IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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BUREAU OF FACILITY STANDARDS
3232 Elder Street
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PHONE 208-334-6626
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January 30, 2015

Gregory Kent, Administrator
Eagle Eye Surgery And Laser Center
3090 Gentry Way, Suite 100
Meridian, ID 83642

RE: Eagle Eye Surgery And Laser Center, Provider #13C0001032

Dear Mr. Kent:

This is to advise you of the findings of the Medicare survey of Eagle Eye Surgery And Laser Center, which was conducted on January 22, 2015.

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

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

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

After you have completed your Plan of Correction, return the original to this office by **February 12, 2015,** and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626, option 4.

Sincerely,

SUSAN COSTA
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

SC/pmt
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13C0001032	A. BUILDING _____ B. WING _____	01/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE EYE SURGERY AND LASER CENTER	3090 GENTRY WAY, SUITE 100 MERIDIAN, ID 83642

(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 1/20/15 to 1/22/15. Surveyors conducting the recertification were: Susan Costa, RN, HFS-Team Leader Laura Thompson, RN, HFS Acronyms used in this report include: ASC - Ambulatory Surgical Center CRNA - Certified Registered Nurse Anesthetist CST - Certified Surgical Technician DC - Discontinue EMS - Emergency Medical Services H&P - History and Physical LMA - Laryngeal Mask Airway lpm - liters per minute OR - Operating Room PACU - Post Anesthesia Care Unit PRN - as needed RN - Registered Nurse VS - Vital Signs	Q 000	RECEIVED FEB 10 2015 FACILITY STANDARDS	
Q 061	416.42(a)(1) ANESTHETIC RISK AND EVALUATION A physician must examine the patient immediately before surgery to evaluate the risk of anesthesia and of the procedure to be performed. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the ASC failed to ensure anesthesia risk was comprehensively evaluated prior to a procedure for 2 of 18 patients (#9 and #16) whose records were reviewed, and had the	Q 061	416.42(a)(1) ANESTHESTIC RISK AND EVALUATION A physician will examine the patient immediately before surgery to evaluate the risk of anesthesia and of the procedure about to be performed. PLAN OF CORRECTION: The Center will ensure that an appropriate assessment of anesthesia-related and procedural risks is completed just prior to every surgical procedure and is present in the medical record prior to the surgical procedure. Staff reviewed the following policies: a) ASA Classification b) Anesthesia Responsibilities c) Anesthesia Documentation Education provided to Medical Staff on Anesthetic Risks and Evaluation 416.42(a)(1) (Attachment A)	2/28/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jindi J Archer — TITLE: Clinical Director — (X6) DATE: 02/09/2015

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 061	Continued From page 1 potential to affect all patients receiving anesthesia. This resulted in the potential of patients being placed at an increased risk of complications as a result of performing a surgery when patients were not stable. 1. Patient #16 was a 46 year old female admitted to the ASC on 5/19/14, for glaucoma surgery to her left eye. During a previous admission dated 3/24/14, Patient #16 was scheduled for glaucoma surgery to the left eye. The procedure was aborted due to a small hemorrhage in Patient #16's eye, which the physician documented may have occurred during a laryngospasm (a brief spasm of the vocal cords which may result in difficulty speaking or breathing) at the beginning of the procedure. The physician documented Patient #16 was under moderate sedation anesthesia and he had begun the surgery when she began to cough. The note further documented it took a long time before the laryngospasm stopped. Patient #16's record included a post-operative note, dated 5/19/14, and signed by the physician. The post-operative note documented general anesthesia was used for Patient #16 to prevent laryngospasm, which had occurred during her previous admission. The note documented Patient #16 had a very unstable airway. The physician also documented there was difficulty during anesthesia, but did not specify why it was difficult. The post-operative note documented Patient #16 was stabilized, and her oxygen saturation levels went back up into the mid 90's. There was no documentation as to what Patient #16's oxygen saturation levels were before they went back up.	Q 061	Continued from page 7 RESPONSIBILITY AND MONITORING: The Center Director, or designee will be responsible for monitoring that patients are examined immediately before any procedure for anesthesia risks and the findings are documented in the patient medical record. The Center Director or designee will review 100% of all medical records for a period of three weeks beginning on 2/9/2015 for compliance with the medical evaluation by anesthesia or the surgeon prior to the procedure documentation. If 100% compliance is not achieved, staff will be re-educated and the monitoring process will start over. The results of all medical record audits will be tabulated and presented to the QAPI committee on a quarterly basis for review and recommendations. Recommendations will be presented to the Governing Body quarterly for review and approval.	

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Q 061	Continued From page 2 The anesthesia form in Patient #16's record, dated 5/19/14, and signed by the CRNA documented Patient #16 was coughing after removal of the LMA (a laryngeal mask airway used to keep the patient's airway open during anesthesia). The CRNA also documented Patient #16's oxygen saturation levels were labile in the 80's and 90's. He further documented Patient #16 was going to be evaluated at a hospital. The CRNA documented Patient #16's VS were stable. Patient #16's record included a post-anesthesia recovery note, dated 5/19/14, and signed by the RN. The recovery note included VS that started at Patient #16's arrival from the OR, and concluded upon her transfer to a hospital. VS were done 5 times at 5 minute intervals. Patient #16's respiratory rate was 42 at 10:05 AM, 40 at 10:10 AM, 36 at 10:15 AM, 36 at 10:20 AM, and 32 at 10:25 AM. The Johns Hopkins Medicine website, accessed 1/26/15, stated a normal respiratory rate for resting adults is 12-16 a minute. Patient #16's respirations did not go below 30. The post-anesthesia recovery note also documented Patient #16's oxygen saturation levels. Patient #16's oxygen saturation levels were 89% at 10:05 AM, 93% at 10:10 AM, 91% at 10:15 AM, 89% at 10:20 AM, and 91% at 10:25 AM. The Mayo Clinic website, accessed 1/27/15, stated normal oxygen saturation levels range from 95-100%. There was no documentation Patient #16 was on supplemental oxygen while in recovery.	Q 061		

