



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

CERTIFIED MAIL: 7007 3020 0001 4038 7501

September 30, 2011

Charlene Woodland, Administrator
Idaho Surgicenter North, LLC
3369 A Merlin Drive
Idaho Falls, ID 83404

RE: Idaho Surgicenter North, LLC, Provider #13C0001035

Dear Ms. Woodland:

Based on the survey completed at Idaho Surgicenter North, LLC, on September 29, 2011, by our staff, we have determined Idaho Surgicenter North, LLC is out of compliance with the Medicare ASC Condition for Coverage of **Quality Assessment & Performance Improvement (42 CFR 416.43)**. 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 deficiency, which caused this condition to be unmet, substantially limit the capacity of Idaho Surgicenter North, LLC, to furnish services of an adequate level or quality. The deficiency is described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567).

You have an opportunity to make corrections of this deficiency, which led to the finding of non-compliance with the Condition for Coverage referenced above by submitting a written Credible Allegation of Compliance/Plan of Correction.

An acceptable Plan of Correction contains the following elements:

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

Charlene Woodland, Administrator
September 30, 2011
Page 2 of 2

- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the PoC is effective in bringing the ASC into compliance, and that the ASC remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
- The administrator's signature and the date signed on page 1 of each form.

Such corrections must be achieved and compliance verified by this office, before November 13, 2011. 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 November 3, 2011.

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **October 12, 2011.**

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,



AIMEE HASTRITER
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

AH/srm

Enclosures

cc: Debra Ransom, R.N., R.H.I.T., Bureau Chief
Kate Mitchell, CMS Region X Office

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

PRINTED: 09/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001035	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/29/2011
--	--	--	--

NAME OF PROVIDER OR SUPPLIER IDAHO SURGICENTER NORTH, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 3369 A MERLIN DRIVE IDAHO FALLS, ID 83404
--	---

(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	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the recertification survey of your Ambulatory Surgical Center. The surveyors conducting the review were:</p> <p>Aimee Hastriter RN, BS, HFS, Team Lead Karen Robertson RN, BS, HFS Mark Grimes, Supervisor of Facility Fire Safety and Construction Program</p> <p>The following acronyms were used in this report:</p> <p>ASC - Ambulatory Surgical Center CDC - Center for Disease Control CRNA - Certified Registered Nurse Anesthetist DEA - Drug Enforcement Administration H&P - History and Physical IV - Intravenous PALS - Pediatric Advanced Life Support QAPI - Quality Assessment/Performance Improvement QI - Quality Improvement RN - Registered Nurse</p>	Q 000		
Q 041	<p>416.41(a) CONTRACT SERVICES</p> <p>When services are provided through a contract with an outside resource, the ASC must assure that these services are provided in a safe and effective manner.</p> <p>This STANDARD is not met as evidenced by: Based on contract review, personnel record review, and staff interview, it was determined the ASC failed to ensure oversight for 3 of 3 contract services reviewed. Failure to ensure oversight of contract services resulted in a lack of appropriate</p>	Q 041		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Admin.	(X6) DATE 10-7-2011
--	-----------------	------------------------

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

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

PRINTED: 09/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001035	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/29/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER IDAHO SURGICENTER NORTH, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 3369 A MERLIN DRIVE IDAHO FALLS, ID 83404
---	---

(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 041	<p>Continued From page 1</p> <p>contract development, incomplete personnel files, and no specified method of monitoring services provided to the ASC. Findings include:</p> <p>1. The ASC failed to ensure oversight of anesthesia services as follows:</p> <p>a. A letter from a group of CRNAs contracted with the ASC was addressed to the ASC's "Governing Board" and served as the contract. The contract was not dated. The contract was not signed by the Governing Body. The contract did not address the delineation of services and expectations between the CRNAs and the ASC's Governing Body or how the ASC monitored anesthesia services.</p> <p>The Practice Administrator, who was a member of the Governing Body, was interviewed on 9/22/11 from 4:00 PM to 5:25 PM. She stated a letter of agreement for the provision of services was accepted by the ASC as a contract. She agreed a contract should be signed by both parties and contain the expectations of both parties entering into the contract.</p> <p>The contract for provision of anesthesia services did not include components related to the responsibilities of each entity, including the ASC's oversight of the contracted service.</p> <p>b. Personnel contracts were reviewed for the four CRNAs who provided services at the ASC. Their personnel files were incomplete as follows:</p> <p>i. Four of 4 CRNAs (A, B, C, D) did not have current CRNA licenses filed in the personnel records.</p>	Q 041		
-------	--	-------	--	--

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

PRINTED: 09/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001035	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/29/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER IDAHO SURGICENTER NORTH, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 3369 A MERLIN DRIVE IDAHO FALLS, ID 83404
---	---

(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 041	<p>Continued From page 2</p> <p>ii. Two of 4 CRNAs (A and B) did not have DEA licenses on file.</p> <p>iii. One of 4 CRNAs (C) did not have PALS certifications on file.</p> <p>iv. One of 2 CRNAs (A) due for reappointment for privileges and credentialing in 2011 were overdue. CRNA A was last reappointed in March of 2009.</p> <p>The personnel files for CRNAs A, B, C, and D were reviewed with the Practice Administrator on 9/21/11 from 1:30 PM to 2:15 PM. She confirmed the personnel files were missing the licenses and certifications and the reappointment of CRNA A was overdue.</p> <p>On 9/21/11 at 2:30 PM, the Practice Administrator provided documentation of current CRNA licenses for CRNAs A, B, C, and D. She stated she was unaware of which documents were the CRNA licensure verification and had put the wrong documents in the personnel records. She stated she had found the licensure verification on-line without difficulty once she knew where to look. The Practice Administrator further stated that she was not sure if each CRNA had a current DEA license and PALS certification. She stated the Director of the CRNA group faxed over the current CRNAs' licenses and certifications and she thought the documentation was complete.</p> <p>The Practice Administrator was interviewed on 9/21/11 at 4:00 PM. She stated reappointment for CRNAs followed the ASC's medical staff bylaw timelines, which indicated reappointment at</p>	Q 041		

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

PRINTED: 09/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001035	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/29/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER IDAHO SURGICENTER NORTH, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 3369 A MERLIN DRIVE IDAHO FALLS, ID 83404
---	---

(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 041	<p>Continued From page 3</p> <p>24 month intervals. She stated CRNA A was overdue for reappointment. She also stated she was unaware CRNAs needed a DEA license to provide anesthesia services independently, as was the practice in the ASC.</p> <p>On 9/23/11 at 9:15 AM, CRNA A was interviewed. He stated that all four of the CRNAs providing services at the ASC had current DEA licenses and PALS certifications. He stated the medical staff coordinator of the hospital where the group also provided anesthesia services kept their information current.</p> <p>The ASC did not ensure personnel records for contract staff was current or complete.</p> <p>2. A letter from a pathology lab contracted with the ASC was addressed to the ASC's physician and dated 10/14/10 and served as a contract for the provision of services. The contract was not signed by the Governing Body. The contract did not address the delineation of services or monitoring between the pathology lab and the ASC's Governing Body.</p> <p>The Practice Administrator, who was a member of the Governing Body, was interviewed on 9/22/11 from 4:00 PM to 5:25 PM. She stated the letter from the pathology lab was considered a contract by the ASC. She agreed the letter did not show delineation of services or monitoring, nor was the letter signed by both parties entering into the contract.</p> <p>The contract for pathology services did not include components related to the responsibilities of each entity, including the ASC's oversight of</p>	Q 041		
-------	---	-------	--	--

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

PRINTED: 09/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001035	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/29/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER IDAHO SURGICENTER NORTH, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 3369 A MERLIN DRIVE IDAHO FALLS, ID 83404
---	---

