COPY

IDAHO DEPARTMENT OF HEALTH & WELFARE

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

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
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CERTIFIED MAIL: 7001670001133151804

August 22, 2014

Joseph Peterson, Administrator
Ambulatory Surgery Center Of Burley
1344 Hiland Avenue, Suite E
Burley, ID 83318

RE: Ambulatory Surgery Center Of Burley, Provider #13C0001028

Dear Mr. Peterson:

Based on the survey completed at Ambulatory Surgery Center Of Burley, on August 7, 2014, by our staff, we have determined Ambulatory Surgery Center Of Burley is out of compliance with the Medicare ASC Conditions for Coverage of **Governing Body and Management (42 CFR 416.41), Surgical Services (42 CFR 416.42), Quality Assessment Performance Improvement (42 CFR 416.43), Medical Records (42 CFR 416.47), Patient Rights (42 CFR 416.50).** To participate as a provider of services in the Medicare Program, an ASC must meet all of the Conditions for Coverage established by the Secretary of Health and Human Services.

The deficiencies, which caused this condition to be unmet, substantially limit the capacity of Ambulatory Surgery Center Of Burley, to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567).

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

<u>An acceptable Plan of Correction contains the following elements</u>:

- 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 each form.

Such corrections must be achieved and compliance verified by this office, before September 21, 2014. To allow time for a revisit to verify corrections prior to that date, it is important that the completion dates on your Credible Allegation/Plan of Correction show compliance no later than September 11, 2014.

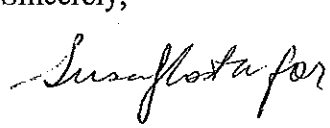
Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **September 8, 2014**.

Failure to correct the deficiencies and achieve compliance will result in our recommending that CMS terminate your approval to participate in the Medicare Program. If you fail to notify us, we will assume you have not corrected.

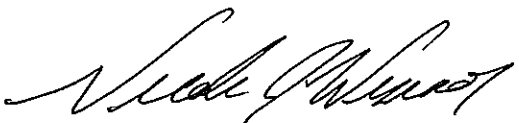
We urge you to begin correction immediately.

If you have any questions regarding this letter or the enclosed reports, please contact me at (208) 334-6626.

Sincerely,



GARY GUILES
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

GG/nw
Enclosures
ec: Debra Ransom, R.N., R.H.I.T., Bureau Chief
Kate Mitchell, CMS Region X Office

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

PRINTED: 08/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13C0001028		08/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMBULATORY SURGERY CENTER OF BURLEY	1344 HILAND AVENUE, SUITE E BURLEY, ID 83318

(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 Medicare recertification survey of your ASC conducted from 8/04/14 to 8/07/14. Surveyors conducting the recertification were: Gary Guiles, RN, HFS, Team Leader Susan Costa, RN, HFS Laura Thompson, RN, HFS Acronyms used in this report include: ASC - ambulatory surgical center CST - certified surgical technician DC - discontinue EGD - esophogastroduodenoscopy (inserting a scope into a patients esophagus, stomach and small bowel) H&P - history and physical HAI - healthcare associated infection IV - intravenous line mm - millimeter PACU - post anesthesia care unit PRN - as needed QA - quality assurance QI - quality improvement VSS - vital signs stable WNL - within normal limits WNL - within normal limits	Q 000	RECEIVED SEP 08 2014 FACILITY STANDARDS	
Q 040	416.41 GOVERNING BODY AND MANAGEMENT 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	Q 040		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: MD CEO — (X6) DATE: 9-5-14

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 040	Continued From page 1 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 plan. This CONDITION is not met as evidenced by: Based on staff interview, observation, and review of medical records, meeting minutes, policies and quality improvement documents, it was determined the ASC's governing body failed to assume responsibility for determining, implementing and monitoring policies governing the ASC's total operation and failed to provide oversight and accountability for the QAPI program. This resulted in a lack of guidance and direction to staff and a failure to sustain regulatory compliance. Findings include: 1. Refer to Q60 Condition for Coverage: Surgical Services as it relates to the governing body's failure to ensure surgical procedures were performed by physicians who had been granted clinical privileges by the governing body. 2. Refer to Q80 Condition for Coverage: Quality Assessment and Performance Improvement as it relates to the governing body's failure to ensure the ASC's quality program was developed, implemented and maintained. 3. Refer to Q160 Condition for Coverage: Medical Records as it relates to the governing body's failure to ensure medical records were complete and accurate. 4. Refer to Q219 Condition for Coverage: Patient Rights as it relates to the governing body's failure	Q 040		

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Q 040	Continued From page 2 to ensure patients were given accurate comprehensive information regarding their rights.	Q 040		
Q 060	416.42 SURGICAL SERVICES Surgical procedures must be performed in a safe manner by qualified physicians who have been granted clinical privileges by the governing body of the ASC in accordance with approved policies and procedures of the ASC This CONDITION is not met as evidenced by: Based on staff interview and review of medical records and physician credentials files, it was determined the ASC failed to ensure surgical procedures were performed by physicians who had been granted clinical privileges by the governing body. This directly impacted the care of 1 of 20 patients (#2) and had the potential to affect all patients receiving care at the facility. This resulted in the potential to allow physicians to perform procedures for which they were not qualified. Findings include: 1. Patient #2's medical record stated he was a 55 year old male who was admitted to the ASC on 6/13/14. The "OPERATIVE REPORT," dated 6/13/14, stated he had an "Open repair of epigastric hernia" performed on that date by Physician A. Physician A's "DELINEATION OF SURGICAL PRIVILEGES FORM," dated 2/01/14, did not include privileges for epigastric hernia repair. The Nurse Manager was interviewed on 8/06/14 beginning at 9:40 AM. She reviewed Physician A's credentials file. She confirmed Physician A	Q 060		

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Q 060	Continued From page 3 had not been granted privileges to perform the hernia repair on Patient #2. The ASC allowed physicians to perform surgery without specific privileges.	Q 060		
Q 080	416.43 QUALITY ASSESSMENT AND PERFORMANCE 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 policies, meeting minutes and quality program documents, it was determined the ASC failed to ensure a quality program was developed, implemented and maintained. This impeded the ability of the ASC to evaluate its practices and improve care. Findings include: 1. Refer to Q81 as it relates to the ASC's failure to ensure its quality program was defined and direction was provided to staff responsible for the program. 2. Refer to Q82 as it relates to the ASC's failure to ensure data was used to monitor the effectiveness and safety of its services, the quality of its care and to track and examine the causes of adverse patient events. 3. Refer to Q83 as it relates to the ASC's failure to ensure distinct improvement projects were conducted. 4. Refer to Q84 as it relates to the ASC's failure to ensure a quality program was defined, implemented and maintained.	Q 080		

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Q 080	Continued From page 4 The cumulative effect of these systematic failures resulted in the inability of the ASC to monitor programs and services.	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 performance improvement activities that - (i) Focus on high risk, high volume, and problem-prone areas. (ii) Consider incidence, prevalence, and severity of problems in those areas. (iii) Affect health outcomes, patient safety, and quality of care. This STANDARD is not met as evidenced by: Based on staff interview and review of policies, meeting minutes and quality program documents, it was determined the ASC failed to ensure its quality program was defined and failed to ensure	Q 081		

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Q 081	Continued From page 5 direction was provided to staff responsible for the program. This prevented the ASC from analyzing its processes in order to improve them. Findings include: 1. The policy "QUALITY ASSURANCE: GOALS AND PHILOSOPHY," updated 6/29/10, stated "The QA Committee will investigate standards of patient care to assure that each patient is receiving the necessary quality service..." The policy did not state how this would occur. The policy did not define the QA Committee or state how often they would meet. The policy did not state how the QA Committee would oversee quality activities at the ASC. Four "Administrative Meeting" minutes were documented from 8/01/13 and 8/01/14. The "Administrative Meeting" minutes stated the "QI Committee Physician" and the "QI Coordinator " attended each meeting. Minutes dated 11/07/13 stated peer review was discussed. The minutes stated "QA" was reviewed but only mentioned 1 incident that occurred post operatively. No quality indicators were mentioned. Minutes dated 1/16/14 stated peer review and "patient care issues" were reviewed. No quality indicators were mentioned. Minutes dated 3/06/14 discussed difficulties obtaining a medication specific to certain surgeries. No quality indicators were mentioned. Minutes dated 5/29/14 stated peer review was discussed and mentioned 2 specific incidents. No quality indicators were mentioned. No specific "QI Committee" minutes were documented. Three "QUALITY IMPROVEMENT COMMITTEE SHEET[s]" were documented in 2014. Each sheet described an incident that had occurred.	Q 081		

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Q 081	Continued From page 6 None of the sheets documented an investigation of the incident nor did they identify causes or postulate courses of action to keep the incidents from recurring. Each sheet was signed as "Reviewed by" the "QI Committee Physician" and the "QI Coordinator." A plan for QI activities, including specific quality indicators, was not documented. Documentation was not present that the ASC had determined priorities for its performance improvement activities, including high risk, high volume, and problem-prone areas. The QI Coordinator was interviewed on 8/05/14 beginning at 2:45 PM. She confirmed a specific plan for quality activities had not been developed. She stated QI Committee minutes did not mention quality indicators or discuss quality activities. She stated ASC documents did not identify high risk, high volume, and problem-prone areas for study. The ASC did not develop a definable quality 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	Q 082		

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Q 082	Continued From page 7 improvements and changes in its patient care. (c)(2) Performance improvement activities must track adverse patient events, examine their causes, implement improvements, and ensure that improvements are sustained over time. (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. This STANDARD is not met as evidenced by: Based on staff interview and review of meeting minutes and quality program documents, it was determined the ASC failed to ensure data was used to monitor the effectiveness, the safety of its services, the quality of its care and track and examine the causes of 3 of 3 adverse patient events. This impeded the ASC's ability to identify opportunities that could lead to improvements in patient care. Findings include: 1. Three "Quality Assurance Reports" were documented from 8/01/13 and 8/01/14. The reports were not dated but were labeled the third quarter of 2013, fourth quarter of 2013, and first quarter of 2014. The 3 reports all discussed data from patient satisfaction questionnaires and mentioned no infections had occurred. Each report also stated 50 records were reviewed and no deficiencies were found. No other data was mentioned in the reports. No data related to facility practices was documented. No recommendations of changes to facility practices were documented. The QI Coordinator was interviewed on 8/05/14	Q 082		

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Q 082	Continued From page 8 beginning at 2:45 PM. She confirmed the lack of data documented in the "Quality Assurance Reports." She stated no recommendations for changes in ASC practices had been proposed based on data gathered for the "Quality Assurance Reports." The ASC did not use data to identify opportunities for improvement. 2. "QI Study" documents contained limited useful data and/or were not used to monitor the effectiveness and safety of its services and quality of care provided. In addition, the documents did not identify opportunities that could lead to improvements and changes in patient care. Examples include: a. A document titled "QI Study: Handwashing Compliance," dated 10/03/13, stated the ASC had a goal of "...95% compliance of performing proper hand hygiene." The document stated compliance rates were 74% for nurses, 60% for physicians, and 86% for anesthesia personnel. The document stated the corrective measure would be for the "[QI Coordinator] to remind staff of the importance of performing proper hand hygiene and encourage the staff to observe and remind others if they notice handwashing opportunities missed." No other recommendations were made. The document stated a repeat study would be performed in 3 months. No repeat hand washing studies were documented. b. A document titled "QI Study: Pre-Operative Lab Work Restudy," dated 10/30/13, stated a critical laboratory value had been missed prior to surgery. The report stated the surgeon designated one of his office staff members to	Q 082		

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Q 082	Continued From page 9 check laboratory reports prior to surgery. The report stated "...no surgeries were canceled the day of surgery due to abnormal lab results..." The report stated the study would be repeated in 3 months. No specific data related to the ASC's practice was documented. No further studies were documented. c. Two documents titled "QI Study: Allergy Effects" stated the ASC wanted to have 100% of completed charts reflect the effects of reported allergies, i.e. rash, hives, etc. The first document, dated 4/19/14, stated 59% of charts contained the information. The document stated the corrective action was to remind nursing staff to collect the information. The second document titled "QI Study: Allergy Effects," dated 7/31/14, stated of 33 patients with documented allergies, 27 had the allergy effects noted. The document stated this amounted to 92% of the charts that met the goal, however only 82% of charts actually met the goal (27/33.) The document stated the corrective action was to remind nursing staff to collect the information. No causes for the lack of compliance were documented in either study. No change in facility practices was recommended in either study. d. A document titled "Benchmarking Study: Colonoscopy," dated 7/30/14, measured the times of colonoscopies at the ASC and compared them with times of colonoscopies at hospitals and an aggregate of ASCs. The purpose of the study was not documented and no conclusions from the study were stated. The QI Coordinator was interviewed on 8/05/14	Q 082		

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Q 082	Continued From page 10 beginning at 2:45 PM. She confirmed the hand washing study had not been repeated. She confirmed no data had been gathered regarding ASC practices in relation to the laboratory work study. She confirmed no changes to facility practices had been recommended based on the allergy study. She confirmed no conclusions or recommendations had been reached from the benchmarking study. She stated no changes to ASC practices had been made in the last year as a result of data from the ASC's quality program. QI Studies did not provide data that was used to improve patient care. 3. Three "QUALITY IMPROVEMENT COMMITTEE SHEET[s]" documented incidents that adversely affected patients in 2014. All 3 incident reports contained a simple narrative of events. None of the incident reports examined facility practices or contained recommendations to improve care. The QI Coordinator was interviewed on 8/05/14 beginning at 2:45 PM. She confirmed the "SHEET[s]" was the equivalent of incident reports. She confirmed the incidents had not been investigated to determine if facility practices had contributed to the events. Also, she stated incidents were not formally tracked to look for trends. The ASC did not investigate incidents that adversely affected patients.	Q 082		
Q 083	416.43(d) PERFORMANCE IMPROVEMENT PROJECTS (1) The number and scope of distinct	Q 083		