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Q 061	Continued From page 3 A transfer form, dated 5/19/14, signed by the RN and physician, documented Patient #16 was transferred via EMS to a local hospital for evaluation at 10:30 AM. According to the documentation Patient #16 was transferred due to brief periods of laryngospasm and bronchospasm (a temporary narrowing of the airways into the lungs caused by contraction of the muscles in the lung walls). The form also documented Patient #16 continued to cough and have difficulty taking deep breaths. Patient #16's VS were documented as a heart rate of 119, respiratory rate of 38, blood pressure 108/60, and an oxygen saturation level of 89% on 4 lpm of oxygen via nasal cannula. During an interview on 1/22/15 at 2:45 PM, the Clinical Director reviewed Patient #16's record. She confirmed the physician documented an unstable airway. The Clinical Director stated she had understood Patient #16 was not going to have the procedure again at the ASC after the first surgery was aborted, due to laryngospasm. She stated a meeting was held with physicians and management after Patient #16 was transferred for complications with anesthesia. The Clinical Director stated during the meeting it was discussed how miscommunication had occurred between the ASC and the physician about Patient #16. The ASC failed to ensure Patient #16 was not at an increased risk for complications related to anesthesia prior to her surgery. 2. Patient #9 was an 81 year old female admitted to the ASC on 12/04/14, for repair of left eyelid defect.	Q 061		

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Q 061	Continued From page 4 Patient #9's record included an H&P dated 12/04/14, which had a section for blood pressure measurement. The section stated if blood pressure measurements were over 150/90, the blood pressure measurement must be repeated. Additionally, the section stated if the repeated blood pressure measurement was over 150/90 the patient must follow up with the primary care physician prior to surgery. Patient #9's initial measurement was 210/101, the repeated measurement was 203/116. However, the H&P was signed by the physician on 12/04/14 at 4:50 PM and Patient #9's surgery began at 5:10 PM. There was no documentation of follow up with the primary care physician prior to surgery or of treatment for Patient #9's elevated blood pressure in the record. In the post-anesthesia recovery record Patient #9's blood pressure measurements were 176/94 at 5:59 PM and 178/96 at 6:05 PM. There was no documentation blood pressure medications were given. Patient #9 was discharged from the ASC at 6:10 PM. The discharge orders and instructions did not have documentation for blood pressure instructions or for Patient #9 to follow up with her primary physician regarding her high blood pressure. During an interview on 1/22/14 at 2:35 PM, the Clinical Director reviewed Patient #9's record and confirmed the elevated blood pressure measurements. She stated some of the eye drops used for procedures cannot be given if the diastolic (lower number) blood pressure is greater	Q 061		

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Q 061	Continued From page 5 than 90. The Clinical Director stated they would treat patients with medication for elevated blood pressure if the patient was already receiving treatment at home for high blood pressure. She confirmed there was no medication given to decrease Patient #9's blood pressure. The Clinical Director stated the physician should not have continued with the procedure with Patient #9's elevated blood pressure measurements. The ASC failed to ensure Patient #9's blood pressure was stable prior to her surgery.	Q 061		
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: (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, policy review, and staff interview, it was	Q 162	416.47(b) FORM AND CONTENT OF RECORD PLAN OF CORRECTION: The ASC must maintain a medical record for each patient. Every record must be accurate, legible, and promptly completed. The Center will provide the patient or the patient's representative with verbal and written notice in advance of the day of the procedure, in a language and manner that the patient or the patient's representative understands. SYSTEMIC CHANGES: 1) The Center will ensure that their limited-English proficient (LEP) patients have access to accurate medical translation of information translated in their language. The Center Director will inservice Center staff and the practice office staff regarding policy "Patient Rights and Responsibilities" and "Patient Admission Process." 2) Documentation including time-based documentation will be complete and accurate on all charts prior to the procedure. 3) All preop orders will be documented and authenticated in the record. 4) The Pre-Anesthestic Assessment and Plan will be documented and authenticated in the record. The documentation policies will be reviewed with all staff members and physicians (Attachment B):	2/28/2015