(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 041	<p>Continued From page 4 the contracted service.</p> <p>3. A "SERVICE AGREEMENT" was completed between a medical waste disposal company and the ASC's Office Manager in June of 2010. The contract was signed by the ASC's Office Manager, but was not signed by a representative of the medical waste disposal company. The contract did not address the delineation of services between the medical waste disposal company and the ASC. The contract did not address how the Governing Body would provide oversight to the medical waste disposal company.</p> <p>During an interview on 9/22/11 at 4:15 PM, the Practice Administrator confirmed the contract with the medical waste disposal company was not signed by both parties entering into the contract and the contract did not include information related to ASC oversight of services provided.</p> <p>The contract for medical waste disposal services did not include components related to the responsibilities of each entity, including the ASC's oversight of the contracted service.</p> <p>The ASC did not ensure oversight for all contract services nor ensure the delineation of services was evident in the contracts.</p>	Q 041		
Q 080	<p>416.43 QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT</p> <p>The ASC must develop, implement and maintain an on-going, data-driven quality assessment and performance improvement (QAPI) program.</p>	Q 080		

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

PRINTED: 09/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001035	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/29/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER IDAHO SURGICENTER NORTH, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 3369 A MERLIN DRIVE IDAHO FALLS, ID 83404
---	---

(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 080	<p>Continued From page 5</p> <p>This CONDITION is not met as evidenced by: Based on staff interview and review of ASC policies, QAPI documents, and Governing Board meeting minutes, it was determined the facility failed to ensure a data driven QAPI program had been developed, implemented, and monitored. This resulted in the inability of the ASC to evaluate its processes and practices. Findings include:</p> <ol style="list-style-type: none"> 1. Refer to Q81 as it relates to the failure of the ASC to ensure the scope of the QAPI program provided sufficient direction to staff to demonstrate measurable improvement in patient health outcomes. 2. Refer to Q82 as it relates to the failure of the ASC to ensure data was used to monitor the effectiveness and safety of its services. 3. Refer to Q83 as it relates to the failure of the ASC to conduct performance improvement projects. <p>The cumulative effect of these negative facility practices prevented the ASC from utilizing information to improve its processes.</p>	Q 080		011 /E1) 391
Q 081	<p>416.43(a), 416.43(c)(1) PROGRAM SCOPE; PROGRAM ACTIVITIES</p> <p>(a)(1) The program must include, but not be limited to, an ongoing program that demonstrates measurable improvement in patient health outcomes, and improves patient safety by using quality indicators or performance measures associated with improved health outcomes and by the identification and reduction of medical errors.</p>	Q 081		011 /E1) 391

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

PRINTED: 09/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001035	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/29/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER IDAHO SURGICENTER NORTH, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 3369 A MERLIN DRIVE IDAHO FALLS, ID 83404
---	---

(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 081	<p>Continued From page 6</p> <p>(a)(2) The ASC must measure, analyze, and track quality indicators, adverse patient events, infection control and other aspects of performance that includes care and services furnished in the ASC.</p> <p>(c)(1) The ASC must set priorities for its performance improvement activities that -</p> <ul style="list-style-type: none"> (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. <p>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 demonstrate measurable improvement in patient health outcomes by using quality indicators and by the identification and reduction of medical errors. This resulted in performance measures that were insufficient to measure the quality of care provided to patients which had the potential to impact all patients receiving services at the ASC. Findings include:</p> <p>1. The "QUALITY IMPROVEMENT MANUAL," dated 6/29/11 was reviewed. A "GENERAL POLICY STATEMENT" indicated the QI committee conducted a "comprehensive program of oversight in order to ensure that patient care is provided at the highest level in the safest</p>	Q 081		09/29/2011

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

PRINTED: 09/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001035	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/29/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER IDAHO SURGICENTER NORTH, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 3369 A MERLIN DRIVE IDAHO FALLS, ID 83404
---	---

(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 081	<p>Continued From page 7</p> <p>environment possible." However, the manual did not include a comprehensive plan with specific activities and quality indicators to be measured. The manual did not contain enough information to constitute a complete QAPI plan and did not specify that the ASC would develop a complete QAPI plan or when the plan would be reviewed or revised.</p> <p>On 9/21/11 at 1:15 PM, the Practice Administrator provided documentation related to the ASC's QI program. She presented a binder which contained policies and procedures and another binder containing QI meeting minutes and data collection and performance improvement activities. She stated she and the Office Manager shared responsibility for the Quality Assessment program and data collection.</p> <p>The information provided by the Practice Administrator was reviewed. A Quality Assurance Summary for the year 2010 indicated seven quality indicators were monitored. These included individual complaints based on patient satisfaction surveys, abnormal physical/lab findings/blood pressures, infections, cardiac/respiratory arrest, transfers to a hospital, mortalities, and "other." The usefulness of measuring these quality indicators was not clear. No incidents related to the indicators had been recorded.</p> <p>The Quality Assurance Summary for the year 2011 was reviewed. The same seven quality indicators were monitored. The only incident recorded related to any of the indicators was the documentation of one patient complaint in May of 2011.</p>	Q 081		

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

PRINTED: 09/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001035	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/29/2011
NAME OF PROVIDER OR SUPPLIER IDAHO SURGICENTER NORTH, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3369 A MERLIN DRIVE IDAHO FALLS, ID 83404	
(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 081	Continued From page 8 The Practice Manager was interviewed on 9/21/11 at 4:45 PM. She confirmed the quality indicators routinely monitored included those related to patient complaints, infections, and complications (specifically the seven indicators mentioned above). In addition, she stated data was maintained in logs related to quality control checks on equipment, but the information was not specifically analyzed for performance improvement. She agreed that quality indicators monitored did not adequately represent facility practices in a way that allowed for measurable improvements to be implemented and monitored. The facility did not ensure quality indicator data, specific to facility practices, was collected. The ASC did not develop policies and systems which provided sufficient direction to staff regarding the development, implementation and monitoring of an applicable, comprehensive QAPI program.	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	Q 082		

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

PRINTED: 09/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001035	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/29/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER IDAHO SURGICENTER NORTH, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 3369 A MERLIN DRIVE IDAHO FALLS, ID 83404
---	---

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

Q 082	<p>Continued From page 9</p> <p>track adverse patient events, examine their causes, implement improvements, and ensure that improvements are sustained over time.</p> <p>(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.</p> <p>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 QAPI program incorporated quality indicator data to monitor the effectiveness and safety of its services and to identify opportunities to improve patient care. This resulted in the ASC's inability to measure the quality of care it provided for all patients receiving care in the facility. Findings include:</p> <p>1. The "QUALITY IMPROVEMENT MANUAL," dated 6/29/11, was reviewed. The manual did not include which quality indicators would be measured or how the data was to be collected and analyzed.</p> <p>The Practice Manager was interviewed on 9/21/11 at 4:45 PM. She confirmed the data routinely monitored included those related to individual complaints based on patient satisfaction surveys, abnormal physical/lab findings/blood pressures, infections, cardiac/respiratory arrest, transfers to a hospital, and mortalities. In addition, she stated data was maintained in logs related to quality control checks on equipment, but the information was not specifically analyzed for performance</p>	Q 082		011 350 2011
-------	---	-------	--	--------------------

