



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

IDAHO DEPARTMENT OF
HEALTH & WELFARE

DEBBY RANSOM, R.N., R.H.I.T. – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Bolsé, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

CERTIFIED MAIL #7007 3020 0001 3745 8054

November 25, 2011

Dr. Scott Magnusson, CEO
North Idaho Pain Center
2003 Lincoln Way Ste 310
Coeur D'Alene, ID 83814

RE: North Idaho Pain Center, provider #13C0001058

Dear Dr. Magnusson:

Based on the revisit at North Idaho Pain Center on November 14, 2011, by our staff, we have determined that North Idaho Pain Center continues to be out of compliance with the Medicare Conditions of Participation of Governing Body and Management (42 CFR 416.41); Quality Assessment and Performance Improvement (42 CFR 416.13); Medical Records (42 CFR 416.47); Patient Rights (42 CFR 416.50); Infection Control (42 CFR 416.51) have not been met.

The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). Also enclosed is your copy of a Post-Certification Revisit Report (CMS-2567B), listing deficiencies that have been corrected.

In our letter to you dated October 12, 2011, we stated: "failure to correct the deficiencies and achieve compliance will result in our recommending that the Centers for Medicare and Medicaid Services (CMS) Region X Office, Seattle, Washington, terminate your approval to participate in the Medicare program."

Because of your failure to correct, we have made that recommendation. CMS will be in contact with you regarding the procedures, timelines, and appeal rights associated with this recommendation that must be followed.

Sincerely,

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

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

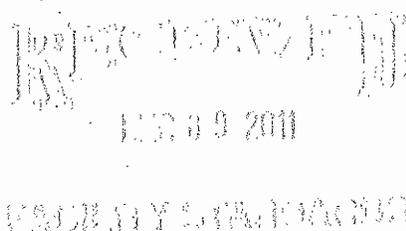
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001058	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 11/14/2011
--	---	--	--

NAME OF PROVIDER OR SUPPLIER NORTH IDAHO PAIN CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2003 LINCOLN WAY STE 310 COEUR D'ALENE, ID 83814
--	--

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

{Q 000}	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the follow-up survey to the 9/30/11 Medicare re-certification survey of your Ambulatory Surgical Center. Surveyors conducting the follow-up were:</p> <p>Gary Guiles, RN, HFS, Team Leader Aimee Hastriter, RN, BS</p> <p>Acronyms used in this report include:</p> <p>AORN - Association of periOperative Registered Nurses ASC - Ambulatory Surgical Center CDC - Center for Disease Control CST - Certified Surgical Technician OSHA - Occupational Safety and Health Administration PIP - Performance Improvement Project RFA - Radio Frequency Ablation RN - Registered Nurse QAPI - Quality Assessment and Performance Improvement QI - unknown, the term QI was not defined in the document provided by the facility</p>	{Q 000}		
{Q 040}	<p>416.41 GOVERNING BODY AND MANAGEMENT</p> <p>The ASC must have a governing body that assumes full legal responsibility for determining, implementing, and monitoring policies governing the ASC's total operation. The governing body has oversight and accountability for the quality assessment and performance improvement program, ensures that facility policies and programs are administered so as to provide quality health care in a safe environment, and develops and maintains a disaster preparedness</p>	{Q 040}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Scott H. Magnuson MD</i>	TITLE	(X6) DATE 07 DEC 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: 11/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001058	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 11/14/2011
NAME OF PROVIDER OR SUPPLIER NORTH IDAHO PAIN CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2003 LINCOLN WAY STE 310 COEUR D'ALENE, ID 83814	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{Q 040}	Continued From page 1 plan. This CONDITION is not met as evidenced by: Based on observation, staff interview, and review of policies and administrative documents it was determined the ASC failed to ensure the Governing Body assumed responsibility for development and oversight of the facility's total operation and the QAPI program. This resulted in a lack of guidance to, and oversight of, the facility's staff and programs. Findings include: 1. A Medicare re-certification survey was conducted on 9/30/11. At that time, it was determined the ASC was not in compliance with 10 Medicare Conditions for Coverage. These included the conditions of Governing Body and Management, Surgical Services, Quality Assessment and Performance Improvement, Environment, Nursing Services, Medical Records, Pharmaceutical Services, Patient Rights, Infection Control, and Patient Admission, Assessment, and Discharge. One "Governing Board" meeting was documented since 9/30/11. Minutes from that meeting, dated 10/31/11, stated: a. The Administrator reviewed changes to the policy and procedure manual. The minutes stated staff had been notified that the updated manual was being printed. The minutes did not contain a list of policies that had been updated. The "Action" column of the minutes stated "The next action will be periodic review of the policies at least every 2 years."	{Q 040}		

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

PRINTED: 11/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001058	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 11/14/2011
NAME OF PROVIDER OR SUPPLIER NORTH IDAHO PAIN CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2003 LINCOLN WAY STE 310 COEUR D'ALENE, ID 83814	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{Q 040}	<p>Continued From page 2</p> <p>b. The facility RN had reviewed the QAPI program and would be commencing a "study on our compliance with our hand washing protocol." The "Action" column of the minutes stated "Will start hand washing study protocol." Otherwise, the QAPI program was not mentioned in the minutes.</p> <p>c. The physician was looking for a different patient satisfaction survey to implement.</p> <p>d. The Administrator had reviewed and revised the job descriptions for staff members.</p> <p>The minutes also stated hand washing was "an issue" at the time of the survey. Otherwise, the results of the survey and the Conditions for Coverage that were found out of compliance were not mentioned. In addition, specific changes to policies and procedures were not listed. Documentation that the ASC had reviewed its processes that led to the findings of non-compliance was not present.</p> <p>The Administrator was interviewed on 11/09/11 beginning at 4:00 PM. She confirmed the meeting minutes. She stated there was no other documentation of action taken by the ASC to correct identified problems.</p> <p>The Governing Body failed to take action to correct identified problems.</p> <p>2. Refer to Q080 as it relates to the failure of the ASC to ensure a comprehensive, data driven QAPI program was developed, implemented and monitored.</p>	{Q 040}		