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Q 083	Continued From page 11 improvement projects conducted annually must reflect the scope and complexity of the ASC's services and operations. (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 This STANDARD is not met as evidenced by: Based on staff interview and review of policies and quality program documents, it was determined the ASC failed to ensure distinct improvement projects were conducted. This impeded the ASC's ability to evaluate and improve care. Findings include: 1. The policy "QUALITY ASSURANCE: GOALS AND PHILOSOPHY," updated 6/29/10, did not contain a definition of performance improvement projects or their equivalents. The policy did not discuss the ASC's role in conducting such projects. No other policy discussed distinct performance improvement projects. No distinct improvement projects were documented between 8/01/13 and 8/01/14. The QI Coordinator was interviewed on 8/05/14 beginning at 2:45 PM. She confirmed policies did not address distinct improvement projects. She also stated no such projects had been conducted in the past year. The ASC did not conduct distinct improvement projects.	Q 083		

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Q 084	Continued From page 12	Q 084		
Q 084	416.43(e) GOVERNING BODY RESPONSIBILITIES The governing body must ensure that the QAPI program- (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. This STANDARD is not met as evidenced by: Based on staff interview and review of policies, it was determined the ASC's governing body failed to ensure a quality program was defined, implemented and maintained. This lack of oversight hindered the ASC's ability to evaluate its practices and improve care. Findings include: 1. The policy "QUALITY ASSURANCE: GOALS AND PHILOSOPHY," updated 6/29/10, stated "The Quality Assurance Committee will operate under the oversight & guidance of the Governing Board & will report to them." The policy did not define the Board's role in quality assurance activities. The "QUALITY ASSURANCE: GOALS AND PHILOSOPHY," policy stated "The QA Committee will investigate standards of patient care to assure that each patient is receiving the necessary quality service..." The policy did not	Q 084		

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Q 084	Continued From page 13 state how this would occur. The policy did not define the QA Committee or state how often they would meet. The policy did not state how the QA Committee would oversee quality activities at the ASC. The QI Coordinator was interviewed on 8/05/14 beginning at 2:45 PM. She confirmed policies did not define the "Governing Board's" role and duties regarding quality. She also confirmed the QA Committee's role and duties were not clearly defined. ASC policies did not specify the "Governing Board's" duties in relation to the oversight of its quality program. 2. The QI Coordinator was interviewed on 8/05/14 beginning at 2:45 PM. She stated a plan for quality activities, including how data would be gathered and utilized, had not been developed. The "Governing Board" did not ensure a plan for quality activities had been developed and implemented. 3. The QI Coordinator was interviewed on 8/05/14 beginning at 2:45 PM. She stated distinct improvement projects had not been defined or conducted. The "Governing Board" did not ensure distinct improvement projects were conducted. 4. The owner and QI Coordinator were interviewed together on 8/05/14 at 4:15 PM. Both stated the time and resources used for quality activities was not tracked.	Q 084		

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Q 084	Continued From page 14 The "Governing Board" did not monitor the time and resources utilized for quality activities in order to ensure sufficient time and resources were allocated to maintain the QAPI program.	Q 084		
Q 141	416.46(a) ORGANIZATION AND STAFFING Patient care responsibilities must be delineated for all nursing service personnel. Nursing services must be provided in accordance with recognized standards of practice. There must be a registered nurse available for emergency treatment whenever there is a patient in the ASC. 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 nursing services were provided in accordance with recognized standards of practice. This affected the care of 5 of 20 patients (#2, #4, #11, #13, #14 and #19) whose records were reviewed. This had the potential to result in negative patient outcomes. Findings include: 1. Patient #14 was a 22 year old male who was admitted to the ASC for a surgical procedure on his ankle. His pre-operative checklist, dated 6/24/14, untimed, documented his height of 6 feet and weight of 229 pounds. a. The National Institutes of Health defines hypotension as <90 systolic, and <60 diastolic. Patient #14's record documented he experienced low blood pressure, without intervention, as follows: His admission to the ASC included a blood	Q 141		

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Q 141	Continued From page 15 pressure reading of 116/75, documented on the pre-operative record. Patient #14's record documented he was transfer to recovery at 12:35 PM. At that time his blood pressure upon was documented as 85/41. Five minutes later it was noted at 84/34. There was no documentation the recovery nurse notified the physician or CRNA of the low blood pressure readings. There was no documentation of intervention to elevate his blood pressure. Additional blood pressure readings for Patient #14's were documented, as follows: - 12:45 PM: 81/46 - 21:50 PM: 84/36 - 12:55 PM: 85/35 - 12:59 PM: 92/48 - 1:15 PM: 95/50 - 1:35 PM: 93/49, which was his last blood pressure before his discharge to home at 1:50 PM. The recovery nurse did not document she informed the physician or CRNA of Patient #14's low blood pressures. During an interview on 8/06/14 beginning at 4:40 PM, the Nurse Manager reviewed Patient #14's record and confirmed the blood pressure readings were low and the physician or CRNA should have been notified before his discharge. b. Patient #14's post-operative orders included the medication "Vicodin" 1-2 tablets every 3 to 4 hours as needed for pain." The post-operative record included documentation Patient #14 received	Q 141		

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Q 141	Continued From page 16 Hydrocodone 10 mg orally for pain at 1:15 PM. The nurse did not include a reassessment of his pain after the medication was administered and before his discharge. During an interview on 8/06/14 beginning at 4:40 PM, the Nurse Manager reviewed Patient #14's record and confirmed there was no evidence his pain was reassessed. 2. Patient #2 was a 55 year old female admitted to the ASC for outpatient surgical procedures that included abdominoplasty, liposuction, and hernia repair. During the post-operative recovery period, she received medications that were not ordered, and/or ordered with specific parameters: - The Post-Operative orders included Fentanyl 25-50 mcg (IV) every 1 hour as needed for pain, and Zofran 4 mg (IV) every 4 hours as needed. - The post-operative recovery record noted Patient #2 received Fentanyl at 4:03 PM and at 4:15 PM. The record indicated Patient #2's pain level at 4:03 PM and at 4:15 PM as a "0". The medication was administered 12 minutes apart, not after an hour as ordered. - The recovery record noted Patient #2 received Phenergan 12.5 mg at 4:40 PM. Her record did not include orders for Phenergan. - Patient #2's record did not document why the medications were administered, nor did it document she was evaluated after the medications were administered. During an interview on 8/05/14 beginning at 9:00 AM, the Nurse Manager reviewed Patient #2's	Q 141		

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Q 141	Continued From page 17 record and confirmed there was no order for the Phenergan. Additionally, the Nurse Manager confirmed the nurse administered the Fentanyl, 2 doses, 12 minutes apart, rather than an hour as ordered. She stated the documentation should describe why the medication was given, and should include an evaluation to determine effect of the medication. 3. Patient #13 was a 51 year old female admitted to the ASC on 7/25/14 for the removal of a mass on her right tonsil. Her post-operative record documented she received Tylenol 500 mg 2 tablets orally at 1:08 PM. Her "POST-OPERATIVE AND DISCHARGE ORDERS," dated 7/25/14 at 12:20 PM, included "Tylenol/Motrin prn pain at home." The order did not include a dose, frequency, or route. During an interview on 8/06/14 beginning at 4:50 PM, the Nurse Manager reviewed Patient #13's record and stated the nurse gave the Tylenol correctly, as it was ordered to be given at home. She confirmed the discharge order did not include route, dose, or frequency, and stated the 2 tablets given were appropriate. 4. Patient #4's medical record documented a 33 year old female who had right shoulder surgery performed on 7/11/14. Patient #4's "POST OPERATIVE RECORD," dated 7/11/14, stated Patient #4 was given Fentanyl 25 mcg IV at 10:07 AM and at 10:15 AM. The record also stated Patient #4 was given Phenergan 10 mg IV at 10:35 AM. An order for the medications was not present in Patient #4's medical record.	Q 141		

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Q 141	Continued From page 18 The Nurse Manager reviewed Patient #4's record with the surveyor on 8/06/14 beginning at 11:20 AM. She confirmed the the Fentanyl and Phenergan doses were given without physician orders. The ASC did not ensure nursing staff administered medications only as ordered. 5. Refer to Q184 as it relates to the ASC's failure to ensure verbal orders for medications were written and signed by the recipient of the order and the physician.	Q 141		
Q 160	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: Based on observation, review of medical records and policies and staff interview, it was determined the ASC failed to ensure medical records were complete and accurate. This resulted in a lack of available information and impeded the ASC's ability to reconstruct the history of patients' care. Findings include: 1. Refer to Q162 as it relates to the governing body's failure to ensure medical records were complete and accurate.	Q 160		
Q 162	416.47(b) FORM AND CONTENT OF RECORD The ASC must maintain a medical record for each patient. Every record must be accurate, legible, and promptly completed. Medical records must include at least the following:	Q 162		

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Q 162	Continued From page 19 (1) Patient identification. (2) Significant medical history and results of physical examination. (3) Pre-operative diagnostic studies (entered before surgery), if performed. (4) Findings and techniques of the operation, including a pathologist's report on all tissues removed during surgery, except those exempted by the governing body. (5) Any allergies and abnormal drug reactions. (6) Entries related to anesthesia administration. (7) Documentation of properly executed informed patient consent. (8) Discharge diagnosis. This STANDARD is not met as evidenced by: Based on observation, review of medical records and policies and staff interview, it was determined the facility failed to ensure medical records were complete and accurate for 15 of 20 patients (#1-#6, #9, #11-#15, #17, #19, and #20) whose records were reviewed. This failure resulted in a lack of complete comprehensive information being available in patient records. Findings include: 1. A facility policy, "REQUIREMENTS FOR SURGICAL PROCEDURES," revised 3/24/10, stated patient medical record were to include the following: - A current H&P done within 30 days. - Required Laboratory tests. - A signed informed consent, including the type of procedure and names of physicians performing the surgery, as well as a completed pre-op checklist. - An anesthesia note prior to surgery.	Q 162		

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Q 162	Continued From page 20 - An operative report, which was to be dictated immediately after surgery and include the preoperative diagnosis, procedures performed, and description of tissues and findings. - A plan of care, including discharge planning, and written and signed discharge instructions, which were to be given to the patient at the time of discharge. Patient records were reviewed. The records did not demonstrate complete and accurate documentation, per facility policy, as follows: a. Patient #2 was a 55 year old female who was admitted on 6/13/14 for an abdominoplasty (tummy tuck) and hernia repair. Her record did not include comprehensive and consistent documentation, as follows: - The Pre and Post-operative orders were on a pre-printed form and included the date and times. The orders were signed by the physician and noted by the ASC nurses, but the signatures did not include times or dates to indicate when they had been signed by the physician and nurses. - Her "ANESTHESIA RECORD" form indicated Patient #2 had an Abdominoplasty, and did not document a hernia repair had been performed. - The form "O.R. PROGRESS NOTES" indicated the preoperative diagnosis was "Epigastric Hernia, " and the operation performed was "Repair Epigastric Hernia." The form did not include the abdominoplasty, as documented by the CRNA on the anesthesia record. - Her Post-Operative Record included a "NURSE'S NOTES," section which indicated	Q 162		

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Q 162	Continued From page 21 Patient #2 arrived in PACU at 2:58 PM. The vital signs section of the record indicated Patient #2 arrived at 3:58 PM. The record included documentation Patient #2 received Fentanyl 25 mcg at 4:03 PM and 4:40 PM, and Phenergan 12.5 mg at 4:40 PM. The form did not indicate why the medications were administered and did not include documentation of re-evaluation for the effects of the medications that were given. - There were 2 operative reports in Patient #2's record, both dated 6/13/14. One report documented the pre-operative diagnosis of epigastric hernia, with the procedure performed as "open repair of epigastric hernia." The other report documented the pre-operative diagnosis of "Excessive abdominal panniculus and lipodystrophy, bilateral flanks and abdomen." The procedure performed was "Abdominoplasty with muscle plication and liposuction, bilateral flanks and upper abdomen." Both reports differed in appearance; the first report (hernia repair) included a header "OPERATIVE REPORT," with the name of the ASC. It had a dictated date and transcription date and initials. The report for the abdominoplasty was in a different font, and there was no indication when it was dictated. However under the physician signature, was the date 8/04/14. During an interview on 8/05/14 beginning at 9:00 AM, the Nurse Manager reviewed Patient #2's record and stated the 2 reports differed because one was submitted to the insurance company for the hernia repair. She stated when the survey team requested records on 8/04/14 for record review as part of the recertification process, she	Q 162		

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Q 162	Continued From page 22 noted Patient #2's record was incomplete. She stated the operative report for the abdominoplasty was obtained and placed into the chart on 8/04/14. The Nurse Manager reviewed the additional forms in Patient #2's record. She confirmed the orders did not include dates and times, as well as, the inaccuracies noted on the anesthesia record, post-operative record and progress notes. b. Patient #5 was a 66 year old male, admitted to the ASC on 7/11/14 for a ligament repair of his right knee. His did not include comprehensive documentation, as follows: - His Operative Report did not document how his leg was prepped before the procedure. - His pre-op orders included Patient #5's name and the date of the scheduled surgery. The orders were signed by the physician, but were not dated and timed to indicate when they were signed. The orders were noted by an ASC nurse and dated, but it was not timed. - His pre-operative checklist did not include the time Patient #5 was admitted to the ASC. - His post-operative orders were not dated or timed to indicate when the physician signed the orders. The nurse noted the orders, but did not include the time they were noted. - His post-operative orders included the medication "Vicodin" 1-2 tablets every 3 to 4 hours as needed for pain. Patient #5's post-operative record included documentation he received Hydrocodone 7.5/325 orally at 1:50 PM. He was not medicated as ordered.	Q 162		

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Q 162	Continued From page 23 The narcotic log in the ASC was reviewed on 8/056/14 at 1:50 PM, and included 2 forms of Hydrocodone/acetaminophen, (tablet and liquid). The liquid form contained Hydrocodone 7.5 mg and acetaminophen 325 mg in 5 ml. The tablet form contained Hydrocodone 10 mg and acetaminophen 325 mg per tablet. According to drugs.com, Vicodin is a brand name for hydrocodone/acetaminophen. However, Vicodin contains 5 mg hydrocodone, and 500 mg of acetaminophen per tablet. During an interview on 8/05/14 beginning at 8:45 AM, the Nurse Manager reviewed Patient #5's record and confirmed his record did not include how his leg was prepped and with what solution before the procedure. She confirmed the forms did not include times and dates. She stated the pre-op orders were initiated in the physician office when Patient #5 was scheduled for his procedure. Additionally, she stated the Vicodin order and the hydrocodone that was administered was the same. She stated the order was written as Vicodin, but it really meant hydrocodone 7.5 mg/acetaminophen 325 mg. She stated the ASC did not have Vicodin as the brand name, but has hydrocodone/acetaminophen. c. Patient #12 was an 81 year old female, admitted to the ASC on 7/22/14 for a surgical procedure to remove excess tissue from her eyelids. Her record did not include comprehensive and consistent documentation, as follows: - A form titled "PROCEDURE RECORD," dated 7/22/14, was pre-printed and appeared to have	Q 162		