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Q 162	Continued From page 6 determined the facility failed to ensure medical records were complete and accurate for 9 of 21 patients (#3, #4, #7, #10, #13, #15, #16, #18 and #19) whose records were reviewed. This failure resulted in a lack of complete and comprehensive information being available in patient records. Findings include: 1. A policy "Interpreter Services" approved 7/12, stated "Language needs are determined for each patient prior to the patient's arrival at the surgery center. Such information may be obtained from the physician's office at the time of scheduling." If unable to determine language needs prior to arrival, the following information is obtained upon admission: - Information regarding the availability of interpreter services is included in the Patient Rights brochure - The patient is asked what language he/she speaks at home. If other than English, it is determined in what language the patient prefers to receive communication. - Information regarding the patient's primary language is recorded in the patient's medical record. The policy also stated,"The patient is offered the provision of interpreter services at no charge to the patient. Center staff who are fluent in the patient's language may also provide interpreter service if requested by the patient. A notation is made in the medical record that the patient has declined the offer of interpreter services and prefers to use a staff member (name is recorded)."	Q 162	Continued from page 6 1) The Medical Record 2) Medical Record Contents-Order 3) Medical Record Entries and Components 4) Physician's Orders 5) Documentation - Guidelines for Nursing Care Staff will be reminded of the importance of accurate charting and documentation. RESPONSIBLE PARTY AND MONITORING: It is the responsibility of the Center Director to ensure that their limited-English proficient (LEP) patients have access to accurate medical translation of information translated in their language. It is the responsibility of the Center Director to ensure that the medical record for each patient is accurate, legible and promptly completed. The Center Director or designee will review 100% of all medical records for a period of three weeks beginning on 2/9/2015 for compliance with the documentation and patient rights policies. The results of all medical record audits will be tabulated and presented to the QAPI committee on a quarterly basis or review and recommendations. Recommendations will be presented to the Governing Body quarterly for review and approval.	

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Q 162	Continued From page 7 According to the U.S. Department of Health and Human Services website, accessed 1/23/15, 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 #4 was a 55 year old male admitted to the ASC on 1/22/15, for Pterygium removal (abnormal tissue of the cornea and white part of the eye) with graft of the right eye. During an observation on 1/21/15 beginning at 11:15 AM, Patient #4 arrived at the ASC with two correctional officers accompanying him. The ASC receptionist was speaking with Patient #4 regarding signing his admission paperwork. She identified at that time he did not speak English, only Spanish. The ASC receptionist confirmed the fact with the correctional officers and asked if they would translate. The officers stated they did not translate for people in custody, it was against regulations. The ASC receptionist stated she would attempt locating a Spanish speaking translator for Patient #4, at a physician's office located near the ASC, by making a phone call. Patient #4 was moved to the pre-surgical area while they were waiting for a translator. The translator arrived at 11:35 AM, 20 minutes after Patient #4's arrival, and was asked by the RN to translate in Spanish. The translator was used for the surgical informed consent and consent for anesthesia. The consents for the procedure and anesthesia were written in English.	Q 162		

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Q 162	Continued From page 8 She did not read the surgical or anesthesia consent forms word by word, but translated what was said by the RN regarding the procedure and anesthesia. Patient #4 signed both consent forms. Neither form indicated a translator was used. The CRNA and physician arrived at Patient #4's bedside at 12:15 PM. The CRNA did not speak with Patient #4 about the anesthesia being used for the procedure. During an interview on 1/21/15 at 11:45 AM, the translator stated she worked in the office of the physician who performed the eye surgery on Patient #4. She confirmed she assisted with translating for the ASC on occasion, but it was not something she did regularly. During an interview on 1/22/15 at 3:05 PM, the Clinical Director reviewed the record and confirmed that a translator was used for Patient #4. She further confirmed the consent forms, for both the surgery and anesthesia, were in English and stated they did not have forms available in Spanish. The Clinical Director also stated it was not indicated on Patient #4's consent forms a translator was used. The ASC failed to ensure that a translator fully informed Patient #4 of the surgical procedure and anesthesia. 2. Patient #18 was a 58 year old male admitted to the ASC on 7/31/14, for strabismus surgery (a condition in which the eyes are not properly aligned). Patient #18's record included post-operative	Q 162		

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Q 162	Continued From page 9 nursing notes after receiving general anesthesia for the eye surgery. The nursing note documented Patient #18 was able to maintain his oxygen saturation level greater than 95% while on room air (without oxygen supplement). The nursing note also documented he was using oxygen at 8 lpm with a non-rebreather mask. Patient #18's record also included documentation that he was receiving 4 lpm of oxygen upon his discharge. During an interview on 1/22/15 at 2:25 PM, the Clinical Director reviewed the record and confirmed Patient #18 could not have been on oxygen and also maintaining the oxygen saturation level on room air at the same time, as documented by the RN. Patient #18's record did not include accurate documentation regarding his oxygen. 3. Patient #16 was a 46 year old female admitted to the ASC on 5/19/14, for glaucoma surgery to her left eye. - Patient #16's record included an anesthesia form dated 5/19/14 and signed by the CRNA. The form documented Patient #16 was using 3 lpm of oxygen via nasal cannula during the procedure. However, the CRNA also documented Patient #16 was intubated with a size 5 LMA. - Patient #16's record included a post-anesthesia recovery note. The recovery note dated 5/19/14 and signed by the RN included VS that began upon Patient #16's arrival from the OR, and concluded upon her transfer to a hospital. VS were done 5 times at 5 minute intervals. Patient	Q 162		

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Q 162	Continued From page 10 #16's respiratory rate was 42 at 10:05 AM, 40 at 10:10 AM, 36 at 10:15 AM, 36 at 10:20 AM, and 32 at 10:25 AM. The RN documented Patient #16's VS were stable upon discharge to the hospital with paramedics. The Johns Hopkins Medicine website, accessed 1/26/15, stated a normal respiratory rate for resting adults is 12-16 a minute. During an interview on 1/22/15 at 2:45 PM, the Clinical Director reviewed the record. She confirmed the documentation of 2 types of oxygen supplementation by the CRNA. The Clinical Director stated she was not sure why the CRNA documented use of oxygen by nasal cannula when the record documented she had an LMA. She also confirmed Patient #16's VS were not stable when she was transferred from the facility to the hospital with paramedics. Patient #16's record did not include accurate documentation. 4. Patient #10 was a 64 year old female who was admitted on 12/09/14 for a cataract removal on her right eye and removal of a lesion on her left lower lid. Patient #10's record included an operative report that was signed by the physician on 12/23/14. The report included as the pre and post operative diagnosis "Left lower lid lesion." The physician described in his report the procedure followed a successful cataract surgery. However, Patient #10's record did not include an operative report for the cataract surgery. During an interview on 1/22/15 at 10:10 AM, the	Q 162		