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

PRINTED: 11/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001058	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/14/2011
NAME OF PROVIDER OR SUPPLIER NORTH IDAHO PAIN CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2003 LINCOLN WAY STE 310 COEUR D'ALENE, ID 83814		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{Q 040}	Continued From page 3 3. Refer to Q160 as it relates to the failure of the ASC to ensure a complete, comprehensive, and accurate medical records system had been developed and implemented. 4. Refer to Q220 as it relates to the failure of the ASC to inform the patient or the patient's representative of the patient's rights, and that patient rights were protected and promoted. 5. Refer to Q240 as it relates to the failure of the ASC to ensure a comprehensive infection control program was developed, monitored and implemented. The cumulative effect of the lack of Governing Body involvement resulted in the inability of the ASC to develop and implement measures to correct system problems.	{Q 040}			
{Q 080}	416.43 QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT The ASC must develop, implement and maintain an on-going, data-driven quality assessment and performance improvement (QAPI) program. This CONDITION is not met as evidenced by: Based on staff interview and review of 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 maintained. This resulted in the inability of the ASC to evaluate its processes and practices. Findings include: 1. Refer to Q081 as it relates to the failure of the	{Q 080}			

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

PRINTED: 11/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001058	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 11/14/2011
NAME OF PROVIDER OR SUPPLIER NORTH IDAHO PAIN CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2003 LINCOLN WAY STE 310 COEUR D'ALENE, ID 83814	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{Q 080}	Continued From page 4 ASC 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. 2. Refer to Q082 as it relates to the failure of the ASC to ensure the QAPI program incorporated quality indicator data into the program. 3. Refer to Q083 as it relates to the failure of the ASC to ensure PIPs were defined and implemented. 4. Refer to Q084 as it relates to the failure of the Governing Body to ensure that the QAPI program was defined and implemented. The cumulative effect of these negative facility practices prevented the ASC from evaluating its practices and processes.	{Q 080}		
{Q 081}	416.43(a), 416.43(c)(1) PROGRAM SCOPE; PROGRAM ACTIVITIES (a)(1) The program must include, but not be limited to, an ongoing program that demonstrates measurable improvement in patient health outcomes, and improves patient safety by using quality indicators or performance measures associated with improved health outcomes and by the identification and reduction of medical errors. (a)(2) The ASC must measure, analyze, and track quality indicators, adverse patient events, infection control and other aspects of performance that includes care and services furnished in the ASC. (c)(1) The ASC must set priorities for its	{Q 081}		

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

PRINTED: 11/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001058	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/14/2011
NAME OF PROVIDER OR SUPPLIER NORTH IDAHO PAIN CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2003 LINCOLN WAY STE 310 COEUR D'ALENE, ID 83814		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{Q 081}	<p>Continued From page 5</p> <p>performance improvement activities that -</p> <p>(i) Focus on high risk, high volume, and problem-prone areas.</p> <p>(ii) Consider incidence, prevalence, and severity of problems in those areas.</p> <p>(iii) Affect health outcomes, patient safety, and quality of care.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of of QAPI documents, it was determined the ASC 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. This resulted in the inability of the ASC to monitor its processes. Findings include:</p> <p>A document titled "QI study: Hand washing," dated 10/23/11, stated the ASC would monitor hand washing for a period of 2 weeks, a total of 6 working days. The ASC had started collecting data on 11/01/11.</p> <p>No documentation was present that other quality indicators were being monitored or were scheduled to be monitored. No QAPI plan was documented.</p> <p>One "Governing Board" meeting was documented since the last survey on 9/30/11. Minutes from the meeting, dated 10/31/11, stated the facility RN had reviewed the QAPI program and would be commencing a "study on our compliance with our hand washing protocol." The</p>	{Q 081}			

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

PRINTED: 11/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001058	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 11/14/2011
NAME OF PROVIDER OR SUPPLIER NORTH IDAHO PAIN CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2003 LINCOLN WAY STE 310 COEUR D'ALENE, ID 83814	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{Q 081}	Continued From page 6 "Action" column of the minutes stated "Will start hand washing study protocol." The minutes also stated the physician was looking for a new patient satisfaction survey to implement. No other mention of a QAPI program or plan was documented in these or other meeting minutes. The RN, noted in the "Governing Board" meeting minutes, was interviewed on 11/09/11 beginning at 11:15 AM. She stated an overall plan outlining the QAPI program had not been developed. She stated the only quality indicator the facility was measuring was related to hand washing. She stated no other quality indicators had been developed or were planned. She also stated the structure of the QAPI program, such as who was responsible for the operation of the program, methodologies for data collection, reviewing data results, and how often the plan would be reviewed and updated, had not been defined. The ASC had not developed a plan to define the scope of its 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: 11/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001058	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/14/2011
NAME OF PROVIDER OR SUPPLIER NORTH IDAHO PAIN CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2003 LINCOLN WAY STE 310 COEUR D'ALENE, ID 83814		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{Q 082}	<p>Continued From page 7</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 of QAPI documents, it was determined the ASC failed to ensure the QAPI program incorporated quality indicator data into the program. This resulted in the inability of the ASC to monitor the effectiveness and safety of its services and quality of its care. Findings include:</p> <p>A document titled "QI study: Hand washing," dated 10/23/11, stated the ASC would monitor hand washing for a period of 2 weeks over 6 working days. The document stated the study would be repeated in 2 months.</p> <p>Data regarding whether or not staff washed their hands was documented on 3 separate days, between 11/01/11 and 11/08/11. No other data was documented through the ASC's QAPI program. No data had been analyzed.</p> <p>The facility RN was interviewed on 11/09/11 beginning at 11:15 AM. She stated the only quality indicator that had been developed and for which data was being gathered was related to hand washing. She stated no other data had been gathered. She also stated a plan for the gathering and use of data had not been</p>	{Q 082}			

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

PRINTED: 11/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001058	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 11/14/2011
NAME OF PROVIDER OR SUPPLIER NORTH IDAHO PAIN CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2003 LINCOLN WAY STE 310 COEUR D'ALENE, ID 83814	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{Q 082}	Continued From page 8 developed.	{Q 082}		
{Q 083}	<p>The ASC failed to gather and utilize data.</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 of QAPI documents, it was determined the ASC failed to ensure PIPs were defined and implemented. This resulted in the inability of the ASC to conduct in depth reviews of the quality of care provided to patients. Findings include:</p> <p>No comprehensive QAPI plan was documented. A definition of PIPs by the ASC was not documented.</p> <p>A document titled "QI study: Hand washing," dated 10/23/11, stated the ASC would monitor hand washing for a period of 2 weeks, a total of 6 working days. The ASC began collecting data related to hand washing on 11/01/11. The study monitored whether or not staff washed their hands in different situations. No documentation was present that other quality indicators were</p>	{Q 083}		

