indicated.</p> <p>The facility failed to ensure pre-printed order sheets accurately reflected the needs of patients.</p>	Q 162		

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Q 181	<p>416.48(a) ADMINISTRATION OF DRUGS</p> <p>Drugs must be prepared and administered according to established policies and acceptable standards of practice.</p> <p>This STANDARD is not met as evidenced by: Based on review of medical records and facility policies, and staff interview it was determined the facility failed to ensure medications orders were documented as administered in accordance with established policies. This impacted 18 of 22 patients (#2, #3, #5, #6, #8 - #20, and #22) whose records were reviewed. This failure had the potential to result in medication errors and negative patient outcome. Findings include:</p> <p>1. Medications were administered without corresponding physician orders as follows:</p> <p>a. Patient #2 was a 21 year old male, admitted to the facility on 8/22/12 for repair of a recurrent dislocation of his left shoulder. Patient #2's "MEDICATION ADMINISTRATION RECORD," dated 8/22/12 documented he received multiple doses of medication including the following:</p> <ul style="list-style-type: none"> - Fentanyl 25 mcg was administered IV at 10:55 AM, 11:10 AM, and 11:40 AM, - Versed 1 mg was administered IV at 11:42 AM, - Versed 2 mg was administered IV at 12:15 PM, - Dilaudid 4 mg two tabs were administered orally at 3:16 PM. <p>The "ANESTHESIA PRE-OP ORDERS," "ANESTHESIA POST-OP ORDERS," and</p>	Q 181	<p>One time orders will be written + signed by fraction.</p> <p>PACU Supervisor to reinforce policy with staff. Staff meeting and policy review through communication book.</p> <p>All charts to be audited and verified the next working day following Surgery.</p> <p>1:1 with PACU Supervisor for non-compliance.</p> <p>PACU Supervisor to oversee verification process, ongoing basis.</p>	11/2/12