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Q 162	Continued From page 24 been copied multiple times resulting in ink speckles and distorted print. The pre-printed diagnosis and procedure of "Mature Cataract and Cataract extraction," was crossed out, and the words "Dermatochalasis and Bilateral upper lid blepharoplasty OU" were written in by hand. The form indicated Patient #12 was taken to the OR at 10:43 AM, and the procedure was started at 10:53 AM. However, the form documented the procedure ended at 10:42 AM. The vital signs documented on the form included the pre-procedural vital signs at 9:15 AM, and then every 10 minutes from 10:43 AM to 11:23 AM. After that, vital signs were documented at 11:29 AM and 11:45 AM. The record also included documentation that Patient #12 was transferred to the recovery area at 11:29 AM. Vital signs were taken upon arrival in recovery and 16 minutes later. The form noted Patient #12 was discharged at 11:47 AM. However, in the comments section, a nurse noted Patient #12 was discharged at 12:45 AM, in stable condition. - A physician's orders sheet, signed by Patient #12's physician, dated 7/08/14, did not include a time. The form was noted by an ASC nurse, and "940" was beside the nurse's signature. However, it did not include a date to indicate when it was noted. Additionally, the orders included "2 mg Valium on arrival." It did not include a route to be administered, either orally or injected. - Patient #12's record did not include a time of admission to the ASC, or the prep used before	Q 162		

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Q 162	Continued From page 25 the procedure. During an interview on 8/06/14 beginning at 5:00 PM, the Nurse Manager reviewed Patient #12's record and confirmed the discrepancies as noted on the procedure record. She stated all patients were prepped with Betadine, unless they had an allergy to it, and in that case Hibiclens would be used. She stated the nursing staff should have used another form, and not the pre-printed form for cataract. The Nurse Manager confirmed the discrepancy in times on the procedure record, and was not able to determine how the times were different. Additionally, the Nurse Manager stated she was aware the physicians and staff were not including dates and times on multiple documents. d. Patient #11 was a 4 year old male admitted to the ASC on 7/24/14 for dental work under general anesthesia. His record did not include comprehensive and consistent documentation, as follows: - His record did not include a time of admission to the ASC. - His consent, dated 7/24/14, was signed by Patient #11's mother. However, the section that noted Patient #11 was a minor and was unable to sign the document authorizing the surgical procedure, was left blank. - A form titled "Preoperative Orders," was signed by the physician and nurse. However, the form was not dated or timed. - The "ANESTHESIA RECORD," dated 7/24/14, noted Patient #11 experienced a difficult and	Q 162		

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Q 162	Continued From page 26 traumatic intubation, which required 3 attempts before successful nasal intubation and administration of general anesthesia. The "POST OPERATIVE RECORD," noted Patient #11 arrived in recovery at 8:39 AM, with labored respirations, and was noted to have stridor, and Racemic epinephrine was administered by means of a nebulizer treatment. (Stridor is defined as an abnormal, high-pitched sound produced by turbulent airflow through a partially obstructed airway.) Patient #11's operative report documented there were no complications, and Patient #11 was transferred to the recovery room in stable condition. The operative report did not include the difficult, traumatic intubation after multiple attempts, or the stridor upon arrival to recovery that required a medicated breathing treatment. During an interview on 8/06/14 beginning at 4:30 PM, the Nurse Manager reviewed Patient #11's record and confirmed the documentation of traumatic intubation, as well as, the respiratory complication of stridor after his extubation. She was unsure why the operative report did not include the incidents. e. Patient #19 was a 68 year old female admitted to the ASC on 8/05/14 for cataract removal from her right eye. Her record did not include comprehensive and consistent documentation, as follows: - A form titled "PHYSICIAN ORDERS FOR OUTPATIENT SURGERY," dated 8/05/14, was a pre-printed order sheet, with spaces to fill in such as times, which eye was to be treated, and the physician's name. The form indicated Patient #19's right eye was to be prepared for the	Q 162		

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Q 162	Continued From page 27 procedure. - Her Operative Report, dated 8/05/14, included preoperative diagnosis as "Vision-impairing cataract, left eye." The operative report documented the procedure performed was on Patient #19's left eye. The surgical procedure was observed by 2 surveyors, and the prep, time out, and procedure was performed on her right eye. During an interview on 8/05/14 beginning at 4:45 PM, the Nurse Manager reviewed Patient #19's record and confirmed the operative report indicated Patient #19's left eye had the procedure performed. f. Patient #14 was a 22 year old male admitted to the ASC on 6/24/14 for a surgical procedure to repair his right ankle. His record did not include comprehensive and consistent documentation, as follows: - A form titled "AMBULATORY SURGICAL CENTER ORDERS," included Patient #14's name and the date of surgery of 6/24/14. The form included pre-printed orders and was signed by Patient #14's physician and the nurse who noted the orders. However, there was no date and time to indicate when the orders were written and noted. - His anesthesia record included documentation that Patient #14 was 6 feet tall and weighed 299 pounds. However, the nursing pre-operative checklist noted Patient #14 was 229 pounds. A 70 pound weight difference had the potential to result in a medication error due to over calculation or under calculation of Patient #14's	Q 162		

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Q 162	Continued From page 28 actual weight. - The record did not indicate what time Patient #14 was admitted to the ASC. - His post-operative record included documentation Patient #14 received Hydrocodone 10 mg orally for pain 7/10 at 1:15 PM. The nurse did not include a reassessment of his pain after the medication was administered and before his discharge. Additionally, the post-operative orders included Vicodin 1-2 tablets every 3 to 4 hours as needed for pain. Patient #14 did not receive medications as ordered by his physician. According to drugs.com, Vicodin is a brand name for hydrocodone/acetaminophen, and contains 5 mg hydrocodone with 500 mg of acetaminophen. The medication ordered was for Vicodin, 1-2 tablets, which would be a dose of 5-10 mg of Hydrocodone and 500-1000 mg of acetaminophen. The medication log in the ASC was reviewed, and did not include Vicodin, it included a generic of Hydrocodone 10 mg and 325 mg acetaminophen. So, by using a different drug, (a generic version) the nurse administered 10 mg of Hydrocodone and 325 mg acetaminophen, which was a lesser dose of acetaminophen than the order. During an interview on 8/06/14 beginning at 4:40 PM, the Nurse Manager reviewed Patient #14's record and confirmed the documentation discrepancies. She confirmed the record did not include times and dates for the physician and nursing signatures. Additionally, she stated the Vicodin order and the hydrocodone that was	Q 162		

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Q 162	Continued From page 29 administered was the same. She stated the order was written as Vicodin, but it really meant hydrocodone 7.5 mg/acetaminophen 325 mg. She stated the ASC did not have Vicodin as the brand name, but has hydrocodone/acetaminophen. g. Patient #13 was a 51 year old female admitted to the ASC on 7/25/14 for the removal of a mass on her right tonsil. Her record did not include comprehensive documentation, as follows: - A form titled "Preoperative Orders," included Patient #13's name and the date of her surgery of 7/25/14. The form was signed by her physician, and included a slash mark to the left of the orders with a signature of the ASC nurse. The orders were not timed and dated to indicate when they were signed and noted. - Her pre-operative checklist did not include the time that Patient #13 was admitted to the ASC. During an interview on 8/06/14 beginning at 4:50 PM, the Nurse Manager reviewed Patient #13's record and confirmed the documents did not indicate when they were signed and noted, as well as, the time of her admission to the ASC. The ASC did not ensure accurate documentation in patient medical records. h. Patient #17 was a 75 year old male admitted to the ASC on 7/8/14 for a surgical procedure on both eyelids. His record did not include comprehensive documentation, as follows:	Q 162		

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Q 162	Continued From page 30 - His "OPERATIVE REPORT" was dictated on 7/8/14 and transcribed on 7/9/14. The report was not signed by the physician as of 8/07/14. - His "PHYSICIAN'S ORDERS" were dated 7/1/14, and signed by the physician, did not include a time next to the signature. Next to the written orders was a signature of a nurse who worked at the ASC, indicating the orders were noted. However, the nurse did not date or time when the orders were noted. - His "IV CONSCIOUS SEDATION MEDICATION ORDERS," dated 7/8/14 was signed by Patient #17's physician but had no time next to the signature. Next to the written orders was a signature of a nurse who worked at the ASC, indicating the orders were noted. However, the nurse did not time when the orders were noted. The Nurse Manager was interviewed on 8/6/14 at 9:17 AM, and after review of the records she stated the operative report was tagged to be signed by the physician and confirmed the physician had not signed the report. She also confirmed the other forms were not dated or timed, either by the physician writing the orders or the nurse noting the orders. i. Patient #6 was a 37 year old male admitted to the ASC on 7/16/14 for EGD with Dilation and Biopsy. His record did not include comprehensive documentation, as follows: - His record included a pre-printed "O.R. PROGRESS NOTES" form which contained two signature lines for the physician and several checkboxes which stated various items such as "Patient seen by surgeon preoperatively and	Q 162		

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Q 162	Continued From page 31 cleared for anesthesia...Heart exam WNL...Lung exam WNL...Dictated...Discharge to...Admit to Hospital..." Patient #6's OR progress notes had a signature near the top and a handwritten comment "see dictation" at the bottom of the page. There was no date or time on the form near the signature or comment. The check box next to "DICTATED" was unmarked. - His "OPERATIVE REPORT" was signed by the physician with no date or time documented next to the signature. - His "ANESTHESIA RECORD" dated 7/16/14, stated Patient #6 had received a total of 850 ml of IV fluids. In the "ENDOSCOPY RECORD" the nurse documented 150 ml of fluids as the total under the section "OR IV CREDIT." The Nurse Manager was interviewed on 8/6/14 at 4:20 PM, after review of the record she confirmed the signature near the top of the "O.R. PROGRESS NOTES" form was the physician ' s who performed the procedure and there was no date or time. She also confirmed the dictation checkbox had not been marked and stated she did not know who wrote the comment at the bottom of the page. She confirmed the physician had not documented the date and time next to the signatures on the forms. She also confirmed the discrepancy in the documentation of the recorded IV fluids during the procedure. j. Patient #15 was a 70 year old female admitted to the ASC for a colonoscopy (an examination of the large intestine). Her record did not include comprehensive documentation, as follows:	Q 162		

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Q 162	Continued From page 32 Her record included a pre-printed "O.R. PROGRESS NOTES" form which contained two signature lines for the physician and several checkboxes which stated various items such as "Patient seen by surgeon preoperatively and cleared for anesthesia...Heart exam WNL...Lung exam WNL...Dictated...Discharge to...Admit to Hospital..." Patient #15's OR progress notes had a signature near the top of the form, but no date or time was present. There was no other documentation on the form. The Nurse Manager was interviewed on 8/6/14 at 4:15 PM, after record review she confirmed the signature on the form was the physician's who performed the procedure. She also confirmed there was no date or time and no other documentation on the note. k. Patient #20 was a 67 year old male admitted to the ASC for a colonoscopy (an examination of the large intestine). His record did not include comprehensive documentation, as follows: His record included a pre-printed "O.R. PROGRESS NOTES" form which contained two signature lines for the physician and several checkboxes which stated various items such as "Patient seen by surgeon preoperatively and cleared for anesthesia...Heart exam WNL...Lung exam WNL...Dictated...Discharge to...Admit to Hospital..." Patient #20's OR progress notes had a signature near the top of the form and a handwritten comment "see op report" near the bottom of the	Q 162		

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Q 162	Continued From page 33 page. There was no date or time on the form near the signature or comment. There was no other documentation on the form. The Nurse Manager was interviewed on 8/6/14 at 4:25 PM, after review of the record she confirmed the document was incomplete, with no date or time next to the physician's signature and all of the checkboxes were unmarked. I. Patient #1's medical record documented a 73 year old female who had EGD performed on 4/30/14. Her record did not include comprehensive and consistent documentation, as follows: - Her physician's "EGD Report," dated 4/30/14 at 1:30 PM, stated "A 15 mm stepwise balloon was introduced [into the pylorus, an area between the stomach and the duodenum] for dilation and the diameter was progressively increased to 18 mm successfully." The report also stated "Patient tolerance to the procedure was excellent. The procedure was not difficult..." The report then stated "Limitations/complications: Perforation." The report ended with "Plan: Admit to hospital. The patient is referred to a general surgeon for evaluation." The report did not explain the "Perforation" further. - Patient #1's record contained pre-printed "POSTOPERATIVE ORDERS" which were dated 4/30/14 but were not timed. The orders included "2. Liquids when reactive." and "6. D/C IV when fluid replacement formula met & tolerating P.O. fluids. 7. Discharge when alert." These orders were contraindicated in a patient with a perforation who was to be evaluated for surgery. The orders were not changed. A handwritten	Q 162		

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Q 162	Continued From page 34 order was written at the bottom of the pre-printed orders to transfer Patient #1 to a nearby hospital by ambulance. The orders were noted by an RN but the time they were noted was not documented. - A nursing note at 11:05 AM on 4/30/14 stated the ASC physician who performed the endoscopy spoke with a physician at the receiving hospital. The nursing note was not signed by the author. Documentation by the physician explaining what happened or what Patient #1 was told was not present in the medical record. The Nurse Manager reviewed Patient #1's record with the surveyor on 8/05/14 beginning at 8:15 AM. She confirmed the lack of documentation by the physician and the lack of times and confusion with the orders. She confirmed nursing notes were not signed by the author. m. Patient #3's medical record documented a 55 year old female who had knee surgery performed on 7/31/14. Her record did not include comprehensive documentation, as follows: - Her anesthesia record, dated 7/31/14, stated she was given Sevoflurane, an inhaled anesthetic, as well as Propofol, an IV anesthetic. A "Post-Op Note" by the anesthetist was dated 7/31/14. The note stated "VSS in PACU [after] uneventful [general anesthesia]." The note was not timed to indicate when Patient #3 was declared stable. The note did not indicate whether the anesthetist examined Patient #3 after surgery in order to evaluate her for anesthesia recovery. The Nurse Manager reviewed Patient #3's record	Q 162		