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

PRINTED: 11/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001058	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/14/2011
NAME OF PROVIDER OR SUPPLIER NORTH IDAHO PAIN CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2003 LINCOLN WAY STE 310 COEUR D'ALENE, ID 83814		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{Q 083}	Continued From page 9 being monitored or were scheduled to be monitored.	{Q 083}			
{Q 084}	<p>The facility's RN was interviewed on 11/09/11 beginning at 11:15 AM. She stated a QAPI plan which defined PIPs had not been developed. She confirmed the only data being collected was related to hand washing. She stated the hand washing study was a PIP but, since the study was minor and there was no definition for PIPs, that was not clear.</p> <p>The ASC had not defined and implemented PIPs.</p> <p>416.43(e) GOVERNING BODY RESPONSIBILITIES</p> <p>The governing body must ensure that the QAPI program-</p> <ol style="list-style-type: none"> (1) Is defined, implemented, and maintained by the ASC. (2) Addresses the ASC's priorities and that all improvements are evaluated for effectiveness. (3) Specifies data collection methods, frequency, and details. (4) Clearly establishes its expectations for safety. (5) Adequately allocates sufficient staff, time, information systems and training to implement the QAPI program. <p>This STANDARD is not met as evidenced by: Based on staff interview and review of of QAPI documents, it was determined the ASC's Governing Body failed to ensure that the QAPI program was defined and implemented. The Governing Body also failed to address the ASC's priorities, failed to specify data collection</p>	{Q 084}			

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

PRINTED: 11/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001058	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/14/2011
NAME OF PROVIDER OR SUPPLIER NORTH IDAHO PAIN CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2003 LINCOLN WAY STE 310 COEUR D'ALENE, ID 83814		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{Q 084}	Continued From page 10 methods, frequency, and details, and failed to clearly establish its expectations for safety. This resulted in the lack of a coherent and comprehensive QAPI program. Findings include: One "Governing Board" meeting was documented between 11/01/10 and 11/07/11. Minutes from that meeting, dated 10/31/11, stated the facility RN had reviewed the QAPI program and would be commencing a "study on our compliance with our hand washing protocol." The "Action" column of the minutes stated "Will start hand washing study protocol." The minutes did not mention an overall QAPI program or plans to implement or maintain such a program. Except for the hand washing study mentioned above, no QAPI plan was documented. The Administrator was interviewed on 11/09/11 beginning at 4:00 PM. She confirmed the meeting minutes. She stated there was no QAPI plan in place beyond the hand washing study. She confirmed the Governing Body had not developed such a plan. She confirmed the Governing Body had not reviewed any data related to QAPI in the past year.	{Q 084}			
{Q 160}	The Governing Body failed to develop, implement, and maintain a QAPI program. 416.47 MEDICAL RECORDS The ASC must maintain complete, comprehensive, and accurate medical records to ensure adequate patient care. This CONDITION is not met as evidenced by:	{Q 160}			

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

PRINTED: 11/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001058	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 11/14/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH IDAHO PAIN CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2003 LINCOLN WAY STE 310 COEUR D'ALENE, ID 83814
--	--

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

{Q 160}	Continued From page 11 Based on staff interview and review of medical records, it was determined the ASC failed to ensure a complete medical records system had been developed and implemented. This resulted in the inability of the ASC to reproduce a complete medical record. Findings include: Refer to Q161 as it relates to the ASC's failure to ensure adequate patient record keeping systems were developed and maintained.	{Q 160}		
{Q 161}	416.47(a) ORGANIZATION The ASC must develop and maintain a system for the proper collection, storage, and use of patient records. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records, it was determined the ASC failed to ensure a system for the proper use of patient records was developed and maintained for 15 of 15 patients (#1- #15), whose records were reviewed. This resulted in the inability to determine which staff had performed specific tasks and documented information. Findings include: The medical records for Patients #1- #15 were reviewed. These were all patients who had procedures performed between 11/01/11 and 11/09/11. All records were missing the names of nursing staff who provided care before, during, and after procedures. In addition, the "Procedure	{Q 161}		

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

PRINTED: 11/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001058	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 11/14/2011
NAME OF PROVIDER OR SUPPLIER NORTH IDAHO PAIN CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2003 LINCOLN WAY STE 310 COEUR D'ALENE, ID 83814	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{Q 161}	Continued From page 12 Flowsheets" did not include the name of the person(s) who documented the care provided to Patients #1- #15 and the flowsheets were not authenticated by the person(s) who wrote them. The RN was interviewed on 11/09/11 beginning at 2:55 PM. She confirmed the medical records did not identify nursing and unlicensed staff who provided care to patients. She stated a meeting was scheduled for 11/14/11 with the company that provided the electronic medical record to explore ways to allow staff to enter the missing information and to authenticate the "Procedure Flowsheets." She stated no alternative system had been developed to ensure the information was documented. She also said there was no time frame for when the system would be fixed.	{Q 161}		
{Q 220}	416.50 PATIENT RIGHTS The ASC did not develop a medical record system that allowed staff to document complete information. The ASC must inform the patient or the patient's representative of the patient's rights, and must protect and promote the exercise of such rights. This CONDITION is not met as evidenced by: Based on observation, staff interview, and review of medical records, it was determined the facility failed to ensure the patients were informed of their rights and their rights of were protected. This resulted in the inability of the facility to promote patient rights. Findings include: 1. Refer to Q221 as it relates to the failure of the ASC to ensure patients were provided with	{Q 220}		

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

PRINTED: 11/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001058	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/14/2011
NAME OF PROVIDER OR SUPPLIER NORTH IDAHO PAIN CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2003 LINCOLN WAY STE 310 COEUR D'ALENE, ID 83814		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{Q 220}	Continued From page 13 information regarding their rights in advance of their procedures.	{Q 220}			
{Q 221}	<p>2. Refer to Q231 as it relates to the failure of the ASC to ensure patients' personal privacy rights were respected.</p> <p>The cumulative effect of these negative facility practices prevented patients from fully exercising their rights.</p> <p>416.50(a)(1) NOTICE OF RIGHTS</p> <p>The ASC must provide the patient or the patient's representative with verbal and written notice of the patient's rights in advance of the date of the procedure, in a language and manner that the patient or the patient's representative understands.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview, and review of patient rights information and medical records, it was determined the ASC failed to ensure 5 of 15 patients (#4, #5, #6, #11, and #12) were provided with information regarding their rights in advance of their procedures. This resulted in a lack of information which patients could use to make informed decisions regarding their care. Findings include:</p> <p>1. Patient #4's medical record documented a 45 year old female who had a right sacroiliac joint injection on 11/02/11. The medical record contained a form titled "Conditions of Admission to North Idaho Pain Center, LLC." The form stated she had "...been provided and understand the verbal and written description of the Patient</p>	{Q 221}			