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001037	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/27/2012
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NAME OF PROVIDER OR SUPPLIER KOOTENAI OUTPATIENT SURGERY CE	STREET ADDRESS, CITY, STATE, ZIP CODE 707 IRONWOOD DRIVE COEUR D'ALENE, ID 83814
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Q 181	<p>Continued From page 20</p> <p>"Kootenai Outpatient Surgery DOCTOR'S ORDERS," each dated 8/22/12, were reviewed. The medical record did not contain orders authorizing the administration of the Fentanyl and Versed. The "Orthopedic Surgery POST-OP ORDERS," signed by a physician on 8/22/12 but not timed, contained an order for Dilaudid 4 mg orally, every four to six hours while in the recovery room. The dose given was documented as two four mg tablets (8 mg total).</p> <p>In an interview on 9/27/12 beginning at 10:25 AM, the Perioperative Manager reviewed Patient #2's record and confirmed the above medications had been documented as administered. The Perioperative Manager stated it appeared as if Patient #2 had a difficult time with pain management. She stated at times, especially during a procedure such as a nerve block by the Anesthetist, her nursing staff would take verbal orders. In reviewing the record for Patient #2 she stated that may have been what occurred. The Perioperative Manager confirmed the documentation for the Dilaudid dose appeared as if Patient #2 received a different dose than what was ordered.</p> <p>b. Patient #8 was a two year old admitted to the facility on 8/17/12 for dental restoration of multiple teeth. His weight on the day of admission was documented at 13.5 kg. Patient #8's "MEDICATION ADMINISTRATION RECORD" was compared with his "ROUTINE ORDERS: PEDIATRIC DENTISTRY" form. The following discrepancy in ordered versus administered medications was noted:</p> <p>- Order: Recovery room for post-op pain:</p>	Q 181		
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Q 181	<p>Continued From page 21</p> <p>Ibuprofen elixir 100 mg/5 ml (not to exceed 5 mg/kg/dose). Patient #8's weight was 13.5 kg, his maximum dose would be 67.5 mg. The MAR reflected Patient #8 had received 75 mg, which was in excess of the maximum dose ordered.</p> <p>In an interview on 9/27/12 beginning at 10:25 AM, the Perioperative Manager reviewed Patient #8's record and calculated the dosage. She confirmed the dose administered was more than the written order. She stated the PACU RN would sometimes receive an order for a medication which was in excess of the exceeded dose order. She stated the order would be written as a "one-time" order. She confirmed there was no "one-time" order written for the Ibuprofen administered to Patient #8.</p> <p>A policy, "ADMINISTRATION OF MEDICATIONS," issued 3/2004, instructed as follows: "Confirm all verbal orders by repeating the complete orders...Record the order in the chart as soon as possible."</p> <p>An additional policy, "PHYSICIAN'S ORDERS," issued 3/2004 stated: "Treatments and/or procedures, or drug administration shall not be implemented without a physician's written signed and dated order. The use of verbal orders shall be minimized in this organization. The physician must sign the order upon arrival in the facility or within 30 days after the order's issue."</p> <p>Medications were administered to Patients #2 and #8 without corresponding physician orders.</p> <p>2. Medication orders were incomplete as follows:</p>	Q 181		
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Q 181	<p>Continued From page 22</p> <p>a. Patient #6 was a 65 year old female admitted to the facility on 8/23/12 for hernia repair. Her medical record contained pre-printed "ANESTHESIA POST-OP ORDERS" signed and dated by the CRNA on 8/23/12. The CRNA indicated Midazolam may be used as needed in the post-operative phase. The order was as follows:</p> <p>- "Midazolam (Versed) titrate 1-2 mg IV every 5 minutes prn anxiety to a max of ___ mg"</p> <p>The maximum dosage of Midazolam was not specified.</p> <p>The Perioperative Manager was interviewed on 9/27/12 at 9:15 AM. She confirmed that the post-op order for Midazolam was not complete.</p> <p>b. Patient #20 was a 67 year old male admitted to the facility on 8/22/12 for right knee surgery. His medical record contained "ANESTHESIA POST-OP ORDERS," signed by the CRNA on 8/22/12 at 10:45 AM. The CRNA indicated Promethazine and Metoclopramide may be used as needed in the post-operative phase. The orders were as follows:</p> <p>- "Promethazine (Phenergan) ___ 12.5 mg / ___ 25 mg PR or ___ 6.25 mg / ___ 12.5 mg IV prn nausea/vomiting, may repeat x 1"</p> <p>- "Metoclopramine (Reglan) ___ 5 mg / ___ 10 mg IV x 1 prn nausea/vomiting"</p> <p>There were several options of routes and dosages of the medication to choose from. The orders for the dosages and routes were not clear.</p>	Q 181	<p><i>Refer to POC Q181</i></p> <p><i>P.g. 20 of 38</i></p>	
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Q 181	<p>Continued From page 23</p> <p>The Perioperative Manager reviewed Patient #20's medical record on 9/27/12 at 9:30 AM. She confirmed that the post-op orders for Promethazine and Metoclopramide were not complete.</p> <p>c. Patient #16 was a 79 year old male admitted to the facility on 7/26/12 for surgery on his right foot. His medical record contained "ANESTHESIA POST-OP ORDERS," signed by the CRNA on 7/26/12 at 2:15 PM. The CRNA indicated Dexamethasone may be used as needed in the post-operative phase. The order was as follows:</p> <p>- "Dexamethasone (Decadron) ___mg IV x 1 prn nausea/vomiting"</p> <p>The dosage of Dexamethasone was not indicated.</p> <p>The Perioperative Manager was interviewed on 9/27/12 at 9:15 AM. She confirmed that the post-op order for Dexamethasone was not complete.</p> <p>d. Patient #17 was a 62 year old male admitted to the facility on 7/26/12 for surgery on his left thumb. His medical record contained "ANESTHESIA POST-OP ORDERS," signed by the CRNA on 7/26/12 at 11:45 AM. The CRNA indicated Promethazine, Dexamethasone, and Midazolam may be used as needed in the post-operative phase. The orders were as follows:</p> <p>- "Promethazine (Phenergan) ___ 12.5 mg / ___ 25 mg PR or ___ 6.25 mg / ___ 12.5 mg IV prn nausea/vomiting, may repeat x 1"</p>	Q 181		