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

PRINTED: 09/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001035	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/29/2011	
NAME OF PROVIDER OR SUPPLIER IDAHO SURGICENTER NORTH, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3369 A MERLIN DRIVE IDAHO FALLS, ID 83404		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 082	<p>Continued From page 10</p> <p>improvement. She agreed that data collected was not analyzed in a way to identify opportunities that could lead to improvements in patient care.</p> <p>2. The "QUALITY IMPROVEMENT MANUAL," dated 6/29/11, contained a section titled, "SUMMARY OF QI PROGRAM." Documentation in this section indicated that QI meetings would be held quarterly and agenda topics would include patient concerns (infection control, patient survey reports, patient transfers, safety, patient incident reports-QA forms, tissue reports, scheduling concerns, patient education, and special studies), anesthesia concerns, equipment issues, QI charts and totals, etc.</p> <p>QI meeting minutes were reviewed for 3/18/11. The minutes contained documentation that one patient complaint had been discussed. The meeting minutes for 7/08/11 included documentation that two patient complaints had been discussed. However, the "Quality Assurance Summary" for 2011 showed only one complaint, which was registered in May of 2011. The data collected did not match what was discussed in meeting minutes.</p> <p>The Practice Administrator was interviewed on 9/28/11 at 10:15 AM. She reviewed the documentation and confirmed that the patient complaints discussed in the meeting minutes should have been tracked in the summary report.</p> <p>3. Performance activity documentation was reviewed. Two studies had been conducted in 2010 and 2011. One study related to appropriate site marking prior to surgery and the second was related to incomplete records. No data was</p>	Q 082		

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

PRINTED: 09/30/2011
FORM APPROVED:
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001035	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/29/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER IDAHO SURGICENTER NORTH, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 3369 A MERLIN DRIVE IDAHO FALLS, ID 83404
---	---

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

Q 082	<p>Continued From page 11</p> <p>present related to the site marking study, either prior to beginning the study in 2010 or after changes had been made to the process. There was documentation presented to the QI committee on 3/18/11 to indicate the ASC continued the study in 2011, however no data had been collected.</p> <p>Data was present to support the initiation of the incomplete records study in 2009. A summary of the study was presented to the QI committee on 2/26/10. The summary indicated changes made in processes based on the data collected and the study was to be continued. Data was again collected and analyzed for 2010. A summary of the study was presented to the QI committee on 3/18/11 and indicated no additional changes were made to improve the process. However, because the ASC's target goal had not been reached the study continued in 2011. No data had been collected for 2011.</p> <p>The Practice Administrator was interviewed on 9/21/11 at 4:45 PM. She explained the site marking study began after the physician recommended evaluating the ASC's current practice to determine if improvements needed to be implemented. She stated the ASC did not collect data prior to the study. She stated changes in their process for site marking were implemented in 2011. She confirmed no data was collected to ensure the changes were effective.</p> <p>The Office Manager was interviewed on 9/21/11 at 4:45 PM. She confirmed that no data had been collected regarding the incomplete record study for 2011. She stated she continued to</p>	Q 082		
-------	--	-------	--	--

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

PRINTED: 09/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001035	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/29/2011
--	--	--	--

NAME OF PROVIDER OR SUPPLIER IDAHO SURGICENTER NORTH, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 3369 A MERLIN DRIVE IDAHO FALLS, ID 83404
--	---

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

Q 082	Continued From page 12 review each record at the end of the surgery day in order to obtain necessary information and signatures to complete the record. She confirmed no data was collected for tracking purposes.	Q 082		
Q 083	<p>Quality indicator data was not used to monitor the effectiveness and safety of ASC services or to identify opportunities to improve patient care.</p> <p>416.43(d) PERFORMANCE IMPROVEMENT PROJECTS</p> <p>(1) The number and scope of distinct improvement projects conducted annually must reflect the scope and complexity of the ASC's services and operations.</p> <p>(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</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of QAPI documents and meeting minutes, it was determined the ASC failed to thoroughly document 2 of 2 performance improvement projects that were conducted, including the reason for implementing the project and a description of the project's results. This resulted in the ASC's inability to derive meaningful data from the studies and had the potential to impact all patients receiving services at the ASC. Findings include:</p> <p>1. During an interview on 9/21/11 at 4:45 PM, the</p>	Q 083		

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

PRINTED: 09/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001035	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/29/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER IDAHO SURGICENTER NORTH, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 3369 A MERLIN DRIVE IDAHO FALLS, ID 83404
---	---

(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 083	<p>Continued From page 13</p> <p>Practice Administrator confirmed that in 2011 two performance improvement projects were conducted. She stated both projects had been ongoing since at least 2010. She stated one study was related to site marking prior to performing surgery and a second study was related to completeness of patient medical records.</p> <p>QAPI documentation was reviewed for the two projects discussed. The documentation lacked either a reason for the study and/or data to support the results of the project and provide evidence that changes made were effective as follows:</p> <p>a. The document "Site Marked Study," undated, indicated data was collected from February 2010 to February 2011 to determine what reminders the ASC would use to "more accurately mark the surgical site on each patient." However, no data was present in QI documentation. This summary was presented to the QI committee on 3/18/11. It was decided the process for marking surgery sites would be altered to include at least two methods to mark the site.</p> <p>There was no documented reason for implementing the "Site Marked Study" in QAPI documentation. There was no documentation of data being used to track the study. Changes were implemented, but no data was gathered or documented to show how effective the changes were. No follow up was done to see if the new site marking practice was effective.</p> <p>The Practice Administrator was interviewed on 9/21/11 at 4:45 PM. She explained the site</p>	Q 083		
-------	--	-------	--	--

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

PRINTED: 09/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001035	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/29/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER IDAHO SURGICENTER NORTH, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 3369 A MERLIN DRIVE IDAHO FALLS, ID 83404
---	---

(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 083	<p>Continued From page 14</p> <p>marking study began after the physician recommended evaluating the ASC's current practice to determine if improvements needed to be implemented. She stated the ASC did not collect data prior to the study. She stated changes in their process for site marking were implemented in 2011. She confirmed no data was collected to ensure the changes were effective.</p> <p>The ASC did not document why the study was implemented or document the data used to track the study.</p> <p>b. QI documentation included a summary report titled "QI STUDY: INCOMPLETE RECORDS," dated 2/17/10. The document indicated data was collected from 2/01/09 through 2/01/10 to determine the ASC's completeness of patient records. The report indicated the ASC's goal was to have 98% of records completed. The report included the quality indicators measured and the data related to the medical records reviewed. The data was tracked and then analyzed. It was determined the completion rate for the time frame above was 65%. The report was presented to the QI committee on 2/26/10. It was determined that because the goal of completion was not met, the study would continue and data would be re-measured over the following 12 months.</p> <p>Another summary report titled, "QI Study: Incomplete Records," dated 3/2011, was present in the QI documentation. The report indicated data was collected from 2/01/10 to 2/01/11 to determine the ASC's completeness of patient records. The goal remained the same: 98% completion rate. The report contained a list of</p>	Q 083		
-------	--	-------	--	--

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

PRINTED: 09/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001035	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/29/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER IDAHO SURGICENTER NORTH, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 3369 A MERLIN DRIVE IDAHO FALLS, ID 83404
---	---

(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 083	<p>Continued From page 15</p> <p>quality indicators measured and the data collected. This data was also tracked and analyzed. It was determined the completion rate for the time frame was 75.5%. The report indicated the study would "continue on a yearly basis to see if our corrected measures are showing improvement over the next 12 months." However, the report did not include additional process changes to assist in continued improvement in completeness of medical records. The report was not mentioned in the QI meeting minutes for 3/18/11.</p> <p>The Office Manager was interviewed on 9/21/11 at 4:45 PM. She confirmed that no data had been collected regarding the incomplete record study for 2011. She stated she continued to review each record at the end of the surgery day in order to obtain necessary information and signatures to complete the record. She confirmed no data was collected for tracking purposes.</p> <p>Performance improvement documentation did not include the reason for implementing the projects and/or a description of the projects' results and data was not collected to ensure implemented changes were effective.</p>	Q 083		
Q 122	<p>416.45(b) REAPPRAISALS</p> <p>Medical staff privileges must be periodically reappraised by the ASC. The scope of procedures performed in the ASC must be periodically reviewed and amended as appropriate.</p> <p>This STANDARD is not met as evidenced by:</p>	Q 122		