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

PRINTED: 11/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001058	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/14/2011
NAME OF PROVIDER OR SUPPLIER NORTH IDAHO PAIN CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2003 LINCOLN WAY STE 310 COEUR D'ALENE, ID 83814		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{Q 221}	<p>Continued From page 14</p> <p>Rights and Responsibilities." The form contained lines for Patient #4's signature and date. The form was not signed signifying she had received the rights information. The form also contained lines stating Patient #4 had been provided with advance directives, privacy practices, and the payment policy. These lines were all signed. No other documentation was present in the record to show Patient #4 had been given a copy of her rights.</p> <p>The RN was interviewed on 11/09/11 beginning at 2:55 PM. She reviewed the record and confirmed there was no documentation to show Patient #4 had been informed of her rights.</p> <p>2. Patient #11 was interviewed on 11/08/11 beginning at 7:35 AM. He was an alert and oriented 25 year old male who was scheduled for a left sacroiliac joint radiofrequency ablation, a procedure whereby an electrical current produced by a radio wave is used to heat up a small area of nerve tissue. He stated he was not given a copy of his rights. He was observed until his procedure began at 8:30 AM. Staff did not offer him or provide him with a copy of his rights during that time.</p> <p>Patient #11's medical record documented he had "...been provided and understand the verbal and written description of the Patient Rights and Responsibilities." The form was dated 11/08/11 but was not timed.</p> <p>The receptionist at the front desk, where patients checked in prior to their procedures, was interviewed beginning at 10:40 AM on 11/09/11. She stated she told patients at the time of check</p>	{Q 221}			

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

PRINTED: 11/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001058	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 11/14/2011	
NAME OF PROVIDER OR SUPPLIER NORTH IDAHO PAIN CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2003 LINCOLN WAY STE 310 COEUR D'ALENE, ID 83814		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{Q 221}	<p>Continued From page 15</p> <p>in that the ASC had a new form which explained patients' rights and responsibilities. She stated patients either took the form or they did not. She stated patients signed the "Conditions of Admission to [name of clinic]" form to verify they were offered the "PATIENT RIGHTS AND RESPONSIBILITIES" document, not that they actually received the information. She stated Patient #11 may not have taken the form.</p> <p>The ASC did not inform Patient #11 of his rights.</p> <p>3. Patient #12 was interviewed on 11/08/11 beginning at 9:10 AM. She was an alert and oriented 47 year old female who was scheduled for a lumbar epidural steroid injection. She stated she was not given a copy of her rights that day. She was observed until her procedure began at 10:25 AM. Staff did not offer her or provide her with a copy of her rights during that time.</p> <p>Patient #12's medical record documented she had "...been provided and understand the verbal and written description of the Patient Rights and Responsibilities." The form was dated 11/08/11 but was not timed.</p> <p>The receptionist at the front desk was interviewed beginning at 10:40 AM on 11/09/11. She stated Patient #12 may not have taken the form.</p> <p>The ASC did not inform Patient #12 of her rights.</p> <p>5. The receptionist was observed admitting Patient #5 to the facility on 11/08/11 at 8:40 AM, for a lumbar epidural steroid injection. She verbally reviewed the information on Advance Directives and then asked Patient #5 to sign and</p>	{Q 221}		

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

PRINTED: 11/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001058	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 11/14/2011
NAME OF PROVIDER OR SUPPLIER NORTH IDAHO PAIN CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2003 LINCOLN WAY STE 310 COEUR D'ALENE, ID 83814	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{Q 221}	<p>Continued From page 16</p> <p>date the areas related to receipt of the privacy practices, payment issues, and rights and responsibilities. The receptionist told Patient #5 she, Patient #5, had received the information during her first visit. The receptionist held up the rights and responsibilities form for Patient #5 to see and stated, "If you'd like a copy I can give you one." She was not observed to review the new information in the rights and responsibilities with Patient #5. Patient #5 did not request a copy of the current form and was not provided one.</p> <p>Documentation that Patient #5 had received a copy of her rights prior to 11/08/11 was not present in her medical record.</p> <p>Patient #5 was interviewed on 11/08/11 at 8:50 AM. She stated she had her first pain injection at the ASC the end of September 2011. She stated she may have been given a copy of the patients' rights and responsibilities at a prior visit but she was not sure. She stated she was not aware that the physician owned the ASC.</p> <p>The Administrator was interviewed on 11/16/11 at 11:10 AM. She stated the ASC first began providing current copies of rights to patients on 11/01/11.</p> <p>Patient #5 was not informed of her rights.</p> <p>6. The receptionist was observed admitting Patient #6 to the facility on 11/08/11 at 10:50 AM. Patient #6 asked the receptionist to read the information regarding Advance Directives to her, which she did. The receptionist then asked Patient #6 to sign that she had received the payment policy and privacy policies. She</p>	{Q 221}		

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

PRINTED: 11/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001058	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/14/2011
NAME OF PROVIDER OR SUPPLIER NORTH IDAHO PAIN CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2003 LINCOLN WAY STE 310 COEUR D'ALENE, ID 83814		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{Q 221}	Continued From page 17 reminded Patient #6 that she, Patient #6, had received information regarding patient rights and responsibilities on her first visit and that Patient #6 just needed to sign that she had received them. The receptionist offered Patient #6 a copy and told her she would give her one but placed the copy back in its holder before Patient #6 could respond. Patient #6 was interviewed on 11/08/11 at 11:00 AM. She stated she had seen the physician several times over the last 3-4 years for pain injections. She stated she probably did receive a copy of the patient rights information but her first visit was a while ago and she did not specifically remember. Patient #6 was not informed of her rights. 7. The receptionist from the clinic next to the ASC was interviewed on 11/09/11 beginning at 10:57 AM. She stated she discharged patients from the clinic where they were scheduled for procedures at the ASC. She stated patients were offered a copy of their rights but she said most patients did not take them. She stated she told patients they could take a copy if they wanted. She said she had them sign a form stating they were offered a copy of the rights.	{Q 221}			
{Q 231}	The ASC failed to inform patients of their rights. 416.50(c)(1) PRIVACY The patient has the right to - Personal privacy This STANDARD is not met as evidenced by:	{Q 231}			