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Q 181	<p>Continued From page 24</p> <p>- "Dexamethasone (Decadron) __mg IV x 1 prn nausea/vomiting"</p> <p>- "Midazolam (Versed) titrate 1-2 mg IV every 5 minutes prn anxiety to a max of __ mg"</p> <p>There were several options of routes and dosages of the Promethazine to choose from. The orders for the dose and route were not clear. The dose of Dexamethasone and the maximum dose of Midazolam were not specified.</p> <p>The Perioperative Manager was interviewed on 9/27/12 at 9:15 AM. She confirmed that the post-op orders for the Promethazine, Dexamethasone, and Midazolam were not complete.</p> <p>e. Medical records for Patients #2, #3, #5, #6, #9 - #19, and #22 contained "ANESTHESIA POST-OP ORDERS" with an order for Diphenhydramine pre-checked on the signed and dated form. The order was as follows:</p> <p>- "Diphenhydramine (Benadryl) __12.5 mg / __ 25 mg IV prn pruritis, may repeat x ___."</p> <p>The dosage to be given and the number of times the dose may be repeated were not documented in any of the above medical records.</p> <p>The Perioperative Manager was interviewed on 9/27/12 at 9:00 AM. She explained the medical records for Patients #2, #3, #5, #6, #9 - #19, and #22 contained the same pre-printed "ANESTHESIA POST-OP ORDERS" form. She confirmed the pre-printed "ANESTHESIA POST-OP ORDERS" contained a pre-marked order for the Diphenhydramine. She confirmed</p>	Q 181	<p>The pre-checked box for Diphenhydramine on the anesthesia Post-op orders will be removed by anesthesia lead.</p> <p>refer to POC Q 181 Pg. 20 of 38</p>	11/12/12

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Q 181	<p>Continued From page 25</p> <p>that because it was an order that was marked, it would be considered an incomplete order because it lacked specification. She stated the RN would need to contact the CRNA or anesthesiologist for additional clarification.</p> <p>The policy titled, "PHYSICIAN'S ORDERS," dated 3/2004, was reviewed. The policy indicated that "Medication orders shall include the indications, drug dosages, and drug calculations as appropriate. No change in drug orders shall be made without the approval of the practitioner."</p> <p>The facility failed to ensure medication order were documented and administered in accordance to facility policies.</p>	Q 181	<p>refer to POC Q181 Pg. 20 of 38.</p>	
Q 222	<p>4166.50(a)(1)(i) NOTICE - POSTING</p> <p>In addition, the ASC must - Post the written notice of patient rights in a place or places within the ASC likely to be noticed by patients (or their representatives, if applicable) waiting for treatment. The ASC's notice of rights must include the name, address, and telephone number of a representative in the State agency to whom patients can report complaints, as well as the Web site for the Office of the Medicare Beneficiary Ombudsman.</p> <p>This STANDARD is not met as evidenced by: Based on observation and staff interview it was determined the ASC failed to ensure posted patient rights information included the name, address, and telephone number of a representative in the State agency to whom patients could report complaints, as well as the Web site for the Office of the Medicare</p>	Q 222	<p>Posting in Lobby</p> <p>PT Rights brochures are due to be updated + will include State agency + web site information under modification and updates in preparation for 2013.</p> <p>Kos Director will be responsible to assure this is completed.</p>	Dec. 2012

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Q 222	Continued From page 26 Beneficiary Ombudsman. This resulted in the potential for patients and their representatives to not be fully informed of their rights. Findings include: A tour was conducted of the ASC on 9/24/12 between 2:30 PM to 3:30 PM with the Administrator. Patient Rights information was observed to be posted in the waiting area. The information posted provided a phone number of the patient advocate office at the adjoining hospital and did not include contact information for the State agency to which patients could report complaints. It also did not include the Web site for the Office of the Medicare Beneficiary Ombudsman. The Administrator confirmed the posted information did not provide the State agency contact and number. The facility did not ensure written patient rights information was posted in the facility that included contact information for the State agency and the Web site for the Office of the Medicare Beneficiary Ombudsman.	Q 222		
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	Q 224	refer to POC Q 222 Pg. 26 of 38.	