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Q 162	Continued From page 11 Clinical Director reviewed Patient #10's record and confirmed the operative report did not include details about the cataract removal on the right eye. Patient #10's record did not include accurate and complete documentation. 5. Patient #15 was a 75 year old male who was admitted on 4/29/14, for the removal of a cataract on his right eye. Patient #15's record included documentation that his scheduled procedure was canceled after his pre-operative assessment revealed elevated blood pressure, as well as, difficulty walking, and possible change in his speech. His record documented he was discharged to a family member and was to go directly to the hospital for evaluation. A transfer form included vital signs, and other pertinent information, but the time of his discharge/transfer was not documented. Patient #15's record included a physician's order sheet for the planned cataract removal procedure. The medications ordered were signed off by the RN. However, not all the medications were administered, and there was no order to cancel the medications that were not given. The physician order sheet included a pre-printed statement at the bottom of the form, "Stable and ready for discharge with responsible adult." The statement was signed by Patient #15's physician on 4/29/14 at 7:30 AM. Patient #15's time of admission to the ASC was documented as 7:40 AM.	Q 162		

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	13C0001032	A. BUILDING _____ B. WING _____	01/22/2015

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Q 162	Continued From page 12 During an interview on 1/22/15 at 10:40 AM, the Clinical Director reviewed Patient #15's record and confirmed that some medications were administered before his transfer to the hospital, and not all were given. She stated the nurse should have obtained an order to cancel the pre-operative orders. The Clinical Director confirmed the physician signed the order for discharge before the time of admission, and could not explain why that was done. Patient #15's record included inaccurate documentation and was not complete. 6. The ASC did not ensure patients were fully informed before signing consents. The receptionist had patients sign consents for the surgical procedure as well as, anesthesia, upon their arrival to the ASC before the procedure. Observations were made of patients as they arrived at the surgery center over a three day period while the survey was conducted. The receptionist would provide the patients with consent forms and other paper work to be signed. The patient would then wait until a nurse called them back to the pre-operative area. During the pre-operative stage the physician and the CRNA would speak with the patient, and details of the procedure would be reviewed. Each patient record included a history and physical form with a section to be completed by the anesthesia provider (CRNA). The CRNA pre-operative assessment section on the form included pre-printed statement: "H&P reviewed. Risks, benefits and options for anesthesia have	Q 162		

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Q 162	Continued From page 13 been reviewed. [See detailed anesthesia consent]." The statement on each form was followed by a signature and time of signing by the anesthesia provider. The following records were reviewed and documented anesthesia consents were signed by the patient before they met with the CRNA: a. Patient #3 was a 91 year old female who was admitted on 1/20/15 at 8:28 AM, for a right eye cataract removal. The consents for "Cataract Operation and/or Implantation of Intraocular Lens," and "Consent for Anesthesia Services," were signed at 8:20 AM on 1/20/14. b. Patient #7 was a 79 year old male who was admitted on 12/18/14 at 12:28 PM, for the removal of a cataract on his left eye. The consents for "Cataract Operation and/or Implantation of Intraocular Lens," and "Consent for Anesthesia Services," were signed at 12:10 PM on 12/18/14. c. Patient #13 was a 66 year old male who was admitted on 5/14/14 at 12:32 PM, for the removal of a cataract on his left eye. The consents for "Cataract Operation and/or Implantation of Intraocular Lens," and "Consent for Anesthesia Services," were signed at 12:30 PM on 5/14/14. d. Patient #19 was a 58 year old male who was admitted on 4/23/14 at 9:45 AM, for the removal of a cataract on his left eye.	Q 162		

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Q 162	Continued From page 14 The consents for "Cataract Operation and/or Implantation of Intraocular Lens," and "Consent for Anesthesia Services," were signed at 8:55 AM and 9:00 AM on 4/23/14. e. Patient #10 was a 64 year old female who was admitted on 12/09/14 at 8:45 AM, for a cataract removal on her right eye and removal of a lesion on her left lower lid. The consents for "Right Eye, Cataract Operation and/or Implantation of Intraocular Lens and Excision of Left Lower Lid Papillomatous lesion, Left Eye," and "Consent for Anesthesia Services," were both signed at 8:40 AM on 12/09/14. f. Patient #4 was a 55 year old male admitted to the ASC on 1/22/15 at 11:15 AM, for Pterygium removal (abnormal tissue of the cornea and white part of the eye) with graft of the right eye. - Patient #4 did not speak English, and a translator was provided by the ASC. The consents for the procedure and anesthesia were written in English. The translator did not read the surgical or anesthesia consent forms word by word, but translated what was said by Patient #4's RN regarding the procedure and anesthesia. Patient #4 signed both the surgical procedure and anesthesia consent forms. Neither form indicated a translator was used. - The CRNA and physician arrived at Patient #4's bedside at 12:15 PM. The CRNA did not speak with Patient #4 about the anesthesia being used for the procedure prior to his signing the consent forms.	Q 162		