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

PRINTED: 09/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001035	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/29/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER IDAHO SURGICENTER NORTH, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 3369 A MERLIN DRIVE IDAHO FALLS, ID 83404
---	---

(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 122	<p>Continued From page 16</p> <p>Based on personnel record review, review of medical staff bylaws, and staff interview it was determined the facility failed to ensure the reappraisal of privileges for 1 of 1 physician practicing at the ASC was completed in accordance with the bylaws. This resulted in the lack of an evaluation for current credentials and failure to ensure medical staff privileges were appropriate for the facility. Findings include:</p> <p>"MEDICAL STAFF BYLAWS," dated 1/30/10, indicated reappraisal was to occur every two years. The reappraisal process at two-year intervals followed the same guidelines as the original application process, including verification of qualifications and licenses, and review and delineation of privileges.</p> <p>In a review of the physician's personnel record on 9/21/11, it was found the physician was last reappraised for credentialing and privileges on 4/10/09. The physician was overdue for reappraisal by more than five months.</p> <p>On 9/21/11 at 4:00 PM, the Practice Administrator was interviewed. She stated she agreed the ASC physician was overdue for reappraisal per medical staff bylaws.</p>	Q 122		
Q 141	<p>416.46(a) ORGANIZATION AND STAFFING</p> <p>Patient care responsibilities must be delineated for all nursing service personnel. Nursing services must be provided in accordance with recognized standards of practice. There must be a registered nurse available for emergency</p>	Q 141		

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

PRINTED: 09/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001035	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/29/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER IDAHO SURGICENTER NORTH, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 3369 A MERLIN DRIVE IDAHO FALLS, ID 83404
---	---

(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 141	<p>Continued From page 17 treatment whenever there is a patient in the ASC.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the ASC failed to ensure an RN was available for emergency treatment when a patient was in the ASC. This directly impacted 2 of 2 patients (#3 and #5) whose procedures were performed on days other than the ASC's established procedure day. This had the potential to negatively impact the care and safety of patients treated in the ASC. Findings include:</p> <p>During an interview on 9/19/11 at 2:30 PM, the Office Manger stated surgeries were normally performed in the ASC every other Friday when the physician, a CRNA, the Practice Administrator, and an RN were present.</p> <p>However, procedures were performed in the ASC without having an RN present as follows:</p> <ol style="list-style-type: none"> 1. Patient #3 was a 65 year old female admitted to the ASC on 9/13/11 for the removal of hardware following her hammertoe surgery on 8/12/11. The hardware removal procedure was done on a Tuesday rather than on a Friday when ASC staff, including an RN, were available. No RN was present in the ASC for Patient #3's hardware removal. 2. Patient #5 was a 67 year old female admitted to the ASC on 6/28/11 for the removal of hardware following her hammertoe surgery on 5/27/11. The hardware removal procedure was done on a Tuesday rather than on a Friday when ASC staff, including an RN, were available. No 	Q 141		
-------	--	-------	--	--

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

PRINTED: 09/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001035	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/29/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER IDAHO SURGICENTER NORTH, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 3369 A MERLIN DRIVE IDAHO FALLS, ID 83404
---	---

(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 141	Continued From page 18 RN was present in the ASC for Patient #5's hardware removal. The Office Manager was interviewed on 9/28/11 at 2:10 PM. She stated the physician operated a foot clinic associated with the ASC. She confirmed the clinic did not have an RN on staff and an RN was only present on a surgery day when the "whole surgery team" was present. She stated on occasion the physician opted to perform surgeries which required no anesthesia services in the ASC with only herself and the physician present. She stated under these circumstances the patients were treated as ASC patients. She reviewed Patient #3's and Patient #5's records and confirmed the lack of an RN available for emergencies during their procedures at the ASC.	Q 141		
Q 242	416.51(b) INFECTION CONTROL PROGRAM The ASC must maintain an ongoing program designed to prevent, control, and investigate infections and communicable diseases. In addition, the infection control and prevent program must include documentation that the ASC has considered, selected, and implemented nationally recognized infection control guidelines. This STANDARD is not met as evidenced by: Based on observation, interview, and review of facility policies it was determined the facility failed to ensure the infection control program mitigated risks of healthcare-associated infections by following guidelines selected by the ASC. This	Q 242		

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

PRINTED: 09/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001035	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/29/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER IDAHO SURGICENTER NORTH, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 3369 A MERLIN DRIVE IDAHO FALLS, ID 83404
---	---

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

Q 242	<p>Continued From page 19</p> <p>impacted 1 of 1 patient (#10) whose surgery was observed and had the potential to impact all patients who received care at the facility. Failure to fully implement infection control guidelines had the potential to compromise safety and increase infection risk for patients. Findings include:</p> <p>The Infection Control Chairperson was interviewed on 9/26/11 at 2:30 PM. She stated the ASC elected to reference the CDC for guidelines related to infection control for hand hygiene, disinfection and sterilization, and environmental infection control.</p> <p>The ASC failed to implement CDC guidelines related to infection control as follows:</p> <p>1. The process for cleaning and sterilization of critical equipment was observed on 9/23/11 from 7:37 AM through 9:00 AM. The room used to decontaminate, package, and sterilize equipment was observed to be less than 50 square feet in area. One wall of the room contained the door. The wall directly across from the door contained the sink. The wall to the right of the sink contained a mounted shelf. The sink was surrounded by the countertop, which provided a surface to the left of the sink and was a continuous surface along the fourth wall of the room. Two autoclaves were located on the counter against the fourth wall. When the door to the room was opened, it was noted to impede access to one of the autoclaves.</p> <p>The Practice Administrator, who was also the scrub technician for the ASC, was interviewed during the observation on 9/23/11 from 7:37 AM through 9:00 AM. She described the flow of</p>	Q 242		011 VEE 391
-------	--	-------	--	-------------------

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

PRINTED: 09/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001035	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/29/2011
NAME OF PROVIDER OR SUPPLIER IDAHO SURGICENTER NORTH, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3369 A MERLIN DRIVE IDAHO FALLS, ID 83404		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 242	<p>Continued From page 20</p> <p>equipment through the room used for decontaminating, packaging, and sterilizing equipment. The Practice Administrator explained that two loads of equipment, including implantable devices, were processed in the autoclaves with the appropriate biological and chemical indicators. She stated these loads were run prior to the first case in the morning, which was scheduled to start at 8:00 AM. However the items in the loads were not to be used until the third case of the day, which was scheduled to start at 11:30 AM. The doors to both autoclaves were noted to be slightly ajar.</p> <p>At 8:55 AM, the Practice Administrator transferred the dirty supplies used during the surgery to a basin which had been placed in the sink. The basin contained hot water and antibacterial soap. She was observed to physically scrub the instruments to ensure all debris was removed. A second basin, containing only hot water, was placed beside the wash basin. The instruments were rinsed in this basin and then placed on a plastic tray to drain and dry. The plastic tray was located just to the left of the sink. The Practice Administrator explained that once the items had dried, a few of the items would be placed in an open tray to be sterilized immediately prior to the third case. She stated items not required for a later case on 9/23/11 would be wrapped and placed in a container on the counter (in the corner farthest away from the sink) for sterilization at the end of the day.</p> <p>On 9/23/11 at 7:37 AM, the Practice Administrator explained the procedure for transporting unwrapped, sterilized items from the autoclave to the sterile surgical table for use. She stated the</p>	Q 242		