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Q 224	<p>Continued From page 27 care.</p> <p>(iii) Document in a prominent part of the patient's current medical record, whether or not the individual has executed an advance directive.</p> <p>This STANDARD is not met as evidenced by: Based on medical record review, patient information review, and staff interview it was determined the ASC failed to ensure documentation was present in the medical records indicating whether an advance directive had or had not been executed. This failure impacted 22 of 22 patients (#1 - #22) whose records were reviewed, and had the potential to impact all patients receiving services from the ASC. As a result, patients missed the opportunity to execute advance directives, if desired, and/or have them honored. Findings include:</p> <p>On 9/24/12 at 3:00 PM the Office Manager provided surveyors with patient information provided to ASC patients. She stated the information was given to patients at the time of their consultation appointment, several days before their procedure. The packet included the following:</p> <ul style="list-style-type: none"> - Patient Rights and Responsibilities - Advance Directives and Life-Sustaining Treatment Choices <p>The packet of information provided to patients preoperatively did not contain Advance Directive forms, or facility policy related to honoring Advance Directives.</p> <p>The Office Manager returned at 4:00 PM with an</p>	Q 224	<p>All pt. to receive advance Directives + Pt Rights upon registration prior to time of surgery. Completed 10/30/12</p> <p>Per of RN will ask pt. of any living will or advance directives</p> <p>RN's office Manager to see that Advance Directive + Pt. Rights are included in registration packet. 10/30/12</p> <p>Advance directive info. will be documented in the EMR.</p>	
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11/7/12 RP

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Q 224	<p>Continued From page 28</p> <p>envelope containing a packet of papers. She stated the envelope was mailed to all Medicare patients. The papers included a statement of physician ownership, Patients Bill of Rights, and Living Will and Durable Power of Attorney for Health Care. A cover sheet stated "Compliance Information Required for Ambulatory Surgical Centers." The Office Manager was not able to explain why only Medicare patients would receive that information.</p> <p>Review of medical records for Patients #1 - #22 showed Advance Directives were not present and there was no indication whether Patients #1 - #22 had an existing Advance Directive, or had been informed of the ASC policy related to honoring Advance Directives.</p> <p>A policy, "ADVANCE DIRECTIVE IN THE ASC," issued 8/2012, stated "The advanced directive status shall be determined prior to the day of the scheduled admission of all adult patients being admitted to the Center for a procedure. This status shall be documented in the patients' chart [sic] in a prominent part of the record where it will be readily noticeable by an ASC staff providing care. Patients shall be advised and shall document in the record their awareness that an advance directive will not be honored during the course of the admission."</p> <p>The policy specified adult patients, and did not address all patients of the ASC.</p> <p>During an interview on 9/27/12 at 10:25 AM, the Perioperative Manager stated Advance Directives were included on the electronic medical record program that they shared with the adjoining</p>	Q 224	<p>Verification of record will be completed the following working day after surgery.</p> <p>PACU Supervisor to monitor on an ongoing basis.</p>	
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Q 224	Continued From page 29 hospital. She stated the screen that covered Advance Directives was part of the patient profile and her staff in the ASC did not utilize that screen as they would not recognize an Advance Directive and resuscitate all patients.	Q 224			
Q 225	The facility did not ensure documentation was present in the medical records indicating whether an advance directive had or had not been executed. 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 staff interview and policy review, it was determined the ASC failed to ensure their	Q 225			

