



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
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July 31, 2013

Steven Farro, Administrator
Idaho Endoscopy Center
6259 West Emerald Street
Boise, ID 83704

RECEIVED

AUG - 8 2013

FACILITY STANDARDS

RE: Idaho Endoscopy Center, Provider #13C0001010

Dear Mr. Farro:

This is to advise you of the findings of the Medicare survey of Idaho Endoscopy Center, which was conducted on July 23, 2013.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicare deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. It is important that your Plan of Correction address each deficiency in the following manner:

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

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the PoC is effective in bringing the ASC into compliance, and that the ASC remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
- The administrator's signature and the date signed on page 1 of the Form CMS-2567.

Steven Farro, Administrator
July 31, 2013
Page 2 of 2

After you have completed your Plan of Correction, return the original to this office by **August 12, 2013**, and keep a copy for your records.

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

Sincerely,



SUSAN COSTA
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

SC/nw
Enclosures

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

PRINTED: 07/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001010	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/23/2013
NAME OF PROVIDER OR SUPPLIER IDAHO ENDOSCOPY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6259 WEST EMERALD STREET BOISE, ID 83704	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 000	INITIAL COMMENTS The following deficiencies were cited during the recertification survey of your Ambulatory Surgery Center. Surveyors conducting the recertification were: Susan Costa, RN, HFS, Team Leader Don Sylvester, RN, HFS Taylor Barkley, REHS Acronyms used in this report include: ASC - Ambulatory Surgical Center IV - Intravenous mcg - microgram mg - milligram RN - Registered Nurse CDC - Centers for Disease Control CMS-Centers for Medicare and Medicaid Services AAAHC-Accreditation Association of Ambulatory Health Care	Q 000		
Q 181	416.48(a) ADMINISTRATION OF DRUGS Drugs must be prepared and administered according to established policies and acceptable standards of practice. This STANDARD is not met as evidenced by: Based on observation, review of agency policies, and staff interview it was determined the agency failed to administer conscious sedation medications in accordance with accepted standards of practice for 2 of 2 patients (#2 and #12) whose procedures were observed. Failure	Q 181		

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FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE
President

(X6) DATE
08/08/13

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

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Q 181	<p>Continued From page 1</p> <p>to adhere to acceptable standards of practice resulted in the potential for patients to receive incorrect doses of medication during procedures and increased the potential for negative patient impact. Findings include:</p> <p>1. According to the textbook of Basic Nursing published by Wolter Klewer Health/Lippincott Williams and Wilkins in 2008, upon receipt of a verbal order the nurse must verify the order by reading back/repeating the order to the physician.</p> <p>The ASC's policy "VERBAL ORDERS MEDICATIONS", dated 6/29/1991 and reviewed by the facility October 2012, stated "IN COMPLIANCE WITH CMS AND AAAHC CROSSWALK, ALL VERBAL ORDERS WILL BE REPEATED FOR VERIFICATION." ASC staff failed to adhere to standards of practice and the ASC's policy as follows:</p> <p>a. Patient #12 was admitted for a cancer screening colonoscopy on 7/23/2013. This procedure was observed by two surveyors on 7/23/2013 starting at 8:00 AM. After Patient #12 was positioned and the procedure was about to begin, an RN was observed administering Demerol and Versed intravenously. During the procedure Demerol and Versed were administered by the RN intravenously based on Patient #12's responses to the procedure. Verbal orders were not observed to be requested by the RN, nor given by the physician, prior to the medication administrations.</p> <p>The RN failed twice to get a verbal order prior to administering intravenous medications.</p> <p>b. Patient #2 was admitted for a cancer</p>	Q 181	<p>Re-education of endoscopy nursing staff at staff meeting. Provider training at Board meeting.</p> <p>A checklist is developed to monitor the identified deficiencies. The ASC manager will observe each employee/provider during procedures initially during the week of 8/12-15/13, intermittently and ongoing observation will occur and be documented as necessary, and at least yearly for each employee. (See attached ASC Verbal Order Checklist.)</p> <p>Documentation of monitoring will be reported to the Data Quality & Systems Department and recorded in the employee education logs.</p>	8/6/13	8/6/13

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Q 181	Continued From page 2 screening colonoscopy on 7/23/2013. This procedure was observed by two surveyors on 7/23/2013 at 11:20 AM. After Patient #2 was positioned and the procedure was about to begin, an RN was observed administering Demerol and Versed intravenously. Twice during the procedure Demerol and Versed were administered by the RN intravenously based on Patient #2's responses during the procedure. Verbal orders were not observed to be requested by the RN, nor given by the physician, prior to the medication administrations. The RN failed three times to get a verbal order prior to administering intravenous medications. The Clinical Nurse Manager was interviewed on 7/23/2013 beginning at 10:30 AM. She stated the nurses work with the physicians enough that they knew the preference of the physician regarding when and how much medication to administer. Therefore, an RN might initiate a dose of medication and later get the physician to approve the dose administered. She also confirmed this practice was generally followed by facility staff during procedures.	Q 181			
Q 241	416.51(a) SANITARY ENVIRONMENT The ASC must provide a functional and sanitary environment for the provision of surgical services by adhering to professionally acceptable standards of practice.	Q 241			