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

PRINTED: 11/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001058	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/14/2011
NAME OF PROVIDER OR SUPPLIER NORTH IDAHO PAIN CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2003 LINCOLN WAY STE 310 COEUR D'ALENE, ID 83814		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{Q 231}	<p>Continued From page 18</p> <p>Based on observation, it was determined the ASC failed to ensure personal privacy was maintained for 2 of 5 patients (#6 and #11) whose procedures were reviewed. This resulted patient privacy being compromised unnecessarily. Findings include:</p> <p>1. Patient #11 was a 25 year old male who had a left sacroiliac joint radiofrequency ablation on 11/08/11. He was observed on that date from 7:35 AM to 8:55 AM. He was taken to the procedure room at 8:10 AM. He was placed prone on the table and his pants were pulled down below his buttocks at 8:15 AM. The door to the hallway where staff and other patients passed by was open. He was left on the table from 8:15 AM to 8:25 AM with his buttocks exposed. At that time, the surveyor closed the door and the physician thanked him for doing so.</p> <p>The ASC did not protect Patient #11's personal privacy.</p> <p>2. Patient #6 was an 80 year old female who had an epidural steroid injection performed on 11/08/11. Patient #6's care was observed on 11/08/11 from 11:50 AM through 12:39 PM. At approximately 12:20 PM, Patient #6 was assisted into a prone position on the procedure table. Her sweatshirt was raised up to the bra line and the top of her pants were lowered to expose her all of her lower back in preparation for the injection. The door was left open while staff went in and out of the room no less than three times from 12:25 PM through 12:35 PM.</p> <p>The ASC did not protect Patient #6's personal privacy.</p>	{Q 231}			

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

PRINTED: 11/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001058	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 11/14/2011
NAME OF PROVIDER OR SUPPLIER NORTH IDAHO PAIN CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2003 LINCOLN WAY STE 310 COEUR D'ALENE, ID 83814	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{Q 240}	<p>416.51 INFECTION CONTROL</p> <p>The ASC must maintain an infection control program that seeks to minimize infections and communicable diseases.</p> <p>This CONDITION is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure a comprehensive infection control program was developed, implemented and monitored. This resulted in the increased risk of infection to patients. Findings include:</p> <ol style="list-style-type: none"> 1. Refer to Q241 as it relates to the ASC's failure to ensure patients were provided with a sanitary environment in accordance with acceptable standards of practice. 2. Refer to Q242 as it relates to the ASC's failure to ensure an ongoing infection program was developed, implemented, and maintained. <p>The cumulative effect of these negative facility practices resulted in inability of the ASC to ensure all reasonable steps had been taken to prevent infections.</p>	{Q 240}		
{Q 241}	<p>416.51(a) SANITARY ENVIRONMENT</p> <p>The ASC must provide a functional and sanitary environment for the provision of surgical services by adhering to professionally acceptable standards of practice.</p> <p>This STANDARD is not met as evidenced by: Based on observation, review of facility policies and staff interview, it was determined the ASC failed to ensure facility policies and standards of</p>	{Q 241}		

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

PRINTED: 11/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001058	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 11/14/2011
NAME OF PROVIDER OR SUPPLIER NORTH IDAHO PAIN CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2003 LINCOLN WAY STE 310 COEUR D'ALENE, ID 83814	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{Q 241}	<p>Continued From page 20</p> <p>practice related to infection control were followed. This directly impacted 3 of 3 patients (#2, #11, and #14) who had an RFA procedure and whose records were reviewed, and had the potential to impact all patients who had RFA procedures at the ASC. This failure had the potential to compromise safety and increase infection risk for all patients treated at the facility. Findings include:</p> <p>Medical records documented 3 patients (#2, #11, and #14) had RFA procedures performed between 11/01/11 and 11/08/11. The facility routinely used a steam sterilizer to reprocess the probes and pads used in these procedures.</p> <p>The facility's "Sterilization" policy, dated 5/15/05, contained a section titled, "FLASH STERILIZATION." The policy stated a sterility indicator was to be placed in each tray to be sterilized. In addition, the policy indicated a biological indicator test would be conducted by the surgical technician on a daily basis.</p> <p>The facility's policy was not implemented as follows:</p> <p>The CST was interviewed on 11/09/11 at 9:00 AM. She demonstrated the process for cleaning and preparing the RFA instruments for sterilization. She stated the probe, and the pad used in the bottom of the tray, were soaked in an alkalizing agent for at least an hour. She referenced a bottle of "Speed-Clean," the alkalizing agent used at the facility. The CST stated she used a capful of the liquid in enough water to cover the probe. She explained that once the instruments were soaked and dried</p>	{Q 241}		

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

PRINTED: 11/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001058	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/14/2011
NAME OF PROVIDER OR SUPPLIER NORTH IDAHO PAIN CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2003 LINCOLN WAY STE 310 COEUR D'ALENE, ID 83814		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{Q 241}	<p>Continued From page 21 everything was wiped down with alcohol wipes.</p> <p>The bottle of Speed-Clean indicated it was a "slightly alkaline, multi-purpose solution used to remove grease and grime from sterilizers." The directions for use included draining the sterilizer reservoir, refilling it with clean distilled or demineralized water, and adding 1 ounce of liquid to a cool chamber. There were no directions on the bottle for use in cleaning instruments.</p> <p>During the interview on 11/09/11 at 9:00 AM, the CST also demonstrated double wrapping the instrument tray and taping the wrapping closed with a chemical indicator tape. The CST was not able to explain how the facility ensured the sterilization process adequately reached the instruments in the tray, as there was no chemical indicator placed in the tray. She stated they had never been required to have other indicators beyond the tape. The CST confirmed that biological indicators were not used by the facility to help ensure the adequacy of the sterilization process.</p> <p>Additionally, the facility's autoclave manual recommended a steam sterilization monitoring program included process monitors such as biological and chemical indicators to indicate if conditions in the sterilizing chamber were adequate to achieve sterilization. The manual recommended following appropriate agency sterilizing monitoring guidelines.</p> <p>The CDC Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008, stated "Like other sterilization systems, the steam cycle is monitored by mechanical, chemical, and</p>	{Q 241}			