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Q 225	<p>Continued From page 30</p> <p>grievance procedure was sufficiently developed for all patients receiving care at the facility. This had the potential to affect how thoroughly the ASC investigated and responded to patient complaints. Findings include:</p> <p>The ASC "Grievance Policy," dated 3/2004, was reviewed. The policy did not include timeframes for the review of grievances or the need for the ASC to provide the patient with a written response that included the following:</p> <ul style="list-style-type: none"> - Who to contact at the ASC. - The steps that were taken to investigate the grievance. - The results of the grievance process. - The date the grievance process was completed. <p>During an interview on 9/27/12 at 9:10 AM, the Administrator confirmed the grievance policy was missing the elements identified above. He stated the ASC had not received any patient grievances during 2012.</p> <p>During an interview on 9/25/12 at 8:45 AM, the Administrator reviewed a poster in the lobby waiting room of the ASC. The poster included patient rights information, with a phone number that he explained was the hospital patient advocacy department. The Administrator stated the hospital the ASC was affiliated with would review and process grievances. The Administrator stated he did not have a formal agreement or contract with the hospital for management of the ASC's grievance process.</p> <p>In an interview on 9/27/12 at 8:15 AM, the Executive Director of Quality and Risk</p>	Q 225	<p>Kos is using Kootenai Medical Centers Risk Management program to its full degree as 11/1/12.</p> <p>Staff addressed through meeting + e-mail communication. All current staff have completed R.M module through KMC.</p> <p>New staff orientation will include R.M module training.</p> <p>It will be the direct Supervisors responsibility to assure all new employees complete the R.M module during orientation.</p>	11/1/12
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NAME OF PROVIDER OR SUPPLIER KOOTENAI OUTPATIENT SURGERY CE	STREET ADDRESS, CITY, STATE, ZIP CODE 707 IRONWOOD DRIVE COEUR D'ALENE, ID 83814
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Q 225	<p>Continued From page 31</p> <p>Management stated the ASC and the hospital were a joint venture and there was an "informal agreement" that her department would manage the receipt and investigation of grievances. She stated the hospital used a "Risk Management" module software program and the ASC was not incorporated into that system. She stated the Risk Management department did not have a grievance log specific to the ASC.</p> <p>The ASC failed to ensure a grievance procedure that addressed timeframes for review and the necessity of a written response, containing all required elements.</p>	Q 225	<p>Grievance Log now housed in KMC RM module.</p> <p>refer to POC Q 225 Pg 31 of 38.</p>	11/1/12
Q 241	<p>416.51(a) SANITARY ENVIRONMENT</p> <p>The ASC must provide a functional and sanitary environment for the provision of surgical services by adhering to professionally acceptable standards of practice.</p> <p>This STANDARD is not met as evidenced by: Based on observations, review of national infection control practice standards, and staff interview, it was determined the ASC failed to ensure the facility systems related to infection control were sufficiently developed, implemented and monitored to ensure patient health and safety. These failures directly impacted 1 of 2 patients (#1) whose procedures were observed, and had the potential to impact all patients receiving care at the facility. This resulted in the inability of the facility to ensure the patients' risk of acquiring health care associated infections was minimized. Findings include:</p> <p>1. On 9/25/12 from 12:30 PM to 12:55 PM, the</p>	Q 241	<p>11/8/12 AP The Risk Management dept will be responsible for the investigation & response to a grievances once it has been logged.</p> <p>Management of Grievances will be monitored by the Kos Director through the RM Module.</p>	

