

10/25/12



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 208-334-6628
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October 12, 2012

Jennie Rawlings, Administrator
PCS Endoscopy Suite
500 S 11th Avenue, Suite 303
Pocatello, ID 83201

RECEIVED

OCT 26 2012

FACILITY STANDARDS

RE: PCS Endoscopy Suite, Provider #13C0001041

Dear Ms. Rawlings:

On October 10, 2012, a follow-up visit of your facility, Pcs Endoscopy Suite, was conducted to verify corrections of deficiencies noted during the survey of August 27, 2012.

We were able to determine that the Conditions of Coverage of **Governing Body and Management (42 CFR 416.41); Surgical Services (42 CFR 416.42); Quality Assessment & Performance Improvement (42 CFR 416.43); Nursing Services (42 CFR 416.46); Patient Rights (42 CFR 416.50) and Infection Control (42 CFR 416.51)** are now met.

Your copy of a Post-Certification Revisit Report, Form CMS-2567B, listing deficiencies that have been corrected is enclosed.

Also enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicare deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction.

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

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

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- Monitoring and tracking procedures to ensure the PoC is effective in bringing the ASC into compliance, and that the ASC remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
- The administrator's signature and the date signed on page 1 of the Form CMS-2567 and State Form 2567.

After you have completed your Plan of Correction, return the original to this office by **October 25, 2012**, and keep a copy for your records.

Thank you for the courtesies extended to the surveyors during their visit. If we can be of any help to you, please call us at (208) 334-6626.