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

PRINTED: 09/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001035	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/29/2011	
NAME OF PROVIDER OR SUPPLIER IDAHO SURGICENTER NORTH, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3369 A MERLIN DRIVE IDAHO FALLS, ID 83404		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 242	<p>Continued From page 21</p> <p>circulating RN ensured the autoclave doors were open wide enough to remove the trays. The Practice Administrator stated while wearing a sterile gown, gloves, and mask, she left her sterile field, entered the small room and removed the trays from the autoclave. She stated she then maneuvered back to the sterile surgical table to deposit the instruments.</p> <p>The CDC "Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008," describe the ideal central processing area. "The central processing area ideally should be divided into at least three areas: decontamination, packaging, and sterilization and storage. Physical barriers should separate the decontamination area from the other sections to contain contamination on used items....The recommended airflow pattern should contain contaminants within the decontamination area and minimize the flow of contaminants to the clean areas..." During the observation, dirty equipment was noted to be processed in close proximity to the packaging and sterilizing sections of the room, with the doors of the autoclaves ajar. This did not allow the facility to ensure cross-contamination did not occur.</p> <p>The CDC "Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008" stated, "When sterile items are open to air, they will eventually become contaminated. Thus, the longer a sterile item is exposed to air, the greater number of microorganisms that will settle on it." The autoclave doors were noted to be ajar for an extended period of time (on 9/23/11 from 7:37 AM through 9:00 AM when the observation ended). The items inside were unwrapped and in</p>	Q 242		

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

PRINTED: 09/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001035	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/29/2011	
NAME OF PROVIDER OR SUPPLIER IDAHO SURGICENTER NORTH, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3369 A MERLIN DRIVE IDAHO FALLS, ID 83404		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 242	<p>Continued From page 22</p> <p>open trays. In addition to being exposed to air during this time frame, the sterile items risked further exposure upon transport from the autoclave to the sterile table.</p> <p>In addition, the ASC's "INFECTION CONTROL MANUAL," dated 6/29/11, indicated the process for transferring sterile items from the autoclave to the sterile surgical field. According to the manual, "All autoclaved items will be transferred by or to [sic] scrub assistant in such a manner that maintains sterile technique." The procedures were described for three scenarios, transfer of a perforated container with a lid, perforated canister with perforation lock, and the transfer of heavy instrument trays. The procedures for each of these involve the autoclaved items being transported (maintaining sterility) to the scrub tech. The manual did not contain a procedure for the scrub tech leaving the sterile field.</p> <p>CDC guidelines and facility policies were not followed to ensure sterility of items used during surgery.</p> <p>2. Patient #10 was a 77 year old female admitted to the ASC on 9/23/11 for removal of a lipoma (fatty tumor) on her right foot. Her surgery was observed on 9/23/11 from 7:40 AM to 9:30 AM. During this time frame the following breaches in infection control related to hand hygiene were observed:</p> <p>a. At 8:17 AM, CRNA A was observed to place the back of his ungloved hand under Patient #10's nose and then to place the same hand on top of Patient #10's head. He was not observed to perform hand hygiene prior to administering</p>	Q 242		09/29/2011

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

PRINTED: 09/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001035	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/29/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER IDAHO SURGICENTER NORTH, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 3369 A MERLIN DRIVE IDAHO FALLS, ID 83404
---	---

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

Q 242	<p>Continued From page 23 medications or handling other equipment.</p> <p>b. At 8:24 AM, the RN removed the sterile gloves she used to prepare Patient #10's foot for surgery. She was not observed to perform hand hygiene after removing the gloves and before assisting the physician to don a sterile gown.</p> <p>c. At 8:25 AM, the RN was observed to pick up a package of gauze from the floor. She was observed to replace the gauze on its shelf and then continue to perform circulating duties. She was not observed to perform hand hygiene.</p> <p>d. At 8:26 AM, CRNA A was observed to set up a music player using a personal music device. Immediately after completing this task he administered a medication to Patient #10. He was not observed to perform hand hygiene between these two tasks. The CRNA was then observed to pick up a piece of equipment that had fallen to the floor. He was not observed performing hand hygiene prior to continuing with anesthesia administration and monitoring duties.</p> <p>e. At 8:48 AM, the RN was observed to reposition the garbage can used to discard items from the sterile field. She was not observed to perform hand hygiene following this and prior to continuing with circulating tasks.</p> <p>f. At 8:55 AM, Patient #10's physician was observed to remove sterile gown and gloves. The physician was not observed to perform hand hygiene after removing the personal protective equipment used during surgery. The physician was then observed to put on clean gloves to assist in the final stages of Patient #10's care.</p>	Q 242		
-------	--	-------	--	--

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

PRINTED: 09/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001035	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/29/2011	
NAME OF PROVIDER OR SUPPLIER IDAHO SURGICENTER NORTH, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3369 A MERLIN DRIVE IDAHO FALLS, ID 83404		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 242	<p>Continued From page 24</p> <p>The physician then removed the clean gloves, but no hand hygiene was observed after removal.</p> <p>The RN was interviewed at 9:00 AM on 9/23/11. She stated she generally washes her hands after an IV line start. At other times she will use hand rub after removing gloves, before starting an IV line, and before preparing medication. She confirmed she does not always perform hand hygiene between glove changes during surgery and probably should.</p> <p>In an interview on 9/23/11 at 9:38 AM, CRNA A stated he "typically" washed his hands before seeing the patient, after seeing the patient, and after surgery. He further stated he "typically" used hand gel sanitizer for hand hygiene.</p> <p>The facility's "Hand Washing Technique" policy, dated 6/29/11, indicated all employees were to wash their hands regularly with antimicrobial soap. According to the policy, hands were to be washed in circumstances including before and after touching body fluids, before and after handling medications, before gloving, after removing gloves, after hands touched a contaminated surface, and before touching a patient.</p> <p>According to the CDC "Guideline for Hand Hygiene in Health-Care Settings," from 10/25/02, hands should be washed when they are "visibly soiled." If hands are not visibly soiled then either hand washing or an alcohol-based hand rub should be used in circumstances including before direct contact with patients, after contact with a patient's intact skin, after contact with inanimate objects in the immediate vicinity of the patient,</p>	Q 242		

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

PRINTED: 09/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001035	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/29/2011	
NAME OF PROVIDER OR SUPPLIER IDAHO SURGICENTER NORTH, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3369 A MERLIN DRIVE IDAHO FALLS, ID 83404		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 242	Continued From page 25 and after removing gloves. The Practice Administrator was interviewed on 9/28/11 at 10:00 AM. She confirmed the facility did not have a policy related to the use of alcohol-based hand gel for hand hygiene. The facility failed to ensure the infection control program mitigated risks of healthcare-associated infections by following guidelines selected by the ASC.	Q 242		
Q 261	416.52(a)(1) ADMISSION ASSESSMENT Not more than 30 days before the date of the scheduled surgery, each patient must have a comprehensive medical history and physical assessment completed by a physician (as defined in section 1861(r) of the Act) or other qualified practitioner in accordance with applicable State health and safety laws, standards or practice, and ASC policy. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the ASC failed to ensure a comprehensive medical H&P assessment was completed no more than 30 days prior to surgery for 2 of 2 sample patients (#3 and #5) whose procedures were done on days other than the ASC's established procedure day. This had the potential to limit access to relevant patient information and negatively impact patient safety during surgery. Findings include: 1. Patient #3 was a 65 year old female admitted to the ASC on 9/13/11 for the removal of hardware following her hammertoe surgery on	Q 261		

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

PRINTED: 09/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001035	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/29/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER IDAHO SURGICENTER NORTH, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 3369 A MERLIN DRIVE IDAHO FALLS, ID 83404
---	---