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

PRINTED: 11/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001058	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/14/2011
NAME OF PROVIDER OR SUPPLIER NORTH IDAHO PAIN CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2003 LINCOLN WAY STE 310 COEUR D'ALENE, ID 83814		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{Q 241}	<p>Continued From page 22</p> <p>biological monitors. Steam sterilizers usually are monitored using a printout (or graphically) by measuring temperature, the time at the temperature, and pressure. Typically, chemical indicators are affixed to the outside and incorporated into the pack to monitor the temperature or time and temperature. The effectiveness of steam sterilization is monitored with a biological indicator containing spores of <i>Geobacillus stearothermophilus</i> (formerly <i>Bacillus stearothermophilus</i>)."</p> <p>The autoclave manual also recommended that items to be sterilized be cleaned in accordance with manufacturers' recommendations. The facility was not able to supply the operation manual for the RFA instruments.</p> <p>The MA was interviewed on 11/08/11 at 3:15 PM regarding the facility's sterilization process. She confirmed that a chemical indicator was not placed in the instrument tray, but the tray was double wrapped and then taped with the chemical indicator tape. She confirmed that the facility was not performing biological testing. She stated her knowledge of how to process instruments for sterilization was learned through her training as an MA and on the job training via her coworkers at the ASC.</p> <p>The personnel records for staff who processed equipment for sterilization were reviewed. The CST's personnel record indicated she had experience with instrument cleaning and packaging for reprocessing, and that she was currently certified as a CST. None of the files contained job descriptions that included processing instruments for sterilization. None of</p>	{Q 241}			

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

PRINTED: 11/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001058	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/14/2011
NAME OF PROVIDER OR SUPPLIER NORTH IDAHO PAIN CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2003 LINCOLN WAY STE 310 COEUR D'ALENE, ID 83814		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{Q 241}	Continued From page 23 the files contained documentation of training or competency testing on the facility's sterilization procedure. The Administrator was interviewed on 11/10/11 at 9:05 AM. She confirmed she did not do training related to the sterilization procedures. She also stated documentation of training for staff members in the use of sterilizing equipment was not available. The Infection Control Officer was interviewed on 11/10/11 at 9:12 AM. She stated the training of each staff member had been on-the-job. She confirmed there was no formal training regarding the sterilization procedure at the facility. The ASC failed to ensure staff followed standards of practice in processing and sterilizing equipment. The facility was unable to ensure each sterilizer cycle was monitored as it occurred and the parameters to achieving sterility were met. This resulted in the inability of the facility to ensure patients' exposure to infectious material was minimized.	{Q 241}			
{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:	{Q 242}			

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

PRINTED: 11/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001058	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 11/14/2011
NAME OF PROVIDER OR SUPPLIER NORTH IDAHO PAIN CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2003 LINCOLN WAY STE 310 COEUR D'ALENE, ID 83814	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{Q 242}	<p>Continued From page 24</p> <p>Based on observation, staff interview and review of policies and infection control documents, it was determined the ASC failed to ensure an ongoing infection control program was developed, implemented, and maintained. The lack of a defined program had the potential to prevent the ASC from identifying infections and maintaining a sanitary environment. Findings include:</p> <p>1. The job description lacked sufficient direction to the Infection Control Officer to ensure a comprehensive infection control program was defined, developed, implemented and maintained as follows:</p> <p>a. The "INFECTION CONTROL OFFICER" job description, dated 10/22/11, indicated "The infection control officer will develop and implement, with the help of the medical director, a comprehensive plan that includes actions to prevent, identify, and manage infections and communicable disease within the ASC."</p> <p>The Infection Control Officer was interviewed on 11/09/11 at 1:45 PM. She stated a comprehensive infection control plan had not been developed. She stated the facility was still in the process of deciding which nationally recognized organizations to refer to regarding infection control issues and education. She stated she felt the AORN standards of practice most closely fit with the facility's practices. She stated this issue was discussed at the board meeting on 10/31/11, but no decision had been made and she confirmed the discussion was not documented.</p> <p>There was no documentation indicating which</p>	{Q 242}		

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

PRINTED: 11/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001058	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 11/14/2011
NAME OF PROVIDER OR SUPPLIER NORTH IDAHO PAIN CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2003 LINCOLN WAY STE 310 COEUR D'ALENE, ID 83814	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{Q 242}	<p>Continued From page 25</p> <p>national guidelines had been chosen and implemented in the facility (i.e. CDC guidelines for handwashing).</p> <p>b. The job description indicated the Infection Control Officer would be the "clinical coordinator for the surgery center" and would be "knowledgeable of the principles and methods of infection control," but did not contain specific requirements. The job description also stated "Education and training will include formal classes and/or online courses specific to infection control in the ambulatory surgery center sponsored by organizations specializing in infection control...no less than every two years." It was not clear what the expectation was for continuing education (i.e. how many classes and how often).</p> <p>The Infection Control Officer was interviewed on 11/09/11 at 1:45 PM. She stated that since the last survey, on 9/30/11, she had participated in 1 infection control related webinar educational program. The title of the webinar was "Infection Prevention Imperative - An Update for 2011," conducted by "Infection Control Today," a trade magazine. She stated that much of the material presented was not applicable to their facility. She further stated staff routinely received OSHA training, but did not receive infection control training related to personal protective equipment or hand hygiene on a regular basis.</p> <p>c. The facility's policy and procedure manual contained a section titled "Asepsis." This section outlined the types of sterilization described in detail in the policy. The types of sterilization procedures described were: "1. Flash Sterilization, 2. Chemical sterilization, 3. Steris</p>	{Q 242}		