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Q 241	<p>Continued From page 32</p> <p>CST was observed as she cleaned instruments in preparation for wrapping and sterilization. The room used to clean instruments contained two wall-length countertops, adjacent to one another. One countertop was used for equipment storage and held a large ultrasonic cleaner. On the other wall were two large sinks and between the sinks was a smaller ultrasonic cleaner. The CST was observed to remove a tray of instruments that had completed a cycle in the large ultrasonic machine, and place them into a nearby sink to be rinsed before being placed on a cart to dry. Once these instruments were out of the way, the CST was observed to manually wash the dirty instruments from a surgery that had just been completed in the sink closest to the entrance of the room. After rinsing the detergent from the instruments, the instruments were placed in a tray and the tray placed in the large ultrasonic machine. The CST explained that throughout the day the sink closest to the door was considered the "dirty" sink and the sink farther from the door was the "clean" sink. She stated that this set up minimized the potential for cross-contamination throughout the room. She explained that one drawback to this set up was that at the end of the day, the only location to empty the dirty contents of the ultrasonic machines was into the "clean" sink. She stated that once the ultrasonic machines had been emptied, then all surfaces in the room (countertops, sink, faucet, back-splashes behind the sinks) were wiped down with a Sani-cloth and then sprayed with a germicidal disinfectant.</p> <p>The Infection Control Officer was interviewed on 9/25/12 at 3:10 PM. She stated she was aware that the use of the "clean" sink to dispose of the</p>	Q 241		
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Q 241	<p>Continued From page 33</p> <p>dirty ultrasonic water was not the best option. She stated that this was an issue the facility staff had discussed at length and they felt they had devised a process to limit risk of cross-contamination. She stated that the needs and use of the room had changed since the time the facility was constructed. She explained that at this time several options regarding how to more permanently improve the functioning of the facility as a whole were under discussion, but it would take time to reach any decisions.</p> <p>The CDC guidelines for Environmental Infection Control in Healthcare Facilities, 2003, recommend using separate sinks for processing clean instruments and disposal of contaminated fluids.</p> <p>The ASC failed to ensure staff followed standards of practice and maintained a separate area for decontamination of instruments and processing of clean instruments. Without such areas to separate clean from dirty activities, the facility was unable to ensure transmission of infectious agents did not occur inadvertently.</p> <p>2. The facility's policy titled, "HANDWASHING," dated 3/2004, was reviewed. The policy indicated that gloves were not "substitutes" for handwashing and that hands were to be washed before and after gloving.</p> <p>Patient #1 was a 28 year old female admitted to the facility on 9/25/12 for urological surgery. Her surgery was observed from 2:00 PM to 2:40 PM. Hand hygiene was not performed in accordance with policy as follows:</p>	Q 241	<p>The clean sink farther from the door has been changed to the dirty sink, whereby both ultrasonics will drain.</p> <p>The sink closest to the door is now the clean sink.</p> <p>All regular staff have been inserviced.</p> <p>We have made available a new position and have advertised / and will be hiring a new employee whose main responsibility will be the cleaning of instruments.</p> <p>Staff meeting is scheduled for 11/6/12 to discuss new employee duties and to assure all on-call staff are inserviced on procedure change.</p> <p>O.R. Supervisor to monitor cleaning of instruments daily + Infection control RN to do periodic surveys of the processing of instruments.</p>	11/1/12 11/2/12

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Q 241	<p>Continued From page 34</p> <p>- At 2:06 PM, after intubation the CRNA was noted to remove her gloves and immediately connect the oxygen supply to the endotracheal tube. No hand hygiene was observed between glove removal and the next task.</p> <p>- At 2:09 PM, the Circulating RN was observed to complete the vaginal skin preparation, insert two suppositories, and remove his gloves. He was not observed to complete hand hygiene before moving to his next task of hooking up the solution used to irrigate the bladder during surgery and charting in the medical record.</p> <p>- At 2:29 PM, the Circulating RN was observed with gloves on. He was speaking on the telephone and removing the plastic cover from the X-ray machine used during surgery. He was observed to remove his gloves and deflate the cuff used on the irrigation bag and then don gloves again to put the operating table back together. He was not observed to perform hand hygiene after removing gloves and before moving to the next task.</p> <p>- At 2:31 PM, the CST completed clean up of the sterile field and removed her gloves. She donned new gloves and began to assist with repositioning the patient. She was not observed to complete hand hygiene between glove changes and moving to a new task.</p> <p>The Infection Control Officer was interviewed on 9/25/12 at 3:10 PM. She stated that within the last week she had completed an in-service with the OR staff regarding hand hygiene. She confirmed that hand hygiene was expected upon the removal of gloves prior to moving to the next</p>	Q 241	<p>1:1 with Director if non-compliant.</p>	