(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 261	<p>Continued From page 26</p> <p>8/12/11. An H&P was in Patient #3's medical record. A history form was completed by Patient #3 on 7/28/11. The RN documented review of the form on 8/11/11. The physician documented review of the history form on 8/12/11 and deferred to the CRNA physical examination completed prior to surgery on 8/12/11. The H&P present in the medical record was from 32 days prior to the 9/13/11 surgery, with no documentation of an updated H&P.</p> <p>On 9/23/11 at 10:15 AM, the Office Manager was interviewed. She reviewed Patient #3's medical record and stated she agreed the H&P was dated by the physician on 8/12/11.</p> <p>The ASC did not ensure a history and physical was completed no more than 30 days prior to Patient #3's surgery on 9/13/11.</p> <p>2. Patient #5 was a 67 year old female admitted to the ASC on 6/28/11 for the removal of hardware following her hammertoe surgery on 5/27/11. An H&P was in Patient #5's medical record. The history form was completed by Patient #5 on 5/03/11. The RN documented review of the form on 5/26/11. The physician documented review of the history form on 5/27/11 and deferred to the CRNA physical examination completed prior to surgery on 5/27/11. The H&P present in Patient #5's medical record was from 32 days prior to the 6/28/11 surgery, with no documentation of an updated H&P.</p> <p>On 9/23/11 at 10:15 AM, the Office Manager was interviewed. She reviewed Patient #5's medical record and stated she agreed the H&P was dated by the physician on 5/27/11.</p>	Q 261		
-------	---	-------	--	--

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

PRINTED: 09/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001035	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/29/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER IDAHO SURGICENTER NORTH, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 3369 A MERLIN DRIVE IDAHO FALLS, ID 83404
---	---

(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 261	Continued From page 27 On 9/29/11 at 9:30 AM, the ASC physician was interviewed. He stated on non-typical surgery days when a patient received only local anesthesia he did not update the H&P. He stated he asked the patient if there had been any changes since he last saw them, but stated he did not document his question or the patient's answers.	Q 261		
Q 262	416.52(a)(2) PRE-SURGICAL ASSESSMENT Upon admission, each patient must have a pre-surgical assessment completed by a physician or other qualified practitioner in accordance with applicable State health and safety laws, standards of practice, and ASC policy that includes, at a minimum, an updated medical record entry documenting an examination for any changes in the patient's condition since completion of the most recently documented medical history and physical assessment, including documentation of any allergies to drugs and biologicals. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the ASC failed to ensure medical records contained documentation of a physical examination of patients or an assessment for changes in condition upon admission since patients' most recent H&Ps. This impacted 2 of 2 sample patients (#3 and #5) whose procedures were done on days other than the ASC's	Q 262		

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

PRINTED: 09/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001035	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/29/2011	
NAME OF PROVIDER OR SUPPLIER IDAHO SURGICENTER NORTH, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3369 A MERLIN DRIVE IDAHO FALLS, ID 83404		
(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 262	<p>Continued From page 28</p> <p>established procedure day. This had the potential to impact patient safety during and after surgery. Findings include:</p> <p>1. Patient #3 was a 65 year old female admitted to the ASC on 9/13/11 for the removal of hardware following her hammertoe surgery on 8/12/11. There was no documentation in the medical record of a pre-surgical physical assessment or an assessment for potential changes in Patient #3's medical history.</p> <p>Patient #5 was a 67 year old female admitted to the ASC on 6/28/11 for the removal of hardware following her hammertoe surgery on 5/27/11. There was no documentation in the medical record of a pre-surgical physical assessment or an assessment for potential changes in Patient #5's medical history.</p> <p>On 9/29/11 at 9:30 AM, the ASC physician was interviewed. He stated on non-typical surgery days when a patient received only local anesthesia he did not update the H&P. He stated he asked the patient if there had been any changes since he last saw them, but he did not document his questions or the patient's answers. He stated he did not do a physical exam unless the patient reported any changes as the patient had just had surgery "a couple of weeks prior."</p> <p>Neither a physical examination of patients nor an assessment for changes in condition for Patients #3 and #5 were documented in their medical records.</p>	Q 262		



IDAHO SurgiCenter North, Ilc

PO Box 1386/ 3369 Merlin Drive, Idaho Falls, ID 83401 / 208-529-0009

October 12, 2011

Bureau of Facility Standards
Re: Survey: #13C0001035

10/12/2011 11:11 AM
10/12/2011 11:11 AM
10/12/2011 11:11 AM

Dear Sirs,

Enclosed you will find the 2567 with the addressed deficiencies. We have included documentation to support our changes. Please let me know if there are pieces missing or if you would like separate material for verification.

Thanks!

Charlene Woodland; Admin.
Toiny Schneider

Q 041: 416.41(a) CONTRACT SERVICES

1. (a) We have contracted with [REDACTED]. The contract has been discussed, signed, and dated by the Governing Body. It delineates services and expectations between the ASC and anesthesia service providers. It also addresses the consequences of inadequate credentialing and that the contract remains in place until one of the parties decides to terminate it in writing. We will monitor them for safe and satisfactory services and address these monitoring practices at upcoming Governing Body and QI meetings. **(The GB minutes from 10-7-2011 and this contract are enclosed.)**

(b) i. All four CRNAs have current and verified RNA licenses on file;

ii. All four CRNAs have current and verified DEA licenses on file;

iii. All four CRNAs have current and verified PALS certifications on file, and

iv. The CRNA who was due for reappointment has reapplied and has been granted privileges by way of a letter from the Medical Director.

Although we have DEA licenses from our RNAs, we have never had a policy that requires DEA licenses of RNAs at our facility. The state of Idaho doesn't require them to have them yet so we won't add this requirement to have these pieces until the state requires it of them.

The method by which credentialing is tracked is a form that lists due dates of expiring credentials. The Practice Administrator who oversees credentialing will create an electronic calendar that delivers reminders, for the sole purpose of tracking these dates, so that these dates are not missed in the future, and present this solution to the Governing Body for approval. **(These pieces from CRNA credential files are enclosed and the Governing Body approved the new tracking system for credentials.)**

2. A contract with [REDACTED] is in place. It was reviewed by Governing Body members, dated and signed. It delineates services and expectations between the ASC and pathologists. It also states that services will be monitored periodically and that the contract remains in place until one of the parties decides to terminate it in writing. We will monitor them for satisfactory services and address these monitoring practices at upcoming Governing Body and QI meetings. **(This contract and CLIA certificate are enclosed.)**

3. The service agreement between waste management services ([REDACTED] and [REDACTED]) is in place; it was signed, dated, and has been in force since May 2010. Terms are specified as well. Governing Body will monitor them for satisfactory service. **(This contract is enclosed.)**

Responsibility: Charlene Woodland will continue to be the credentialing officer for all staff members.

Responsible Member: Toiny Schneider will be responsible for maintaining all contracts with services.

Q 080: 416.43 QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT

We have re-developed the way we collect data to make our assessment of performance relevant and something that we can use to improve services to patients and make our methods safe for them. We will implement and maintain an on-going, data driven quality assessment and performance improvement program (QI). These changes have been added to the QI Program that is currently in place and changes will be made to the current policy manual as necessary. Measuring this data with new quality indicators will help us to track information that will enable us to improve patient outcomes and patient safety at our facility. We have entered this into policy and made changes to the QI Manual.

Responsible Member: Charlene Woodland, Admin.