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Q 162	Continued From page 35 with the surveyor on 8/04/14 beginning at 5:08 PM. She confirmed the Post-Op note was not timed and did not indicate if Patient #3 had been evaluated by the anesthetist for anesthesia recovery. n. Patient #4's medical record documented a 33 year old female who had right shoulder surgery performed on 7/11/14. Her record did not include accurate documentation, as follows: Her anesthesia record, dated 7/11/14, stated she was given Sevoflurane and Propofol for anesthesia. A nursing note in the "POST OPERATIVE RECORD," dated 7/11/14, stated Patient #4 arrived in the PACU at 9:45 AM. Her blood pressure at that time was noted as 80/30. (Her blood pressure on the "Pre-Operative Checklist," prior to surgery at 8:35 AM, was 119/72). A "Post-Op Note" by the anesthetist was dated 7/11/14 at 9:46 AM. The note stated "VSS in PACU [after] uneventful [general anesthesia]." It was not clear how the anesthetist determined Patient #4's vital signs were stable after 1 minute in the PACU. The Nurse Manager reviewed Patient #4's record with the surveyor on 8/06/14 beginning at 11:20 AM. She confirmed the documentation by the anesthetist for Patient #4 was not accurate. o. Patient #9's medical record documented a 77 year old male who had left knee surgery performed on 8/01/14. His anesthesia record, dated 8/01/14, stated he was given Sevoflurane and Propofol for anesthesia. A nursing note in the "POST OPERATIVE RECORD," dated 8/01/14, stated Patient #9 arrived in the PACU at 11:43 AM. A "Post-Op Note" by the anesthetist	Q 162		

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Q 162	Continued From page 36 was dated 8/01/14 at 11:47 AM. The note stated "VSS in PACU [after] uneventful [general anesthesia]." It was not clear how the anesthetist determined Patient #4's vital signs were stable after 4 minutes in the PACU. The Nurse Manager reviewed Patient #9's record with the surveyor on 8/06/14 beginning at 4:30 PM. She confirmed the documentation by the anesthetist for Patient #9 was not accurate. The ASC did not ensure medical records contained comprehensive, accurate information. 2. Refer to Q261 as it relates to the ASC's failure to ensure each patient record included a comprehensive history and physical which was performed not more than 30 days prior to the date of the scheduled procedure. 3. Refer to Q262 as it relates to the ASC's failure to ensure patient records included documentation that patient assessments were completed prior to surgical procedures. 4. Refer to Q266 as it relates to the ASC's failure to ensure patients records included documentation that patients were discharged on the order of a physician.	Q 162		
Q 181	416.48(a) ADMINISTRATION OF DRUGS Drugs must be prepared and administered according to established policies and acceptable standards of practice.	Q 181		

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Q 181	Continued From page 37 This STANDARD is not met as evidenced by: Based on observation, policy review, record review and staff interview, it was determined the ASC failed to ensure medications were properly stored and discarded when outdated and that medications were administered as ordered for 5 of 20 patients (#2, #4, #12 - #14) whose records were reviewed. This resulted in the potential for medication errors and possible adverse outcomes. Findings include: 1. The ASC policy titled "PHARMACEUTICAL SERVICES ADMINISTRATION AND STORAGE, " revised November 2012, stated medication storage drawers would be checked monthly for outdated medications and disposed of accordingly. It also stated multi-dose vials would be dated upon opening and discarded after 28 days. During a tour of the ASC on 8/4/14 starting at 3:00 PM, the following expired and opened and undated medications were observed to be in circulation for patient use: a. The OR #1 anesthesia cart contained open and partially used Petroleum jelly which expired in 6/14. Additionally, OR #1 had 2 tubes of KY Jelly, 1 tube of Petroleum jelly, and Maxitrol ophthalmic drops which had been opened but were not dated. b. OR #2 contained Flurbiprofen Sodium Ophthalmic 0.03% which expired in 5/14. Additionally, OR #2 had a 10 ml syringe with 2.5 ml of clear liquid which was not dated. c. The crash cart included three 20 ml bottles of Dantrolene Sodium which expired in 1/11, 25 vials	Q 181		

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Q 181	Continued From page 38 of Pitressin 1 ml, which expired in 7/14 and Petroleum jelly which expired in 7/14. Additionally, the crash cart contained a small plastic amber medication bottle with 10 pills was inside. The bottle was opened and no expiration date was present on the written label. The Nurse Manager for the ASC was present during the tour and removed the medications after she confirmed they were expired, or opened and undated. The ASC failed to ensure expired or opened and undated medications were removed from patient use. 2. Medications were administered without orders and without complete orders, as follows: a. Patient #2 was a 55 year old female admitted to the ASC for outpatient surgical procedures that included abdominoplasty, liposuction, and hernia repair. During the post-operative recovery period, she received medications that were not ordered, and/or ordered with specific parameters: - The Post-Operative orders included Fentanyl 25-50 mcg (IV) every 1 hour as needed for pain, and Zofran 4 mg (IV) every 4 hours as needed. - The post-operative recovery record noted Patient #2 received Fentanyl at 4:03 PM and at 4:15 PM. The record indicated Patient #2's pain level at 4:03 PM and at 4:15 PM as a "0". The medication was administered 12 minutes apart, not after an hour as ordered. - The recovery record noted Patient #2 received Phenergan 12.5 mg at 4:40 PM. Her record did	Q 181		

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Q 181	Continued From page 39 not include orders for Phenergan. - Patient #2's record did not document why the medications were administered, nor did it document she was evaluated after the medications were administered. During an interview on 8/05/14 beginning at 9:00 AM, the Nurse Manager reviewed Patient #2's record and confirmed there was no order for the Phenergan. Additionally, the Nurse Manager confirmed the nurse administered the Fentanyl, 2 doses, 12 minutes apart, rather than an hour as ordered. She stated the documentation should describe why the medication was given, and should include an evaluation to determine effect of the medication. b. Patient #12 was an 81 year old female, admitted to the ASC on 7/22/14 for a surgical procedure to remove excess tissue from her eyelids. Her physician's orders, dated 7/08/14, included "2 mg Valium on arrival." However, the route of administration was not included. During an interview on 8/06/14 beginning at 5:00 PM, the Nurse Manager reviewed Patient #12's record and confirmed the route of administration for the Valium was not ordered. She stated Patient #12 received the Valium orally at 9:40 AM. c. Patient #14 was a 22 year old male admitted to the ASC on 6/24/14 for a surgical procedure on his right ankle. Medications were not administered as ordered as follows: Patient #14's post-operative orders included the medication "Vicodin" 1-2 tablets every 3 to 4 hours as needed for pain." His post-operative	Q 181		

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Q 181	Continued From page 40 record included documentation Patient #14 received Hydrocodone 10 mg orally for pain 7/10 at 1:15 PM. Patient #14 did not receive medications as ordered by his physician. According to drugs.com, Vicodin is a brand name for hydrocodone/acetaminophen, and contains 5 mg hydrocodone with 500 mg of acetaminophen. The medication ordered was for Vicodin, 1-2 tablets, which would be a dose of 5-10 mg of Hydrocodone and 500-1000 mg of acetaminophen. The medication log in the ASC was reviewed, and did not include Vicodin, it included a generic of Hydrocodone 10 mg and 325 mg acetaminophen. So, by using a different drug, (a generic version) the nurse administered 10 mg of Hydrocodone and 325 mg acetaminophen, which was a lesser dose of acetaminophen than the order. During an interview on 8/06/14 beginning at 4:40 PM, the Nurse Manager reviewed Patient #14's record and stated the Vicodin order and the hydrocodone that was administered was the same. She stated the order was written as Vicodin, but it really meant hydrocodone 7.5 mg/acetaminophen 325 mg. She stated the ASC did not have Vicodin as the brand name, but has hydrocodone/acetaminophen. d. Patient #13 was a 51 year old female admitted to the ASC on 7/25/14 for the removal of a mass on her right tonsil. Patient #13's post-operative record documented she received Tylenol 500 mg 2 tablets orally at 1:08 PM. Her "POST-OPERATIVE AND DISCHARGE ORDERS," dated 7/25/14 at 12:20 PM, included	Q 181		

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Q 181	Continued From page 41 "Tylenol/Motrin prn pain at home." The order did not include a dose, frequency, or route. During an interview on 8/06/14 beginning at 4:50 PM, the Nurse Manager reviewed Patient #13's record and stated it was appropriate for the nurse to give the Tylenol, as it was ordered to be given at home, and any home medications could be administered in the post-operative phase. She confirmed the discharge order did not include route, dose, or frequency, and stated the 2 tablets given was appropriate. e. Patient #4's medical record documented a 33 year old female who had right shoulder surgery performed on 7/11/14. Patient #4's "POST OPERATIVE RECORD," dated 7/11/14, stated Patient #4 was given Fentanyl 25 mcg IV at 10:07 AM and at 10:15 AM. The record also stated Patient #4 was given Phenergan 10 mg IV at 10:35 AM. An order for the medications was not present in Patient #4's medical record. The Nurse Manager reviewed Patient #4's record with the surveyor on 8/06/14 beginning at 11:20 AM. She confirmed the Fentanyl and Phenergan doses were given without physician orders. The ASC did not ensure nursing staff administered medications only as ordered. 3. Refer to Q184 as it relates to the ASC's failure to ensure verbal orders for medications were written and signed by the recipient of the order and the physician.	Q 181		
Q 184	416.48(a)(3) VERBAL ORDERS	Q 184		

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Q 184	Continued From page 42 Orders given orally for drugs and biologicals must be followed by a written order signed by the prescribing physician. This STANDARD is not met as evidenced by: Based on observation, review of records and staff interview, it was determined the ASC failed to ensure verbal orders for medications were written and signed by the recipient of the order and the physician for 2 of 20 patients (#11 and #19) whose records were reviewed. This resulted in the administration of medications without orders. Findings include: 1. Patient #11 was a 4 year old male admitted to the ASC on 7/24/14 for dental work under general anesthesia. His record contained documentation he was administered a medication that was not ordered: The "POST OPERATIVE RECORD," noted Patient #11 arrived in recovery at 8:39 AM, with labored respirations, and was noted to have stridor. Racemic epinephrine was administered by means of a nebulizer treatment. The record did not include orders for the medication. During an interview on 8/06/14 beginning at 4:30 PM, the Nurse Manager reviewed Patient #11's record and confirmed there was no written order for the Racemic epinephrine. She stated the RN providing post-operative care for Patient #11 probably got a verbal order and forgot to write it down. 2. Patient #19 was a 68 year old female admitted	Q 184		

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Q 184	Continued From page 43 to the ASC on 8/05/14 for cataract removal of her right eye. Her care was observed throughout her ASC stay by at least 2 surveyors. In the pre-operative phase, eye drops were administered in her right eye. Her nurse stated she needed "10%" drops as she had brown eyes, and they were difficult to dilate. Phenylephrine 10%, 1 drop was placed in her right eye at 10:38 AM. The nurse was noted to add the Phenylephrine as a verbal order on to the pre-printed order sheet that was dated 8/05/14 and signed at 8:30 AM by the physician. She wrote the verbal order in a space between the pre-printed orders for Vigamox and the IV start. The verbal order was not written separately on a separate order sheet. During an interview on 8/06/14 beginning at 4:45 PM, the Nurse Manager reviewed Patient #19's record and confirmed the verbal order for the eye drop was written on a previously signed order sheet. Verbal orders were not written by the nurse then signed by the physician.	Q 184		
Q 219	416.50 PATIENT RIGHTS Condition for Coverage - Patient Rights The ASC must inform the patient or the patient's representative or surrogate of the patient's rights and must protect and promote the exercise of these rights, as set forth in this section. The ASC must also post the written notice of patient rights in a place or places within the ASC likely to be noticed by patients waiting for treatment or by the	Q 219		

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Q 219	Continued From page 44 patient's representative or surrogate, if applicable. This CONDITION is not met as evidenced by: Based on observation, record review and staff and patient interview, it was determined the ASC failed to ensure patients' were informed of their rights. This resulted in the potential for patients' rights to be violated. Findings include: 1. Refer to Q221 as it relates to the ASC's failure to ensure posted patient rights information was accurate. 2. Refer to Q223 as it relates to the ASC's failure to ensure patients were notified in writing of physician ownership or financial interest in the ASC. 3. Refer to Q224 as it relates to the ASC's failure to ensure patients or their representatives were provided with information regarding advanced directives. 4. Refer to Q229 as it relates to the ASC's failure to ensure patients were fully informed about their procedure and the expected outcome before it was performed. The cumulative effect of these systematic failures resulted in a lack of information being provided to patients and the potential for patient rights to be violated.	Q 219		
Q 221	416.50(a) NOTICE OF RIGHTS An ASC must, prior to the start of the surgical procedure, provide the patient, or the patient's representative, or the patient's surrogate with verbal and written notice of the patient's rights in	Q 221		

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Q 221	Continued From page 45 a language and manner that ensures the patient, the representative, or the surrogate understand all of the patient's rights as set forth in this section. The ASC's notice of rights must include the address and telephone number of the State agency to which patients may report complaints, as well as the Web site for the Office of the Medicare Beneficiary Ombudsman. This STANDARD is not met as evidenced by: Based on observation and staff interview it was determined the ASC failed to ensure posted patient rights information included the correct name and telephone number of a representative in the State Agency to whom patients could report complaints. This resulted in the potential for patients and their representatives to not be fully informed of their rights. Findings include: A tour was conducted of the ASC on 8/04/14 between 2:30 PM to 3:30 PM with the Nurse Manager. Patient Rights information was posted in the waiting area. The information posted incorrectly listed an individual's name and phone number who the ASC identified as the Deputy Director of Idaho Board of Health and Welfare. The phone number was called and was that of the State of Idaho Public Information Officer. The State Agency to report complaints to was not provided in the posted Patient Rights information. The Nurse Manager confirmed the appropriate information was not posted. The facility did not ensure correct patient rights information was posted.	Q 221		
Q 223	416.50(b) NOTICE - PHYSICIAN OWNERSHIP The ASC must disclose, in accordance with Part 420 of this subchapter, and where applicable,	Q 223		