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Q 162	Continued From page 15 During an interview on 1/22/15 beginning at 10:10 AM, the Clinical Director reviewed the above patient records and confirmed the consents were signed before the patients were brought back to the pre-operative area. The Clinical Director further stated that when patients arrived at the ASC, the receptionist would have them sign all the forms, including the consent forms. Informed consent was not obtained before the consents were signed.	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. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the ASC failed to ensure medications were administered in accordance with a physician's order for 7 of 21 patients (#1, #2, #3, #7, #10, #13, and #19) who received medication and whose records were reviewed. This resulted in the potential for missed doses and/or incorrect frequency of medication administration. Findings include: 1. Patients who were scheduled for a cataract removal had a form in their record titled "Cataract Nurses Notes." The form included pre-operative, intraoperative, and post operative/recovery drug administration, vitals, and other information. Medication orders with dosages and frequency of administration were pre-printed on the form, and	Q 181	416.48(a) ADMINISTRATION OF DRUGS PLAN OF CORRECTION: Drugs will be prepared and administered per established policy, established standard of care, and only with specific physician orders at all times. IMMEDIATE ACTION: All medications will be ordered by a physician or other qualified member of the medical staff acting within the scope of their practice, prior to the administration in the ASC by the nursing staff. All doctor's orders will be signed prior to administration. SYSTEMIC CHANGES: The clinical staff have been in-serviced on the ASC's policies on: 1) Medication Administration 2) Physician's Orders 3) The Idaho Nurse Practice Act (Attachment C). All medication orders will be signed prior to the administration of the medication. RESPONSIBLE PARTY/MONITORING: The Center Director is responsible for monitoring compliance with medication administration The Center Director or her designee will audit all medical records for documentation of a physician's order and signature prior to administration and the administration of the ordered dosage of all medications for a period of 3 weeks beginning	2/28/2015

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Q 181	Continued From page 16 the nursing staff would circle which drug was given and write in the times of administration. There was space on the form to enter additional medications as well. The section of the form that documented medication administration during the pre-operative phase indicated medications were not administered as ordered as detailed in the following patient examples: a. Patient #19 was a 58 year old male who was admitted on 4/23/14, for the removal of a cataract on his left eye. Tetracaine eye drops were ordered every 5 minutes, times of administration were 9:45 AM and 10:39 AM, (54 minutes between doses). Cyclopentolate 1% eye drops were ordered every 5 minutes times 3 doses, time of administration was 9:40 AM only (1 dose given, not 3 as ordered). Ketorolac X 2, (dose and concentration of drug was not specified). During an interview on 1/22/15 at 10:00 AM, the Clinical Director reviewed Patient #19's record and confirmed the times and frequency of drug administration were not consistent with what was ordered. Additionally, she confirmed that Ketorolac is available in 5% solution, and the nurse who provided pre-operative care for Patient #19 did not write in the dose as it was ordered. She stated the medications used to dilate the eye work differently for each case, and it is the nurses' discretion if more or less of the medication is needed. She stated the preprinted	Q 181	Continued from page 16 2/9/2015. If 100% compliance is achieved, ongoing spot check monitoring shall occur on at least a monthly basis. If 100% compliance is not achieved, re-education shall occur and the monitoring process will start over. The results of all audits will be tabulated and presented to the QAPI Committee on a quarterly basis or review and recommendations. Recommendations will be presented to the Governing Body quarterly for review and approval.	

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Q 181	Continued From page 17 nurses notes are outdated and need to be revised. Patient #19's medications were not administered as ordered. b. Patient #13 was a 66 year old male who was admitted on 5/14/14, for the removal of a cataract on his left eye. Tetracaine eye drops were ordered every 5 minutes, times of administration were 12:32 PM and 2:10 PM, (1 hour and 38 minutes apart). Cyclopentolate 1% eye drops were ordered every 5 minutes times 3 doses, times of administration were 12:31 PM and 12:34 PM, (3 minutes apart, and only 2 doses were administered). Ketorolac X 2, (dose and concentration of drug was not specified). His record included a physician order sheet, and under the section "Postoperative," was a handwritten order for Valium 5 mg. Beside the order was written "Given in pre-op." During an interview on 1/22/15 at 10:05 AM, the Clinical Director reviewed Patient #13's record and confirmed the times and frequency of drug administration were not consistent with what was ordered. Additionally, she confirmed that Ketorolac is available in 5% solution, and the nurse who provided pre-operative care for Patient #13 did not write in the dose as it was ordered. The Clinical Director stated the Valium order was added to the order sheet by the staff at the physician's office during the pre-op appointment. She stated it was written in the wrong section of	Q 181		

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Q 181	Continued From page 18 the form, and should have been included in the pre-operative section of the order sheet. Patient #13's medications were not administered as ordered. c. Patient #10 was a 64 year old female who was admitted on 12/09/14 for a right eye cataract removal and removal of a lesion on her left lower lid. Tetracaine eye drops were ordered every 5 minutes, times of administration were 8:45 AM and 9:25 AM, (40 minutes apart). Formula One eye drops were ordered every 5 minutes times 2 doses, times of administration were 8:55 AM and 9:05 AM, (10 minutes apart). During an interview on 1/22/15 at 10:10 AM, the Clinical Director reviewed Patient #10's record and confirmed the times and frequency of drug administration were not consistent with what was ordered. Patient #10's medications were not administered as ordered. d. Patient #7 was a 79 year old male who was admitted on 12/18/14 for a left eye cataract removal. Marcaine .075% eye drops were ordered every 5 minutes, times of administration were 12:31 PM, 12:50 PM, and 1:28 PM, (19 minutes and 38 minutes apart). Formula One eye drops were ordered every 5 minutes times 3 doses, times of administration	Q 181		