Q 081: 416.43(a); (c)(1) PROGRAM SCOPE

We have re-developed our current QI program by implementing and planning to maintain an on-going, data driven quality assessment and performance improvement program (QAPI). Changes to our present QI program to address this deficiency were approved at our last Governing Body meeting. We will maintain the program by monitoring and reporting findings at all our quarterly Governing Body meetings. We will determine which data will be collected in order to improve quality of services and safety practices for patients. Some of the things we will assess in greater detail in the future are policy review, quality assurance committee meetings, professional liability, peer review, tissue review, patient services, patient bill of rights and responsibilities, hours of operation, elder abuse, patient satisfaction, grievance procedure, quality improvement standard for peri-operative nursing, patient outcomes; standards of peri-operative care, standards review, employee orientation and evaluation, incident reports, cost analyses, reportable events, MSDS and OSHA issues, contracted services, infection control, universal precautions and blood borne pathogens, fire and disaster plans, environmental controls, and environmental safety and compliance issues. We will implement methods that best measure quality with appropriate indicators. Over the coming months we modify old methods as well as add indicators for measuring data that relate to appropriate practices such as Use of Alcohol Based Hand Rubs, Patient Drug Reactions, Appropriate Charting of Updated H&Ps, Surgical Site Identification, and others as we determine appropriate and measurable. In determining which practices should be evaluated, we will consider high risk and problem areas. We will maintain an ongoing assessment of selected practices by measuring with quality indicators.

This new program will provide the platform for collecting and measuring relevant data in order to improve patient health outcomes and patient safety. The process will include identifying relevant issues, collecting data, measuring data using quality indicators, and evaluation of the data for effectiveness of and improvement to quality of care. The goal of implementing these processes is to track information that will enable us to improve patient outcomes and patient safety at our facility. The QI Committee consists of Teri Fry, RN; Toiny Schneider, Perioperative Assistant; and Char Woodland, Admin. The staff assignments in regard to QI will be as follows: RNs and Peri-operative assistants are responsible for recording measurable data; Peri-operative assistant is responsible for gathering the data for the Practice Administrator; The Practice Administrator is responsible for compiling and reporting of the data to the

Governing Body. The Governing Body will review the reported data and present the findings to staff at Quality Improvement meetings. The changes to our existing program have been added to our existing policy and approved by the Governing Body at our last meeting. It will be reviewed yearly by the Governing Body and revised as necessary.

Responsible Member: Charlene Woodland; Admin.

Q 082: 416.43(b), 416.43(c)(2), 416.43(c)(3) PROGRAM DATA; PROGRAM ACTIVITIES

- b. (1) We will incorporate quality indicator data for patient care and services that we provide that measures the effectiveness of our practices.
- b. (2) We will collect data in order to monitor its effectiveness and identify opportunities to make improvements to patient care and safety.
- c. (2) We will put in place a way to track adverse events, examine causes and make improvements in such a way that they are sustainable over time.
- c. (3) We will put preventative practices in place and train all staff so that they are familiar with the new practices. These strategies will be patient driven so as to improve quality of patient care and patient safety. We will use indicators and collect data that will be measured with patient health outcomes in mind. One indicator we can add to the summary report is that of negative patient comments. Regarding data collected for studies; we will begin attaching the data collected from indicators so that there is a way to see where the result came from. We will make specific staff assignments as to who will be responsible for certain items. By making assignments for certain indicators to be measured, we will be more effective in compiling and completing the QAPI program which ultimately will help us meet our goal of improving patient health outcomes. Specific assignments and ways of collecting data to be included with studies will be put in place when our policy is amended by Governing Body. (detailed under Program Scope above)

It will be implemented by 11-3-2011.

Responsible Member: Charlene Woodland, Admin.

Q 083 416.43(d) PERFORMANCE IMPROVEMENT PROJECTS

1. We will track information for studies/projects that are relevant to our facility's services and practices.
2. We will document that studies/projects are being conducted by addressing them in Governing Body and QI (on agendas and in minutes) including a reason for the study and the results of the study. The completed/closed studies will be closed when outcomes are

optimal or goals have been reached and filed by year, in a binder labeled: Studies and Projects. The binder will be kept at the Nurse's Station at the ASC. As long as studies remain open, they will include the measurable data from quality indicators. Studies and projects that are closed will be revisited periodically by tracking measurable data through indicators to determine whether or not the practices are still satisfactory or if a project needs to be completed to ultimately ensure improved outcomes for patient health and safety.

It is obvious to us that we are missing pieces of the QAPI program which could possibly lead to adverse events. We will make changes to our QI program in order to implement processes that will elevate our standard making our facility not only compliant, but one that is a high quality ASC that provides services and care that not only ensure, but enhance patient health outcomes.

The changes to our QI program that include QAPI pieces will be implemented by 11-3-2011.

Responsible Member: Charlene Woodland; Admin.

Q 122: 416.45(b) REAPPRAISALS

While all credentials were current and verified for [REDACTED], he had not reapplied since 04-10-2009. Privileges for the physician have been reviewed by the Governing Body and granted per re-application for his requested privileges. We have discussed this citation and have changed our physician reapplication rule, making re-application due every 3 years. Last fall when AAAHC surveyed the facility, they made a recommendation that we re-credential doctors every 3 years rather than 2; we were doing this, but had failed to change the policy to allow it. (Signed application documents including Delineation of Privileges and Letter granting privileges to [REDACTED] are enclosed.)

Responsible Member: Charlene Woodland; Admin.

Q 141: 416.46(a)

It is our intention to follow the rule to have an RN on the premises when patients require a procedure performed in the ASC in order to comply with standards of practice. All future procedures will be scheduled to be performed on designated surgery days. If a patient requires an emergency procedure, special arrangements will be made with an available RN on staff to come to the ASC for the procedure. This policy is in place and doesn't require any changes at this time. We will discuss the issue at Governing Body meeting upcoming.

Responsible Member: Charlene Woodland; Admin.

Q 242: 416.51(b) INFECTION CONTROL PROGRAM

1. The room used to clean, decontaminate, package and sterilize instruments is quite small and requires specific housekeeping and sterilizing measures. It houses 2 autoclaves which open automatically when the cycles finish. Our present practice is to run the power instruments at the beginning of the day so that they will be ready for the first case. This is the best way to do it as there are no contaminated instruments being transported into that room until after the first case is over. There is also no traffic in and out of that room. On a surgery day when there is more than one case, the instruments to be flashed sterilized are cleaned, decontaminated, and put on a tray, then in the autoclave for sterilization. While the cycles run (13 minutes), the sinks, counters, and surfaces are wiped with a disinfectant and the room is prepared as if it were being readied for the first case. *This process is repeated for subsequent cases.* (On the survey day, we did run the instruments for the 3rd case early in the day which allowed them to sit through the cleaning processes with the door 'popped' and still latched, but not ajar. In any case it was slightly cracked and could have caused a problem for the patient which is not acceptable. However, this is NOT usual our practice.)

While the autoclave is running and after the workroom is clean, the door is closed to reduce traffic and the supplies for the next case are opened on a table. The scrub tech scrubs, gowns and gloves, then sets up the case in a sterile fashion. When the autoclave opens automatically, it 'beeps' to notify us that it is finished. The RN goes through the door and opens the autoclave for the tech, then leaves the workroom. The tech then walks 10 feet to the workroom, retrieves the instrument tray from the autoclave with sterile towels and transports it to the sterile table in the OR. The distance to the workroom is short and immediately accessible from the OR. This distance does not pose a risk for infection if the door is adequately open. Our practice for transporting instrument trays is stated above. We have added a policy detailing the practice of transporting sterile instruments. It was discussed in Governing Body and added to the Infection Manual. **(Changes to our Autoclave Transfer policy are outlined in the Infection Manual on pages 56-58. These pages and agenda/minutes are enclosed.)**