Sincerely,



AIMEE HASTRITER
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

AH/nw

Enclosures

cc: Linda Bedker, CMS Region X Office

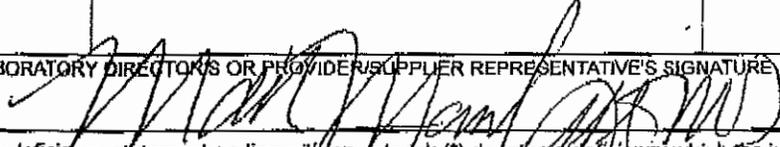
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001041	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 10/10/2012
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NAME OF PROVIDER OR SUPPLIER PCS ENDOSCOPY SUITE	STREET ADDRESS, CITY, STATE, ZIP CODE 500 S 11TH AVENUE, SUITE 303 POCATELLO, ID 83201
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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{Q 000}	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the follow up survey of your Ambulatory Surgical Center. Surveyors conducting the follow up were:</p> <p>Aimee Hastriter RN, HFS, Team Lead Susan Costa RN, HFS</p> <p>Acronyms used in this report include:</p> <p>ASC - Ambulatory Surgical Center CDC - Center for Disease Control and Prevention DON - Director of Nursing mcg - microgram mg - milligram ml - milliliter USP - United States Pharmacopeia</p>	{Q 000}	<p style="text-align: center;">RECEIVED</p> <p style="text-align: center;">OCT 26 2012</p> <p style="text-align: center;">FACILITY STANDARDS</p>	
{Q 181}	<p>416.48(a) ADMINISTRATION OF DRUGS</p> <p>Drugs must be prepared and administered according to established policies and acceptable standards of practice.</p> <p>This STANDARD is not met as evidenced by: Based on observation, review of drug labeling information, and staff interview, it was determined the facility failed to administer, prepare, label and store medications in accordance with acceptable standards of practice. The failure to adhere to acceptable standards of practice resulted in the potential for all patients receiving medications in the ASC to experience adverse drug reactions and/or medication administration errors. Findings include:</p>	{Q 181}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE GOVERNING BODY	(X6) DATE 10-25-12
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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{Q 181}	<p>Continued From page 1</p> <p>1. On 10/10/12 at 10:20 AM during a review of the medication cabinet in the endoscopy room, pre-filled syringes with needles attached, were observed as follows:</p> <ul style="list-style-type: none"> - A syringe, containing 1 ml of clear fluid with a label which read "Fentanyl 50 mcg, 9/21/12." The label was not timed. - A syringe, containing 2 ml of clear fluid with a label which read "Fentanyl 50 mcg, 10/03/12." The label was not timed. <p>The DON, who was present during the review of the medication cabinet, stated that due to a national shortage of Fentanyl, the drug had not been available as 2 ml ampules. She stated the Fentanyl the ASC used was provided in 5 ml glass ampules. The DON stated during a procedure the "usual" dose would be 100 mcg/2 ml, and there would be a remainder in the ampule of 150 mcg/3 ml. She stated when she drew up a dose of medication from a glass ampule, she would prepare two additional syringes, one syringe with 2 ml, and the remaining 1 ml would be in the second syringe for a future patient use.</p> <p>A drug insert for Fentanyl 50 mcg/ml, 5 ml ampules, stated: "Do not administer unless solution is clear and container undamaged. Discard unused portion. Fentanyl Citrate Injection, USP equivalent to 50 mcg (0.05 mg) fentanyl/mL, is supplied in single-dose glass containers. The solution contains no bacteriostat, antimicrobial agent or added buffer and is intended only for use as a single-dose injection. When smaller doses are required, the unused portion should be discarded in an appropriate</p>	{Q 181}	<p>Q 181: All medications used in the ASC will be used according to drug insert directions. Fentanyl supplied in 5 ml vials (50 mcg per ml) labeled as "single dose" ampules will be used for only one patient. Fentanyl remaining in the ampule at the end of the procedure will be discarded according to ASC policy. The DON will monitor that medications labeled as "single dose" are used for only one patient, with remaining medication disposed of.</p> <p>The DON will monitor medication logs and waste logs to ensure that they accurately reflect the amount of Fentanyl used and wasted at the end of each procedure. Incident reports will be initiated if discovered that "single dose" medication vials are being used for more than one patient, and reported to the governing body during quarterly meetings.</p> <p>(Action by the DON will be taken to correct this prior to the quarterly meeting if discovered). The DON will instruct staff working within the ASC of the difference between "single dose" and "multiple dose" vials, and ensure that medications are used according to dosage and administration guides from medication package insert.</p>	
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[Q 181]	<p>Continued From page 2 manner."</p> <p>In a return to the medication storage area on 10/10/12 at 1:00 PM, the Fentanyl packaging was reviewed, and noted to read: "Single Use Only." At that time, an additional syringe was noted in the drawer as follows:</p> <p>- A syringe, containing 2 ml of clear fluid with a label which read "Romazicon 0.2 mg, 9/19/12." The label was not initialed or timed.</p> <p>The DON was present during the revisit on 10/10/12 at 1:00 PM. She verified the syringe of Romazicon, and stated it was a "rescue" drug, and she would always have a syringe drawn up and ready to administer.</p> <p>A drug insert for Romazicon (generic name-Flumazenil), dated and revised July 2011, stated:</p> <p>"DOSAGE AND ADMINISTRATION: Flumazenil injection is recommended for intravenous use only. If flumazenil injection is drawn into a syringe, it should be discarded after 24 hours. For optimum sterility, flumazenil injection should remain in the vial until just before use."</p> <p>During an interview on 10/10/12 at 1:10 PM, the DON stated she had researched the CDC website and it was her understanding it was acceptable practice to draw up a medication into a sterile syringe for up to 28 days. The DON was unable to provide a policy or CDC documentation regarding the dispensing of single use medications for multiple patient uses.</p>	[Q 181]	<p>In addition, according to the package insert guide, Flumazenil will not be pre-drawn and kept for "rescue" use. If needed, Flumazenil will be drawn up at the time it is ordered by the physician. All staff will be educated to keep package inserts</p> <p>with medications for reference if needed. The DON will monitor the medication drawer to ensure that Flumazenil isn't being kept in a pre-drawn syringe. If found in a pre-drawn syringe, and incident report will be initiated and the DON will take corrective action to educate staff to the reason this is unacceptable. All incident reports will be reported to the governing body during quarterly meetings.</p>	
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{Q 181}	Continued From page 3 The facility failed to ensure acceptable standards of practice related to medication preparation and administration were followed.	{Q 181}		
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