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

PRINTED: 11/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001058	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 11/14/2011
NAME OF PROVIDER OR SUPPLIER NORTH IDAHO PAIN CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2003 LINCOLN WAY STE 310 COEUR D'ALENE, ID 83814	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{Q 242}	<p>Continued From page 26 System, 4. Gas Sterilization."</p> <p>According to the CDC Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008, "'Flash' steam sterilization was originally defined by Underwood and Perkins as sterilization of an unwrapped object at 132 [degrees Centigrade] for 3 minutes at 27-28 lbs. of pressure in a gravity displacement sterilizer 843 [reference notation]. Currently, the time required for flash sterilization depends on the type of sterilizer and the type of item...Flash sterilization is a modification of conventional steam sterilization (either gravity, prevacuum, or steam-flush pressure-pulse) in which the flashed item is placed in an open tray or is placed in a specially designed, covered, rigid container to allow for rapid penetration of steam."</p> <p>The CST was interviewed on 11/09/11 at 9:00 AM. She stated the facility used steam sterilization to sterilize RFA instruments. During the interview the CST demonstrated double wrapping the instrument tray and taping the wrapping closed with a chemical indicator tape. The CST was not able to explain how the facility ensured the sterilization process adequately reached the instruments in the tray, as there was no chemical indicator placed in the tray. She stated they had never been required to have other indicators beyond the tape. The CST confirmed that biological indicators were not used by the facility to help ensure the adequacy of the sterilization process.</p> <p>The facility's "FLASH STERILIZATION" (immediate use sterilization) procedure was reviewed with the Infection Control Officer on 11/09/11 at 1:45 PM. She stated she was not</p>	{Q 242}		

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

PRINTED: 11/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001058	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 11/14/2011
NAME OF PROVIDER OR SUPPLIER NORTH IDAHO PAIN CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2003 LINCOLN WAY STE 310 COEUR D'ALENE, ID 83814	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{Q 242}	<p>Continued From page 27</p> <p>aware that the facility did not truly "Flash Sterilize" equipment (the equipment was wrapped and a complete cycle was run) and was not aware of the details of the "Flash Sterilize" procedure. She stated she was not aware the policy required a sterility indicator to be placed in each tray of items to be sterilized or that biological indicators were to be performed. She confirmed she did update the procedure to include the new information related to tracking of sterilized items to patients. She stated the facility did not use chemical or gas sterilization and did not use the Steris System.</p> <p>The sterilization policy/procedure had not been updated to reflect the current practice and incorporate appropriate standards of practice.</p> <p>d. The facility used a form titled "MONTHLY INFECTION CONTROL ASSESSMENT TOOL" to evaluate various aspects of infection control on a monthly basis. The form was divided into several sections including availability of personal protective equipment, staff compliance with use of protective equipment, proper housekeeping, proper storage of supplies, employee infection control program, and a section related to quality improvement in the infection control program.</p> <p>The Infection Control Officer was interviewed on 11/09/11 at 1:45 PM. She explained that once a month she completed a "MONTHLY INFECTION CONTROL ASSESSMENT TOOL" form for the facility. She reviewed the last form completed, dated 10/31/11. She explained the form was not truly completed in one day. She stated the marks indicating the facility met her expectations were based on her observations throughout the month. For example, she stated she did not specifically</p>	{Q 242}		

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

PRINTED: 11/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001058	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 11/14/2011
NAME OF PROVIDER OR SUPPLIER NORTH IDAHO PAIN CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2003 LINCOLN WAY STE 310 COEUR D'ALENE, ID 83814	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{Q 242}	<p>Continued From page 28</p> <p>spend time observing staff properly use personal protective equipment but overall observed them providing patient care. She confirmed she marked on the form that infection control surveys were done monthly to determine post-procedure infections. However, she stated that follow up phone calls to patients were made on a weekly basis, and the physician submitted a report regarding post-procedure infections on a quarterly basis. She explained that post-procedure follow up phone calls were made on Monday of the following week, which was at a minimum the 3rd day after the procedure. She stated if patients were not available at the time of the call, a message was left for them to contact the office with any concerns or questions. No further attempts to contact patients were made.</p> <p>The completion the "MONTHLY INFECTION CONTROL ASSESSMENT TOOL" appeared to be one specific day rather than the actual date the observations occurred. General observations of staff utilizing personal protective equipment or performing hand hygiene over a month's period of time would not be sufficient to ensure appropriate practices were followed each time they were required.</p> <p>The ASC failed to ensure an ongoing infection control program was developed, implemented, and maintained.</p>	{Q 242}		

	Action	Improvement	Implementation	Completion date	Monitoring/tracking	Responsible person(s)
Q 040	<p>The Governing Body (GB) has decided to meet quarterly in order to insure that the ASC stays on top of compliance. An agenda template has been developed for these meetings to insure that all pertinent topics are covered. The ASC has enlisted the help of an outside consultant to help guide us through this review and to help set programs in place necessary to continue to meet compliance. The GB will continue the relationship with the consultant after this process as a resource in the future to assist with compliance. In addition, the GB has decided to achieve certification through AHCCC as further demonstration of its commitment to striving to attain the highest quality care. NIPC plans to submit for this certification in 6 months.</p>		<p>A GB meeting was held. The minutes are included as an attachment. This meeting addressed the concerns of CMS survey.</p>			<p>Scott Magnuson, MD</p>

RECEIVED
 12/14/2011
 1:27 PM

Q 040	1 b.	A comprehensive QAPI program has been developed. (See QAPI program in attachments.) The GB has adopted the QAPI program (see minutes).	A QAPI program has been adopted.	The program has been adopted and started. Studies are ongoing (see attachments).	19-Dec-11	Quarterly QI meetings and quarterly GB meetings	Scott Magnuson, MD
Q 040	1 c.	A patient satisfaction survey has been identified.	This is a more comprehensive patient satisfaction survey than the one currently in use.	Michele Magnuson and Machel Barnhart, RN have been charged with reviewing the survey instrument and putting an implementation plan together prior to the next GB meeting.	19-Dec-11	QAPI meetings and GB meetings	Michele Magnuson; Machel Barnhart, RN; Scott Magnuson, MD
Q 040	1 d.	The GB has reviewed and accepted the revised job descriptions for staff members.	Job descriptions are up to date.	See GB meeting minutes.	19-Dec-11	Reviewed yearly with the policies.	Scott Magnuson, MD
Q 040	2	See response to Q 080					
Q 040	3	See response to Q 160					
Q 040	4	See response to Q 220					
Q 040	5	See response to Q 240					
Q 080		A comprehensive QAPI program has been developed and implemented	A QAPI plan is in place. (see attached plan) 3 separate studies are in place. (see attachments)	These studies are ongoing.	19-Dec-11	QAPI meetings quarterly	Machel Barnhart, RN (QAPI); Scott Magnuson, MD (GB)
Q 080	1	See response to Q 081					
Q 080	2	See response to Q 082					
Q 080	3	See response to Q 083					
Q 080	4	See response to Q 084					