The CDC has a description for the "ideal" central processing area in their "Guidelines for Disinfection and Sterilization in Healthcare Facilities, 2008". Upon reading this guideline, it was found to apply to all Healthcare Facilities, including hospitals with much larger work spaces. The issues that we appreciate are the small space and the passage door. We've talked about taking off the door, which isn't an optimal solution; and we've discussed changing the modality of the door; changing it to a swinging door. Changing the door to a swinging door would enable the tech to pass through the door and retrieve the instruments without having to move behind the door and encounter possible contamination of sterile items. The setup of the room is definitely a challenge because of the square footage, and where receptacles and plumbing are located. Because we are no longer following the CDC's Guidelines, we will follow AORN's recommendation for movement of sterile equipment which states: "Surgical supplies prepared for surgical procedures outside the surgical suite should be transported to the surgical suite to maintain cleanliness and sterility and to prevent physical damage." We have implemented a

policy (previous paragraph) that will ensure this policy and we will continue to address possible solutions by addressing them at our next Governing Body and QI meetings. **(Governing Body minutes are enclosed)**

2. (a-f) In our policy manual it states that we follow the CDC Guidelines in relation to practices for alcohol based hand rub use, but we had failed to have a written policy in our Infection Manual. The observations of the surveyors revealed inconsistencies in the way the hand rub was used by staff members. After discussing this deficiency and the CDC guidelines, we have removed the statement that we follow the CDC guidelines from our policy and added our own policy for Hand Rub Use in the Infection Manual using AORN guidelines (pg 12). We will have an in-service that instructs the staff on the added policy at our next QI meeting. All staff will be required to attend. **(Governing Body minutes and pg 12 from the Infection Manual are enclosed.)**

Responsible Member: Charlene Woodland; Admin.

Q 261: 416.52(a) ADMISSION ASSESSMENT

1. Per surveyor findings, the H&Ps had not been more than verbally updated prior to their subsequent surgeries at the ASC. Although the H&Ps had been reviewed by both the doctor and the RN on pt #5, they had not been updated. We intend to be sure that this is being done on all our patients for all surgeries and that it is documented. Our practice will be amended to include a documented updated comprehensive H&P by the physician from now on; the doctor will date and sign each updated H&P. This documentation will be part of the patient's medical record. We will discuss this change to our 'pre-anesthesia' form and to our practices in Governing Body and QI meetings upcoming. **(agenda/minutes are enclosed.)**

Responsible Member: Toiny Schneider

Q 262: 416.52(a) PRE-SURGICAL ASSESSMENT

2. In the instance of the cases done on non-typical surgery days, the H&Ps were not updated from a few weeks prior. We will change our practices by updating H&Ps each time the patient comes back regardless of the time lapse in order to promote safety and compliance with the standard. In both of the cases cited, the H&Ps were present, but not updated at 2 weeks. Documentation of the updates will be part of the patient's medical record. We will discuss this change to our practices in our next Governing Body and QI meetings. **(agenda/minutes are enclosed.)**

Responsible Member: Toiny Schneider

RECEIVED
OCT 21 2011

10-21-2011

ADDENDUM TO 2567

FACILITY STANDARDS

Q 141:

To begin immediately: Although the policy of having an RN present for surgical procedures is in place, we have decided to make it a subject for a study to determine if we need to follow it as a project. We have a form in place (attached) that is part of each patient's surgery record that includes the verification of an RN, with places for the RNs initials. Our RN on staff will initial and sign the forms where it is required in medical records. Quarterly, Toiny will evaluate these forms for completeness and track the information for 100% accuracy. Toiny will also collect this data and report it to Charlene Woodland each quarter. Charlene will compile it for review at quarterly Governing Body and Quality Improvement meetings. If we meet our goal of 100% presence of RN in the OR, we will close the study. If we fail to meet our goal of 100% in regard to RN presence in the OR, we will continue to track this data and will continue to do so until we reach or surpass our goal.

Q 082: PROGRAM DATA; PROGRAM ACTIVITIES

To begin immediately: In relation to program data collection for Quality Improvement (QAPI) studies and specifically for 'Site Identification', we have created a form (attached) that includes a place to verify each step of the Identification process throughout the pre-operative period. Some of the data include date, patient initials, site marked, pt verbal approval, doctor confirmation, consent match, card overturned. The process continues in the OR with a place to document the patient's verbal confirmation, RN confirmation, a visual of the patient's initials on the identified foot, and verification of time out performed in the OR. All of this information relates to verification of site ID. Each person will be oriented as to the purpose of the form and their responsibility for certain items on the form. The form will be evaluated before the pt leaves the facility for completeness by Toiny Schneider, the perioperative assistant.

This is just one example, but this *is the way* we will implement our policy to incorporate indicator data to measure the effectiveness of our practices. This data will be collected and reported to Charlene Woodland on a quarterly basis. Charlene will compile the data and present it as a study for review at quarterly Governing Body meeting and Quality Improvement meeting. Based on the indicators, we will determine whether the process is complete enough to secure patient safety. If it appears that we are meeting our goal of 100% successful Site ID over a period of 6 months by collecting at least 90% of the data required for review, we will close the study. If we have failed to collect at least 90% of the data, we will continue this process of data collection on this form for another 6 months until our goal is met or surpassed.

Other studies that are being conducted have to do with the Admissions Assessment issue of H&P Review and Hand Rub Practices. Both of these studies will be done similarly with forms documenting specific

data collection. Toiny will be responsible for the H&P Review Study. Teri Fry, RN will be responsible for documentation and collection of data for the Hand Rub Study. We have data collection forms for all of these studies. The collected data will be reported quarterly to Charlene. Charlene will compile it and present it in report form at Governing Body for review. These reports will also be presented to the staff at Quality Improvement meetings quarterly.

Q 261-262: ADMISSIONS ASSESSMENT AND Q 262 PRE-SURGICAL ASSESSMENT:

To begin immediately: We have forms in place that address this concern (attached). They are the patient's H&P and the Pre-Anesthetic Evaluation.

On one page of the patient's H&P, there is a spot for the doctor to sign his initial review of the H&P in a BOX. His subsequent review(s) will be signed and dated at the bottom of the section entitled 'Family History' to confirm his subsequent review of the H&P.

On the Pre-Anesthetic Evaluation, a spot under "Past Medical History" has been added for confirmation of "H&P Review". The RNA will check this time prior to surgery and sign this form when the pt has been cleared for discharge.

These forms are part of the patient's permanent record and will be evaluated the same way that "Site ID" form will be evaluated for completeness on each surgery day by Toiny Schneider. The information will also be the subject for a study and will be entered into a form to be evaluated. The data will be collected from the pt charts and reported to Charlene Woodland quarterly. Charlene will then compile the data in Governing Body where it will be reviewed for completeness and effectiveness. Our goal is 100% H&P Review to be performed by the doctor and the RNA. If we meet our goal of 100% of H&P Review" confirmations, we will close this study. If we fail to meet our goal of 100% we will continue monitoring this process until we do meet or surpass our goal.

Q 242: INFECTION CONTROL PROGRAM

To begin October 28th, 2011: In regard to tracking data for the Hand Rub Study, we will meet on 10-28-2011 as the Infection Control Committee to determine which pieces of information we need to include as we evaluate effectiveness of our policy, we will then create a form to be completed each surgery day, by respective committee members. Also, on 10-28-11, we will also have our first in-service on the new Hand Rub Policy. Teri Fry, Infection Control Officer will teach this in-service; all staff will be required to sign in and be present. Toiny will be responsible for recording and documenting practices of all staff in the pre-operative area, Teri Fry will be responsible for recording and documenting practices observed in the OR of all staff, and Charlene will be responsible for documenting and recording practices of Housekeeping staff as they relate to Infection Control and as they relate to the Hand Rub Policy in the Infection Manual. All of these results will be collected and compiled by Toiny Schneider and submitted to Charlene Woodland. She will report the findings to Governing Body for review. All staff members will be monitored for compliance. Our goal is to meet 90% staff compliance in regard to this policy. If we fail to meet 90% compliance, we will continue to collect data and in-service the staff in regard to this policy

quarterly until we meet or surpass our goal. The goal for completion of this form to track the determined data is 11-03-2011.