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Q 241	Continued From page 35 task.	Q 241		
Q 262	<p>The facility failed to ensure infection control policies were developed, implemented, and monitored to ensure patient health and safety.</p> <p>416.52(a)(2) PRE-SURGICAL ASSESSMENT</p> <p>Upon admission, each patient must have a pre-surgical assessment completed by a physician or other qualified practitioner in accordance with applicable State health and safety laws, standards of practice, and ASC policy that includes, at a minimum, an updated medical record entry documenting an examination for any changes in the patient's condition since completion of the most recently documented medical history and physical assessment, including documentation of any allergies to drugs and biologicals.</p> <p>This STANDARD is not met as evidenced by: Based on review of medical records and interview it was determined the facility failed to ensure patients received a pre-surgical assessment prior to procedures for 1 of 2 patients (#1) whose surgical procedures were observed. Failure to perform this pre-surgical assessment had the potential to impact patient safety during and after the procedure. Findings include:</p> <p>1. Patient #1 was a 28 year old female admitted to the facility 9/25/12 for a laser lithotripsy of a stone formation in her right ureter.</p> <p>A CRNA who was not wearing a stethoscope entered the pre-op room at 12:35 PM to speak with Patient #1. He identified himself to the</p>	Q 262	<p>Staff inservice to reinforce Policy on hand washing.</p> <p>Infection Control officer to perform observation surveys to monitor compliance.</p> <p>1:1 with director for employees found to be non-compliant.</p> <p>1:1 with Medical Director For Practitioners found to be non-compliant.</p> <p>Portable hand Antiseptic Pumps will be located at each Nurses station in the O.R.S for easy access.</p>	<p>11/16/12</p> <p>completed 10/24/12</p>

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Q 262	<p>Continued From page 36</p> <p>patient and stated he would not be providing her anesthesia but would be reviewing her chart, and discussed the plans for anesthesia. The CRNA left the area and was not observed to listen to Patient #1's heart and lungs.</p> <p>Review of Patient #1's "ANESTHESIA EVALUATION NOTE," timed 12:35 PM, documented her lungs were noted to have decreased breath sounds in the bases.</p> <p>A second CRNA came in to speak with Patient #1 at 1:00 PM. She identified herself as the Anesthetist who would be taking care of Patient #1 during the procedure. She asked Patient #1 if she had any questions, reviewed the information on the clipboard, and assessed her mouth for airway and mobility. The second CRNA was not observed to listen to the heart and lungs.</p> <p>At 1:05 PM, after the CRNA left the patient care area, she was questioned by the surveyor about a pre-surgical assessment. The CRNA stated she would not listen to a patient's heart and lungs if her partner had done it already. She stated the first CRNA had written out his assessment, so she took his word that he had completed it.</p> <p>The first CRNA was contacted by phone at 1:34 PM. He confirmed he did not listen to breath or heart sounds although he had documented he did, and stated it would be done by the Anesthetist upon patient arrival to the operating room once she was on the table.</p> <p>At 1:10 PM the physician performing the surgical procedure came in to the pre-operative area to speak with Patient #1. He reviewed plans for the</p>	Q 262		

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Q 262	<p>Continued From page 37 procedure with her, and left the patient cubicle without performing an assessment. There was no documentation in the pre-op record of an update for any changes in Patient #1's condition since the history and physical had been performed.</p> <p>The facility did not ensure physicians performed complete physical assessments prior to surgical procedures.</p>	Q 262	<p>This issue has been reviewed with anesthesia lead.</p> <p>Mandator meeting with anesthesia staff scheduled to review assessment policy + expectations.</p> <p>Issues related with pt.#1 have been directly addressed with CRNAs involved, by Director of KOS.</p> <p>Anesthesia will monitor compliance on an ongoing basis + review cases 1:1 as indicated.</p>	11/21/12
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