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Q 181	Continued From page 19 were 12:35 PM and 12:54 PM, (only two doses given, and 19 minutes apart). During an interview on 1/22/15 at 10:20 AM, the Clinical Director reviewed Patient #7's record and confirmed the times and frequency of drug administration were not consistent with what was ordered. Patient #7's medications were not administered as ordered. e. Patient #3 was a 91 year old female who was admitted on 1/20/15 for a right eye cataract removal. Tetracaine eye drops were ordered every 5 minutes, times of administration were 8:35 AM and 9:21 AM, (46 minutes apart). Topicamide 1% eye drops were ordered every 5 minutes times 3 doses, times of administration were 9:00 AM, 9:03 AM, and 9:06 AM, (3 minutes apart). Formula One eye drops were ordered every 5 minutes times 2 doses, times of administration were 8:38 AM and 8:51 AM, (13 minutes apart). During an interview on 1/22/15 at 10:25 AM, the Clinical Director reviewed Patient #3's record and confirmed the times and frequency of drug administration were not consistent with what was ordered. Patient #3's medications were not administered as ordered. f. Patient #1 was a 71 year old female admitted	Q 181		

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Q 181	Continued From page 20 on 1/19/15, for cataract surgery of her right eye. Tetracaine 0.5% eye drops times 1 dose was ordered, the times of administration were 7:06 AM and 7:28 AM (2 doses were given). Tropicamide 1% eye drops were ordered every 5 minutes times 3 doses, time of administration was 7:23 AM (2 doses were not given as ordered). Formula One eye drops were ordered every 5 minutes times 3 doses, times of administration were 7:10 AM and 7:17 AM (7 minutes apart, one dose was not given). During an interview on 1/22/15 at 2:15 PM, the Clinical Director reviewed Patient #1's record and confirmed the times and frequency of drug administration were not consistent with what was ordered. She stated the form had been revised and the form in Patient #1's record was the previous version. Patient #1's medications were not administered as ordered. Patients who were admitted for procedures other than cataract removal had pre-printed order sheets and nursing notes in their records. However, the medication orders were written in. The times of administration and dosages were not administered as ordered. 2. Patient #2 was a 65 year old female who was admitted on 12/01/14 for a procedure to remove nodules on her right cornea. Vigamox eye drops were ordered to be	Q 181		

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Q 181	Continued From page 21 administered every 5 minutes for 3 doses, 45 minutes prior to the procedure. The times of administration were 11:30 AM, 12:00 PM, and 12:13 PM, (30 minutes and 13 minutes apart). Tetracaine eye drops were ordered to be administered every 5 minutes for 3 doses, 45 minutes prior to the procedure. The times of administration were 11:35 AM, 12:03 PM, and 12:16 PM, (28 minutes and 13 minutes apart). During an interview on 1/22/15 at 10:30 AM, the Clinical Director reviewed Patient #2's record and confirmed the times and frequency of drug administration were not consistent with what was ordered. Patient #2's medications were not administered as ordered. The ASC did not ensure patient medications were administered as they were ordered by the physician.	Q 181		
Q 220	416.50 NOTICE - POSTING ... 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 patient's representative or surrogate, if applicable. This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the ASC failed to ensure patient rights information was posted. This resulted in the potential for patients and their representatives to not be fully informed of their rights. Findings include:	Q 220	416.50(a)(1) NOTICE OF RIGHTS PLAN OF CORRECTION: The ASC must post the written notice of patient rights in a place or places within the ASC likely to be noticed by patients waiting for treatment. SYSTEMIC CHANGES: A new/updated posting in the lobby regarding patient rights and responsibilities will be posted and will include the Idaho Department of Health complaint office along with the phone number. The posted sign will indicate whom to contact for grievances, notification of physician ownership and rights to receive considerate, respectful, and dignified care.	2/6/2015

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Q 220	Continued From page 22 During a tour of the facility with the Clinical Director on 1/20/15 at 2:00 PM, a notice of patient privacy practices was posted in the waiting room. The patient privacy practices posted, described how medical information about the patient may be used and disclosed. The posting also described how the medical information may be accessed by the patient. There was not a posting in the ASC which included the notice of patient rights. During an interview on 1/22/15 at 3:20 PM, the Clinical Director confirmed the information posted in the waiting room did not include patient rights. She also confirmed patient rights were not posted in the waiting room or another area of the ASC. The Clinical Director stated brochures which include patient rights information, as well as State agency contact information, were available for patients and their family members in the waiting room. The ASC did not post patient rights information in an area where it was noticeable by patients or by the patient's representative.	Q 220	Continued from page 22 RESPONSIBLE PARTY AND MONITORING: The Center Director will be responsible for continual monitoring of the lobby postings to ensure that any updates to the contact information or required content are incorporated. Results of compliance monitoring will be reported reported to the the QAPI Committee with results and recommendations submitted to the Governing Body for review and reporting.	
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 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	Q 221	416.50(a)(1) NOTICE OF RIGHTS PLAN OF CORRECTION: The Center will provide the patient or the patient's representative with verbal and written notice in advance of the day of the procedure, in a language and manner that the patient or the patient's representative understands. SYSTEMIC CHANGES: 1) All patients will be provided with a copy of the right information, entitled: Patient's Rights and Notification of Physician Ownership. All patients will be required to sign and date this document on the last page to indicate that they had received this information, both verbally and in writing.	2/6/2015