Q 081	NIPC has put into place a QAPI plan that measures, analyzes and tracks quality indicators, adverse patient events, infection control and other aspects of performance that includes care and services furnished in the ASC.	The QAPI plan has been developed. The QI committee meets quarterly at least. An agenda template for the meetings has been developed to insure all aspects of the QAPI plan are addressed. This is also part of the GB meeting agenda template to insure that the GB is an integral part of this process as well.	Studies based on this plan have been initiated (see attachments). This includes the handwashing study, a study on blood glucose monitoring, and a study on sterile processing and instrument handling. The handwashing data collection is complete. The data have been analyzed. A follow up plan has been made (see attachments).	19-Dec-11 QI coordinator monitors these studies on an ongoing basis. QAPI meetings and GB meetings are quarterly and these studies are discussed at those meetings.	Machel Barnhart, RN (QAPI)
Q 082	A QAPI plan has been established.	QAPI studies are being conducted. A new patient satisfaction survey has been identified and is being prepared for implementation. A new Incident Report form has been developed	See column to left. See staff meeting minutes for discussion of QI plan.	19-Dec-11 Quarterly QAPI meetings and quarterly GB meetings.	Machel Barnhart, RN (QAPI); Scott Magnuson, MD (GB)
Q 083	A comprehensive QAPI program has been developed. (See QAPI program in attachments.) A 10 step QI plan format has been adopted to clearly show how PIPs are decided upon and implemented (see attachment)	A clear plan for PIPs is in place.	Already implemented. See attachments for PIPs underway.	19-Dec-11 Quarterly QAPI meetings and quarterly GB meetings.	Machel Barnhart, RN (QAPI)

Q 084	A comprehensive QAPI program has been developed. (See QAPI program in attachments.) The GB has adopted the QAPI program (see minutes). The QAPI coordinator has designated time to work on the QAPI program. An ongoing relationship with the consultant will provide a resource on which to draw upon as this program goes forward.	QAPI plan defines data tracking. QI committee meeting quarterly. Reports to GB who then establishes priorities for PIPs.	Implemented. See attachments for QAPI plan, studies underway, 10 step QI plan format for studies.	19-Dec-11	Quarterly meetings of QI committee. Quarterly meetings of GB.	Machel Barnhart, RN (QAPI); Scott Magnuson, MD (GB)
Q 160	See response to Q 161					
Q 161	This CfC has been met. The GB has met with the EMR template editor and Machel Barnhart, RN to review the information the EMR is recording. Appropriate changes have been made to document who provided care to the patients seen.	The EMR has been updated so that nursing staff entries (VS, standing orders, discharge orders) are now name/date/time stamped. Future updates will include MD e-signature of standing orders and medication orders	The Medical Director/GB and nursing staff continues to work with the template editor to ensure EMR records accurately reflect the course of care and satisfy documentation requirements.	19-Dec-11	Ongoing. Quarterly QAPI meetings and quarterly GB meetings.	Scott Magnuson, MD
Q 220	1	see response to Q 221				
Q 220	2	see response to Q 231				

Q 221	<p>Kate Mitchell in the Seattle CMS office was called on 11/16/2011 to discuss this issue and for clarification. This policy has been revised. The verbage used when patients are given their rights and responsibilities has been standardized to ensure consistency. Patients sign, date and time that they have received their rights. Also, at the time of the procedure, the patients are again asked if they have received their rights and responsibilities and if they understand them or have any questions about them. This is documented on the consent for the procedure.</p>	<p>This system helps to ensure that patients have been given adequate notice of their rights and responsibilities and that opportunities are there for a patient to ask any questions they may have.</p>	<p>This policy has been implemented</p>	<p>19-Dec-11 Ongoing.</p>	<p>Michele Magnuson</p>
Q 231	<p>NIPC's policy is to ensure patient privacy. These privacy issues were addressed at a staff meeting. Specifically the issue of keeping procedure room doors shut when patients were in there was addressed. In addition, it was decided that as a further measure to ensure privacy, a privacy film will be placed over the windows in the doors.</p>	<p>Patient privacy is a serious concern for NIPC. This has been addressed and improved upon.</p>	<p>The privacy of our patients in the ASC has been reviewed with our staff. The privacy film on the windows is scheduled to be placed on 12/9/2011.</p>	<p>19-Dec-11 Ongoing.</p>	<p>Machel Barnhart, RN (QAPI); Michele Magnuson; Scott Magnuson, MD (GB)</p>
Q 240	1	see response to Q 241			
Q 240	2	see response to Q 242			

Q 241

The policy for sterilization of RFA probes has been updated and revised. This has been based on manufacturer recommendations, CDC guidelines, and AAMI guidelines. The staff has been trained in this procedure. This has been documented. A new log has been created for tracking the sterilization process. Internal indicators are being used. Biological indicators are being used. Outdated policies have been removed.

The procedure for sterilization of the RFA probes meets current standards.

This has been implemented through update of the policies and procedures. The company representative for the RFA probes has provided information on sterilization procedures for their instruments. Education of staff has been completed with the 3M sterilization specialist. A QAPI study has been initiated on sterilization and instrument handling (see attachment).

19-Dec-11 Ongoing.
Quarterly
QAPI
meetings and
quarterly GB
meetings.

Machel
Barnhart, RN;
Scott
Magnuson, MD

Q 242

In concert with consultant, NIPC developed an Infection Control plan that is comprehensive (see attachment). The plan was developed using CDC, APIC, and other sources (i.e., American Society of Regional Anesthesia and Pain Medicine) as guidelines. This plan has been adopted by the GB. The job description for the Infection Control officer has been rewritten. Outdated policies for infection control have been removed from the policy manual (see GB meeting minutes). The Monthly Infection Control Assessment Tool was reassessed and Machel Barnhart, RN was educated on how to use the tool correctly. Instead of filling it out retrospectively, she will be addressing the different categories periodically throughout the month and marking the tool at that time so she is not relying on memory to determine if there were any deviations from the standards.

A more comprehensive IC plan has been developed and initiated.

The IC plan has been reviewed and adopted by the Governing Board. The IC officer job description was rewritten. This was reviewed with the IC officer. In an effort to stay abreast of ongoing issues in infection control and to use the educational resources offered, a membership in APIC has been obtained including the local chapter. Machel Barnhart, RN, as IC officer, will attend the local meetings. Her time for attendance at these meetings and for educational offerings through APIC will be covered. An annual review of the IC plan will be done by the GB. If necessary, more frequent review will be done.

19-Dec-11 Ongoing.

Machel
Barnhart, RN;
Scott
Magnuson, MD