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Q 241	Continued From page 3 This STANDARD is not met as evidenced by: Based on observations, review of facility policies, and staff interview, it was determined the ASC failed to ensure staff followed acceptable standards of practice to reduce the possibility of spreading infectious diseases for 2 of 2 patients (#2 and #12) whose procedures were observed, and had the potential to affect all patients receiving care at the facility. Failure to follow acceptable standards of practice had the potential to compromise safety and increase infection risk for all patients treated at the facility. Findings include: The CDC "Guidelines for Hand Hygiene in Health-Care Settings, and Hand Hygiene Basics" updated 7/30/12, was reviewed. According to the guidelines, "Healthcare providers should practice hand hygiene at key points in time to disrupt the transmission of microorganisms to patients including: before patient contact; after contact with blood, body fluids, or contaminated surfaces (even if gloves are worn); before invasive procedures; and after removing gloves (wearing gloves is not enough to prevent the transmission of pathogens in healthcare settings). In addition, the guidelines include "...hand hygiene, either hand washing or decontamination with an alcohol based hand sanitizer, is recommended including when hands are not visibly soiled, after contact with patient's intact skin, when moving from a contaminated body site to clean body site, and after contact with inanimate objects in the immediate vicinity of the patients." 1. The facility's policy, "UNIVERSAL PRECAUTIONS," dated 12/27/12, indicated that hand washing or hand hygiene was to occur	Q 241	Re-education of endoscopy nursing staff at staff meeting. Provider training at Board meeting. A checklist is developed to monitor the identified deficiencies. The ASC manager will observe each employee/provider during procedures initially during the week of 8/12-15/13, intermittently and ongoing observation will occur and be documented as necessary, and at least yearly for each employee. (See attached ASC Infection Control Hand Hygiene Checklist which has been added to the Infection Control Surveillance Program.) Documentation of monitoring will be report to the Data Quality & Systems Department and recorded in the employee education log.	8/6/13 8/6/13	

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Q 241	<p>Continued From page 4</p> <p>"before and after contact with patients even if gloves have been used." Additionally, the policy included: "Disposable gloves shall not be washed, disinfected, or reused." In the following examples staff failed to perform hand hygiene and/or proper glove use after contact with contaminated objects:</p> <p>a. Patient #12 was admitted to the facility on 7/23/13 for a colonoscopy. Care for Patient #12 was observed from admission at 7:45 AM through post-procedural recovery at 9:30 AM.</p> <p>- From 8:20 AM until 9:00 AM, the nurse assisting with Patient #12's procedure was noted to use one pair of gloves during the entire procedure. The nurse was noted to draw up medication without gloves on and administer IV sedation to the patient. She then entered data on the computer, put on a pair of gloves and removed medication from a locked drawer. After drawing up medication, the nurse administered an additional dose of sedation to Patient #12. She then assisted the physician during the procedure by applying pressure to Patient #12's abdomen. The nurse disposed of the medication syringes, entered data into the computer, turned and placed one hand on the foot of the bed, and one hand on the blood pressure machine storage basket. Without changing her gloves or using hand hygiene, the nurse assisted with biopsy. She used gauze to wipe the biopsy instrument, placed the specimens into containers, then entered data into the computer. After writing in a book, the specimen containers were labeled, and she returned to the computer. At the completion of the procedure the nurse removed her gown, then her gloves. The nurse wasted the remainder of medication, disposed of medication syringes,</p>	Q 241			

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Q 241	<p>Continued From page 5 then used hand sanitizer.</p> <p>Each of the procedure rooms had a sink as well as a waterless hand sanitizer dispenser. However, the hand sanitizer dispenser was located on a wall close to the doorway at the head of Patient #12's bed, and was not easily accessible for the nursing staff to use.</p> <p>b. Patient #2 was admitted to the facility on 7/23/13 for a colonoscopy. Care for Patient #2 was observed during the procedure from 11:20 AM to 12:30 PM.</p> <p>- At 11:23 AM after speaking with Patient #2 then performing an examination the physician put gloves on without performing hand hygiene. He then started the procedure.</p> <p>- The nurse was observed to put on gloves, touch Patient #2, enter data into the computer, and make notations in a notebook. IV sedation was administered at 11:35 AM, then data was entered into the computer. A blue cover gown was hanging on a hook in the room, the nurse placed the cover gown on and secured the ties. A canister of "Sani wipes" was obtained, and wipes were withdrawn from the canister and placed on the counter by the nurse work area. Additional IV sedation was administered to Patient #2, then the nurse returned to data entry on the computer. The nurse took a soiled glove from the physician, discarded it, and was noted to use a "Sani wipe" to wipe down her gloves. Patient #2 was assisted into position, then the nurse returned to the computer. After the computer, the nurse placed one hand on the foot of the bed, and one hand on the blood pressure machine storage basket briefly before obtaining a biopsy instrument from</p>	Q 241			

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Q 241	<p>Continued From page 6</p> <p>a cabinet. The nurse assisted with biopsy of multiple specimens, wiping the biopsy tubing with a gauze. After placing the specimens into jars, the nurse changed her gloves. Hand hygiene was not performed between glove change. An additional biopsy was obtained and placed into a jar and labeled. The nurse switched the suction canisters. When the procedure was completed, the nurse removed her gloves and assisted the patient with transfer to the recovery area. Hand hygiene was not observed.</p> <p>The nurse for Patient #2 was interviewed directly after the procedure on 7/23/13 at 12:30 PM. She confirmed she had not performed hand hygiene between glove changes. She confirmed the use of "Sani wipes" after handling contaminated items and stated that was just as effective as changing her gloves. The nurse verified the location of the hand sanitizer was across the room from her work area, and difficult to access. She then pulled out a bottle of sanitizer gel from a drawer and placed it on the counter of her work area.</p> <p>The Clinical Director was interviewed on 7/23/13 beginning at 10:30 AM regarding expectations related to hand hygiene. She stated it was an expectation for staff to perform hand hygiene after removing gloves.</p> <p>The ASC did not ensure staff followed national guidelines and facility policies for infection control.</p>	Q 241			