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Q 221	Continued From page 23 Medicare Beneficiary Ombudsman. This STANDARD is not met as evidenced by: Based on observation, patient and staff interview, and review of printed patient information forms, it was determined the ASC failed to ensure information related to patient rights was provided to each patient in a language or manner that was understood prior to the surgical procedure. This was directly observed with 2 of 2 patients (#4 and #21), and had the potential for all patients and their representatives to not be fully informed of their rights. Findings include: A trifold information brochure was available in the waiting area of the ASC on a table. It included patient rights and notification of Physician Ownership. The font size on the brochure was very small, and difficult to read. One patient was interviewed on 1/21/15 at 11:45 AM, as she was ready to be discharged from the ASC. She stated she did not receive notice of patient rights. The patient had a folder with patient information. She stated her physician had provided the folder at the pre-operative appointment. The folder included information about the ASC, an appointment sheet, and pre-operative instructions. There was no information regarding patient rights in the folder. The post-operative recovery care RN was interviewed on 1/21/15 at 11:45 AM. She reviewed the patient's folder and confirmed the patient rights information was not there. She brought the patient record, and the patient rights information was in her record. She stated all patients receive the folder of information, including the rights and notification of physician ownership during the pre-operative appointment.	Q 221	2) The Center will ensure that their limited-English proficient (LEP) patients have access to accurate medical translation of information translated in their language. The Center Director will inservice Center staff and the practice office staff regarding policy "Patient Rights and Responsibilities" and "Patient Admission Process." The Center Director will in-service Center staff and the practice office staff regarding policy 1-3 Patient Rights and Responsibilities and Patient Brochure (Attachment B). Nursing staff completing the Pre Procedure assessment will verify that the patient has received the Patient Rights and Responsibilities and that they have no questions regarding them and have reviewed them. RESPONSIBILITY AND MONITORING: The Center Director is responsible for ensuring compliance with the notice and that staff member review patient rights with the patient. It is the responsibility of the Center Director to ensure that their limited-English proficient (LEP) patients have access to accurate medical translation of information translated in their language. The Center Director or designee will review 100% of all medical records for a period of three weeks beginning on 2/9/2015 for complianee with the Notice of Rights notification process. If 100% compliance is not achieved, staff will be re-educated and the monitoring process will start over. The Center Director will report the results of the audits to the QAPI Committee quarterly with results and recommendations submitted to the Governing Body for review and reporting.	

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	13C0001032	A. BUILDING _____ B. WING _____	01/22/2015

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Q 221	Continued From page 24 The day of the procedure the trifold information sheet was signed by the patient and placed in the chart. She confirmed the patient information regarding rights was taken away from the patient. Patient #4 was a 55 year old male admitted to the ASC for Right Eye Pterygium removal (abnormal tissue of the cornea and white part of the eye) with graft. During an observation on 1/21/15 beginning at 11:15 AM, Patient #4 arrived at the ASC with two correctional officers accompanying him. The ASC receptionist started to speak with Patient #4 regarding signing his admission paperwork. She identified at that time he did not speak English, only Spanish. The ASC receptionist confirmed the fact with the correctional officers and asked if they would translate. The officers stated they did not translate for people in custody, it was against regulations. The ASC receptionist stated she would attempt to locate a Spanish speaking translator. Patient #4 was moved to the pre-surgical area while they were waiting for a translator. An individual arrived to translate at 11:35 AM, 20 minutes after Patient #4's arrival. She was identified as an office worker at the office of the physician who was to perform the surgical procedure on Patient #4. The RN who admitted Patient #4 worked with the translator as she spoke to him in Spanish. The translator was used for the surgical informed consent and consent for anesthesia. The translator was noted to not read the surgical or anesthesia consent forms word by word, but translated what was said by the RN regarding the procedure and anesthesia. She was not observed to review the	Q 221		

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Q 221	Continued From page 25 information brochure with Patient #4 regarding patient rights. Patient #4 signed the patient rights brochure and both consent forms. None of the forms that Patient #4 signed were written in Spanish. During an interview on 1/21/15 at 2:30 PM, the Clinical Director confirmed the brochure that included information regarding contacts for filing complaints/grievances, including the ASC, the state website, and state contact were taken away from patients when they signed it and it was placed in their record. She stated the brochures were available in the reception area of the ASC, if patients wanted an additional copy. Additionally, the Clinical Director stated that most non-English speaking patients came with a family member that would translate for them. Although patients received information regarding patient rights, the information was then taken away before the surgical procedure was performed. Additionally, non-English speaking patients were not provided with clear and accurate information in a manner they understood.	Q 221		
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, observation, policy review, and staff interview, it was determined the ASC failed to ensure that patients were fully	Q 229		