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Q 223	Continued From page 46 provide a list of physicians who have financial interest or ownership in the ASC facility. Disclosure of information must be in writing. This STANDARD is not met as evidenced by: Based on review of patient medical records and patient and staff interview, it was determined the ASC failed to ensure patients were notified in writing of physician ownership or financial interest in the ASC. This directly impacted 2 of 2 patients (#19 and #20) interviewed and had the potential to impact all patients receiving care at the ASC. This resulted in patients being referred to the facility and having surgical procedures performed without the knowledge that the referring physicians had ownership in the ASC. Findings include: 1. The form "PATIENT RIGHTS," not dated, was given to all patients prior to surgery. The form did not include disclosure that the ASC was physician owned. Patients #19 and #20 were interviewed on 8/05/14 and 8/06/14 respectively. They stated the following: a. Patient #19 was a 68 year old female admitted to the ASC on 8/05/14 for cataract removal from her right eye. Her care was observed from her arrival at 10:00 AM, through to her discharge after the procedure was completed at 11:15 AM. During an interview on 8/05/14 beginning at 10:00 AM, Patient #19 was asked if she was aware the ASC was physician owned. She stated she did not know that and confirmed she had not received written information regarding physician ownership. b. Patient #20 was a 67 year old male admitted to the ASC for a colonoscopy on 8/06/14. His care	Q 223		

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Q 223	Continued From page 47 was observed from his arrival at 8:30 AM, through to his discharge after the procedure was completed at 11:30 AM. During an interview on 8/06/14 beginning at 8:45 AM, Patient #20 stated he was aware the ASC was physician owned, he said "...of course, it's a small town." When asked if he received written information regarding physician ownership, he stated no, he did not receive written information. The nurse who provided post-procedural care for Patient #20 was interviewed on 8/06/14 beginning at 11:15 AM. She stated she was not aware if patients were informed of physician ownership or financial interest in the ASC. She stated she did not know how that process occurred and was not aware of the requirement. The Nurse Manager was interviewed on 8/06/14 beginning at 4:30 PM. She stated the ASC was physician owned. She confirmed the rights form given to patients did not disclose this information. The ASC did not disclose information regarding physician ownership/financial interest in the ASC.	Q 223		
Q 224	416.50(c)(1)(2)(3) ADVANCED DIRECTIVES The ASC must comply with the following requirements: (1) Provide the patient or, as appropriate, the patient's representative with written information concerning its policies on advance directives, including a description of applicable State health and safety laws and, if requested, official State advance directive forms.	Q 224		

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Q 224	Continued From page 48 (2) Inform the patient or, as appropriate, the patient's representative of the patient's rights to make informed decisions regarding the patient's care. (3) Document in a prominent part of the patient's current medical record, whether or not the individual has executed an advance directive. This STANDARD is not met as evidenced by: Based on policy review, record review, and staff interview, it was determined the ASC failed to provide patients or their representatives with information regarding advanced directives for all patients receiving services at the facility, including 20 of 20 patients (#1 - #20) whose records were reviewed. This resulted in patients not being fully informed of advance directive information prior to having procedures at the facility. Findings include: 1. The ASC's policy manual did not include a patient rights policy regarding advanced directives. Upon request, the ASC's Nurse Manager provided a sample packet of information given to patients prior to their procedures. The sample packet did not include information regarding advanced directives and the form "PATIENT RIGHTS," not dated, which was given to all patients prior to surgery, did not include information related to advanced directives. The medical records for Patients #1 - #20 were reviewed. None of the medical records included information regarding advanced directives. Additionally, Patients #19 and #20 were interviewed on 8/05/14 and 8/06/14 respectively. They stated the following: a. Patient #19 was a 68 year old female admitted	Q 224		

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Q 224	Continued From page 49 to the ASC on 8/05/14 for cataract removal from her right eye. Her care was observed from her arrival at 10:00 AM, through to her discharge after the procedure was completed at 11:15 AM. During an interview on 8/05/14 beginning at 10:00 AM, Patient #19 was asked if she was informed regarding advanced directives. She stated she was not aware of the ASC policy regarding advanced directives, and did not receive information, either written or orally on that topic. b. Patient #20 was a 67 year old male admitted to the ASC for a colonoscopy on 8/06/14. His care was observed from his arrival at 8:30 AM, through to his discharge after the procedure was completed at 11:30 AM. During an interview on 8/06/14 beginning at 8:45 AM, Patient #20 was asked if he was informed regarding advanced directives. He stated he was not aware of the ASC policy regarding advanced directives, and did not receive information, either written or orally on that topic. The nurse who provided post-procedural care for Patient #20 was interviewed on 8/06/14 beginning at 11:15 AM. She stated she was not aware if patients were informed of the policy regarding advanced directives and that she did not know how to respond if asked by a patient. When asked during an interview on 8/05/14 at 9:00 AM, the Nurse Manager stated there was no policy or information provided to patients regarding advance directives. The ASC failed to provide patients or their representatives with information regarding	Q 224		

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Q 224	Continued From page 50 advanced directives prior to their procedures.	Q 224		
Q 229	416.50(e)(1)(iii) EXERCISE OF RIGHTS - INFORMED CONSENT [(1) The patient has the right to the following:] (iii) Be fully informed about a treatment or procedure and the expected outcome before it is performed. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the ASC failed to ensure that patients were fully informed about procedures and the expected outcomes before it was performed for 1 of 1 patient (#7) reviewed who did not speak English. This resulted in the potential lack of information being provided to a patient on which to based informed consent decisions. Findings include: 1. According to the U.S. Department of Health and Human Services when obtaining informed consent a translator may be helpful in facilitating conversation with a non-English speaking subject, but routine unplanned translation of the consent document should not be substituted for a written translation. The ASC failed to ensure informed consent as follows: Patient #7 was an 88 year old male admitted to the ASC for cataract removal and lens implant. The nurse's note in the "SPECIAL PROCEDURE RECORD" documented Patient #7 is Spanish speaking only. The "CONSENT TO OPERATE" form was in English and Patient #7 had signed at the bottom. The form did not contain a signature for a patient representative or translator. There was no other documentation that a translator was	Q 229		

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Q 229	Continued From page 51 used for the informed consent. The Nurse Manager was interviewed on 8/6/14 at 9:23 AM, after review of the record she stated that an employee from the physician's office was used as a translator for Patient #7. She confirmed that the signature of the witness on the consent was not the translator used, and was the signature of a nurse that worked for the ASC that did not speak Spanish. The ASC failed to document Patient #7 was fully informed of the procedure.	Q 229		
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. This STANDARD is not met as evidenced by: Based on observation, interview, policy review and record review, it was determined the facility failed to maintain a sanitary and functional environment for all patients receiving care at the facility. This resulted in the potential for infections to occur and for expired supplies to be used. Findings include: 1. During a tour of the ASC on 8/04/14 beginning at 3:00 PM, the patient rooms for pre and post-operative recovery were observed. There were 3 private rooms, each with a door that closed. Each door had a handle, and the door, when opened, would open into the room. It would not be possible for the individual to open the door without touching the handle and pulling it towards	Q 241		

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Q 241	Continued From page 52 themselves. The rooms did not have a sink for hand washing. Each room had a can of foam type hand sanitizer on the wall by the door. The Nurse Manager accompanied the surveyors during the tour, and when questioned about hand washing facilities, pointed to a room down the hallway that was designated as a patient restroom. The restroom door opened out towards the hallway, so the individual opening the door would need to push the lever type handle down, and then pull the door towards them. Once inside, the sink for hand washing was shallow and small, the faucet knobs had to be touched by the individual to turn on. The Nurse Manager stated the staff could also use the scrub sinks that were in the Operative Suite anteroom that was located behind a set of double doors that also had handles. The ASC patient care area did not have an available and easy access for staff to wash their hands if they were visibly soiled. The nearest sink and hand washing facilities were behind at least 2 doors that required touching to release the handles. The Nurse Manager stated the patient rooms each had hand sanitizer and that was sufficient for their needs. 2. On 8/06/14 beginning at 8:00 AM, the Nurse Manager accompanied the surveyors during a tour of the laundry facilities. The room was located in the ASC, behind the general office area. The room had a washing machine, two dryers, a small refrigerator, a sink, counter top, and storage racks with supplies. Additionally, the room had a large plastic container the Nurse	Q 241		

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Q 241	Continued From page 53 Manager stated held the dirty linens. a. The Nurse Manager stated the laundry was sorted into 2 loads, patient linens, sheets, gowns, other laundry items, and staff scrubs. She stated the water temperature was "hot," but was unable to produce a temperature log more recent than 2003. b. The plastic container with soiled linens was next to the small refrigerator. c. The refrigerator held juices and sodas, as well as, medications for patient use. Two boxes, one of Duovisc and one of Clotest, were removed by the Nurse Manager, she stated she did not know why medication was stored in a patient refreshment refrigerator. 3. During observation of instrument cleaning and disinfection on 8/06/14 beginning at 11:00 AM, the CST demonstrated how she cleaned instruments, and prepared them for processing. She stated the ASC did not have a log for recording instrument loads in case of sterilization failure. She was unable to describe how instruments would be identified as used for which patients in case of infection or breach of product integrity. 4. The Centers for Disease Control guidelines state adherence to the proper use of disinfectants will minimize exposure to HAI risks and reduce the frequency of outbreaks. Another area for microorganisms to build up in the cleaning process may be dilute solutions of the detergents or disinfectants, storage for long periods of time,	Q 241		

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Q 241	Continued From page 54 or incorrect preparation. A tour of the ASC was conducted with the Nurse Manager on 8/4/14 at 3:00 PM. During the tour the following was observed: a. The cleaning supply closet contained 3 opened and partially full plastic water bottles and a spray bottle of "Clorox Bleach," which was not labeled for medical grade cleaning. b. The cleaning cart contained an unlabeled spray bottle of undetermined fluid (3/4 full), a spray bottle of "Clorox Clean-Up," which was not labeled for medical grade cleaning, a spray bottle of Iodine & Betadine Remover which expired on 3/4/13, and a spray bottle of Virex II 256 disinfectant which did not have an expiration date. c. In OR #1 contained a spray bottle of Virex II 256 disinfectant which did not have an expiration date. The Nurse Manager for the ASC was present during the tour and removed the cleaning supplies after she confirmed they were not appropriate for use. The ASC did not ensure a functional and sanitary environment.	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.	Q 242		

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Q 242	Continued From page 55 This STANDARD is not met as evidenced by: Based on observation, staff interview and review of quality documents, it was determined the ASC failed to ensure an ongoing program to prevent infections was maintained. This affected the care of 1 of 2 patients (#19) whose care was observed and had the potential to affect all patients receiving care at the ASC. This resulted in the potential for patient infections. Findings include: 1. Patient #19's "OPERATIVE REPORT," dated 8/05/14, documented a 68 year old female who had cataract extraction and lens replacement on that date. Patient #19's care was observed immediately following surgery. She was transferred from the operating room to a recovery room in the "Same Day Surgery" unit at 11:01 AM. The RN positioned Patient #19 on arrival. She documented in the paper medical record. She gave Patient #19 juice and administered an oral medication at 11:06 AM. She documented more on the medical record. She donned gloves and discontinued Patient #19's IV at 11:11 AM. She removed the gloves. She removed the vital sign monitoring equipment. She then assisted Patient #19 with transfer to a wheelchair and accompanied the patient to her vehicle at 11:17 AM. She returned to the recovery room and charted again. Only then did the RN perform hand hygiene. She did not perform hand hygiene from 11:01 AM to 11:19 AM. Patient #19's RN was interviewed on 8/05/14 at 11:20 AM. She confirmed she had not performed	Q 242		

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Q 242	Continued From page 56 hand hygiene while she was recovering Patient #19. The RN did not perform appropriate hand hygiene. 2. A document titled "QI Study: Handwashing Compliance," dated 10/03/13, stated the ASC had a goal of "...95% compliance of performing proper hand hygiene." The document stated compliance rates were 74% for nurses, 60% for physicians, and 86% for anesthesia personnel. The document stated a repeat study would be performed in 3 months. No repeat hand washing studies were documented. The QI Coordinator was interviewed on 8/05/14 beginning at 2:45 PM. She confirmed the hand washing study had not been repeated and surveillance of staff hand washing had not been done. The ASC failed to monitor infection control practices to ensure staff followed the facility's guidelines.	Q 242		
Q 261	416.52(a)(1) ADMISSION ASSESSMENT Not more than 30 days before the date of the scheduled surgery, each patient must have a comprehensive medical history and physical assessment completed by a physician (as defined in section 1861(r) of the Act) or other qualified practitioner in accordance with applicable State health and safety laws, standards or practice, and ASC policy. This STANDARD is not met as evidenced by:	Q 261		

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Q 261	Continued From page 57 Based on record review, policy review, and staff interview it was determined the ASC failed to ensure a comprehensive history and physical was performed not more than 30 days prior to the date of the scheduled procedure for 5 of 20 patients (#2, #6, #11, #12, and #19) whose records were reviewed. This had the potential to prevent the finding of possible contraindications to the procedures being performed. Findings include: 1. The policy "REQUIREMENTS FOR SURGICAL PROCEDURES" revised on March 2010, stated a current history and physical done within 30 days of the scheduled procedure must be available in the patient's medical record. The ASC failed to follow the policy as follows: a. Patient #6 was a 37 year old male admitted to the ASC for EGD with dilation (a procedure which stretches a narrow or blocked portion of the esophagus). His H&P was dated 5/29/14, 48 days prior to the scheduled procedure. The Nurse Manager was interviewed on 8/6/14 at 4:20 PM, after review of the record she confirmed that the history and physical was not completed in less than 30 days, per the ASC policy. Patient #6's H&P was not completed within 30 days of his procedure. b. Patient #11 was a 4 year old male admitted to the ASC on 7/24/14 for dental work under general anesthesia. Patient #11's preoperative order sheet indicated his diagnosis was "Early Childhood Caries." His record included an H&P, dated 6/19/14, which was more than 30 days	Q 261		

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Q 261	Continued From page 58 before the procedure. The H&P contained conflicting information and did not include evidence it was reviewed for accuracy. It included statements of "The patient is toilet trained for bladder. The patient is having problems with bladder toilet training. Bladder toilet trained at 3 months." The H&P also noted "Last dental visit was 5/30/14, concerns are abscess. Patient does not have caries." During an interview on 8/06/14 beginning at 4:30 PM, the Nurse Manager reviewed Patient #11's record and confirmed the H&P was greater than 30 days before the procedure and it had conflicting information that did not appear to be corrected. c. Patient #12 was an 81 year old female, admitted to the ASC on 7/22/14 for a surgical procedure to remove excess tissue from her eyelids. Her record included a form titled "SURGICAL HISTORY & PHYSICAL," and was dated 7/08/14. The form included a list of Patient #12's current medications. The H&P list was compared to a list that was brought in with Patient #12 the day of her procedure, and the medications were different as follows: The H&P included Voltaren, Ocuvite, and Aspirin, which was not on the list Patient #12 brought in. Patient #12's medication list included the following medications that were not included on the H&P completed by her physician: Vitamins, Magnesium, Glucosamine, Calcium, Fish Oil, perservision, and Aleve.	Q 261		

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Q 261	Continued From page 59 The H&P stated Patient #12 did not have previous surgical procedures. However, a form in her record titled "DIAGNOSTIC SUMMARY," dated 7/22/14, documented Patient #12 had knee surgery, as well as, cataract extraction in each eye. Patient #12's H&P was not a comprehensive physical assessment and did not include evidence of vital signs, auscultation of her heart and lungs, and other evaluation to indicate she was an appropriate ASC candidate. During an interview on 8/06/14 beginning at 5:00 PM, the Nurse Manager reviewed Patient #12's record and confirmed the discrepancies between the H&P and the medication list she brought in the day of her procedure. She confirmed the H&P was not comprehensive and did not include an assessment of her heart and lungs. d. Patient #19 was a 68 year old female admitted to the ASC on 8/05/14 for cataract removal from her right eye. She was selected as a patient to be followed before, during and after her procedure by the survey team. Her record included a form titled "SURGICAL HISTORY & PHYSICAL," and was dated 7/08/14. The form included a list of Patient #19's current medications. The H&P list was compared to a list that was brought in with Patient #19 the day of her procedure, and the medications were different as follows: The H&P did not include lovastatin, cyclobenzaprine, trazadone, or stool softener that was on the list Patient #19 brought with her to the ASC on 8/05/14.	Q 261		

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Q 261	Continued From page 60 The H&P stated Patient #19 did not have a family or social history, and the section for medical conditions was left blank. During a review of her medications and individual patient interview on 8/05/14 beginning at 10:00 AM, Patient #19 indicated she was being treated for depression, anxiety, high blood pressure, high cholesterol, and gastric reflux. Patient #19's H&P was not a comprehensive physical assessment, and did not include evidence of vital signs, auscultation of her heart and lungs, and other evaluation to indicate she was an appropriate ASC candidate. During an interview on 8/06/14 beginning at 4:45 PM, the Nurse Manager reviewed Patient #19's record and confirmed the H&P was not comprehensive. e. Patient #2 was a 55 year old female who was admitted on 6/13/14 for an abdominoplasty (tummy tuck) and hernia repair. Her record included an H&P, dated 6/12/14. Her H&P information was not accurate, as follows: The section "Past Medical/Surgical History" listed elevated cholesterol and cholecystectomy. It did not include hypertension, for which she took spironolactone and moexipril that was identified in the pre-op anesthesia evaluation. Additionally, the H&P did not include documentation Patient #2 had four Caesarean Sections, which was also noted in the pre-op anesthesia evaluation. The section "Review of Systems"' noted "No weight loss or gain, but positive fever/chills, malaise, fatigue...Positive for sore throat, blocked	Q 261	oops! 2nd page	

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Q 261	Continued From page 61 nasal breathing, snoring. Cardiac: No heart disease, murmur, elevated cholesterol, or surgery." Patient #2 was documented as having hypertension, elevated cholesterol, and at least 5 surgeries. During an interview on 8/05/14 beginning at 9:00 AM, the Nurse Manager reviewed Patient #2's record and confirmed the inaccuracies noted on the H&P. The ASC did not ensure each patient record included a comprehensive history and physical which was performed not more than 30 days prior to the date of the scheduled procedure.	Q 261		
Q 262	416.52(a)(2) PRE-SURGICAL ASSESSMENT Upon admission, each patient must have a pre-surgical assessment completed by a physician or other qualified practitioner in accordance with applicable State health and safety laws, standards of practice, and ASC policy that includes, at a minimum, an updated medical record entry documenting an examination for any changes in the patient's condition since completion of the most recently documented medical history and physical assessment, including documentation of any allergies to drugs and biologicals. This STANDARD is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the ASC failed to ensure assessments were completed prior to surgical procedures for 6 out of 20 patients (#2, #6, #7, #12, #15 and #17) whose records were reviewed. This resulted in the potential for	Q 262		

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Q 262	Continued From page 62 patients to receive inadequate care during their procedures. Findings include: 1. A policy "APPROPRIATENESS OF PROCEDURE" dated May 2003, stated all patients having operative or other procedures will be examined by a physician immediately prior to surgery, to evaluate the risk of the procedure to be performed. The ASC failed to ensure the policy was implemented, as follows: Each medical record included a form titled "HISTORY AND PHYSICAL UPDATE." The form included a pre-printed statement, "The History and Physical was reviewed, the patient was examined, and no change has occurred in the patient's condition since the History & Physical was completed." The form included a space for the physician to sign and date. However, patient H&P Update forms were not consistently dated and timed, as follows: a. Patients #6, #7 and #15's H&P Update forms were signed by the physician. However, there was no date or time next to the signature on the forms. There was no further documentation in the records that an assessment had been completed by the physician prior to Patient #6, #7 and #15's procedures. b. Patient #2, #12 and #17's H&P Update forms were signed by the physician and dated. However, the forms did not include the time next to the signature on the forms. It was not clear if the physicians signed the forms before or after the procedures were performed. During an interview on 8/05/14 beginning at 9:00 AM, the Nurse Manager reviewed Patient #2's	Q 262		

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Q 262	Continued From page 63 record and confirmed the lack of include dates and times. The Nurse Manager was also interviewed on 8/6/14 at 4:20 PM. After reviewing the records and ASC policy she confirmed that Patient #6, #7 and #15 did not have a date or time next to the physician signature on the H&P Update forms and that Patient #17's form did not have a time. Further, during an interview on 8/06/14 beginning at 5:00 PM, the Nurse Manager reviewed Patient #12's record and confirmed the H&P Update form did not have a time next to the physician's signature. She stated she was aware the physicians and staff were not including dates and times on multiple documents. The ASC did not ensure assessments were completed prior to surgical procedures.	Q 262		
Q 266	416.52(c)(2) DISCHARGE - ORDER [The ASC must -] Ensure each patient has a discharge order, signed by the physician who performed the surgery or procedure in accordance with applicable State health and safety laws, standards of practice, and ASC policy. This STANDARD is not met as evidenced by: Based on observation, record review and staff interview it was determined the facility failed to ensure patients were discharged on the order of a physician for 6 of 20 patients (#7, #10, #12, #14, #17, and #19) whose records were reviewed. This resulted in patients being discharged without an evidence-based determination that they were medically stable. Findings include: 1. The policy "REQUIREMENTS FOR	Q 266		

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Q 266	Continued From page 64 SURGICAL PROCEDURES" revised March 2010, states written and signed discharge instructions are to be given to the patient at the time of discharge. The ASC failed to adhere to their policy as follows: a. Patient #19 was a 68 year old female admitted to the ASC on 8/05/14 for cataract removal from her right eye. Her record included a pre-printed form titled "PHYSICIAN ORDERS FOR OUTPATIENT SURGERY," which contained post-operative and discharge orders. The form was dated 8/05/14 at 8:30 AM. However, Patient #19 was a sample patient whose care was observed by at least one surveyor from the time of her admission to the ASC through to her discharge. Patient #19 did not arrive at the ASC until 10:00 AM. The orders for post-operative care and discharge were signed by Patient #19's physician before she arrived at the facility and the physician was not observed to evaluate Patient #19 before she was discharged. b. Patient #12 was an 81 year old female, admitted to the ASC on 7/22/14 for a surgical procedure to remove excess tissue from her eyelids. A form titled "PROCEDURE RECORD," dated 7/22/14, included a pre-printed statement "Seen by Dr. prior to discharge," followed by a check mark. Additionally, a form, titled "POST-OPERATIVE DISCHARGE ORDERS," signed by Patient #12's physician, was not dated or timed. The orders had a slash mark to the left of the orders, followed by an RN's signature. However, the nurse did not date or time her	Q 266		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 266	Continued From page 65 signature. During an interview on 8/06/14 beginning at 5:00 PM, the Nurse Manager reviewed Patient #12's record and confirmed the discharge orders were not dated and timed by her physician, to indicate he had assessed her for appropriateness of discharge. c. Patient #14 was a 22 year old male admitted to the ASC on 6/24/14 for a surgical procedure to repair his right ankle. A form, titled "POST-OPERATIVE DISCHARGE ORDERS," signed by Patient #14's physician, was not dated or timed. Additionally, the orders had a slash mark to the left of the orders, followed by an RN's signature. However, the nurse did not date or time her signature. During an interview on 8/06/14 beginning at 4:40 PM, the Nurse Manager reviewed Patient #14's record and confirmed the orders were not dated and timed to indicate he was assessed for his readiness for discharge. d. Patient #7 was an 88 year old male admitted to the ASC for cataract removal and lens implant. The procedure began on 7/21/14 at 8:44 AM and ended at 9:04 AM. Pt was noted as discharged at 9:15 AM by the nurse on the "SPECIAL PROCEDURE RECORD." The order for Patient #7 to be discharged after instructions was noted at 7:20 AM on 7/21/14 by the nurse at the ASC, prior to the start of the procedure. The Nurse Manager was interviewed on 8/6/14 at	Q 266		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13C0001028		08/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMBULATORY SURGERY CENTER OF BURLEY	1344 HILAND AVENUE, SUITE E BURLEY, ID 83318

(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 266	Continued From page 66 9:23 AM, after review of the record she confirmed Patient #7's discharge order was written prior to the procedure being performed. e. Patient #17 was a 75 year old male admitted to the ASC for repair of both eyelids. The "Post-Operative Discharge Orders" were noted by the nurse and signed by the physician, but there was no date or time next to either signature. The Nurse Manager was interviewed on 8/6/14 at 9:17 AM, after review of the record she confirmed there was no date or time on the discharge orders by the physician or the nurse. f. Patient #10's medical record documented a 66 year old male who had a colonoscopy performed on 7/09/14. The untitled anesthesia flow sheet for Patient #10 stated anesthesia started at 11:48 AM and ended at 12:48 PM. Untitled physician orders, dated 7/07/14, stated "Anesthesia provider on-call will discharge with requirements met." A "Post-Op Note" by the anesthetist, dated 7/09/14 at 12:48 PM, stated "Discharged to holding room. VSS." The "ENDOSCOPY RECORD," dated 7/09/14, stated Patient #10 was discharged at 1:45 PM. No order was present in Patient #10's medical record to discharge him from the ASC. The Nurse Manager reviewed Patient #4's record with the surveyor on 8/06/14 beginning at 4:30 PM. She confirmed an order to discharge Patient #10 was not documented. The ASC did not ensure patient records included documentation that patients were discharged on the order of a physician.	Q 266		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	13C0001028		08/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMBULATORY SURGERY CENTER OF BURLEY	1344 HILAND AVENUE, SUITE E BURLEY, ID 83318

(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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Plan of Correction
Provider/Supplier ID Number 13C0001028

Name of Provider:
Ambulatory Surgery Center of Burley
1344 Hiland Ave. Suite E
Burley, ID 83318
Date Survey Completed 08/07/2014

RECEIVED
SEP 17 2014
FACILITY STANDARDS

Reference Tag Q 040: GOVERNING BODY AND MANAGEMENT

1. The Governing Board has met and is reviewing the request for privileges of all the providers who perform surgery at our surgery center. No surgeries will be performed at the ASC of Burley that the Governing Board has not granted privileges for. Every procedure performed at the ASC will be monitored on an ongoing basis to assure the provider has training to perform the procedure and that privileges have been granted by the Governing Board before that procedure is performed. This will assure the safety of our patients by assuring surgeons are not performing procedures for which they are not trained and competent.
   Date of Completion: 9/19/2014
2. The Governing Board has approved the policies and procedures that spell out the composition of the QAPI Committee, ensuring the board will do an annual risk assessment (done in 2013 but not done by 8/7/14), and provide direction for QI studies. The board met 9/3/14 and performed a risk assessment identifying three areas of high risk. Out of that risk assessment the board directed the committee to perform two QI studies. The results of the studies are to be reported by the QAPI Committee back to the Governing Board. The Board will then continue to provide direction to the Committee regarding modifications, etc. that may be needed and to assess for improvement of outcomes or reduction of errors.
   A functioning QAPI program will help ensure the ASC is evaluating its practices, improving patient care, and increasing patient safety.
   DoC: Done
3. Refer to Tag Q 060

Reference Tag Q 060: SURGICAL SERVICES

1. The Delineation of Privileges for each surgeon with privileges at the ASC has been reviewed by the Governing Board to assure they are not performing any surgery for which they do not have credentials. If they had not filled out "Request for Privileges" within the past 5 years the form was redone. All privileges were updated. Physician A was granted privileges to perform epigastric hernia repair with abdominoplasty.
   Purpose: To assure the surgical procedures performed in the ASC are done in a safe manner by qualified physicians who have been granted clinical privileges by the governing body in accordance with our policies and procedures.
   DoC: 9/16/14

Reference Tag Q 080: QUALITY ASSESSMENT AND PERFORMANCE
Refer to Q 81: PROGRAM SCOPE; PROGRAM ACTIVITIES

(a)(1) See #$4 Tag Q84. Additionally, the QAPI Committee will review each patient care issue and adverse incident to try and determine the cause of the problem and any suggestions for improvements to be made to prevent further occurrences of the problem.
(a)(2) The ASC tracks patient care issues, infection rates, patient satisfaction, adverse patient events to monitor for quality. This is analyzed by the QAPI Committee and the Governing Board. This will be documented in their meeting minutes.
(c)(1) The Governing Board met 9/3/14 and identified three high-risk problem-prone areas which can affect health outcomes, patient safety, and quality of care. The Governing Board set priorities by defining two QI studies to be carried out to determine cause, set correction, and monitor for response.