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Q 229	Continued From page 26 informed about procedures and the expected outcomes before it was performed for 2 of 20 patients (#4 and #9) whose records were reviewed. This resulted in the potential lack of information being provided to a patient on which to based informed consent decisions. Findings include: A policy "Interpreter Services" approved 7/12, stated "Language needs are determined for each patient prior to the patient's arrival at the surgery center. Such information may be obtained from the physician's office at the time of scheduling." If unable to determine language needs prior to arrival, the following information is obtained upon admission: - Information regarding the availability of interpreter services is included in the Patient Rights brochure - The patient is asked what language he/she speaks at home. If other than English, it is determined in what language the patient prefers to receive communication. - Information regarding the patient's primary language is recorded in the patient's medical record. The policy also stated,"The patient is offered the provision of interpreter services at no charge to the patient. Center staff who are fluent in the patient's language may also provide interpreter service if requested by the patient. A notation is made in the medical record that the patient has declined the offer of interpreter services and prefers to use a staff member (name is recorded)."	Q 229	416.50(a)(1) EXERCISE OF RIGHTS - INFORMED CONSENT PLAN OF CORRECTION: The patient has the right to be fully informed about a treatment or procedure and the expected outcome before it is performed. SYSTEMIC CHANGES: 1) The Center will ensure that documentation is complete and accurate on all charts prior to the procedure. There will be properly executed patient informed consent on all charts prior to the procedure. Patient's rights will be honored as directed by the patient during the informed consent process. Patients will be informed of the alternatives to the procedure and or the risks and benefits of treatment alternatives verbally by their physician. This exchange will be documented on the "Patient Consent to Medical Treatment or Surgical Procedure and Acknowledgement of Receipt of Medical Information" form. 2) The Center will ensure that their limited-English proficient (LEP) patients have access to accurate medical translation of information translated in their language. The Center Director will inservice Center staff and the practice office staff regarding policy "Patient Rights and Responsibilities" and "Patient Admission Process." The documentation policy "Consent Informed" will be reviewed with all staff members and physicians. (Attachment D) RESPONSIBILITY AND MONITORING: The Center Director is responsible for ensuring compliance with the informed consent policy. It is the responsibility of the Center Director to ensure that their limited-English proficient (LEP) patients have access to accurate medical translation of information translated in their language. The Center Director or designee will review 100% of all medical records for a period of three weeks beginning on 2/9/2015 for compliance with the informed consent policy. If 100% compliance is not achieved, staff and physicians will be re-educated and the monitoring	2/28/2015

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Q 229	Continued From page 27 1. According to the U.S. Department of Health and Human Services website, accessed 1/23/15, 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 #4 was a 55 year old male admitted to the ASC on 1/22/15, for Pterygium removal (abnormal tissue of the cornea and white part of the eye) with graft of the right eye. During an observation on 1/21/15 beginning at 11:15 AM, Patient #4 arrived at the ASC with two correctional officers accompanying him. The ASC receptionist was speaking with Patient #4 regarding signing his admission paperwork. She identified at that time he did not speak English, only Spanish. The ASC receptionist confirmed the fact with the correctional officers and asked if they would translate. The officers stated they did not translate for people in custody, it was against regulations. The ASC receptionist stated she would attempt locating a Spanish speaking translator for Patient #4, at a physician's office located near the ASC, by making a phone call. Patient #4 was moved to the pre-surgical area while they were waiting for a translator. The translator arrived at 11:35 AM, 20 minutes after Patient #4's arrival, and was asked by the RN to translate in Spanish. The translator was used for the surgical informed consent and consent for anesthesia. The consents for the procedure and anesthesia were written in English.	Q 229	Continued from page 27 process will start over. The Center Director will report the results to the QAPI Committee quarterly with results and recommendations submitted to the Governing Body for review and reporting.	

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Q 229	Continued From page 28 She did not read the surgical or anesthesia consent forms word by word, but translated what was said by the RN regarding the procedure and anesthesia. Patient #4 signed both consent forms. Neither form indicated a translator was used. The CRNA and physician arrived at Patient #4's bedside at 12:15 PM. The CRNA did not speak with Patient #4 about the anesthesia being used for the procedure prior to him signing the consent form. During an interview on 1/21/15 at 11:45 AM, the translator stated she worked in the office of the physician who performed the eye surgery on Patient #4. She confirmed she assisted with translating for the ASC on occasion, but it was not something she did regularly. During an interview on 1/22/15 at 3:05 PM, the Clinical Director reviewed the record and confirmed that a translator was used for Patient #4. She further confirmed the consent forms, for both the surgery and anesthesia, were in English and stated they did not have forms available in Spanish. The Clinical Director also stated it was not indicated on Patient #4's consent forms a translator was used. She also confirmed the anesthesia consent was signed prior to the CRNA speaking with Patient #4. The Clinical Director stated it was their practice for the anesthesia consent to be signed by patients upon arrival to the ASC, prior to discussing anesthesia with the CRNA. The ASC failed to document Patient #4 was fully informed of the surgical procedure and anesthesia.	Q 229		

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Q 229	Continued From page 29 2. Patient #9 was an 81 year old female admitted to the ASC on 12/04/14, for repair of left eyelid defect. Patient #9's record included a consent for anesthesia. She signed the consent at 2:50 PM on 12/04/14. The CRNA documented on the anesthesia record that anesthesia started at 4:51 PM on 12/04/14. The anesthesia consent form was not signed, timed, or dated by the CRNA performing the anesthesia. There was no documentation Patient #9 was informed of the risks and benefits of the anesthesia that was used for her surgery, prior to receiving anesthesia. During an interview on 1/22/15 at 2:35 PM, the Clinical Director reviewed the record and confirmed the anesthesia consent form was not signed by the CRNA. She confirmed the forms were to be signed by the CRNA performing the anesthesia. The ASC failed to ensure Patient #9 was fully informed of anesthesia that was used for her procedure.	Q 229		