1. QUALITY ASSURANCE GOALS AND PHILOSPHY was updated 9/4/14. The QA Committee met 9/9/14 to review, study, and remedy patient care and employee issues using the Quality Improvement study format. Administrative meetings will include discussion of quality indicators commencing with the next Administrative meeting. During the QA Committee meeting on 9/9/14 QI studies to be begun were discussed, as well as quality indicators (Infection Control, Patient Care Issues, Chart Reviews, and Patient Satisfaction Questionnaire results) were discussed.

Purpose: To define a quality program that is ongoing and demonstrates measurable improvement in patient health outcomes, identifies and reduces medical errors by measuring, analyzing, and tracking quality indicators and then setting priorities for its performance improvement activities that focus on high risk, high volume, and problem-prone areas.
DoC: Done (9/9/2014)

Refer to Q 82: PROGRAM DATA; PROGRAM ACTIVITIES

1. The three "Quality Assurance Reports" referenced are dated (July—Sept 2013, Oct—Dec 2013, and Jan—Mar 2014). Our QA reports is the site we use to record the data we are tracking for QA purposes (volume of surgical procedures, patient satisfaction results, patient care issues, infection rates, complaints, chart review results). This information is then reported to the QA/QI committee for review and analysis. Any recommendations of changes, etc. would be recorded in our quarterly QI/QA and Governing Board meeting minutes. The QI Coordinator mis-spoke when she said no recommendations for changes in ASC practices had been proposed based on data gathered for the QA Reports (QI study done on pain control, admission/registration process, etc. which have resulted in improvement of care and outcomes).
2. A. The initial QI study done on Handwashing Compliance showed our baseline for compliance among nurses was 59%, physicians, 0%, and anesthesia 23%. The study referenced in the report does show that we had achieved improvement (thereby improving patient care). The Governing Board met 9/4/14 and after looking at high risk, high volume, and problem prone areas identified our highest areas of risk. From that a priority was set of resuming our QI study on handwashing (duration of 1 year) and beginning one on medication errors. The Governing Board will monitor and provide guidance to ensure the QI studies are done and continued.
   b. A follow-up study has been done.
   c. The referenced report has been corrected. Causes for lack of compliance were considered and corrective action also changed.
   d. The document titled "Benchmarking Study: Colonoscopy," dated 7/30/14, was the report of the results of the data from our center compared to the study. The purpose of the study and conclusions reached was documented in the Governing Board Meeting minutes dated 8/1/14: "We do a very small volume of these compared to the numbers used to create the data but we matched up well. Our time in the OR was a little higher than the ASCs in the study but our total time in the facility was a little less. We have had no complications from any of the colonoscopies Dr X has performed so we feel confident we are doing an acceptable, safe colonoscopy in our facility." As a multi-specialty facility we do fewer numbers of many different types of surgeries/procedures than

single-specialty centers so a benchmarking study done on large volumes of a single procedure helps us to identify how we "measure up."

3. The policy "Adverse Events" dated 12/13/12 has been updated to read "an analysis will be performed." The survey report needs to be corrected because the perforation required transfer to a local hospital, the tachycardic patient was treated by anesthesia being discontinued, patient recovered, discharged and instructed to follow up with primary care provider. Although not recorded, the microscope failure was analyzed immediately, a technician contacted, and the microscope repaired. The surgery was not affected beyond a slight delay as the second microscope was moved into the OR and used to complete the surgery. The QAPI Committee has been informed that each adverse incident will be investigated to try and determine the cause and corrective actions to be taken to prevent future incidents of the same nature from occurring. This has been done intuitively but will now be documented before being presented to the Medical Director for review. This will be reported to the Governing Board and any direction from them reported to the QAPI Committee.
4. In a QI study done the previous year on Missing Lab Work/Critical Lab Values a problem was identified by the QI Committee (a critical lab value was missed by the physician's office) which had the potential of patient harm. The Committee did an analysis, determined some potential causes, implemented changes, and began a QI study to monitor for effectiveness and change. This was taken to the Governing Board as a recommended QI study, approved, and results reported back to the Governing Board. The monitoring process showed that there have been no further incidents of this type. The ASC has used data to monitor the effectiveness and safety of its services in the past. The Governing Board has met, performed a risk assessment, and provided direction to the QAPI Committee for the development of QI Studies to assess and monitor for improvement. When the QI Committee met it reviewed the Patient Care issues which had been identified to try and determine the cause of the problem and any suggestions for improvements to be made to prevent further occurrences of the problem.
   Purpose: To use the data collected by the QAPI program to identify opportunities for improvement, improve patient care, and investigate incidents that occur which adversely affect patients.
   DoC: Done (9/9/2014)

Reference Tag Q 083: PERFORMANCE IMPROVEMENT PROJECTS

1. The Governing Board directed the QI/QA Committee to meet with the Medical Director to review the policies and procedures on Performance Improvement, Quality Assurance and report to them for approval any changes/improvements. The policies "QUALITY IMPROVEMENT QUALITY IMPROVEMENT STUDIES" (dated 6/99, updated 3/12 and 9/14), "POSSIBLE SOURCES OF IDENTIFIABLE PROBLEMS FOR QI STUDIES," and "QUALITY IMPROVEMENT PROGRAM" (worksheet) define performance improvement projects. These policies were in the P & P manual in plastic sleeves following the referenced "QUALITY ASSURANCE GOALS AND PHILOSOPHY." A QI study (improvement project) on Allergy Effects was documented.

Purpose: To ensure distinct improvement projects are conducted annually and documented.
DoC: 9/3/14, 9/4/14, 9/11/14

Reference Tag Q 084 GOVERNING BODY RESPONSIBILITIES

1. Under "GOVERNANCE GOVERNING BODY AND MANAGEMENT" it defines the role of the Governing Board's role in QA activities: "The Governing Body will address Quality Improvement, Risk Management, Utilization, Peer Review, Infection Control, Patient Satisfaction, Safety Program." Policies "QUALITY ASSURANCE GOALS AND PHILOSOPHY" and "QUALITY IMPROVEMENT QUALITY

IMPROVEMENT STUDIES" have been updated to define the Governing Board's role and the QA Committee's role in relation to overseeing and conducting the quality program. Done 9/4/14

2. The QI Coordinator mis-spoke when she said a plan for quality activities, including how data would be gathered and utilized had not been developed. The plan was listed in the P & P Manual in section 5 Quality Assurance and Improvement and has been utilized to gather data and use it to improve quality of care. Some of these policies have been updated to more clearly define the plan. Done 9/4/14
3. The policy stating a root cause analysis will be done has been updated to read an analysis of the cause will be done. No root cause analysis was done as there was not a need for it in the 3 adverse events referenced. . The Governing board will ensure that each adverse incident is investigated. They have informed the QAPI Committee that each adverse incident will be investigated to try and determine the cause and corrective actions to be taken to prevent future incidents of the same nature from occurring. (This has been being done intuitively but will now be documented before being presented to the Medical Director for review.) This will be reported to the Governing Board and any direction from them reported to the QAPI Committee.
4. The Governing Board has identified two distinct improvement projects and directed the QI/QA Committee to conduct these.
5. The time and resources used for quality activities is being tracked so sufficient staff, time, and resources are allocated.

Purpose: That the Governing Board ensures the QAPI program is defined, implemented, and maintained by the ASC – addressing priorities, data collection methods, frequency, establishing expectations for safety, and ensuring adequate allocation of resources, staff, and training to implement the program.
DoC: 9/3/14, 9/4/14, 9/9/14

Reference Tag Q141: ORGANIZATION AND STAFFING

1. Pt #14's BP was hypotensive by the NIH definition but he was a young, healthy, athletic male. He was asymptomatic on arrival in PACU (alert, oriented, no dizziness) and had run these BP's throughout his operative procedure. Because of his age and good health his low BP was not seen as abnormal nor a problem to be treated by the anesthesia provider. His condition was stable and remained such. He was discharged ambulatory with no symptoms. The CRNA knew of his BP as it had been that throughout his OR time and is recorded on their anesthesia record as the admission BP. The physician will be informed of vital signs that are in the abnormal range and his response documented. (staff inserviced) 9/9/2014
   b. The physician's orders referenced on pgs 16, 17, 23, 24, 29. 40. 41 were updated 08/06/14 to accurately reflect the order. See attached form **#10** (done) This will eliminate medication errors resulting from inaccurate orders. Lack of reassessment for pain after administration of pain medication. Inservice done with staff on the necessity for reassessing of pain to document patient's response to administered medication on every patient receiving pain medication. Done 9/9/14
2. Medications are to be administered according to the 5 R's – the right patient, drug, dose, route, and time. Our charting must accurately reflect a proper order for a drug that administered and the correct dosage and time for it to be administered. A QI study has been ordered by the governing board to determine the cause of our inaccurate orders, missing orders, incorrect time administration, and missing dosage amounts. This has been done and corrective measures instituted. These will be monitored by a follow up QI study to measure for effectiveness and maintenance. This will be reported by the QAPI Committee to the Governing Board. Staff inserviced on documenting why medication is administered and reassessing for effect. Done 9/9/14
3. All medication orders for home or in ASC are to include a dose, frequency, and route. If the order is incomplete the surgeon will be asked to complete it. Monitored by QI study on Medication Errors. Done 9/9/14
4. See tags 2 & 3

Purpose: To ensure nursing services are provided in accordance with recognized standards of practice so as to eliminate the potential for negative patient outcomes.
PoC: Done 9/4/14 and 9/9/14

Reference Tag Q 160: MEDICAL RECORDS
The ASC will maintain complete, comprehensive, and accurate medical records to ensure adequate patient care. Refer to Tag Q 162

Reference Tag Q162: REQUIREMENTS FOR SURGICAL PROCDEDURES

a. The medical record will accurately document the procedure performed (in all the appropriate places – nurse's notes, anesthesia record, op report), the correct time each event occurred during the patient's presence in the ASC, all orders signed, timed, and dated. See #2 under Tag Q 141
b. The medical record will accurately report prep solution used before the procedure. All orders will be signed, dated, and timed by provider ordering. When the order(s) is noted it will be signed, dated, and timed by the nurse noting the order(s). Chart review worksheets are currently being utilized as a QA indicator (recorded in quarterly QA report). Each chart will be checked for completeness of med orders, presence of signatures, time, and date, missing data (blanks, missing preps &/or prep solution), incorrect entries (times, etc.), H & P within 30 days, required laboratory results on chart prior to being placed on the wall as complete. These indictors will be added to the chart review worksheet for documentation of completeness and accuracy for QA purposes. Done 9/8/14. Incorrectly medicated – see 1b Reference Q 141. Done 8/6/14. Added to drug formulary Hydrocodone 7.5/325mg to ensure correct medication and dosage administered. Done 8/29/14. On the pre-op checklist page under the "Comments" section the first notation made was "1045 to SDS." The blank at the top of the page showing time will also be filled in. There are to be no blanks spaces on our charts. Staff informed, included in chart reviews. Done 9/9/14
c. Ophthalmic Procedure Record for all ophthalmic procedures (not just blepharoplasty) has been redone to make them more legible. Chart review worksheets updated to include accuracy of times, presence of signature, date, and time on all orders and notations. Done 9/8/14 During phase 2 recovery (which is where this patient was recovered) vital signs are taken every 15 min. A monitor with alarms is attached to the patient so if the nurse is out of the room and their O2 sats fall, pulse rate slows or increases, the alarms will sound. This patient received Valium 2 mg po and IV Versed for sedation (had been lightly sedated only so the surgeon could rouse him during the procedure to open his eyes at different times). All drug orders are to include route. Physician's office contacted to include "p.o." on the Valium 2 mg order. Monitored on chart reviews. Done 8/28/14 Prep solution used for presurgical prep is to be documented. Ophthalmic record updated to include check marks for prep and solution used. Done 9/9/14 On the ophthalmic record the first notation made is "0940 to SDS." Reference b above
d. On the pre-op checklist page under the "Coments"section the first notation made was " Reference b above. Chart review checklist to monitor that all orders are signed, dated, and timed. Done 9/8/14. Anesthesia and provider inserviced on need to communicate difficult/traumatic intubation and/or respiratory difficulty post op so they can be included in operative report dictated by surgeon. Done 9/11/14)
e. The referenced Operative Report had been printed out but not signed by the physician at the time of the surveyors' review. (The op report was dictated the day of surgery, transcribed that night, printed out and placed on the chart in the morning. The surgeon would sign the op report the following week when he returned for his next surgeries.) The surgeon is to review the op report for accuracy before signing. When the op reports are printed out and placed on the chart they will be checked by the person adding the report to ensure the accuracy of the op site. Being monitored on chart reviews. Done 9/9/14

f. All orders will be dated, timed, and signed and all orders when they are noted by nurse will be dated, timed, and signed. Being monitored on chart review worksheet. Done 9/9/14 The anesthetist inaccurately copied the patient's weight. This was a serious error. Anesthetist notified of error. Adverse incident report filled out for review by QI/QA Committee. States that pt #14's record did not indicate what time Patient #14 was admitted to the ASC. On the page titled "Pre-Operative Checklist" under comments it says "1025 To SDS amb with boot on rt ankle." Reference b above. Order sheet redone to accurately reflect physician's medication order (done 8/7/14) All patients will be reassessed after pain med administered for patient's response. Reference Q 141 1b. Drug formulary reference Tag Q 162 b.
g. All orders will be signed, timed, and dated. All orders when noted by nurse will be signed, timed and dated. Monitored on chart reviews. Reference b above. On the "Pre-Operative Checklist" the first item under "Comments" is "1115 to SDS". Reference b above
h. All op reports are to be signed by the surgeon during his next visit to the ASC. This surgeon comes every other week (should have been in the facility 7/22/14) but had no surgery that day. The chart got misfiled after being used by the coder for billing purposes so obtaining the surgeon's signature was missed. The Nurse Manager has instructed the coder on the proper placement of charts for obtaining signatures once coding is completed. Done 8/26/14. All orders will be signed, dated, and timed by physician and signed, dated, and timed by nurse noting the order.
i. Progress Report removed from endoscopist's record as he immediately prints out his op report which documents everything on the lower part of the Progress Report. Now has a form which contains only a signature line for the items "Patient seen by surgeon preoperatively and cleared for anesthesia. . . Heart exam WNL. . .Lung exam WNL and checkboxes for these items. This signature will be dated and timed. Done 9/4/14. The date and time have been added to the operative report which is electronically signed by the endoscopist to complete his record (done 9/2/14). As mentioned above, the endoscopist now signs, dates, and times that he has checked and cleared the patient for anesthesia. This is being monitored on chart reviews. Done 9/2/14. In the report it states pt #6 received a total of 850ml of fluids under ANESTHESIA RECORD (this is fluid administered in the OR). On the endoscopy record it states the OR IV CREDIT was 150ml which is the balance of the 1000ml IV fluid bag. The anesthesia record states the amount of fluid administered in the OR while the Endoscopy record states the amount of fluid remaining to be infused. There is no discrepancy (850 + 150 = 1000)
On the ENDOSCOPY RECORD sheet it has been added "Total IV Fluid" to eliminate confusion as to how much IV fluid was administered as a total in the OR and in Same Day. Done 9/16/14
j. See "i" above.
k. See "i" above
l. The Medical Director reviewed the EGD report with the endoscopist who felt his op report dictation was adequate. The pre-printed orders referenced were not crossed out but they were not noted by the nurse. A handwritten (verbal) order was instead written below those orders to transfer the patient to the hospital which had agreed to assume the care of the patient. A verbal order such as this will be written on a separate physician order sheet to be signed by the surgeon. Staff instructed 9/9/14. All orders will be signed, dated, and timed by the nurse noting them. Done 8/7/14
m. Anesthesia note recording VSS in PACU to them means the first set of vitals taken in the PACU are consistent with what they have been in the OR. As soon as the patient arrives in PACU O2 is applied if indicated and a set of vital signs obtained. This can easily occur within 1 minute of arrival in PACU and if they are consistent with what the patient has had for vital signs during his surgical procedure (which patient #4's were) the anesthetist determines the vital signs are stable. The anesthesia providers have stopped making this notation but feel strongly it is an appropriate notation. All notations such as this will be timed. Done 9/10/14
n. See m above
o. See m above

Purpose: To maintain an accurate, legible, and promptly complete medical record for each patient.

DoC: 9/11/14

Reference Tag Q 181: ADMINISTRATION OF DRUGS

1. a. Even though we have been doing monthly (documented) checks for outdated drugs, some outdated meds were found. All medications will continue to be checked monthly for outdates and when a drug is found which expires within the month, brightly colored round sticker dots have been purchased to apply to the drug. This will provide an easy visual check for all the drugs outdating that month and make it obvious they need to be removed by the outdate. All medications, fluids, and lubricants will be dated with the date they were opened. Any medication found that has not been dated on opening will be discarded. Done 9/11/14

   B Whenever any medication is drawn up into a syringe the syringe is to be labeled with the drug name, strength, date, initials of person drawing it up, and expiration date of med. Staff reminded of this (9/9/14) and random checks are being done by nurse manager to check for compliance.

   c. The expired Dantrolene bottles which had been brought up for use during the MH drill had somehow gotten placed on top of the crash cart. All medications will be checked for outdate (even those we know have a long expiration date such as the remaining Dantrolene). The Pitressen had been ordered and the in date medication had been placed in the cart without removing the outdated med. Adding the colored stickers to the soon to outdate med will help us remember to remove the med when the new is added. Done 9/11/14. No undated medication will be put out for patient use.

   Purpose: To ensure expired or opened and undated medications were removed from patient use.

2. A. As the QAPI Committee reviewed the medication errors which had been found in our charts as part of the QI study on med errors, it was evident that the nursing staff has been receiving med orders from the anesthesia providers verbally and not recording them or getting them signed. A PACU/SDS Anesthesia Order sheet was developed and is being placed on each chart with an anesthesia record for the anesthesia provider to fill out and sign, date, and time. Each medication will be administered as ordered (route, dosage, frequency, drug). Included in the chart will be documentation as to why a drug is being administered and an evaluation of the effect of the drug. Inservice done with staff on the necessity for reassessing of pain to document patient's response to administered medication on every patient receiving pain medication. Done 9/9/14

   B. All medication orders will include the route of administration. Physician's office contacted to change orders to include "p.o." on order sheet. Done 8/28/14

   c. Physician order sheet updated. Done 8/7/14 Hydrocodone 7.5/325 added to drug formulary

   d. All medication orders will be complete as to drug, dose, frequency, and route. If any of the order is missing the surgeon will be contacted to complete the order. Done 9/9/14

   e. See #2a above

   Purpose: To assure nursing staff administers medication only as ordered.

Reference Tag Q 184: VERBAL ORDERS

1. When the patient arrived in PACU he was noted to have respiratory stridor. The anesthetist who accompanied the patient to PACU gave a verbal order to administer the Racemic epi treatment and was present as it was administered. The verbal order was not followed up by a written order. All verbal orders will be written down (now have PACU/SDS Anesthesia order sheets to be filled out and signed by anesthesia providers with a place to write in any other order such as a Racemic epi nebulizer treatment), signed, signed, and dated by anesthesia provider. A verbal order will not be "added in" on an existing, previously signed order sheet but will be written on a separate physician order sheet and the surgeon's signature (dated and timed) will be obtained as quickly as possible.

Reference Tag Q 219: PATIENT RIGHTS
Refer to Q 221: NOTICE OF RIGHTS

1. The patient's rights notice posted in the ASC has been translated into Spanish and is offered in English or Spanish depending on the preference of the patient. The information for contacting the State agency (the correct address and telephone number) to which the patients may report complaints has been corrected. (Number dialed by Nurse Manager to confirm this was indeed where patients can report complaints.) Done 8/7/2014
   Purpose: To assure patients and their representatives be fully informed of their rights.
   DoC: 8/7/2014

Reference Tag Q 223: NOTICE – PHYSICIAN OWNERSHIP
The form "PATIENT RIGHTS" is given to all patients prior to surgery. We find that many leave this paper lying on the desk. The very last item at the bottom of page three (below the contact information for the state agency) is a line stating "The Ambulatory Surgery Center of Burley is owned by Dr. Joseph R. Petersen". In addition, to the right side of the window where patients register, is an 8 x 11 piece of paper which states as the first item that the Ambulatory Surgery Center of Burley is owned by Dr. Joseph R. Petersen, Orthopedic Surgeon. Following that is the list of credentialed surgeons who perform surgery at the ASC. On the registration desk where the patients fill out their paperwork a typed notice in large, bold font has been taped (inside a plastic sleeve) stating:
"Please Note:
The Ambulatory Surgery Center of Burley is owned by Dr. Joseph R. Petersen, Orthopedic Surgeon"
The Ambulatory Surgery Center of Burley does not honor living wills/advanced directives." Done 8/27/14
When the patients register we make sure they read the notice. Done 8/27/14
The nursing staff and registration staff has been reminded of this requirement and the importance of making sure the patients are given copies of the PATIENT RIGHTS document as well as having them read the notice in the sleeve taped to the registration desk.
Purpose: To ensure the ASC discloses the name of the physician who has ownership of the ASC of Burley.

Reference Tag Q 224: ADVANCED DIRECTIVES

1. The survey report states "The ASC's policy manual did not include a patient rights policy regarding advanced directives." This is in error. See attached Policy **#9**.
   The patient rights notice given to the patient had been updated to reflect that the surgery center does not honor living wills/advance directives. The nurse manager has no explanation for where the old version of patient rights came from but the updated version is what is being given to the patients. Done 8/7/14 When the patient/patient's representative presents to the registration window to fill out their registration paperwork, their attention is directed to the notice posted on the desk stating:
   "Please Note:
   The Ambulatory Surgery Center of Burley is owned by Dr. Joseph R. Petersen, Orthopedic Surgeon"
   The Ambulatory Surgery Center of Burley does not honor living wills/advanced directives." Done 8/27/14
   We have now made determining the patient's Advance Directive status part of the admission process (added to intake area of each document). If the patient has a living will/advanced directive they are again told of the ASC's policy regarding living wills/advanced directives.
   On the pre-assessment form filled out by our patients there is a question asking if they have a living will **(see #8)**. We added this to our endoscopy procedure record and to the new ophthalmic record. (9/12/14) The nurse manager mis-spoke when she said there is no information provided to patients regarding advance directives.
   The charts which were surveyed were reviewed and the following was found:

5 of the charts were endoscopy patients and there is no place to indicate living will status on this form. This has been corrected. Done 9/11/14
4 of the charts were ophthalmic patients and again there is no place to indicate living will status on this form. This has been updated and added. Done 9/10/14
11 of the charts had the pre-assessment form which included the question re: living wills. Three of them were pediatric patients (no living will in place), a fourth was a 20 year old healthy male (who checked no on the form). One patient left the question blank. Of the remaining 6 patients one checked yes and the remainder checked no.
Purpose: To assure the patients are aware of the ASC of Burley's policy regarding advanced directives/living wills prior to their procedures.
DoC: Done 9/12/14

Reference Tag Q 229: EXERCISE OF RIGHTS – INFORMED CONSENT
The consent form has now been translated into Spanish so is available in English or Spanish. For our Spanish speaking patients they will now be given the consent form to read in Spanish. If a translator is used (we occasionally have elderly Spanish people who are unable to speak English or read Spanish), the translator's signature will be required on the consent form. Done 9/5/14
Purpose: To assure the patients are fully informed about a treatment or procedure before it is performed in a written document the patient can understand.
DoC: 9/5/14

Reference Tag Q 241: SANITARY ENVIRONMENT

1. The physical plant as it is now was approved during our initial accreditation survey and in each succeeding survey. We will have "U" door handles installed in the patient rooms so someone inside the room would be able to open the door using an elbow/arm as they are designed for. We will have a similar handle installed on the door leading into the decontamination room where there is a sink with "wing" faucet handles which can be turned on by using arm/elbow. This will allow someone with visibly soiled hands to access a sink without having to touch to release handles. New handles ordered 9/11/14 to be installed on arrival.
2. A. An inline thermostat was ordered and installed on the hot water heater in the laundry room. This gives a constant read out of the water temperature. This will be recorded weekly. Done 8/28/14
   B. The food refrigerator has been moved away from the dirty laundry area.
   C. The food refrigerator is never to hold medication which all the staff is aware of. A lock has been ordered for a refrigerator. When it comes, it will be applied to the medication refrigerator and that refrigerator will be moved upstairs and placed in the OR hallway (next to the crash cart), making access to the med refrigerator much easier.(completion 9/12/14)
3. Instrument trays which are multiples (eye, myringotomy) have now been numbered (the # written on the metal part of the tray). A copy is made of the day's schedule and the # is recorded on that next to the appropriate pt. (Pt A had tray #5, Pt. B had tray #6, Pt C had tray #7, Pt D had try #5, etc.). This sheet is kept until after the next biological is run and we know there was not a sterilizer issue in the interim. In this manner if we had to track a specific tray to a specific patient it could be done. Done 8/26/14
4. A. All unlabeled plastic spray bottles have been removed from the cleaning cart and housekeeping reminded that all containers must be labeled with contents and appropriate OSHA information.
   B. All cleaning products used in the ASC must be labeled as suitable for medical grade cleaning. The Clorox Clean Up has been removed. The expired solutions have been removed and a label affixed to the spray bottles so when they are filled/refilled the date can be recorded to document the solution is not expired. Done 8/7/14

C. All plastic spray bottles used in the ASC have had a label affixed so when they are filled/refilled the date can be recorded
Purpose: To ensure a functional and sanitary environment.
DoC: 8/7/14

Reference Tag Q 242: INFECTION CONTROL PROGRAM

1. The results of the surveryor's observations were reviewed in QA/QI meeting 9/9/14. The 5 Moments of hand hygiene again reviewed and the rationale behind it.
2. The Governing Board identified the risk of SSI's as one of our biggest areas of risk and has instructed that the hand hygiene QI study be revisited for the duration of one year.

Purpose: To assure monitoring of infection control practices to ensure staff follows the facility's guidelines.
DoC: 9/9/14

Reference Tag Q 261: ADMISSION ASSESSMENT

1. A & B. Prior to the surgical procedure, as the chart is being assembled, it will be checked to ensure the H & P has been performed within 30 days of the procedure date. This item has been added to our Chart Review Worksheet to be included in our recorded chart reviews to check for compliance.(Patient #6 has since returned for another procedure and his H & P was current.) The Nurse Manager has spoken with the physician offices and reminded them of the requirement.
   C & D. As the chart is being assembled prior to the surgical procedure, if there is a med list provided by the patient, it is being compared to the meds listed on the H & P. If there is a discrepancy it is noted and the patient asked about it. During the physical admission of the patient, the nurse is reviewing the med list(s) to make sure the patient has correctly identified what they are taking. If there is a discrepancy found, the surgeon will be notified. The nurse manager has contacted the physician's office to inform them of the issue and to request they get a current list of medications from their patients as well as do a more comprehensive H & P. These charts are being reviewed for compliance.
   E When conditions or surgeries are discovered which are not included in the H & P, the surgeon will be notified of the discrepancy so the "changes" portion of the H & P update sheet can be filled out.
   Purpose: To ensure each patient's record contains a comprehensive H & P performed not more than 30 days prior to the date of the scheduled procedure.
   DoC: Done 8/28/14, 9/9/14

Reference Tag Q 262: PRE-SURGICAL ASSESSMENT

1. A & B When the patient is seen by the surgeon preoperatively they will DATE and TIME their signature showing they have cleared the patient for anesthesia/procedure. They will date and time their signature on the H&P Update form at the same time. Physicians have been informed they must date and time their signatures andthe nursing staff is working with the surgeons to make sure they are signing, dating, and timing the form when they visit the patient preoperatively.

Purpose: To ensure assessments are completed prior to surgical procedures.
DoC: 8/11/14

Reference Tag Q 266: DISCHARGE – ORDER

1. A. All patients will be discharged by a physician. The time the physician sees the patient for discharge is being noted in the chart and the time is being added to the discharge order. If the surgeon is unable to physically assess the patient (in a TF case for example) a verbal report will be given to the physician and documented in the chart "Physician states patient may be discharged."
   B The discharge order (even if written preoperatively) will not be noted until after the procedure has been performed. All orders will be signed, dated, and timed and all orders when noted will be signed, dated, and timed. (Physicians and staff notified 8/7/14)

C See B above
D See B above
E See B above
F See 1a above
All of these are being monitored on chart checks prior to the charts being placed on the wall as complete.
Purpose: To ensure patient records include documentation that patients are discharged on the order of a physician.
DoC: 8/11/14

Person responsible for implementing the acceptable POC:
Shirley Ramey, RN
Nurse Manager